FY 2019

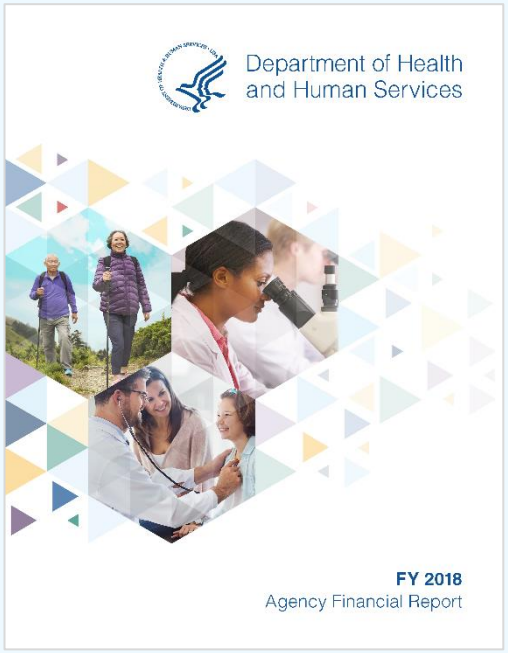
AGENCY FINANCIAL REPORT

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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 6 consecutive years HHS has been recognized by the Association of Government Accountants' (AGA) Certificate of Excellence in Accountability Reporting (CEAR) Program for the merit of its Agency Financial Report. The CEAR Program was established in collaboration with the Chief Financial Officers Council and Office of Management and Budget to further performance and accountability reporting. Through the program, agencies improve accountability by streamlining reporting and enhancing the effectiveness of reports to clearly display what an agency accomplished and the challenges that remain.

The CEAR Program also recognizes agencies as Best-In-Class for notable or creative reporting practices that pique the public's interest. In May 2019, AGA presented HHS with a Best-In-Class Award for our Fiscal Year 2018 Agency Head Message.



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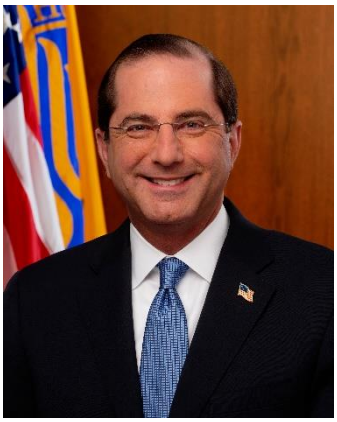
Message from the Secretary



Alex M. Azar II

I am pleased to present the Fiscal Year (FY) 2019 Agency Financial Report for the United States Department of Health and Human Services (HHS). This report contains our financial and performance highlights for the FY ended September 30, 2019.

Each day, the men and women of HHS proudly execute our mission to enhance and protect the health and well-being of all Americans. Through more than 300 programs across our Operating Divisions, HHS facilitates effective health care and human services and fosters advances in science and public health. With such a vital mission, it is important to work toward a clearly established vision: a future state where our health care, public health, human services, and science programs work better for the Americans we serve. We identified three particular pillars to support our efforts: facilitating patient-centered markets in health care, protecting life and lives, and promoting independence for all Americans.

These pillars help us execute the Department's five strategic goals, represented in our 2018 – 2022 Strategic Plan. This year's accomplishments and priorities, highlighted here and explored further in the "Management's Discussion and Analysis" section of this report, fit within those pillars.

Facilitating Patient-centered Markets in Health Care

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

In 2019, HHS took significant steps to deliver the kind of health care system this Administration has envisioned: a personalized, patient-centric, affordable system that puts you, the patient, in control and treats you like a person, not a number. To deliver on this vision, the Department aims to facilitate patient-centered health care markets.

Work on this front included the proposal of an interoperability rule to give patients secure access to their electronic health information at no cost. In addition, the Department took steps toward providing patients with clear, accessible information about the price of their care, and requiring hospitals to make their real prices known to patients. Moreover, HHS made progress toward increasing competition and strengthening negotiations in prescription drug markets, leading to a projected drop in Medicare Part D average basic premiums for the third straight year.

The Centers for Medicare & Medicaid Services also launched an initiative called Primary Cares, which will transform payment models for primary care providers that serve millions of Medicare patients and free the providers to spend more time with their patients. These efforts will lead to lower costs for both patients as well as the federal health care programs, allowing us to better steward taxpayers' resources.

Protecting Life and Lives

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

In 2019, the Department made significant strides on key health challenges affecting the lives of many Americans. The Administration's continued focus on combating America's crisis of opioid addiction and overdose through its 5-Point Opioid Strategy is beginning to show results. Provisional counts of drug overdose deaths showed a decline from 2017 to 2018, the first decline in more than two decades.

HHS has also been raising the alarm and educating the medical and educational communities about increasing tobacco use among youth, driven mainly by e-cigarettes. The Youth Tobacco Prevention Plan is a series of actions to stop youth use of tobacco products, especially e-cigarettes, with special focus on three key areas: preventing youth access to tobacco products; curbing marketing of tobacco products aimed at youth; and educating teens about the dangers of using any tobacco product, including e-cigarettes, as well as educating retailers about their key role in protecting youth. The Administration is making it clear that we will not stand idly by as these products become an on-ramp to combustible cigarettes or nicotine addiction for a generation of youth. Similarly, we are warning of the serious dangers the increasing use of marijuana poses for pregnant women and youth. The Surgeon General's advisory cautions the nation about marijuana's dangerous effects, and our targeted communications campaign is ensuring communities have accurate information about marijuana's risks.

Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences
This is an exciting time for biomedical innovation, and HHS is striving to foster medical advancement through our health policies and direct support of biomedical research. Innovation is keenly needed in the area of kidney care. A new HHS initiative, Advancing Kidney Health in America, aims to improve the quality of life and spur innovation to create alternative options available to kidney patients. In FY 2019, HHS awarded multiple winners in the ongoing KidneyX Redesign Dialysis prize competition to accelerate the development of innovative medical products and approaches that can significantly improve how we prevent, diagnose, and treat kidney diseases.

Promoting Independence for All Americans

Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan
The HHS mission goes well beyond supporting Americans' health. Our programs also protect the economic and social well-being of Americans throughout life's duration.

We play a vital role in providing human services to those who are especially vulnerable. In 2019, HHS dealt with significant pressure on its program to care for unaccompanied alien children who arrive at the southern border. By the end of FY 2019, we will have cared for the largest number of unaccompanied children in the program's history. Delivering this care effectively required closely coordinated logistical and financial management, and, with help from Congress, we are now more ready than ever to handle future surges. In partnership with our grantees, we can provide food, shelter, medical services, and education to unaccompanied children, while working to place those children with a safe sponsor as soon as possible.

HHS has taken deliberate steps to protect Americans' fundamental rights, as well. HHS is committed to promoting the rights of conscience and religious liberty in healthcare and human services. The Department issued a new conscience rule, which will help protect individuals' and health care entities' rights of conscience in HHS-funded programs.

Stewardship

Strategic Goal 5: Promote Effective and Efficient Management and Stewardship
HHS is dedicated to ensuring taxpayer resources are spent on effective programs that deliver results efficiently. As the single largest cabinet agency by spending, representing more than one-third of the total federal budget, HHS maintained its reputation for excellence in budgetary management and enhanced its financial practices.

HHS is committed to sound stewardship and ensuring the transparency and accountability of the resources Congress and the taxpayers entrust to us. For the 21st 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 changes in law that would impact underlying assumptions of financial projections.

These statements were developed based upon current law using information from the 2019 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 also evaluated our internal control and financial management systems, as required by the *Federal Managers' Financial Integrity Act of 1982* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. We identified material noncompliances with: the *Improper Payments Information Act* (IPIA), with two instances related to Error Rate Measurement; the *Social Security Act* related to the Medicare appeals process; and the Federal Acquisition Regulation related to contracting for services. 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

Though we are proud of our accomplishments in 2019, there are always opportunities for improvement. We worked closely with the Office of Inspector General to gain its perspective about our most significant management and performance challenges, which are presented in the "Other Information" section under *FY 2019 Top Management and Performance Challenges Identified by the Office of Inspector General*. We are committed to addressing these challenges, including delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity.

Conclusion

Everyone at HHS is proud to serve our fellow Americans. From articulating a strategic vision and executing on that vision through our programs, to reviewing our performance and financial management each year, each HHS employee's work is essential to our mission of improving the health and well-being of every American.

This report is a clear statement of the progress we have made and the opportunities we have to improve our programs to work better for the people we serve. Each year brings new challenges, but I am confident that the men and women of HHS will continue to meet them in the coming years.

/Alex M. Azar II/

Alex M. Azar II
Secretary
November 13, 2019

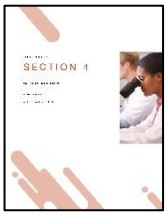
About the Agency Financial Report

The HHS FY 2019 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, 2018, through September 30, 2019. 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 supplemental 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 financial information and real property footprint data. It also includes a summary of the financial statement audit and management assurances, civil monetary penalties, and a detailed payment integrity report. It concludes with the Inspector General's assessment of the Department's management and performance challenges.



Appendices
This section includes information that supports the sections of the AFR. This includes a glossary of acronyms used throughout the report and 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 *President's Budget* in February 2020 include:

1. FY 2021 *Annual Performance Plan and Report*
2. FY 2021 *Congressional Budget Justification*

MANAGEMENT'S
DISCUSSION & ANALYSIS

SECTION 1

IN THIS SECTION

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// Systems, Legal Compliance, and Internal Control

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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 programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life.

HHS is responsible for more than 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 state, local, tribal governments, state or county agencies, private sector grantees, tribes, tribal organizations, and Urban Indian organizations that provide many HHS-funded services at the local level. The HHS Office of the Secretary and the 11 Operating Divisions (OpDivs), including 8 Public Health Service and 3 human service agencies of HHS administer more than 300 programs covering a wide spectrum of activities. 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. In addition, Staff Divisions (StaffDivs) provide leadership, direction, and policy guidance to the Department.

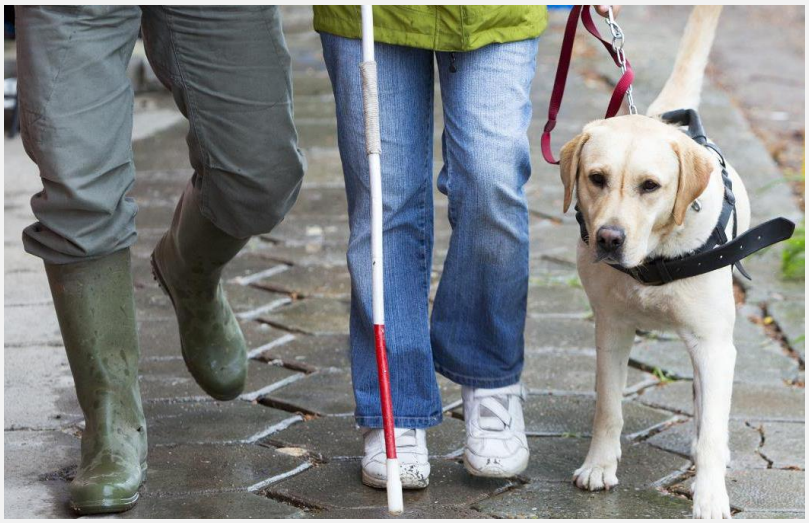
Did you know?

Between February 2014 and November 2016, the Food and Drug Administration's (FDA) award-winning "The Real Cost" campaign prevented up to 587,000 youths ages 11-19 from trying cigarettes. This smoking prevention campaign educates more than 10 million at-risk youth in the U.S. about the harmful effects tobacco. FDA's Youth Tobacco Prevention Plan will expand "The Real Cost" campaign to help teens understand the risks of e-cigarettes. To learn more about the real cost of tobacco, smoking, and vaping, visit TheRealCost.BeTobaccoFree.hhs.gov.

HHS, through its programs and partnerships:

- 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.

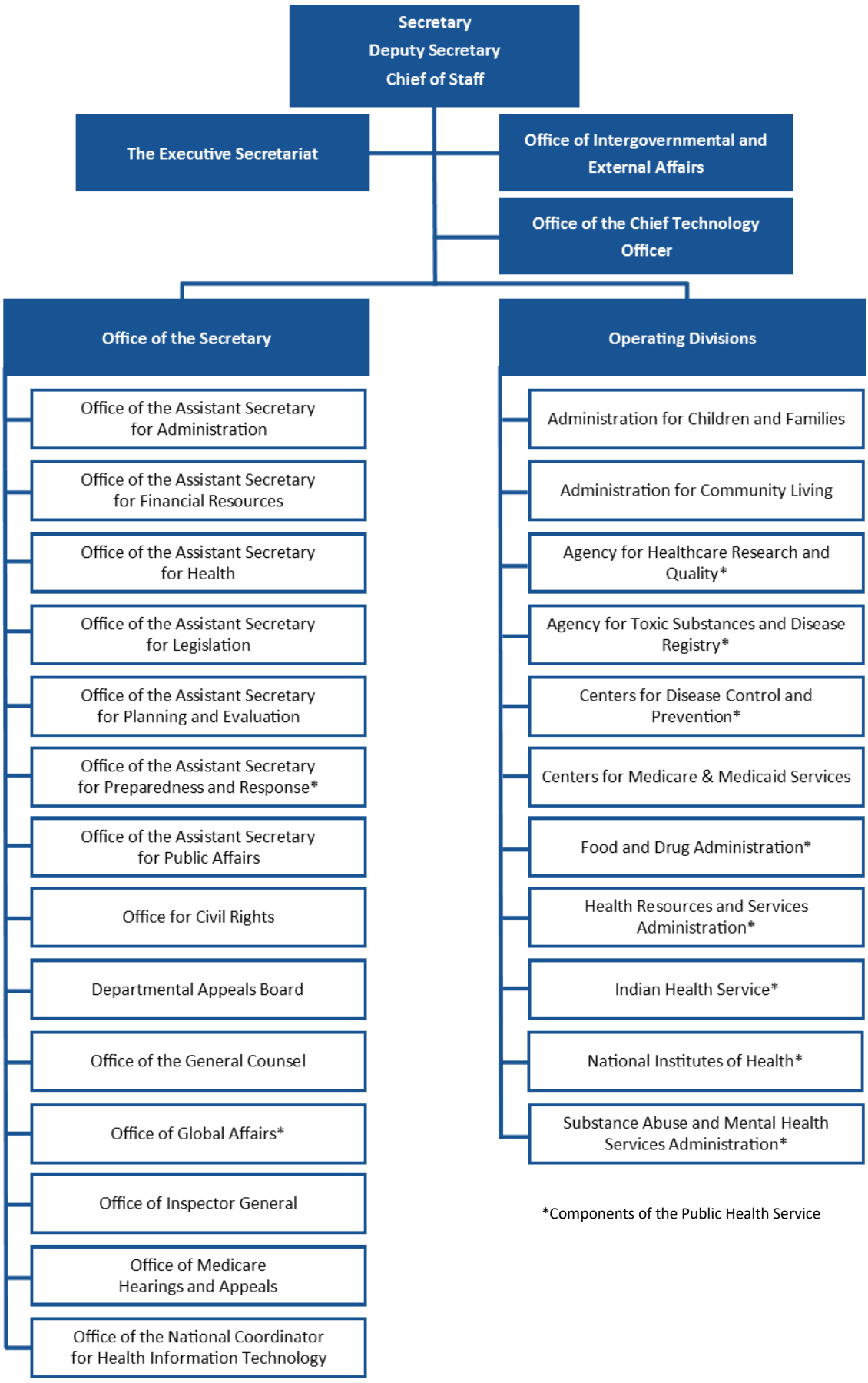
Did you know?



Serious difficulty seeing is the fifth most common form of disability among adults with disabilities in the U.S. The Centers for Disease Control and Prevention supports 19 state disability and health programs and 2 National Centers on Health Promotion for People with Disabilities, all of which promote healthy lifestyles and improving quality of life for people with disabilities. To learn more, visit Centers for Disease Control and Prevention.gov.

Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework for sound business operations and management controls. The Office of the Secretary, with the Secretary, provides the overarching vision and strategic direction for the Department, and leads HHS and its OpDivs to provide a wide range of services and benefits to the American people. The HHS organizational chart is presented on the next page. For additional information, refer to the HHS website.



*Components of the Public Health Service

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?

Medicare is composed of different parts that cover specific services.

Medicare Part A (Hospital Insurance)
Part A covers inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Medicare Part B (Medical Insurance)
Part B covers doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a premium for Part B.

Medicare Fee-for-Service
Often referred to as the "Original Medicare," Medicare Fee-for-Service (FFS) is a federal health insurance program that provides Medicare Part A and Medicare Part B to eligible citizens.

Medicare Part C (Medicare Advantage)
Medicare pays a fixed amount to approved private companies to offer Part C Medicare Advantage Plans. Part C provides the same coverage benefits as Part A and Part B, and may offer Part D coverage or other extra coverage options (e.g., vision, hearing, dental and/or health and wellness programs). Private Medicare Advantage companies must follow requirements set by Medicare; however, Part C plans can have varying amounts of out-of-pocket costs or qualification rules based on the coverage provider.

Medicare Part D (Prescription Drug Coverage)
Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a prescription drug plan approved by Medicare. Most people pay a monthly premium for Part D.

Visit Medicare.gov to find more information.

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, 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 flag providers with a record of 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 573 federally recognized tribes in 37 states. Visit IHS for more information.

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 oversees the Secretary's operations and coordinates the Secretary's work.

- The Executive Secretariat (ES)
ES 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.

- Office of Intergovernmental and External Affairs (IEA)
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 Chief Technology Officer (CTO)
CTO harnesses the power of data, technology, and innovation to create a more modern and effective government that works to improve the health of our nation.

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. It 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 the development of 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 (APGs), the President's Management Agenda (PMA), and the government-wide Cross-Agency Priority (CAP) Goals.

Within HHS, Strategic Planning, Enterprise Risk Management, Performance Management, and Evaluations work closely together to strategically manage their overlapping activities and deliverables. Figure 1 below illustrates HHS's approach to strategic management, which works to integrate planning, performance, enterprise risk management, and evaluation processes to support HHS programs. The following pages provide more information about the HHS strategic goals and objectives for FY 2018—2022.

Figure 1: Strategic Management at HHS

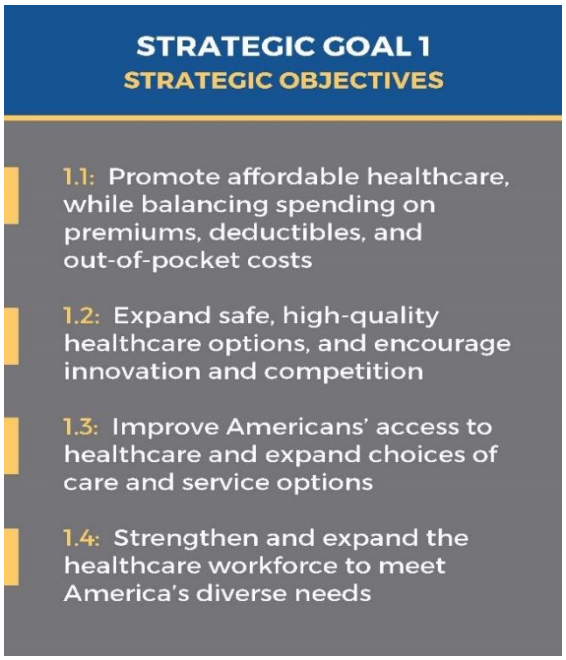
Strategic Goals

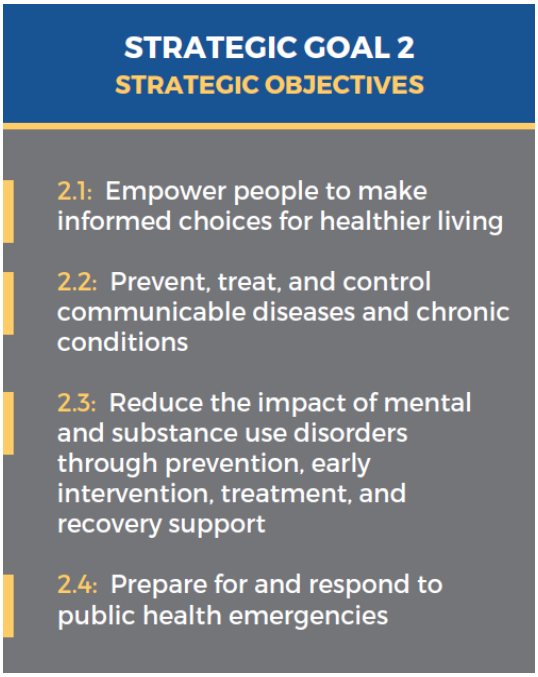
The HHS Strategic Plan FY 2018–2022 is comprised of five strategic goals, representing input from all HHS OpDivs and StaffDivs, as well as over 13,000 public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The Department's five strategic goals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





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.

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. HHS focuses on fostering environments where individuals and families can be socially and economically independent.

STRATEGIC GOAL 3
STRATEGIC OBJECTIVES

- 3.1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity
- 3.2: Safeguard the public against preventable injuries and violence or their results
- 3.3: Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives
- 3.4: Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

STRATEGIC GOAL 4
STRATEGIC OBJECTIVES

- 4.1: Improve surveillance, epidemiology, and laboratory services
- 4.2: Expand the capacity of the scientific workforce and infrastructure to support innovative research
- 4.3: Advance basic science knowledge and conduct applied prevention and treatment research to improve health and development
- 4.4: Leverage translational research, dissemination and implementation science, and evaluation investments to support adoption of evidence-informed practices

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.

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 more than 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 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.

Agency Priority Goals

APGs are a set of ambitious but realistic performance objectives that the Department expects to achieve within a 24-month period. 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 FY 2018 – 2019 APGs are:

- Increase capacity to prevent health threats originating abroad from impacting the United States;
- Reduce opioid-related morbidity and mortality;
- Increase combined data analysis of disparate datasets in order to achieve better insights; and
- Improve treatment for individuals with Serious Mental Illness.

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 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 HHS OpDiv/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.

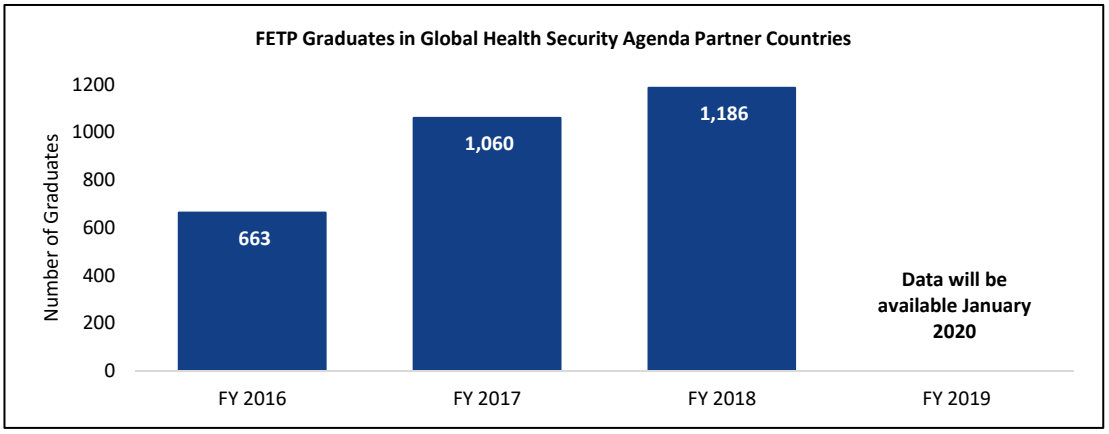
Each agency within HHS is responsible for certifying that these data undergo a thorough quality assurance process and provides to the Performance Improvement Officer a signed letter of attestation. Data quality information for the APG-related measures mentioned below can be found online at Performance.gov. 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

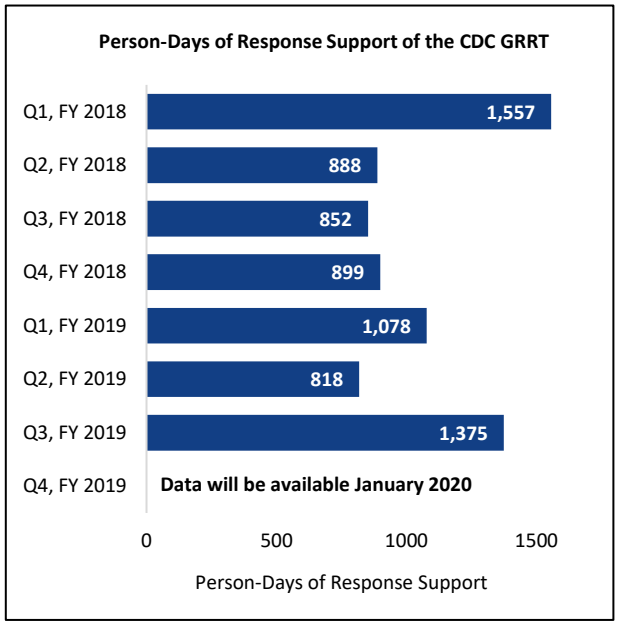
In FY 2019, HHS monitored over 900 performance measures to manage departmental programs and activities, and to improve the efficiency and effectiveness of these programs. For this report, HHS chose to highlight the achievements in three APGs: Health Security, Reducing Opioid Morbidity and Mortality, and Serious Mental Illness. For more detailed information on HHS's APG accomplishments, refer to the HHS page on Performance.gov.

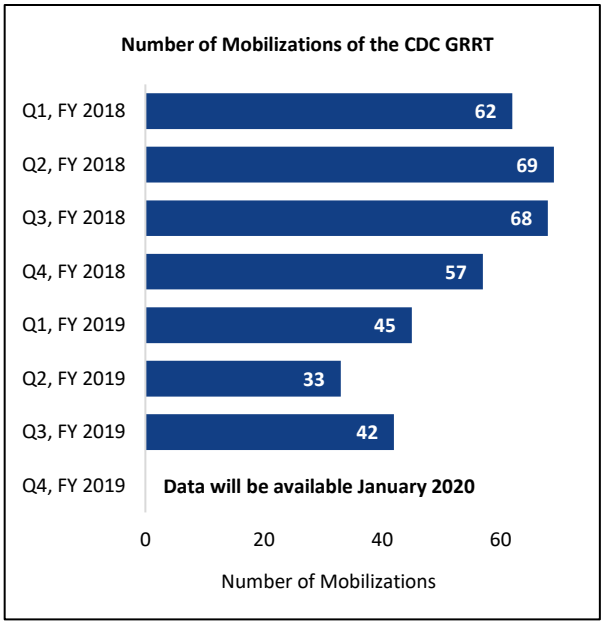
Health Security. Infectious diseases originating abroad can quickly and unpredictably spread to the U.S. HHS works with partner countries to improve their capacities to prevent, detect, and respond to health threats at their points of origin. For this APG, HHS has focused on building capacity in 17 partner countries. HHS's International Field Epidemiology Training Programs (FETP), are a key resource for strengthening countries' capacities for surveillance, epidemiology, and outbreak response. HHS has implemented FETP in over 70 countries, which include the 17 partner countries identified for the Health Security APG.

FETP programs provide on-the-job training to build critical skills for effectively conducting infectious disease surveillance at the local level. Graduates are trained disease detectives with the skills to collect, analyze, and quickly interpret disease information to save lives. FETP graduates assist their countries in transitioning from U.S.-led global health investments to long-term host country ownership of the methods for detection and prevention.



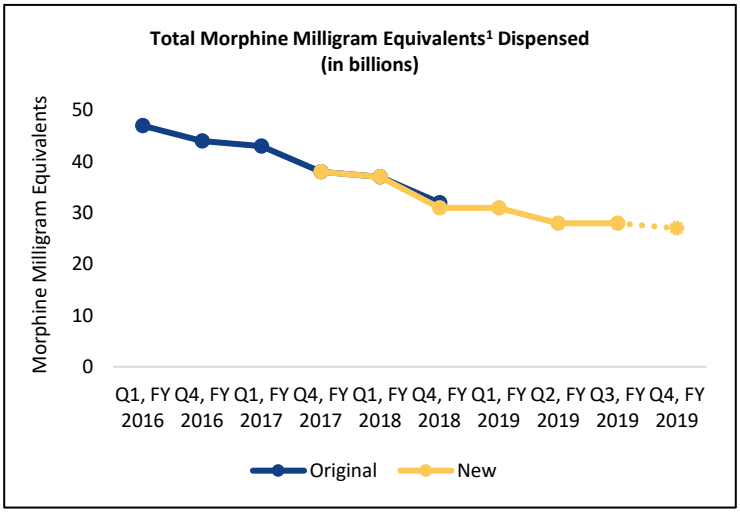
HHS maintains the capability to rapidly provide personnel and operational resources for health threats in its partner countries. For example, HHS's Global Rapid Response Team (GRRT) is a highly trained workforce ready to deploy on short notice anywhere in the world. GRRT provides emergency response staff, and employs and deploys field-based leaders, scientific experts, and support for response management and operations. The data presented capture the impact of U.S.-supported activities. HHS will report how much progress each partner country made from FY 2018—2019 on Performance.gov.





Reducing Opioid Morbidity and Mortality. Opioid misuse and overdose present a nationwide public health challenge. Death by drug overdose is the leading cause of injury death in the U.S. Overdose deaths involving heroin have increased significantly in recent years. There were 6.5 times more heroin overdose deaths in 2017 than in 2007. The surge of fentanyl use has been the main driver in increasing synthetic opioid deaths. 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. Target the availability and distribution of overdose-reversing drugs;
3. Strengthen public health data and reporting;
4. Support cutting-edge research; and
5. Advance the practice of pain management.

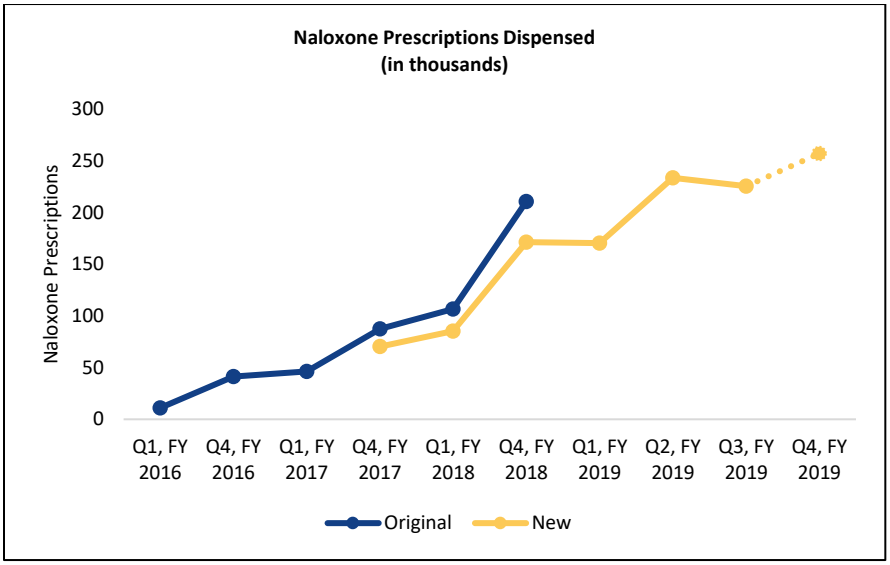


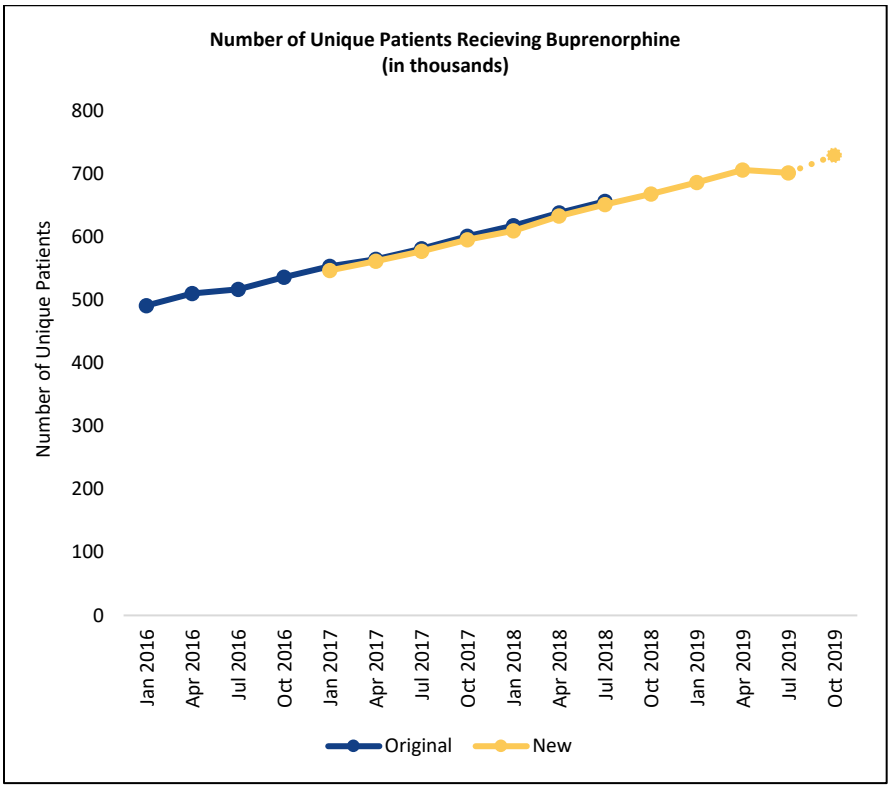
[1] Morphine Milligram Equivalents is a standardized unit of the amount of opioid prescribed that allows HHS to combine opioids of varying potencies and dosages into one composite measure.

HHS has continued to monitor progress on the implementation of this 5-Point Strategy through a variety of reporting tools, which include the HHS Reducing Opioid Morbidity and Mortality APG. This APG reports multiple key indicators; HHS provides three in this report – decrease the Morphine Milligram Equivalents dispensed,

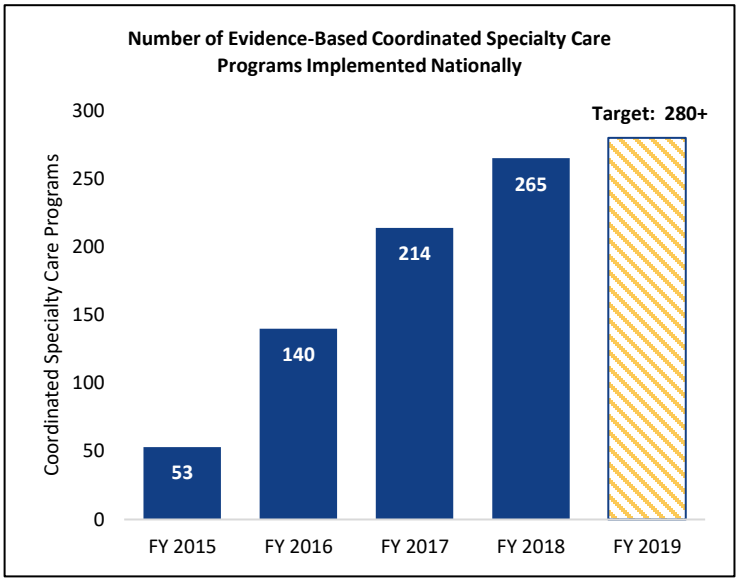
increase naloxone access, and increase the number of unique patients receiving buprenorphine prescriptions. Please refer to Performance.gov for information on the remaining key indicators and other report updates.

In FY 2019, HHS began reporting data that exclude voided or reversed prescriptions. This change caused a break in the trend lines between FY 2018 and FY 2019. HHS revised the targets for these measures to reflect the baseline of the new dataset. HHS increased the target for Naloxone Prescriptions Dispensed based on linear projections for FY 2017—2018 data. The new target is a 150 percent increase in prescriptions in FY 2019. A dotted line in the charts indicates targets for FY 2019. FY 2019 end-of-year results will be available by December 2019.





Serious Mental Illness. Approximately 114,000 youth and young adults experience a first episode of psychosis (FEP) every year, with life-altering disruptions in school, work, and social adjustment. Typically, treatment for FEP is delayed 1 to 3 years after symptoms appear, and treatment is often fragmented and ineffective. Without timely and effective care, symptoms and functional impairments typically worsen, and individuals are at high risk for suicide, substance misuse, school dropout/unemployment, criminal justice involvement, and involuntary hospitalization. Most communities lack the infrastructure and programming to address this critical period. Coordinated Specialty Care is an evidence-based practice that uses an interdisciplinary team approach to provide personalized care to individuals with FEP. A required 10 percent early intervention set-aside within the SAMHSA Mental Health Block Grant (MHBG) provides a platform for states to build Coordinated Specialty Care programs.[1] FY 2019 data for this measure will be available in March 2020.



Did you know?

One in five people in the U.S. have a mental health condition. Mental health challenges are not always obvious. To learn more about signs and symptoms of mental health conditions, visit the National Institute of Mental Health website. For general information on mental health and to locate local treatment services, visit the Substance Abuse and Mental Health Services Administration website.

[1] Each state that receives a SAMHSA MHBG must use 10 percent of that grant to support evidence-based programs that provide treatment for those with FEP.

Looking Ahead to 2020

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 2020 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

Drug Pricing: HHS will continue its efforts to lower the list prices of prescription drugs through competition, negotiation, 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 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 focus on improving and developing price and quality transparency initiatives to ensure that healthcare patients can make well-informed decisions about their care.

The Healthcare Workforce and Infrastructure: HHS will 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.

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 choices. We will address the value of health care services by moving from a system where payments are made based on the volume of services provided 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

Kidney Health: HHS aims to reduce morbidity and mortality associated with end-stage renal disease and to increase 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.

Maternal Health: To improve maternal health outcomes, HHS is developing strategies for women to attain and maintain healthy outcomes throughout the life course, an approach to conceptualizing health care needs and services; 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 aims to improve the quality of maternal health

data and bolster research efforts to better understand risk factors while continuing to identify effective, evidence-based, best practices in maternal health.

The Opioid Crisis: HHS will continue to empower states and local communities on the frontlines of the opioid crisis by implementing its 5-Point Strategy. We will advance efforts to increase access to treatment by (1) addressing workforce shortages and treatment coverage, including medication-assisted treatment; (2) increase the timeliness and accuracy of data to monitor opioid use, misuse, and overdose; (3) improve pain management with a focus on increasing the availability of effective non-opioid alternatives; (4) better target the availability of overdose-reversing drugs; and (5) support cutting edge research on pain and addiction. HHS will add to this focus efforts to address the increasing number psychostimulant-involved overdose deaths—sometimes referred to as the "fourth wave" of the opioid crisis.

Rural Health: HHS will continue to improve access to, and the 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.

Suicide Prevention: HHS will increase its emphasis on and direct greater resources toward suicide prevention. Suicides rose nearly 30 percent between 1999-2016 and have increased in 49 of the 50 states with 25 states experiencing increases over 30 percent. With the rising number of suicides among adults, particularly middle-aged and older adults, focusing on preventing suicide among adults is urgently required to reduce suicide nationally.

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

Dependence to Independence: To build self-sufficiency and move families from dependence to independence, HHS will strive to fully engage all Americans and move them from the economic sidelines into the workforce. We will launch the U.S. Interagency Council on Economic Mobility to streamline and coordinate federal programs and policy designed to promote work and economic mobility across the lifespan.

Child Welfare and Adoption: HHS will work to increase child and family well-being by putting greater emphasis on preventing child maltreatment. We will continue to look at increasing adoptions, an underutilized option in the U.S., for teens and women facing a crisis pregnancy, and to achieve permanency for children in the child welfare system, especially older children.

Did you know?

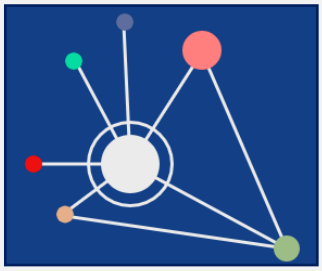
There are more than 100,000 children and teens in foster care awaiting the love and security of a permanent home. Adoption from foster care is a great way to help a child while growing your family. To learn more about foster care, visit the Administration for Children and Families website.

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 are beginning to implement the *Foundations for Evidence-Based Policymaking Act of 2018* which will create a new paradigm for developing and using evidence for decision-making. Efforts across HHS continue 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.

Did you know?

The HHS Office of the Chief Technology Officer and the Chief Data Officer have been co-hosting a series of Roundtables to identify ways to improve the use and sharing of health data to achieve the HHS mission. These Roundtables discuss opportunities and strategies for sharing and utilizing health data for artificial intelligence to improve health care. To learn more about the HHS data initiative, visit the HHS website.



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

Enterprise Risk Management: Federal agencies are charged with implementing an enterprise risk management approach to address significant risks, improve mission delivery, and prioritize corrective actions. Enterprise risk management is a strategic discipline that seeks to proactively and deliberatively address the full spectrum of an organization's risks. HHS uses a framework that outlines building blocks being used to develop and implement a successful enterprise risk management discipline within the Department. Making enterprise risk management part of how the Department functions improves HHS's ability to deliver on our mission of enhancing and protecting the health and well-being of all Americans.

HHS ACCELERATE: Initially part of *ReImagine HHS*, the HHS ACELERATE program was developed to help address acquisition challenges across the Department, and enable HHS to effectively extract value from its $24 billion spend and vast amount of behavioral and transactional data related to acquisition.

ACCELERATE is a transformative program that revamps the ways HHS acquires goods and services, conducts its acquisition operations and invests in acquisition support technology. It uses a combination of emerging technologies, including blockchain, artificial intelligence, and robotic process automation, to create and extract value from a standardized acquisition data layer. This is a first of a kind solution in government and enables acquisition savings, workforce savings through measurable process improvement such as reduced time to award, and IT investment savings. This system will revolutionize the acquisition lifecycle for all stakeholders.

Systems, Legal Compliance, and Internal Control

Systems

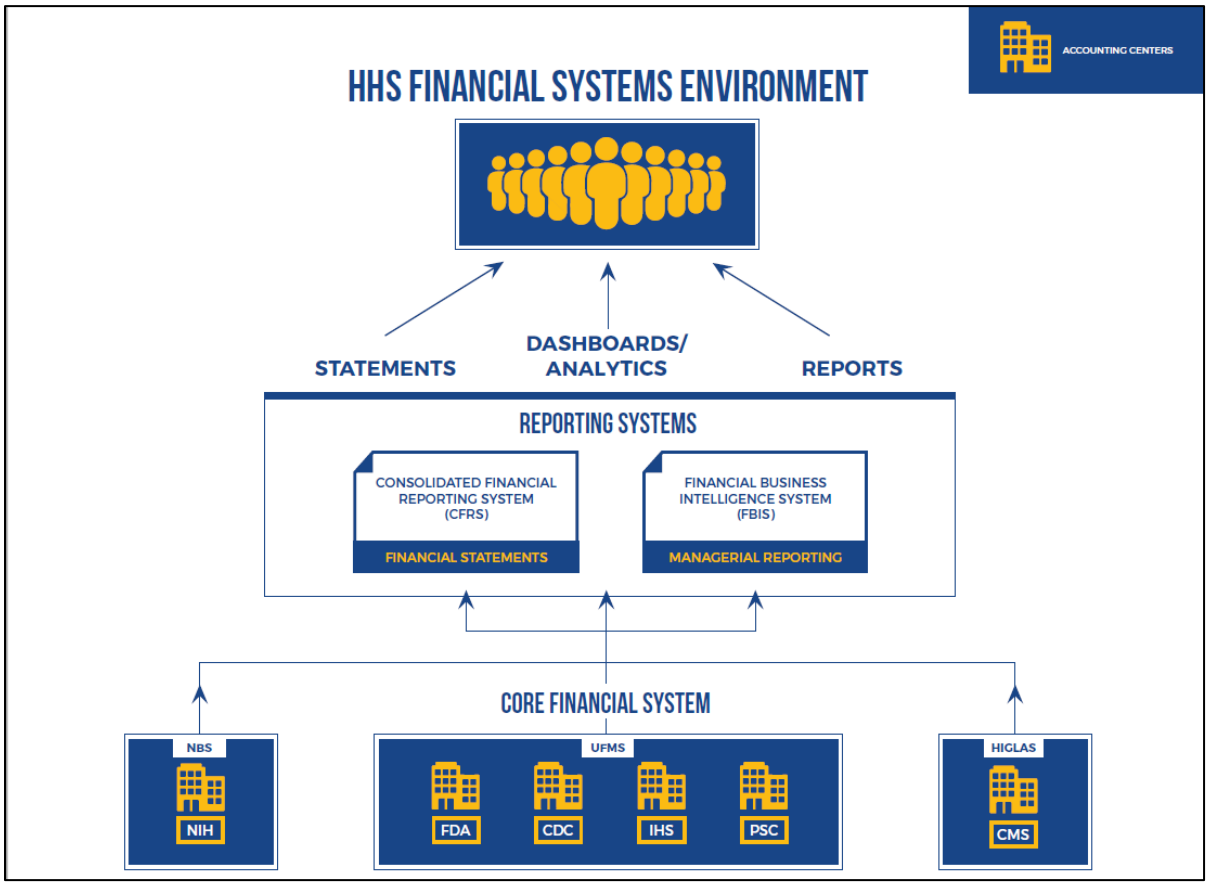
HHS's Chief Financial Officer (CFO) community continuously strives to enhance the financial management systems environment to sustain HHS's diverse portfolio of mission-oriented programs and business operations. The purpose of the financial management systems environment is to: (1) efficiently process 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 robust financial systems framework at HHS forms the financial and accounting foundation for managing the approximately $1.9 trillion in budgetary resources entrusted to the Department in FY 2019.

Outlined in detail in the figure and tables that follow, the HHS financial management systems environment consists of a core financial system (with three instances, or components) and two Department-wide reporting systems used for financial and managerial reporting. Together, these systems support the Department's financial accounting and reporting needs.

Figure 3 graphically depicts the current financial management systems environment.

Figure 3: HHS Financial Management Systems Environment



Core Financial System

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

Three Instances of the Core Financial System

Instance	Description
Healthcare Integrated General Ledger Accounting System (HIGLAS)	HIGLAS supports four lines of CMS business, which include the Medicare FFS, Medicare Secondary Payer, Federal Facilitated Marketplace, and the Administrative Program Accounting activities. It processes an average of five million transactions daily.
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 supports grant funding to 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 (i.e., mixed business systems) to create a secure, reliable, and highly available financial management environment supporting the following Accounting Centers: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for all other OpDivs (except CMS, NIH, and the other three UFMS Accounting Centers) and all StaffDivs.

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

System	Description
Consolidated Financial Reporting System (CFRS)	CFRS systematically consolidates information from all three instances of the core financial system. It generates 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 at all levels by retrieving, combining, and consolidating data from the core financial system. It provides tools for analyzing data and presenting actionable information, including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting. FBIS enables executives, managers, and operational end users to make informed business decisions to support their organization's mission.

Relevant Legislation and Guidance

The HHS financial management systems environment must comply with all relevant 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*
- Office of Management and Budget (OMB) directives and U.S. Department of the Treasury (Treasury) guidance related to these laws

Financial Systems Environment Improvement Strategy

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The portfolio of projects within these programs addresses immediate business needs and positions the Department to take advantage of state-of-the-art tools and technology. The goals of the strategy 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. This is a multi-year initiative, and the Department continues to make significant progress in each of the following six key strategic areas.

1. **Financial Systems Modernization**

   - *Strategy*: HHS initiated 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 is now directing resources toward incrementally improving the efficiency and effectiveness of the modern financial systems environment. Taken together, the design of these projects will significantly mature the HHS financial systems environment, offering benefits that include: safeguarding system security and privacy; enhancing information access; complying with and implementing evolving federal requirements; achieving efficiencies and promoting standardization; eliminating security and control vulnerabilities; and maximizing the return on existing system investments.

   - *Progress*: In FY 2019, the Department transitioned from the partially manual *Digital Accountability and Transparency Act of 2014* (DATA Act) solution, to a system-based reporting process. This significantly reduced the stakeholder data calls and manual crosswalks needed to produce DATA Act-compliant outputs, leveraging reports now available directly from the financial system. The solution links data across multiple enterprise-wide systems – improving enterprise-wide data quality and integration –

and enables HHS to continue to accurately report approximately $330 billion in quarterly obligation award activity. Further, the HHS solution enables microservice-based automated integration with the Department of Treasury (Treasury) Broker – the first Broker integration of its kind in the federal government, which significantly improves the efficiency of reporting enterprise-wide data.

Additionally, HHS modernized key financial system infrastructure, generating a cost avoidance of over $9.17 million, while enabling improved customer experience through enhanced system performance of up to 45-60 percent across key programs, minimized maintenance downtimes (increased system availability), and increased network bandwidth. Looking forward, the Department developed a comprehensive implementation strategy for a Department-wide electronic invoicing solution 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 the Treasury Invoice Processing Platform implementation team, to ensure the enterprise-wide solution adheres to the diverse HHS business needs.

2. Business Intelligence and Analytics

- *Strategy*: Leveraging the FBIS platform, HHS is expanding the use of business intelligence and analytics across the Department to establish an information-driven financial management environment in which 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 first deployed in FY 2012, FBIS has provided operational and business intelligence to users across the HHS financial management community. FBIS offers accurate, consistent, near real-time data from UFMS and NBS (together serving 5 of 6 HHS Accounting Centers) and summary data from HIGLAS, supporting over 1,500 users across the Department. In FY 2019, HHS continued extending the FBIS solution, enhancing the Department's managerial reporting capabilities and facilitating improved stewardship and decision making. This included developing new, insight-driven FBIS reports and dashboards: (1) the Control Monitoring Dashboard was matured further to extend the FY 2017 UFMS security redesign and strengthen segregation of duties controls; and (2) Project Analytics dashboards and reports, including a Project Executive dashboard that offers a comprehensive organizational view, empowering executives by providing the visibility and control they need to monitor performance and project health. To better serve current users and promote the growth of FBIS, HHS spent significant effort in FY 2019 focusing on the FBIS customer experience. This included tailored training and workshops, as well as developing a Customer Strategy to better understand user behavior, business needs, and engagement opportunities. Based on user feedback, the initiation of a targeted performance improvement effort resulted in 50-90 percent performance improvement in report run times and a significant increase in FBIS user satisfaction.

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*: For the first time in 23 years of *Chief Financial Officers Act of 1990* (CFO Act) audits, in FY 2018 HHS no longer had a material weakness in its financial management systems, as a result of the Department's integrated strategy to mature its financial systems security and controls environment and remediate vulnerabilities. In downgrading the material weakness to a significant deficiency, the independent auditors specifically noted the "differential investments in key financial systems" provided a more mature controls baseline. Building on this significant progress, HHS continues to execute on its strategy to strengthen oversight, improve risk management, and enhance information and communication. Persistent weaknesses are being addressed, and targeted efforts are further reducing risk across the financial management systems portfolio as the annual closure rate of findings in high-risk control areas (access controls, configuration management, and segregation of duties) continues to increase year-over-year. Beyond simply tracking closure of individual weaknesses to assess progress, HHS also developed and has continued to refine a comprehensive management framework, including evaluation criteria and target measurements, to better inform HHS leadership and other stakeholders of overall progress made, the current maturity level of the security and control environment, and the associated level of risk. This framework provided HHS management with the evidence-based, objective data required to assert that the Department did not have a material weakness.

  Encouraging collaboration and communication across the Department, the Financial Management Governance Board (FGB) chartered a cross-functional working group with representation from OpDiv CFO, Chief Information Officer (CIO), and Chief Information Security Officer Communities, that continues to meet monthly to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. Additionally, in FY 2019 the Department hosted its second annual HHS IT Audit, Internal Control, and Risk Management workshop, which earned recognition from Department CIO and CFO leadership as a key forum for driving improved IT security and control maturity across the Department.

4. Governance

- *Strategy*: The Department established the FGB as an executive-level forum to address enterprise-wide issues impacting HHS and its OpDivs, including those related to financial management policies and procedures, financial data, financial systems, and technology. 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*: The FGB convenes monthly to facilitate executive-level oversight of financial management-related areas by engaging senior leadership from the OpDivs and StaffDivs; as well as across functions such as finance, budget, acquisitions, grants, human resources, and IT. The FGB effectively transformed 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, 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 serves as an advisory body, providing actionable recommendations to support project teams and guide future initiatives. Recent areas of focus have included key initiatives and federal mandates, such as the continued modernization of the Department's financial accounting systems, the implementation of the DATA Act long-term solution, and the HHS Consolidated

Acquisition Solution PRISM upgrade. The FGB anticipates focusing on key topics that will enable the HHS financial management community to effectively address evolving opportunities and challenges.

5. Program Management

- *Strategy*: HHS established Department-wide financial systems program management to support FSIP, FBIP, and enhance collaboration across project teams. Enterprise program management provides a sustaining framework that OpDivs, StaffDivs, and CFO community stakeholders across HHS can collaborate on programs and projects to realize strategic goals and outcomes. Enterprise program management provides leadership support by developing and maintaining processes, standards, tools, and best practices for program and project management. This includes the Financial Systems Consortium, a body of federal project managers and contractors representing the three core financial systems: UFMS, HIGLAS, and NBS. The Consortium 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 forum 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 Financial Systems Consortium continues to play a critical role in support of major system enhancements. In FY 2019, enhancements included developing a framework (Strategic Template and Resources Tools) for enterprise-wide projects that aligns with HHS's Enterprise Performance Life Cycle process and assists project managers in identifying necessary deliverables for successful implementation. 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 environment 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*: Examples of sharing opportunities pursued to-date include, transitioning key financial systems to a cloud service provider, the use of shared acquisition contracts and streamlining of system operations and maintenance contracts, the implementation of a Department-wide Accounting Treatment Manual, consolidation of three legacy managerial reporting systems into FBIS, and sharing solutions across the HHS financial community. Currently, the HHS finance, acquisition, and IT communities are collaboratively implementing the Department-wide solution for electronic invoicing, as well as developing and refining an implementation plan for the U.S. Department of the Treasury's Government Invoicing solution. Implementation of these solutions will support specific business needs identified across HHS while maintaining compliance with the Office of Management and Budget (OMB) direction and Treasury requirements. The FGB continues to assess future sharing opportunities across the enterprise to further align with financial management and system policies, business processes and operations, and the overall financial system vision and architecture.

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 three 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.

Improper Payments Information Act of 2002, Improper Payments Elimination and Recovery Act of 2010, and Improper Payments Elimination and Recovery Improvement Act of 2012

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 no or insufficient documentation to support the payment as proper or improper are cited as improper payments. The *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments, and for high risk programs, to estimate the amount of improper payments 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 compliance with the IPIA, as amended, HHS completed 31 improper payment risk assessments in FY 2019 (representing risk assessments of programs and charge cards) and determined that these programs were not susceptible to significant improper payments. In addition, HHS is publishing improper payment estimates and associated information for seven high risk programs in this year's AFR, of which four programs reported lower improper payment rates in FY 2019 compared to FY 2018. Lastly, HHS also utilizes the Do Not Pay portal to check payments and awardees to identify potential improper payments or ineligible recipients. In FY 2019, HHS screened more than $493.4 billion in Treasury-disbursed payments through the Do Not Pay portal. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Payment Integrity Report."

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."

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 field, format, 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 the initial one. HHS submissions average over $300 billion in award-level obligations per quarter. HHS completely reconciles to an average of 98 percent of award-level obligations. HHS has undergone both GAO and OIG audits of their DATA Act submission since the initial reporting window, yielding a zero percent error rate on sampled records through FY 2018.

In June of 2018, the revised Appendix A to OMB Circular A-123 contained a cover letter adding a requirement for agencies to develop and execute a Data Quality Plan. Consideration of this plan must be included in agencies' existing annual assurance statement for internal controls over reporting beginning in FY 2019 and continuing through the assurance statement covering FY 2021, at a minimum, or until agencies determine that they can provide reasonable assurance over the data quality controls that support achievement of the reporting objectives in accordance with the DATA Act. HHS's Data Quality Plan was finalized on October 1, 2018.

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 2019, HHS continued its "M3" improvement initiative to strengthen performance on the agency's biannual Committee on Oversight and Government Reform scorecard. For example, HHS emphasized *Federal Information Security Management Act* and cybersecurity throughout FY 2019, understanding that these elements would impact agency scores on the revised Biannual Scorecard 8.0. To that end, the Office of the CIO focused on implementing modern tools and capabilities that enhance HHS's cybersecurity posture while lowering risk exposure.

On June 26, 2019, the Committee on Oversight and Government Reform released its Biannual Scorecard 8.0. HHS's overall grade on this new Scorecard decreased from the previous version, attributed mainly to the CIO's reporting structure. We are working with our regulators to address this challenge and expect improvements on future Scorecards. It is notable that HHS maintained the four "A's" previously received under FITARA 7.0, and under FITARA 8.0, HHS also identified additional IT portfolio cost savings and adopted an incremental delivery approach for 97 percent of its projects. HHS's ability to adopt new processes that align with FITARA is a testament to how HHS has matured, monitored, and maintained through its "M3" initiative.

Grants Oversight and New Efficiency Act

The Grants Oversight and New Efficiency Act (GONE Act) was signed into law on January 28, 2016 with the goal to facilitate the closing of expired grants and cooperative agreements, and to improve government efficiency. The GONE Act requires federal agencies to submit to Congress a report for all grants and cooperative agreements expired for 2 or more years and their attributed dollar balances, which have not been closed out. Agencies were also required to explain, for the 30 oldest federal grant awards, why each grant had not been closed out.

In 2019, HHS submitted an updated report for all grants and cooperative agreements reported in the FY 2017 GONE Act submission identifying whether each remained open or had been closed. In addition, HHS also provided an update on the 30 oldest federal grants.

Although GONE Act reporting requirements are complete, HHS continues to prioritize long-standing management challenges specifically related to closeout. Under the direction of the Deputy Secretary, the Department established an Executive Steering Committee comprised of senior executives to provide guidance and approval to take one-time actions to reduce the backlog and conduct business process re-engineering.

In August 2018, the Department established the Grants Closeout Remediation Integrated Project Team (IPT) with the specific purpose of reducing the current backlog of open but expired documents. The IPT, comprised of subject-matter experts across the Department, defined and analyzed the population of open grants and associated closeout risks. As of September 30, 2019, the team successfully closed approximately 14,000 documents.

In March 2019, the Department established the Business Process Re-engineering IPT, comprised of grants policy and operations experts across the Department, to develop recommendations to improve business processes and prevent future backlogs.

Fraud Reduction and Data Analytics Act of 2015

The Department continues to engage in various fraud reduction efforts, including activities to meet the requirements under the *Fraud Reduction and Data Analytics Act of 2015* (FRDAA). Since FRDAA's enactment in 2016, HHS has participated in the required OMB-led interagency working group. As part of this working group, in FY 2019 HHS assisted in developing a fraud taxonomy that agencies can use to identify potential fraud vulnerabilities. Also in FY 2019, HHS attended the Improper Payment and Fraud Prevention International Forum with the United Kingdom and Canada and participated in other interagency discussions around fraud risk management. These meetings shared lessons learned and discussed future opportunities for sharing best practices, knowledge, and experience to assist agencies in identifying and preventing fraud. In addition, HHS collaborated with Treasury on the implementation of the Program Integrity Antifraud Playbook (Playbook), including attending interagency meetings and discussions, and providing Treasury with information on HHS's program integrity and analytic efforts. The Playbook, released in October 2018, includes many resources for agencies to consider in developing antifraud initiatives. HHS will continue working with OMB and other agencies to implement FRDAA and to further advance fraud risk management activities.

HHS continues to take steps, at both the Department and OpDiv/StaffDiv levels, to implement FRDAA, 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 are below:

- HHS is drafting a Fraud Risk Management Implementation Plan that outlines actions taken or planned to enhance financial and administrative controls relating to fraud. HHS expects to complete this implementation plan in FY 2020;
- HHS is considering fraud and financial management risk as part of its internal control assessments and in accordance with the law and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*;
- HHS is considering fraud risk in individual programs or payment activities as part of its improper payment risk assessments, and HHS is analyzing the FY 2018 and FY 2019 data; and
- HHS continually reviews and updates its financial policies and provides relevant and timely training sessions. For example, in FY 2019, HHS held a grants training conference for OpDiv/StaffDiv representatives that included a joint HHS and OIG session on fraud-related observations, and fraud indicators that lead to a suspension and debarment.

HHS OpDivs and StaffDivs 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, or other 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. Some specific efforts at two Divisions are described below:

- NIH assessed the extramural grant program in FY 2019 following the GAO Fraud Risk Framework. The fraud risk assessment helped NIH identify vulnerabilities and develop mitigation strategies to proactively help reduce the risk of fraud in NIH extramural programs. In response to the fraud risk assessment, NIH launched an online Fraud Awareness Training course. This course is available to all NIH personnel via the HHS Learning Management System. This course provides NIH staff with a definition of fraud, circumstances that lead to fraud, common examples of fraud, and how to report suspected fraud. This training raises NIH's fraud awareness by familiarizing employees with the types of fraud that potentially impact NIH operations. The training contributes to NIH's organizational culture of accountability by ensuring alertness and stewardship practices for public funds by NIH personnel.

- CMS 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 Vulnerability Collaboration Council (VCC), is comprised of 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. By aligning with the GAO framework, CMS standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the development of measurable, verifiable, and time-bound action plans.

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. Agency heads must annually 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 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 that agencies 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 2019 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. More information on the Department's internal control efforts and the HHS Statement of Assurance follows.

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 also continuing to make progress toward adopting Enterprise Risk Management and integrating with Internal Control.

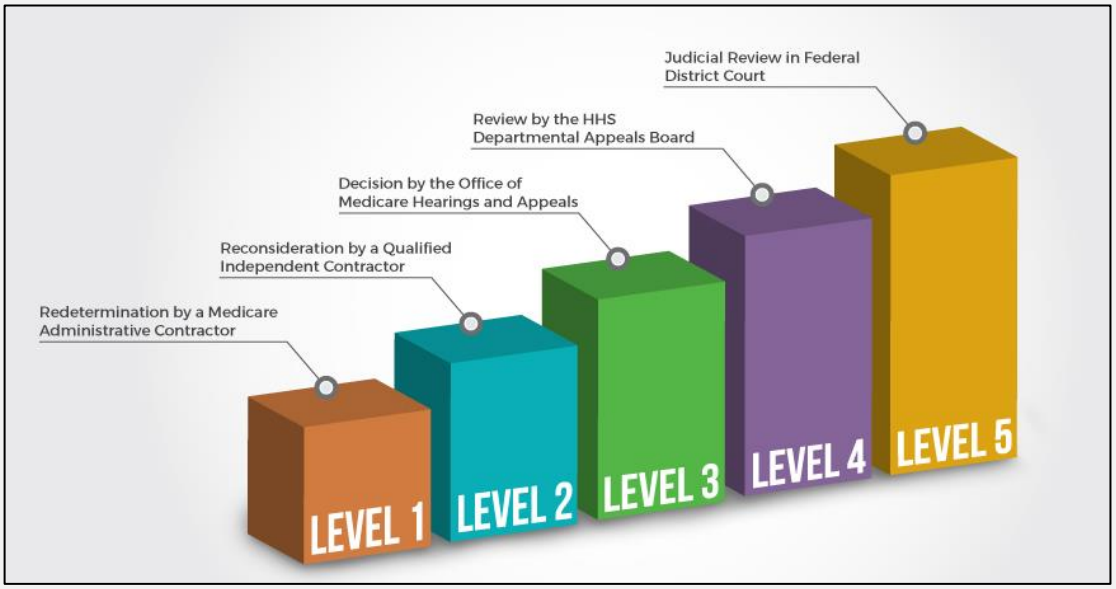
HHS management is directly responsible for establishing and maintaining effective internal controls in their respective areas of responsibility. As part of this responsibility, management regularly evaluates internal control and HHS executive leadership provides annual assurance statements reporting on the effectiveness of 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.

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 2019 OMB Circular A-123 assessment recognizes material noncompliances with: the *Improper Payments Information Act* (IPIA), with two instances related to Error Rate Measurement; the *Social Security Act* related to the Medicare appeals process; and the Federal Acquisition Regulation related to contracting for services. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMIA.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high-quality services to the American people, and maximizes desired program outcomes.

Did you know?

There are five levels in the Medicare Part A and Part B appeals process. The levels are:



For more information on the Medicare Appeals process, refer to CMS.gov.

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, 2019, with the exception of material noncompliances with: the *Improper Payments Information Act* (IPIA), with two instances related to Error Rate Measurement; the *Social Security Act* related to the Medicare appeals process; and the *Federal Acquisition Regulation* related to contracting for services.

HHS is taking steps to address the material noncompliance related to the Medicare appeals process and Federal Acquisition Regulation, as described in the "Corrective Action Plans" section. Remediation for one 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. HHS is addressing the other instance of material noncompliance related to Error Rate Measurement, as described in the "Corrective Action Plans" section.

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, 2019

Summary

1. Error Rate Measurement

HHS identified two instances of material noncompliance with IPIA: (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 IPIA requirements.

HHS identified the TANF process limitation in a prior year and it continues to exist in FY 2019. The TANF program is unable to report an error rate for FY 2019 due to statutory limitations precluding HHS from requiring states to participate in a TANF improper payment measurement.

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 2019 include:

- The reintegration of the PERM eligibility component for the first 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 2019, 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 2019, 318,254 appeals were waiting to be adjudicated by OMHA and 17,719 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 (and without any additional appeals), it would take 2 years for OMHA and 8 years for the DAB to process their respective backlogs.

3. Contracting

HHS has identified (1) several known and potential violations of laws and regulations related to its acquisition processes at both the Department and Operating Division Levels, and (2) related internal control vulnerabilities. Management identified several noncompliance issues related to the Federal Acquisition Regulation (FAR) and began a broader review of acquisition compliance.

Corrective Action Plans

1. Error Rate Measurement

Since TANF is a state-administered program, 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 2020 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 is developing a notice of proposed rulemaking (NPRM) to introduce more stringent requirements designed to strengthen the integrity of the eligibility determination process and avoid improper payments. The proposed rule will address several of the most persistent drivers of eligibility errors such as insufficient recordkeeping, verification of eligibility, redeterminations, and compliance with eligibility requirements when individuals experience a change in circumstances that may impact eligibility. The Center for Medicaid and CHIP Services (CMCS) within HHS's Centers for Medicare & Medicaid Services (CMS) also is publishing an Information Bulletin to remind states about federal requirements and expectations already codified in existing regulations for completing renewals for Medicaid and CHIP beneficiaries. HHS will also complete the review of the remaining 34 states under the new eligibility component and establish a baseline in FY 2021 once all states are measured under the new requirements.

In addition to the NPRM, to further address PERM errors that may be related to a need for states to implement or increase operational process efficiencies, CMCS will use learning collaboratives and targeted technical assistance to identify root cause analysis for states with chronic processing issues to develop best practices that can be shared. In summary, HHS will:

- Develop a notice of proposed rulemaking to strengthen the integrity of the eligibility determination process;
- Increase the timeline density of oversight by using the Medicaid Eligibility Quality Control (MEQC) program in the two off-cycle PERM years to address Medicaid beneficiary eligibility vulnerabilities on areas not addressed through PERM reviews and on areas identified as error-prone through the PERM program;
- Conduct risk based audits of beneficiary eligibility determinations in states identified as such in PERM, OIG, and state auditor findings;
- Conduct outreach during off-cycle PERM years to address issues identified in corrective action plans; and
- Facilitate national best practice calls to share ideas across states to increase support in areas where deficiencies may be due to operational inefficiencies.

In addition, HHS works closely with all states through enhanced technical assistance and guidance 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 the major causes of improper payments.

Lastly, the FY 2020 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 authority to recover overpayments from states that receive federal resources for ineligible or misclassified beneficiaries.

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 2020 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 2020 President's Budget, HHS projects that the backlog at Level 3 would be approximately 100,000 appeals by the end of FY 2021, while the backlog at Level 4 could start decreasing in future years.

3. Contracting

HHS places a high priority on complying with appropriations and acquisitions law, and avoiding violations of the FAR. When a violation is suspected, HHS obtains legal review and advice from the Office of the General Counsel before determining whether a violation exists. HHS management has taken certain corrective actions in FY 2019, including a reorganization of the HHS Acquisitions office resulting in a separate Office of Acquisitions with independent executive oversight, and a review of its policies and procedures against current federal government regulations. HHS is still in the process of reviewing its acquisition program. The review of this matter will continue in FY 2020 to ensure timely corrective actions, as appropriate.

Financial Summary and Highlights

HHS received an unmodified audit opinion on the principal financial statements and notes[2] for the year ended September 30, 2019. This is the 21st 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.

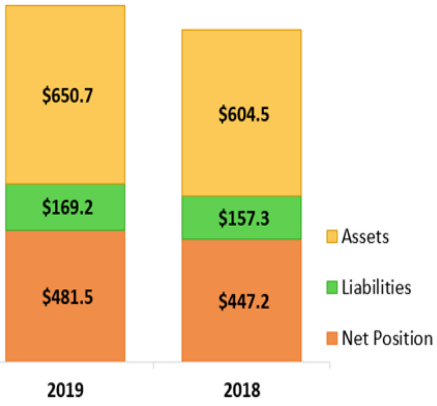
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2018 Financial Report of the United States Government*, HHS's net operating cost was larger than any single agency across the entire federal government.[3] A similar relationship 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 2019 and FY 2018 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)

	2019	2018	$ Change (2019-2018)	% Change (2019-2018)
Fund Balance with Treasury	$ 296.3	$ 250.2	$ 46.1	18%
Investments, Net	309.3	307.1	2.2	1%
Accounts Receivable	25.0	27.9	(2.9)	(10)%
Advances	2.6	2.9	(0.3)	(10)%
Other Assets	17.5	16.4	1.1	7%
Total Assets	**$ 650.7**	**$ 604.5**	**$ 46.2**	**8%**
Accounts Payable	$ 2.4	$ 2.0	$ 0.4	20%
Entitlement Benefits Due and Payable	110.1	99.1	11.0	11%
Accrued Liabilities	15.5	14.5	1.0	7%
Federal Employee and Veterans' Benefits	14.8	14.4	0.4	3%
Other Liabilities	26.4	27.3	(0.9)	(3)%
Total Liabilities	**$ 169.2**	**$ 157.3**	**$ 11.9**	**8%**
Net Position	**$ 481.5**	**$ 447.2**	**$ 34.3**	**8%**
Total Liabilities and Net Position	**$ 650.7**	**$ 604.5**	**$ 46.2**	**8%**



[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 25 percent of the federal government's total costs, Social Security Administration's net cost is 23 percent, Department of Defense's net cost is 15 percent, Department of Veterans Affairs' net cost is 8 percent, and Treasury's Interest on Treasury Security Held by the Public's net cost is 8 percent. All remaining agencies combined only represent 21 percent. Source: *FY 2018 Financial Report of the United States Government* fiscal.treasury.gov/fsreports/rpt/finrep/fr/fr_index.html

Assets

The total Assets for HHS were $650.7 billion at year-end, representing the value of what HHS owns and manages. This is an increase of approximately $46.2 billion or 8 percent over September 30, 2018. Fund Balance with Treasury (FBwT) and Investments comprise $605.6 billion or 93 percent of HHS's total assets, which increased $48.3 billion or 9 percent.

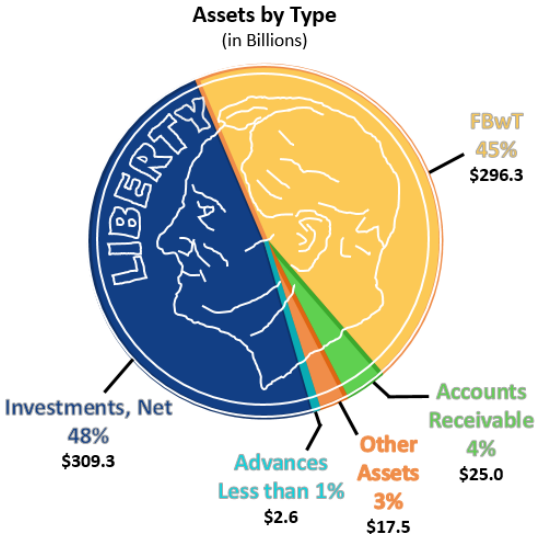
The FBwT line contains the largest net change between FY 2019 and FY 2018 with a $46.1 billion or 18 percent increase. This primarily consists of a $36.3 billion increase in Supplementary Medical Insurance (SMI), $2.0 billion in Medicaid due to retention of full FY 2019 definite authority, $2.5 billion in the Refugee and Entrant Assistance program, and $1.2 billion for the Temporary Assistance for Needy Families program.

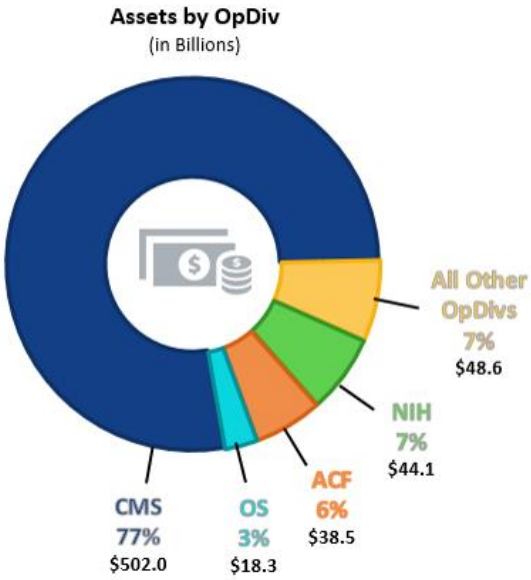
Investments had an increase of $2.2 billion or 1 percent primarily due to an increase of $6.5 billion in SMI premiums, offset by a decrease of $4.4 billion in Hospital Insurance (HI).

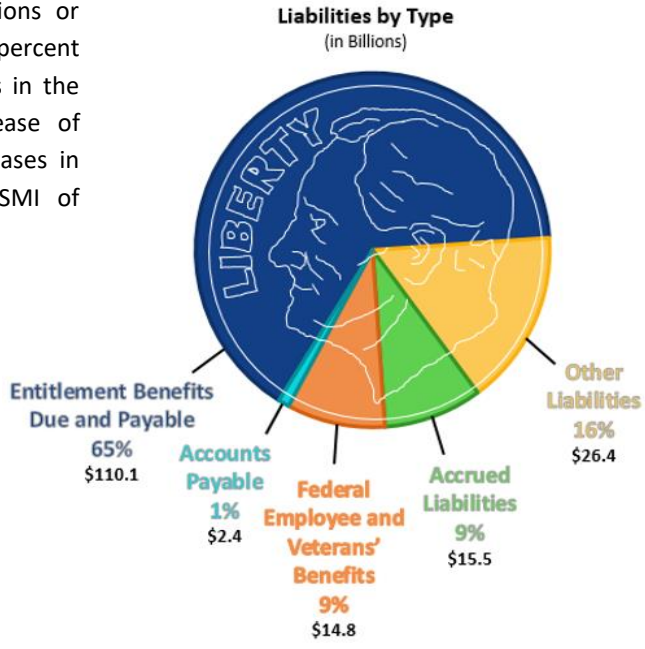
The HHS "Assets by OpDiv" chart demonstrates asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $355 million at AHRQ (shown in All Other OpDivs) to $502.0 billion at CMS. CMS had the largest percentage and dollar value asset increases at $34.7 billion or 7 percent over FY 2018 primarily due to the changes in FBwT and Investments mentioned above.

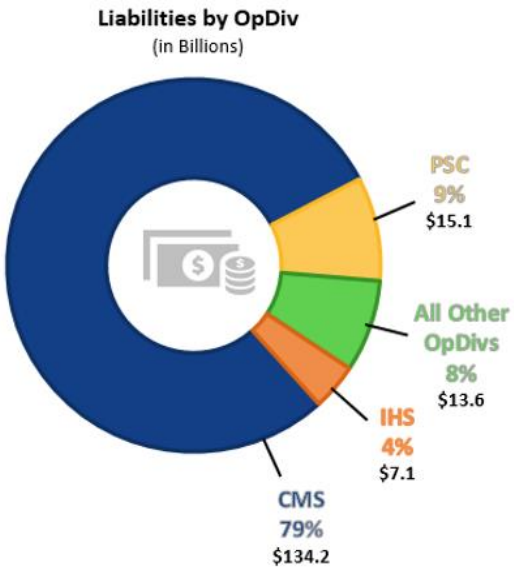
Liabilities

The total Liabilities for HHS were $169.2 billion at year-end, representing the amounts HHS owes from past transactions or events. This is an increase of approximately $11.9 billion or 8 percent over September 30, 2018. The majority of the increase is in the Entitlement Benefits Due and Payable line. This increase of $11.0 billion or 11 percent from FY 2018 consists of increases in medical services/claims incurred but not reported for SMI of $6.5 billion, $2.9 billion in HI, and $1.6 billion in Medicaid.







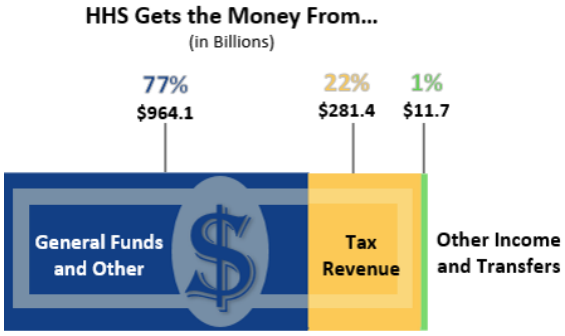


The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS, excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports $134.2 billion or 79 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $29 million. CMS had the largest OpDiv dollar value increase in liabilities over FY 2018 of $10.7 billion.

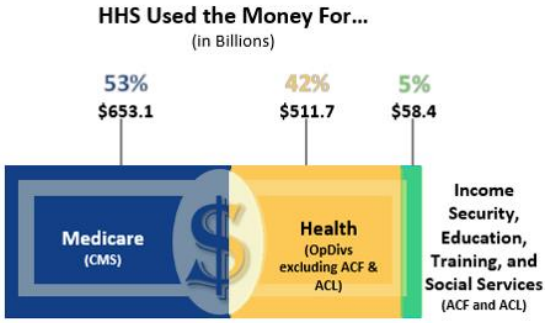
Statement of Changes in Net Position

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.

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 since FY 2018 by $53.9 billion or 6 percent. The fluctuations in tax revenue of $16.9 billion or 6 percent is related to the *Federal Insurance Contributions Act* (FICA) and *Self Employed Contributions Act* (SECA).



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, 2019, totaled approximately $1.2 trillion. 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, where HHS has many.

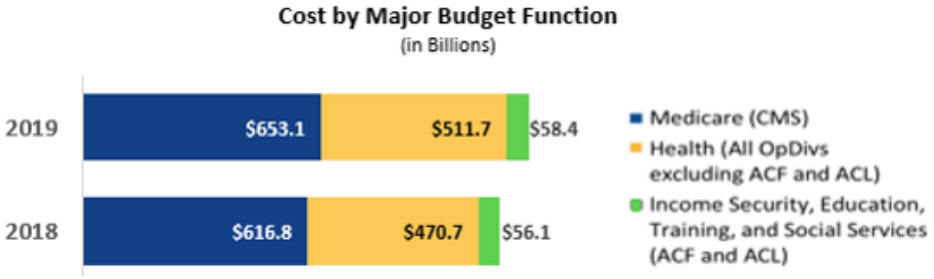
[4] Totals in the chart are exclusive of Intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section III, Other Information.

The table below presents FY 2019 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 $78.0 billion or 8 percent over FY 2018. The majority of this increase relates to Medicaid benefit expenses of $27.5 billion. In addition, SMI and HI expenses increased by $26.6 billion and $16.1 billion, respectively. There was an increase in total Net Cost of Operations for the remaining HHS segments at $1.5 billion or 1 percent over FY 2018.

Net Cost of Operations
(in Billions)

	2019	2018	$ Change (2019-2018)	% Change (2019-2018)
Responsibility Segments:				
CMS Gross Cost	$ 1,201.6	$ 1,115.2	$ 86.4	8%
CMS Exchange Revenue	(114.7)	(106.3)	(8.4)	8%
CMS Net Cost of Operations	$ 1,086.9	$ 1,008.9	$ 78.0	8%
Other Segments:				
Other Segments Gross Cost	$ 141.9	$ 140.2	$ 1.7	1%
Other Segments Exchange Revenue	(6.0)	(5.8)	(0.2)	3%
Other Segments Net Cost of Operations	$ 135.9	$ 134.4	$ 1.5	1%
Net Cost of Operations	**$ 1,222.8**	**$ 1,143.3**	**$ 79.5**	**7%**

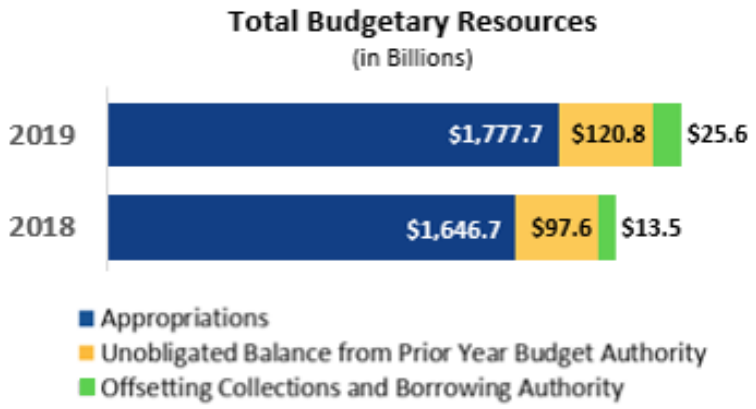
HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in the "Other Information" section of this report. The graph below shows the two-year cost trends for these major budget functions.[5] In FY 2019, total net costs for Medicare of $653.1 billion and Health of $511.7 billion account for 95 percent of HHS's annual net costs.



Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2019 and FY 2018, and the status of those resources at the fiscal year-end. The primary components of HHS's resources, totaling approximately $1.9 trillion for FY 2019, 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 $166.4 billion or 9 percent, over FY 2018. The following graph highlights trends in these balances over the past 2 fiscal years.

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



The increase in appropriations of $131.0 billion or 8 percent is primarily related to increases in Payments to the Trust Funds (PTF) of $50.1 billion, SMI of $44.4 billion, HI of $28.8 billion, CHIP of $5.1 billion, and Medicaid of $1.3 billion. For further details, see the Combining Statement of Budgetary Resources in the "Financial Section" of this report.

The increase of $23.2 billion or 24 percent in unobligated balance from prior year budget authority is primarily due to unobligated balances brought forward from the preceding fiscal year of $15.1 billion in Medicaid, $12.6 billion in All Others/Program Management, $6.4 billion in PTF, and $4.3 billion in CHIP. The increase is offset by a decrease in recoveries of prior year unpaid obligations of $9.8 billion and an additional decrease due to the change in unobligated balance of $9.8 billion.

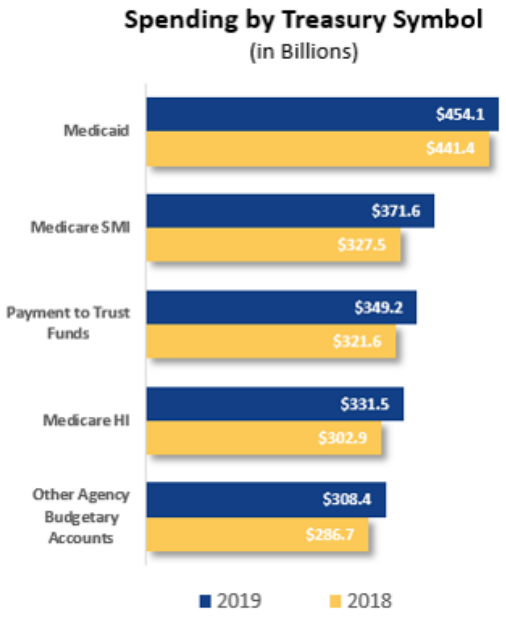
Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The chart below illustrates spending as of September 30, 2019 and 2018 for the top four 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 2019 were approximately $1.8 trillion with an 8 percent increase over FY 2018.

The HHS's total spending is once again significantly represented by four of CMS's TAS (Medicaid, Medicare SMI, PTF, and Medicare HI) at 83 percent of HHS total obligations.

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 $884.2 billion or 49 percent. HHS is the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling $789.1 billion or 43 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.



Statement of Social Insurance

The Statement of Social Insurance 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 regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Did you know?

Medicare spending accounts for 15 percent of the entire federal budget. Learn more about CMS's 5 part strategy intended to modernize program integrity methods at CMS.gov.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Trustees Report).

The Statement of Social Insurance 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) decreased from $(4.7) trillion, determined as of January 1, 2018, to $(5.5) trillion, determined as of January 1, 2019.

Including the combined HI and SMI trust fund assets increases the present value. As of January 1, 2019, the future cash flow for all current and future participants was $(5.2) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI trust fund assets, is $(12.7) 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, and thus, the HI trust fund assets have been declining. The following table shows that 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 has steadily dropped from 73 percent at the beginning of FY 2015 to 62 percent at the beginning of FY 2019.

Trust Fund Ratio Beginning of Fiscal Year[6]	
FY	HI
2019	62%
2018	66%
2017	66%
2016	67%
2015	73%

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 2019 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2019 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 2018 were $200.4 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

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 89 percent in 2026 to 78 percent in 2043 and then to increase to about 83 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 2018 to about 2.2 by 2093. 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 $5.3 trillion, which is 0.9 percent of taxable payroll and 0.4 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the Statement of Social Insurance. 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

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

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 five 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 $(36.8) 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 2018, SMI expenditures were 2.1 percent of GDP. By 2093, SMI expenditures are projected to grow to 4.2 percent of the GDP.

The following table presents key amounts from CMS's basic financial statements for fiscal years 2017 through 2019.

Table of Key Measures[7]
(in Billions)

	2019	2018	2017
Net Position (end of fiscal year)			
Assets	$ 502.0	$ 467.3	$ 444.2
Less Total Liabilities	134.2	123.5	137.5
Net Position (assets net of liabilities)	**$ 367.8**	**$ 343.8**	**$ 306.7**
Costs (end of fiscal year)			
Net Costs	$ 1,087.3	$ 1,009.1	$ 963.3
Total Financing Sources	1,079.0	1,017.7	984.6
Net Change in Cumulative Results of Operations	**$ (8.3)**	**$ 8.6**	**$ 21.3**
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 1/1/2019)	$ (5,484)	$ (4,708)	$ (3,532)
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 1/1/2018)	$ (4,708)	$ (3,532)	$ (3,822)
Change in Present Value	**$ (776)**	**$ (1,176)**	**$ 290**

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

[7] The table or other singular presentation showing the measures described above.

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, 2019, decreased by $201 billion due to advancing the valuation date by one year and including the additional year 2093, by $200 billion due to changes in projection base, and by $402 billion due to changes in economic and health care assumptions. However, the present value increased by $27 billion due to changes in demographic assumptions. The net overall impact of these changes is a decrease in the present value of $776 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 Required Supplementary Information (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 2019 Trustees Report, 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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FINANCIAL SECTION

SECTION 2

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Message from the Principal Deputy Assistant Secretary

I am honored to join Secretary Azar in presenting the Fiscal Year (FY) 2019 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). HHS is responsible for more than a quarter of all federal outlays and administers more grant dollars than all other agencies combined. HHS's Chief Financial Officer (CFO) community works to enhance and sustain a financial management environment that ensures accountability and manages risk related to the significant budgetary resources entrusted to the Department.

For the 21st consecutive year, we received an unmodified (clean) audit opinion on our financial statements from our independent auditors. A clean opinion confirms that our financial statements are presented fairly, in all material respects, and conform with generally accepted accounting principles. The AFR's "Financial Section" provides detailed information about HHS's financial statements and activities that contributed to this opinion.

The CFO community is employing financial management best practices and process improvement frameworks to strengthen our application of statutes, regulations, and other financial management requirements, resulting in stronger internal controls over financial operations. By promoting continuous process improvements across the HHS financial management environment, we are finding opportunities to modernize outdated business processes, increase stakeholder satisfaction, improve program performance, and create effective partnerships throughout the organization.

Furthermore, to better serve the needs of our customers, the CFO community is also leveraging technology and innovation to develop products and services that improve the quality and reliability of financial data, enhance the user experience, facilitate cross-functional collaboration, and reduce cost by shifting from low-value activities to high-value work. By establishing a culture of innovation, our Operating Divisions and Staff Divisions are able to realize significant business process efficiencies and achieve value for their stakeholders.

Additionally, HHS's FY 2018 financial report received the Association of Government Accountants' *Certificate of Excellence in Accountability Reporting*, our sixth consecutive award. This review program was established over 20 years ago in collaboration with the CFO Council and the Office of Management and Budget to help agencies effectively present financial management activities in AFRs and Performance and Accountability Reports.

I want to thank our employees and partners for their remarkable efforts and dedication. HHS's AFR is a reflection of our extraordinary dedication to our mission. Together, we look forward to expanding the Department's financial management capabilities.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary for Financial Resources
November 13, 2019

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV 13 2019

TO: The Secretary

FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2019*, A-17-19-00001

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2019 financial statements, conclusions about the effectiveness of internal controls, 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, 2019 and 2018, 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, 2019, 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 2019 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, 2019, 2018, 2017, 2016, and 2015, and the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018. 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. There has been a significant reduction in the number of high-risk internal control deficiencies noted in prior years because of management's continued focus on HHS enterprise-wide corrective actions. Ernst & Young also noted that HHS continues to emphasize "the maturation of the HHS internal controls program" by making investments in key 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 2019 audit, Ernst & Young noted that HHS made significant progress in addressing certain issues that have impaired its ability to overcome significant deficiencies reported in prior years. HHS reorganized the Office of Grants and Acquisition Policy and Accountability (OGAPA) into two offices, the Office of Grants and the Office of Acquisitions, which now have separate directors who report to the Assistant Secretary of Administration. Ernst & Young also noted that HHS continued efforts to clean up its data. This included closing older grant obligations in support of the Grants Oversight and New Efficiency Act (GONE) (P.L. No. 114-117).

  Although HHS made progress in these areas, the FY 2019 audit still identified a series of deficiencies in financial systems and processes for producing financial statements, including the lack of integrated financial management systems, antiquated processes that impacted journal entries to its financial and budgetary amounts, and insufficient analysis and oversight of certain significant accounts and programs. Ernst & Young specifically described concerns over the number and amount of nonstandard journal entries, HHS's acquisition processes, Medicaid oversight, and the Statement of Social Insurance. Ernst & Young noted 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 the volume and dollar value of them are a significant portion of HHS's overall financial activity.

Ernst & Young also noted HHS, over the past several years, has identified a series of (1) concerns related to internal control and (2) violations of laws and regulations related to its acquisition processes at both the HHS Department and Operating Division levels. HHS management took certain corrective actions in FY 2019. As stated above, HHS reorganized its Acquisitions office, which resulted in a separate Office of Acquisitions with separate executive oversight. HHS has started a review of its policy and procedures against current Federal Government regulations and a review of the implementation and execution of such policies and procedures at one location. As of the date of Ernst & Young's *Report on Internal Control*, HHS has not completed the review of its acquisition policies and procedures and had not completed related corrective actions as a result of this review.

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. CMS still did not have reliable historical claims-level data, so 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 2019 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. These formula errors were not detected by CMS'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 identified several instances of noncompliance with laws and other matters. During FY 2019, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, 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 CHIP, with error rates in excess of 10 percent. These are also violations of the IPIA. We will report further on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2020. HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. No. 101-508) related to an obligation of funds for conference spending at the Food and Drug Administration and certain contract obligations at CMS that occurred in FYs 2014 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.

2015 and at HHS's Program Support Center (PSC) that occurred between FY 2006 and FY 2011. 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). Finally, as discussed above, HHS identified potential violations with laws and regulations related to its acquisition processes.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 19-03, 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 2019 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 Carrie A. Hug, Assistant Inspector General for Audit Services, at (202) 619-1157 or Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-19-00001.

Attachment

Page 5—The Secretary

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

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

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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, 2019 and 2018, 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 statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, 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 statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, 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, 2019 and 2018, and the related consolidated statement 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 23 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 24 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2019, 2018, 2017, 2016, and 2015, the current-law expenditure projections reflect the positions 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 24, 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 significant issues 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 statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018.

Disclaimer of Opinion on the Statement 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, 2019, 2018, 2017, 2016, and 2015, and the related changes in the social insurance program for the periods ended January 1, 2019 and 2018.

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, 2019 and 2018, 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, Required Supplementary Stewardship Information, 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, 2019, 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' 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, 2019

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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, 2019, 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, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 13, 2019. 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, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS' internal control over financial reporting (internal control) to determine the 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' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 19-03. We did not test 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 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.

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

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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 2019 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, 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 significant reduction of the number of internal control deficiencies that contributed to the FY 2018 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 to prioritize the maturation of the HHS internal controls program. This focus on strengthening controls coupled with operationalizing a number of differential investments made in key financial systems (i.e., Unified Financial Management System (UFMS) access control/segregation of duties redesign) have provided a more mature controls baseline.

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

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 significant deficiency is based on the following:

- **Access controls –** We identified four (4) high risk access control exceptions across three (3) of the applications in-scope of our review, which spanned non-Centers for Medicare & Medicaid Services' (CMS) systems. Specifically, we noted (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) management was unable to produce a complete and accurate population of all current database administrators (DBAs) and Developers, (3) management did not recertify all privileged users as part of the FY19 annual recertification effort, 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.

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- **Configuration management** – We identified one (1) configuration management exception in an in-scope, non-CMS application. Specifically, we noted 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, the remediation, mitigation of risks, or monitoring of vulnerabilities, identified related to system configurations with the Central Office information systems, were not performed or not performed timely.

- **Segregation of duties** – We identified three (3) segregation of duties exceptions across two (2) applications in scope of our review which spanned non-CMS systems. Specifically, we noted (1) Management has not implemented a process for validating the completeness and accuracy of supporting their segregation of duties (SOD) monitoring controls and sufficient evidence was not provided to support all SOD rules/colliding transactions, (2) management has not documented a complete and accurate listing of all cross-application SOD conflicts between two (2) financially significant applications, and (3) management was unable to provide evidence to demonstrate that appropriate monitoring procedures were performed for a user with a segregation of duties waiver.

Recommendations

HHS should continue the progress achieved in FY2019 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 FY2019 Financial Statement Audit centered on access controls, configuration management, and segregation of duties;

- 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;

- Execute on planned modernization of legacy systems with further investment, while ensuring that any major changes to the IT environment are performed with internal controls at the forefront, leading to strengthened overarching governance/oversight to improve sustainability of controls; and

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

We have performed a separate financial statement audit of CMS for FY2019 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.

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Financial Systems, Analysis and Reporting

During FY 2019, HHS made significant progress in addressing certain issues that have impaired its ability to overcome its significant deficiencies in the past. Improvements included:

- Reorganizing its Office of Grants and Acquisition Policy and Accountability (OGAPA) into two separate offices: Office of Grants and the Office of Acquisitions. Each office reports to a separate Deputy Assistant Secretary who report up to the Assistant Secretary for Financial Resources.
- Continued clean-up efforts of its data, including closing older grant obligations in support of the GONE Act.
- Performed a hardware refresh for the financial systems hosted at Oracle Managed Cloud Services (UFMS, FBIS, CFRS and supporting systems).
- Developed a proof of concept, known as Snap, to modernize the delivery and accessibility of HHS accounting guidance. Snap is transforming the excel-based Accounting Treatment Manual (ATM) to an interactive platform that provides a centralized, automated, and intuitive presentation of accounting treatment information.
- Developed a comprehensive Department-wide DATA Act systems-based solution that significantly improved enterprise-wide data quality and integration, enabling HHS to link financial data to corresponding data in grants, financial assistance, and acquisition systems; eliminating interim solution manual crosswalks; and establishing microservice-based, automated interconnectivity to the Treasury DATA Act Broker.

Although progress in certain areas have 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 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 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 2019, although HHS' annual total budgetary resources was $1.9 trillion, HHS was required to process approximately 9,498 manual entries totaling an absolute value of more than $623.3 billion to its NIH Business System (NBS) or Unified Financial Management Systems (UFMS). Although the number of manual entries decreased, there was a 32% overall increase in absolute dollar value compared to FY 2018 where 9,914 manual entries totaling an absolute value of more than $471.0 billion were posted. 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

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automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. Although necessary to ensure balances are accurate, the volume and dollar value of manual entries is significant compared to the HHS's overall activity.

HHS Procurement Processes

Over the past several years, HHS has identified several (1) concerns related to internal control and (2) violations of laws and regulations related to its acquisition processes at both the HHS department and Operating Division Levels. We have reported current and potential violations within our accompanying Report on Compliance and Other Matters. HHS management has taken certain corrective actions in FY 2019, including a reorganization of the HHS's Acquisitions office resulting in a separate Office of Acquisitions with separate executive oversight, a review of its policy and procedures against current Federal government regulations, and a review of the implementation and execution of such policies and procedures at one location. As of November 13, 2019, HHS has not completed its review and related corrective actions.

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, 2019. 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, CMS must continue to work with states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research. At this time the information contained within T-MSIS requires additional verification before it would be considered reliable. CMS should continue to enhance the usefulness of T-MSIS data so they will be able to perform robust analytical procedures and develop benchmarks to monitor and identify risks associated with the Medicaid program. Examples of risks to monitor could include outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures and/or allow CMS to assess the reliability of the T-MSIS data. Given that CMS does not currently maintain reliable historical claims level detail for Medicaid, data analyses have been limited. At this time, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine

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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 2019 financial statements and is subject to volatility based on the complexity and judgement 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' analysis will not be reflected in CMS' financial statements in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents 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' policies and procedures. 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. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Recommendations

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

- We recommend that HHS continue its review over all of its 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's personnel to provide assurances that processes are executed properly. Further, we recommend that the on-going monitoring process be enhanced to provide stronger internal controls so that anomalies can be prevented or identified timely.

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- We recommend that CMS continue to refine its financial management controls as a means to improve its accounting, analysis, and oversight of financial management activity, primarily relating to the oversight of the Medicaid program. Additionally, we recommend that CMS 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. Finally, we recommend that CMS 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 its accruals. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Status of Prior Year Findings

In the reports on the results of the FY 2018 audit of the HHS consolidated financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Significant Deficiencies		
Issue Area	**FY 2018 Summary Control Issue**	**FY 2019 Status**
Financial Information Systems	• Access Controls • Configuration Management • Segregation of Duties • Risk Management	Significant progress noted; certain issues need continued focus. Modified Repeat Condition

Financial Systems, Analysis, and Reporting	• Non-Standard Journal Voucher Processes
	• CMS Oversight Processes
	  ○ Medicaid Oversight
	  ○ Statement of Social Insurance
		Progress noted.
		Modified Repeat Condition.

HHS's Response to Findings

HHS's response to the findings identified in our audit are included in the accompanying letter dated November 13, 2019. 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 the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 13, 2019

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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, 2019, 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, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 13, 2019. 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, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 19-03, including 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 2019, 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 an obligation of funds for conference spending at Food and Drug Administration and 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. Additionally, 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*. Finally, HHS places a high priority on complying with appropriations and acquisitions law and avoiding violations of the Federal Acquisition Regulation (FAR). When a violation is suspected, HHS obtains legal review and advice from the Office of the General Counsel (OGC) before determining whether a violation exists. HHS internal reviews have revealed noncompliance issues related to three subparts of the FAR, including FAR 4.4, FAR 17.5, and FAR 17.7.

The *Improper Payments Information Act of 2002* (IPIA) (P.L. 107-300) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) (P.L. 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Acts. 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 percent. 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' response to the findings identified in our audit are described in their letter dated November 13, 2019. 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, 2019

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: Joanne Chiedi, Acting Inspector General

From: Jen Moughalian, Principal Deputy Assistant Secretary

Subject: FY 2019 Independent Auditors' Financial Statement Audit Report

Thank you for the opportunity to comment on the FY 2019 Independent Auditors' Report. We appreciate the tremendous effort put forth by the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP (EY), to audit the Department of Health and Human Services' (HHS) financial statements.

We are proud to once again have an unmodified opinion on our financial statements. We acknowledge the identified material noncompliances with laws and regulations, and we generally concur with the auditor's findings. We will continue to actively engage in effective corrective actions and monitor remediation efforts. The Department has diligently worked to improve our control environment, and we intend to remain flexible as new challenges and concerns emerge.

The Department has greatly benefited from the annual audit process and its resulting perspective and insight over the years. We thank OIG and EY for their effort and look forward to partnering with you and our valued stakeholders to address these issues and improve our financial management practices.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary
November 13, 2019

Principal Financial Statements

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

As of September 30, 2019 and 2018
(in Millions)

	2019	2018
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 296,257	$ 250,163
Investments, Net (Note 4)	309,349	307,115
Accounts Receivable, Net (Note 5)	812	1,129
Advances (Note 8)	180	255
Total Intragovernmental Assets	**606,598**	**558,662**
Accounts Receivable, Net (Note 5)	24,156	26,802
Inventory and Related Property, Net (Note 6)	10,781	9,815
General Property, Plant and Equipment, Net (Note 7)	6,544	6,350
Advances (Note 8)	2,452	2,694
Other Assets	197	204
Total Assets	**$ 650,728**	**$ 604,527**
Stewardship Land (Notes 19)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 1,153	$ 1,029
Other Liabilities (Note 13)	5,573	8,080
Total Intragovernmental Liabilities	**6,726**	**9,109**
Accounts Payable	1,221	957
Entitlement Benefits Due and Payable (Note 10)	110,100	99,148
Accrued Liabilities (Note 12)	15,543	14,521
Federal Employee and Veterans' Benefits (Note 11)	14,826	14,386
Contingencies and Commitments (Note 14)	17,083	13,475
Other Liabilities (Note 13)	3,695	5,736
Total Liabilities	**169,194**	**157,332**
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 18)	57,968	22,934
Unexpended Appropriations - All Other funds	170,438	163,667
Cumulative Results of Operations - Funds from Dedicated Collections (Note 18)	258,392	262,972
Cumulative Results of Operations - All Other funds	(5,264)	(2,378)
Total Net Position - Funds from Dedicated Collections	**316,360**	**285,906**
Total Net Position - All Other Funds	**165,174**	**161,289**
Total Net Position	**481,534**	**447,195**
Total Liabilities and Net Position	**$ 650,728**	**$ 604,527**

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, 2019 and 2018
(in Millions)

	2019	2018
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,201,630	$ 1,115,161
Exchange Revenue	(114,723)	(106,304)
CMS Net Cost of Operations	$ 1,086,907	$ 1,008,857
Other Segments:		
Administration for Children and Families (ACF)	$ 56,087	$ 54,091
Administration for Community Living (ACL)	2,176	1,994
Agency for Healthcare Research and Quality (AHRQ)	335	344
Centers for Disease Control and Prevention (CDC)	12,285	12,382
Food and Drug Administration (FDA)	5,339	5,023
Health Resources and Services Administration (HRSA)	11,655	11,684
Indian Health Service (IHS)	7,550	10,766
National Institutes of Health (NIH)	35,822	33,587
Office of the Secretary (OS)	3,439	3,221
Program Support Center (PSC)	2,771	2,588
Substance Abuse and Mental Health Services Administration (SAMHSA)	4,525	4,124
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 141,984	$ 139,804
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes (Note 11)	(27)	416
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 141,957	$ 140,220
Exchange Revenue	(6,015)	(5,806)
Other Segments Net Cost of Operations	135,942	134,414
Net Cost of Operations (Note 20)	**$ 1,222,849**	**$ 1,143,271**

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
Consolidated Statement of Changes in Net Position

For the Year Ended September 30, 2018

(in Millions)

	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 17,284	$ 129,688	$ -	$ 146,972
Budgetary Financing Sources:				
Appropriations Received	376,964	653,567	-	1,030,531
Appropriations Transferred in/out (+/-)	-	1	-	1
Other Adjustments (+/-)	(34,637)	(85,787)	-	(120,424)
Appropriations Used	(336,677)	(533,802)	-	(870,479)
Total Budgetary Financing Sources	5,650	33,979	-	39,629
Total Unexpended Appropriations	**$ 22,934**	**$ 163,667**	**$ -**	**$ 186,601**
Cumulative Results of Operations:				
Beginning Balances	$ 257,676	$ (1,730)	$ -	$ 255,946
Budgetary Financing Sources:				
Other Adjustments (+/-)	(3)	(5)	-	(8)
Appropriations Used	336,677	533,802	-	870,479
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	264,566	-	-	264,566
Nonexchange Revenue - Investment Revenue	9,746	27	-	9,773
Nonexchange Revenue - Other	4,946	-	-	4,946
Donations and Forfeitures of Cash and Cash Equivalents	75	-	-	75
Transfers-in/out without Reimbursement (+/-)	(5,203)	2,551	-	(2,652)
Other (+/-)	-	1	-	1
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	(2)	3	-	1
Imputed Financing	64	1,001	(323)	742
Other (+/-)	(8)	(1)	-	(9)
Total Financing Sources	610,858	537,384	(323)	1,147,919
Net Cost of Operations (+/-)	605,562	538,032	(323)	1,143,271
Net Change	5,296	(648)	-	4,648
Cumulative Results of Operations:	**$ 262,972**	**$ (2,378)**	**$ -**	**$ 260,594**
Net Position	**$ 285,906**	**$ 161,289**	**$ -**	**$ 447,195**

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, 2019 and 2018
(in Millions)

	2019	2018
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 120,849	$ 97,593
Appropriations (Discretionary and Mandatory)	1,777,690	1,646,670
Borrowing Authority (Discretionary and Mandatory)	5	(127)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	25,621	13,644
Total Budgetary Resources (Note 21)	**$ 1,924,165**	**$ 1,757,780**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 21)	$ 1,814,780	$ 1,680,053
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	50,356	43,508
Exempt from Apportionment, Unexpired Accounts	172	188
Unapportioned, Unexpired Accounts	30,976	9,970
Unexpired Unobligated Balance, End of Year	81,504	53,666
Expired Unobligated Balance, End of Year	27,881	24,061
Unobligated Balance, End of Year	109,385	77,727
Total Budgetary Resources (Note 21)	**$ 1,924,165**	**$ 1,757,780**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory) (Note 20)	1,706,314	1,589,140
Distributed Offsetting Receipts (Note 20)	(492,692)	(468,877)
Agency Outlays, Net (Discretionary and Mandatory) (Note 20)	**$ 1,213,622**	**$ 1,120,263**

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, 2019 and Prior Base Years

(in Billions)

		Estimates from Prior Years			
	2019	2018	2017	2016	2015
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 11,995	$ 11,323	$ 10,679	$ 10,294	$ 9,134
SMI Part B	27,556	24,143	21,641	19,386	17,027
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 or over)					
HI	559	525	492	455	382
SMI Part B	5,232	4,725	4,122	3,660	3,300
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	11,805	10,959	10,567	9,952	8,386
SMI Part B	6,864	5,586	5,019	4,437	3,668
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants					
HI	24,359	22,807	21,738	20,701	17,902
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 20,028	$ 18,604	$ 17,193	$ 16,800	$ 14,494
SMI Part B	27,270	23,832	21,392	19,178	16,818
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 and over)					
HI	5,348	5,027	4,539	4,285	3,803
SMI Part B	5,741	5,180	4,531	4,026	3,637
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	4,467	3,884	3,539	3,437	2,791
SMI Part B	6,641	5,442	4,860	4,281	3,540
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants:					
HI	29,843	27,515	25,270	24,523	21,089
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 23 and 24)					
HI	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)	$ (3,187)
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 23 and 24)					
HI	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)	$ (3,187)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	200	202	199	194	197
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	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 23 and 24)					
HI	$ (5,283)	$ (4,506)	$ (3,333)	$ (3,628)	$ (2,990)
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	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, 2019 and Prior Base Years

(in Billions)

		Estimates from Prior Years			
	2019	2018	2017	2016	2015
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)	$ 6,843	$ 6,266	$ 5,572	$ 5,067	$ 4,569
Expenditures	12,140	11,222	10,027	9,263	8,328
Income less expenditures	(5,297)	(4,957)	(4,455)	(4,196)	(3,759)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	46,731	42,643	39,250	37,339	32,585
Expenditures	54,479	49,612	45,514	43,637	37,736
Income less expenditures	(7,748)	(6,970)	(6,264)	(6,298)	(5,151)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,045)	(11,926)	(10,719)	(10,493)	(8,909)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,740)	(11,637)	(10,425)	(10,230)	(8,643)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	21,669	19,477	18,456	17,992	14,898
Expenditures	14,108	12,258	11,268	11,320	9,176
Income less expenditures	7,561	7,219	7,187	6,672	5,722
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,484)	(4,708)	(3,532)	(3,822)	(3,187)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (5,179)	$ (4,418)	$ (3,237)	$ (3,559)	$ (2,921)

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, 2018 to January 1, 2019

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
Total Medicare (Note 25)					
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 25)					
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 25)					
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 25)					
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.

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

January 1, 2017 to January 1, 2018

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
Total Medicare (Note 25)					
As of January 1, 2017	$ 63,277	$ 66,809	$ (3,532)	$ 295	$ (3,237)
Reasons for change					
Change in the valuation period	2,355	2,523	(168)	-	(168)
Change in projection base	(502)	419	(921)	(5)	(926)
Changes in the demographic assumptions	(551)	(985)	434	-	434
Changes in economic and health care assumptions	3,176	3,162	14	-	14
Changes in law	629	1,165	(535)	-	(535)
Net changes	5,107	6,283	(1,176)	(5)	(1,181)
As of January 1, 2018	$ 68,385	$ 73,092	$ (4,708)	$ 290	$ (4,418)
HI - Part A (Note 25)					
As of January 1, 2017	$ 21,738	$ 25,270	$ (3,532)	$ 199	$ (3,333)
Reasons for change					
Change in the valuation period	747	915	(168)	11	(157)
Change in projection base	(612)	309	(921)	(8)	(929)
Changes in the demographic assumptions	(214)	(648)	434	-	434
Changes in economic and health care assumptions	1,223	1,208	14	-	14
Changes in law	(74)	461	(535)	-	(535)
Net changes	1,069	2,245	(1,176)	3	(1,173)
As of January 1, 2018	$ 22,807	$ 27,515	$ (4,708)	$ 202	$ (4,506)
SMI - Part B (Note 25)					
As of January 1, 2017	$ 30,783	$ 30,783	$ -	$ 88	$ 88
Reasons for change					
Change in the valuation period	1,154	1,154	-	(10)	(10)
Change in projection base	197	197	-	2	2
Changes in the demographic assumptions	(358)	(358)	-	-	-
Changes in economic and health care assumptions	2,087	2,087	-	-	-
Changes in law	591	591	-	-	-
Net changes	3,670	3,670	-	(8)	(8)
As of January 1, 2018	$ 34,453	$ 34,453	$ -	$ 80	$ 80
SMI - Part D (Note 25)					
As of January 1, 2017	$ 10,756	$ 10,756	$ -	$ 8	$ 8
Reasons for change					
Change in the valuation period	455	455	-	(1)	(1)
Change in projection base	(87)	(87)	-	1	1
Changes in the demographic assumptions	21	21	-	-	-
Changes in economic and health care assumptions	(133)	(133)	-	-	-
Changes in law	113	113	-	-	-
Net changes	368	368	-	-	-
As of January 1, 2018	$ 11,124	$ 11,124	$ -	$ 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 214 appropriation fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. 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 one (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. 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 Fiscal Year (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 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).

F. Changes, Reclassifications and Adjustments

Certain FY 2018 balances have been reclassified to conform to FY 2019 financial statement presentations. The effects are immaterial.

G. 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 (RDS). In addition, the Low Income Subsidy (LIS) 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 2019. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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 (See Note 4).

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.

The *Children's Health Insurance Program Reauthorization Act of 2009* established a Child Enrollment Contingency Fund to cover shortfalls in funding for the States. This fund is invested in interest-bearing Treasury securities.

N. 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 on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for

reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. 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.

O. 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.

P. 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 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 Strategic National Stockpile (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.

Q. 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.

R. 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.

S. 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

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

T. 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.

U. 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.

V. 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.

Medicare

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that

have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2019 and 2018 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 represents 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 calendar year 2019. 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, 2019.

Medicaid and CHIP

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.

Other

The Other liability line item includes estimates of payments due to those participating in Exchange activities.

W. 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 3 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 1 percent of each employee's pay to the Thrift Savings Plan and matches the first 3 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.

X. 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.

Y. 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 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 2019 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 April 22, 2019, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance 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, required by the Affordable Care Act, 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, 2019, except that the projections disregard payment

reductions that would result from the projected depletion of the Medicare Hospital Insurance 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.

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

	2019	2018
Non-Entity Intragovernmental Assets	$ 1	$ -
Non-Entity With the Public Assets	46	45
Total Non-Entity Assets	47	45
Total Entity Assets	650,681	604,482
Total Assets	**$ 650,728**	**$ 604,527**

Note 3. Fund Balance with Treasury (in Millions)

	2019	2018
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 50,528	$ 43,696
Unavailable	58,857	34,031
Obligated Balance not yet Disbursed	258,872	237,535
Non-Budgetary Fund Balance with Treasury	(72,000)	(65,099)
Total Fund Balance with Treasury	**$ 296,257**	**$ 250,163**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $16.6 billion as of September 30, 2019 ($14.7 billion in FY 2018). The restricted amount is primarily for PPACA, CHIP, CMS Program Management, and State Grants and Demonstrations.

Note 4. Investments, Net (in Millions)

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**

2018	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 301,003	$ -	$ 2,249	$ 303,252	$ 303,252
Non-Marketable: Market-Based	3,827	20	16	3,863	3,863
Total, Intragovernmental	**$ 304,830**	**$ 20**	**$ 2,265**	**$ 307,115**	**$ 307,115**

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, 2020 through June 30, 2034, with interest rates ranging from 1.875 percent to 5.125 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2020, with interest rates ranging from 1.625 percent to 2.125 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2019 through FY 2024. The Market-Based Notes paid from 1.0 percent to 2.375 percent during October 1, 2018 to September 30, 2019, and 1.0 percent to 2.0 percent during October 1, 2017 to September 30, 2018. 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 2019, yielded from 1.9439 percent to 2.5115 percent depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

2019	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, 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**

2018	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 1,129	$ -	$ 1,129	$ -	$ 1,129
Total, Intragovernmental	**$ 1,129**	**$ -**	**$ 1,129**	**$ -**	**$ 1,129**
With the Public					
Entity					
Medicare	$ 21,039	$ -	$ 21,039	$ (3,286)	$ 17,753
Medicaid	5,101	-	5,101	(957)	4,144
Other	5,379	305	5,684	(824)	4,860
Non-Entity	12	65	77	(32)	45
Total with the Public	**$ 31,531**	**$ 370**	**$ 31,901**	**$ (5,099)**	**$ 26,802**

As of September 30, 2019, the other accounts receivable with the public is primarily related to collections for Exchange activities and restitution. For FY 2019, restitution gross balances are approximately $2.2 billion with a net balance of $67 million ($2.0 billion with a net balance of $65 million in FY 2018).

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

	2019	2018
Inventory Held for Sale or Use	$ 91	$ 48
Stockpile Materials Held for Emergency or Contingency	10,690	9,767
Inventory and Related Property, Net	**$ 10,781**	**$ 9,815**

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

			2019		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	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**

			2018		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	771	-	771
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,191	(3,247)	2,944
Equipment	Straight-Line	3-20 Yrs	2,146	(1,258)	888
Internal Use Software	Straight-Line	5-10 Yrs	3,439	(1,805)	1,634
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(71)	48
Leasehold Improvements	Straight-Line	*Life of Lease	56	(45)	11
Totals			**$ 12,776**	**$ (6,426)**	**$ 6,350**

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

Note 8. Advances (in Millions)

	2019	2018
Intragovernmental		
Advances to Other Federal Entities	$ 180	$ 255
Total Intragovernmental	**$ 180**	**$ 255**
With the Public		
Grant Advances	2,395	2,644
Other	57	50
Total with the Public	**$ 2,452**	**$ 2,694**

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

	2019	2018
Intragovernmental		
Accrued Payroll and Benefits	$ 53	$ 55
Other	1,533	1,533
Total Intragovernmental	**$ 1,586**	**$ 1,588**
Federal Employee and Veterans' Benefits (Note 11)	14,826	14,386
Accrued Payroll and Benefits	722	681
Contingencies and Commitments (Note 14)	17,083	13,475
Accrued Liabilities	5,057	6,933
Other	229	231
Total Liabilities Not Covered by Budgetary Resources	$ 39,503	$ 37,294
Total Liabilities Covered by Budgetary Resources	127,437	117,991
Total Liabilities Not Requiring Budgetary Resources	2,254	2,047
Total Liabilities	**$ 169,194**	**$ 157,332**

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

	2019	2018
Medicare Fee-For-Service	$ 54,752	$ 51,031
Medicare Advantage/Prescription Drug Program	16,839	11,165
Medicaid	37,147	35,570
CHIP	1,360	1,377
Other	2	5
Totals	**$ 110,100**	**$ 99,148**

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 (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (d) periodic interim payments for services rendered in the current fiscal year

but paid in the subsequent fiscal year; and (e) an estimate of retroactive settlements of cost reports. The September 30, 2019 and 2018 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 2019. 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, 2019.

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.

The Other line item includes estimates of payments due to those participating in Exchange activities.

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

	2019	2018
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 13,758	$ 13,338
PHS Commissioned Corp Post-Retirement Health Benefits	792	772
Workers' Compensation Benefits (Actuarial FECA Liability)	276	276
Total, Federal Employee and Veterans' Benefits	**$ 14,826**	**$ 14,386**

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,219 active duty officers and 7,244 retiree annuitants and survivors. As of September 30, 2019, the actuarial accrued liability for the retirement benefit plan was $13.8 billion and $0.8 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, 2019, and September 30, 2018, were:

	2019	2018
Discount rate	3.76 percent	3.92 percent
Annual basic pay scale increase	2.31 percent	2.62 percent
Annual inflation	2.01 percent	2.12 percent

	2019	2018
Beginning Liability Balance	$ 14,110	$ 13,253
Expense		
Normal Cost	397	380
Interest on the liability balance	542	526
Actuarial (Gain)/Loss		
From experience	77	57
From assumption changes		
Change in discount rate assumption	307	236
Change in inflation/salary increase assumption	(213)	109
Change from Experience Study	(105)	-
Change in mortality rate/others	(16)	71
Total From assumption changes	$ (27)	$ 416
Net Actuarial (Gain)/Loss	50	473
Total expense	989	1,379
Less amounts paid	(549)	(522)
Ending Liability Balance	**$ 14,550**	**$ 14,110**

The above shows key valuation results as of September 30, 2019, and 2018, 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 June 30, 2019, and actuarial assumptions. The September 30, 2019, valuation includes an increase in liabilities of $440 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 changes in other actuarial assumptions since the prior valuation, 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 2019 has decreased relative to the prior year expense.

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 2019 and 2018, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior 4 years. Interest rate assumptions utilized for discounting as of September 30, 2019, and September 30, 2018, as follows.

	2019	2018
Wage Benefits	2.610% in Year 1 and years thereafter	2.716% in Year 1 and years thereafter
Medical Benefits	2.350% in Year 1 and years thereafter	2.379% 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
2019	N/A	N/A
2020	1.47%	2.86%
2021	1.85%	3.05%
2022	2.12%	3.09%
2023	2.17%	3.47%
2024	2.21%	3.88%

Note 12. Accrued Liabilities (in Millions)

	2019	2018
Grant Liability	$ 7,582	$ 7,588
Other Accrued Liabilities	7,961	6,933
Accrued Liabilities	**$ 15,543**	**$ 14,521**

Note 13. Other Liabilities (in Millions)

	2019		2018	
	Intragovernmental	With the Public	Intragovernmental	With the Public
Accrued Payroll & Benefits	$ 151	$ 1,197	$ 141	$ 1,108
Advances from Others	520	842	899	888
Deferred Revenue	-	1,250	-	1,066
Custodial Liabilities	332	8	342	8
Legal Liabilities	1,172	-	1,155	-
Other	3,398	398	5,543	2,666
Total Other Liabilities	**$ 5,573**	**$ 3,695**	**$ 8,080**	**$ 5,736**

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, 2019, $3.2 billion ($5.0 billion in FY 2018) is still owed and is reported as Other. Legal Liabilities of $1.2 billion as of September 30, 2019 ($1.2 billion as of September 30, 2018) consist of reimbursable claims due to the Judgment Fund, which is administered by Fiscal Service.

Note 14. Contingencies and Commitments (in Millions)

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.

Medicaid Audit and Program Disallowances

The Medicaid amount of $9.9 billion ($6.3 billion in FY 2018) 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 $5.2 billion in FY 2019 ($4.8 billion in FY 2018).

Other contingent liabilities against HRSA have been accrued in the financial statements for the Vaccine Injury Compensation program and other Health Center claims.

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 $223.6 billion, as of September 30, 2019, ($230.9 billion as of September 30, 2018), 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)

	2018			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 1,757,780	$ 1,680,053	$ 468,877	$ 1,589,140
Expired Accounts	(25,399)	-	-	-
Other	235	(31)	134	7
Budget of the U.S. Government	**$ 1,732,616**	**$ 1,680,022**	**$ 469,011**	**$ 1,589,147**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2019, has not been published, therefore, no comparisons can be made between FY 2019 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2021 President's Budget* is expected to be released in February 2020 and may be obtained from OMB or from Government Printing Office.

HHS reconciled the amounts of the FY 2018 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2018 from the Appendix in the *FY 2020 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays (i.e., gross outlays less offsetting collections), as presented above.

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)

	2019			2018		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 323	$ 2,527	$ 2,850	$ 249	$ 2,873	$ 3,122
Undelivered Orders, Unpaid	7,052	131,458	138,510	6,474	122,662	129,136
Total Undelivered Orders	**$ 7,375**	**$ 133,985**	**$ 141,360**	**$ 6,723**	**$ 125,535**	**$ 132,258**

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 $141.4 billion of budgetary resources obligated for undelivered orders as of September 30, 2019 ($132.3 billion as of September 30, 2018).

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 major fund's purpose and how HHS accounts for and reports the funds.

2019 Balance Sheet as of September 30	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**

2018 Balance Sheet as of September 30	Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 27,389	$ 11,152	$ -	$ 38,541
Investments	303,253	3,862	-	307,115
Other Assets	90,933	6,908	(74,037)	23,804
Total Assets	**$ 421,575**	**$ 21,922**	**$ (74,037)**	**$ 369,460**
Entitlement Benefits Due and Payable	$ 62,196	$ 3	$ -	$ 62,199
Other Liabilities	84,031	11,361	(74,037)	21,355
Total Liabilities	**$ 146,227**	**$ 11,364**	**$ (74,037)**	**$ 83,554**
Unexpended Appropriations	$ 22,855	$ 79	$ -	$ 22,934
Cumulative Results of Operations	252,493	10,479	-	262,972
Total Liabilities and Net Position	**$ 421,575**	**$ 21,922**	**$ (74,037)**	**$ 369,460**
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 717,153	$ (2,586)	$ (142)	$ 714,425
Less: Exchange Revenues	100,322	8,683	(131)	108,874
Net Cost of Operations	**$ 616,831**	**$ (11,269)**	**$ (11)**	**$ 605,551**
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 276,993	$ (2,033)	$ -	$ 274,960
Nonexchange Revenue	278,884	374	-	279,258
Other Financing Sources	336,302	948	(11)	337,239
Net Cost of Operations	(616,831)	11,269	11	(605,551)
Change in Net Position	$ (1,645)	$ 12,591	$ -	$ 10,946
Net Position End of Period	**$ 275,348**	**$ 10,558**	**$ -**	**$ 285,906**

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 573 federally recognized tribes in 37 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI 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	2019	2018
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)

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)
Investment	17	-	17
Other Asset – Regulatory Assets	(76)	(249)	(325)
	(398)	**(2,901)**	**(3,299)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	301	(11,168)	(10,867)
Salaries and Benefits	(12)	(47)	(59)
Environmental and Disposal Liabilities	-	3	3
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(39)	(3,007)	(3,046)
	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[8]			(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**

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

2018	Intragovernmental	With the Public	Total
Net Cost of Operations	**$ 3,897**	**$ 1,139,374**	**$ 1,143,271**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation	-	(751)	(751)
Property, Plant, and Equipment Disposal & Reevaluation	-	(2)	(2)
Other	-	(16)	(16)
	-	**(769)**	**(769)**
Increase/(Decrease) in Assets:			
Accounts Receivables	141	(6,282)	(6,141)
Investment	44	-	44
Other Asset – Regulatory Assets	24	(28,420)	(28,396)
	209	**(34,702)**	**(34,493)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	(194)	8,805	8,611
Salaries and Benefits	(4)	(103)	(107)
Environmental and Disposal Liabilities	-	(11)	(11)
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(766)	(2,942)	(3,708)
	(964)	**5,749**	**4,785**
Other Financing Sources:			
Federal Employee Retirement Benefit Costs Paid by OPM and Imputed to the Agency	(742)	-	(742)
Transfers out (in) Without Reimbursement	3,289	-	3,289
	2,547	**-**	**2,547**
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	10	246	256
Acquisition of Inventory	1	740	741
Other	189	4,351	4,540
	200	**5,337**	**5,537**
Net Outlays	**$ 5,889**	**$ 1,114,989**	**$ 1,120,878**
Federal Share of Child Support Collections and Other[9]			(615)
Net Outlays, Net			**$ 1,120,263**
Related Amounts on Combined Statement of Budgetary Resources			
Outlays, Net			1,589,140
Distributed Offsetting Receipts			(468,877)
Agency Outlays, Net			**$ 1,120,263**

[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., obligating) 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. Object Classes are the criteria by which both group spending activity by type. 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 FY. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current FY. 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 amount agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by program with spending greater than $1.0 billion are presented separately. Grants, Subsidies, & Contributions, Insurance Claims and Indemnities, Other Contractual Services and Personnel Compensation & Benefits are the object

[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.

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 object class definition.

Combined Schedule of Spending

For the Years Ended September 30, 2019 and 2018
(in Millions)

What Money is Available to Spend	2019	2018
Total Resources	$ 1,924,165	$ 1,757,780
Less Amount Available but Not Agreed to be Spent	50,528	43,696
Less Amount Not Available to be Spent	58,857	34,031
Total Amounts Agreed to be Spent	**$ 1,814,780**	**$ 1,680,053**

Who Did the Money Go To	2019	2018
Federal	$ 10,522	$ 9,133
Non-Federal	1,804,258	1,670,920
Total Amounts Agreed to be Spent	**$ 1,814,780**	**$ 1,680,053**

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 Child 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**

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2018

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 437,108	$ -	$ 101	$ 19	$ 4,164	$ 441,392
Federal Supplementary Medical Insurance Trust Fund	-	322,244	88	1	5,146	327,479
Payments to Trust Funds	251,278	-	-	-	70,309	321,587
Federal Hospital Insurance Trust Fund	-	298,861	10	-	4,056	302,927
Medicare Prescription Drug Account	-	81,100	-	1	426	81,527
Taxation on OASDI Benefits, HI	24,192	-	-	-	-	24,192
State Children's Health Insurance Fund	17,484	-	5	-	-	17,489
Temporary Assistance for Needy Families	16,612	-	90	11	3	16,716
Children and Families Services Programs	11,244	-	384	149	13	11,790
Payments for Foster Care and Permanency	8,185	-	33	-	2	8,220
National Cancer Institute	3,678	-	1,683	555	132	6,048
Indian Health Services	2,571	10	888	1,455	821	5,745
Primary Health Care	5,118	-	240	74	12	5,444
National Institute of Allergy and Infectious Diseases	3,297	-	1,582	344	116	5,339
Payment to States for the Child Care and Development Block Grant	5,128	-	102	2	-	5,232
Payments to States for Child Support Enforcement and Family Support Programs	3,805	-	624	-	-	4,429
Risk Adjustment Program Payments	-	3,865	-	-	11	3,876
Substance Abuse Treatment	3,640	-	112	9	-	3,761
Low Income Home Energy Assistance	3,638	-	3	-	-	3,641
National Heart, Lung, and Blood Institute	2,715	-	508	160	33	3,416
Child Care Entitlement to States	2,955	-	18	-	2	2,975
National Institute of General Medical Sciences	2,653	-	113	30	1	2,797
National Institute on Aging	2,281	-	220	76	22	2,599
Refugee and Entrant Assistance	2,070	-	360	15	6	2,451
Ryan White HIV/AIDS Program	2,240	-	96	26	4	2,366
Public Health and Social Services Emergency Fund	338	-	1,291	157	453	2,239
Aging and Disability Services Programs	2,124	-	48	30	6	2,208
National Institute of Diabetes and Digestive and Kidney Diseases	1,673	-	239	121	28	2,061
Health Care Fraud and Abuse Control Account	1	-	1,371	59	588	2,019
National Institute of Neurological Disorders and Stroke	1,603	-	254	96	26	1,979
NIH Service and Supply Fund	-	-	1,310	287	350	1,947
PSC Service and Supply Fund	-	-	1,655	157	84	1,896
National Institute of Mental Health	1,421	-	232	105	18	1,776
Social Services Block Grant	1,661	-	10	1	-	1,672
Mental Health	1,445	-	89	5	1	1,540
National Institute of Child Health and Human Development	1,042	-	329	104	20	1,495
National Institute on Drug Abuse	955	-	238	66	12	1,271
Public Health Preparedness and Response	630	-	258	122	162	1,172
Chronic Disease Prevention and Health Promotion	758	-	275	129	8	1,170
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	742	-	187	176	19	1,124
Other Agency Budgetary Accounts	14,418	1,185	14,368	7,573	3,502	41,046
Total Amounts Agreed to be Spent	**$ 840,703**	**$ 707,265**	**$ 29,414**	**$ 12,115**	**$ 90,556**	**$ 1,680,053**

Note 22: 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, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
ASSETS			**ASSETS**
Intra-Governmental Assets			**Intra-Governmental Assets**
Fund Balance with Treasury	$ 296,257	$ 296,257	Fund Balance with Treasury
		307,302	*Federal Investments*
		2,047	*Interest Receivable – Investments*
Investments, Net	309,349	309,349	Total Reclassified Investments, Net
		223	*Accounts Receivable*
		589	*Transfers Receivable*
Accounts Receivable, Net	812	812	Total Reclassified A/R
Advances	180	180	Advances to Others and Prepayments
Total Intra-Governmental Assets	**606,598**	**606,598**	**Total Intra-Governmental Assets**
Accounts Receivable, Net	24,156	24,156	Accounts and Taxes Receivable, Net
Inventory and Related Property, Net	10,781	10,781	Inventory and Related Property, Net
General PP&E, Net	6,544	6,544	PP&E, Net
Advances	2,452	2,452	Other Assets
		187	*Loans Receivable, Net*
		9	*Other Assets*
Other Assets	197	196	*Total Reclassified Other Assets*
Total Assets	**$ 650,728**	**$ 650,727**	**Total Assets**
LIABILITIES			**LIABILITIES**
Intra-Governmental Liabilities			**Intra-Governmental Liabilities**
		$ 163	*Accounts Payable*
		989	*Transfers Payable*
Accounts Payable	$ 1,153	1,152	Total Reclassified Accounts Payable
		332	*Liability to General Fund for Custodial and Other Non-Entity Assets*
		29	*Liability to the GF for Custodial and Other Non-Entity Assets*
		1,209	*Accounts Payable*
		124	*Benefit Program Contributions Payable*
		520	*Advances from Other & Deferred Credits*
		3,359	*Loans Payable*
Other Liabilities	5,573	5,573	*Total Reclassified Other – Miscellaneous Liabilities*
Total Intra-Governmental Liabilities	**6,726**	**6,725**	**Total Intra-Governmental Liabilities**
Accounts Payable	1,221	1,221	Accounts Payable
Federal Employee and Veteran Benefits	14,826	14,827	Federal Employee and Veteran Benefits Payable
Benefits Due and Payable	110,100	110,101	Benefits Due and Payable
Contingent Liabilities	17,083	17,083	Other Liabilities
Accrued Liabilities	15,543	15,543	Other Liabilities
		1	*Loan Guarantee Liabilities*
		220	*Environmental and Disposal Liabilities*
		3,472	*Other Liabilities*
Other Liabilities	3,695	3,693	*Total Reclassified Miscellaneous Liabilities*
Total Liabilities	**$ 169,194**	**$ 169,193**	**Total Liabilities**
NET POSITION			
Unexpended Appropriations – Funds from Dedicated Collections	$ 57,968	$ 57,968	Net Position – Funds from Dedicated Collections
Unexpended Appropriations – All Other Funds	170,438	170,438	Net Position – Funds Other than those from Dedicated Collections
Cumulative Results of Operations – Funds from Dedicated Collections	258,392	258,392	Net Position – Funds from Dedicated Collections
Cumulative Results of Operations – All Other Funds	(5,264)	(5.264)	Net Position – Funds Other than those from Dedicated Collections
Total Net Position	**481,534**	**481,534**	**Total Net Position**
Total Liabilities & Net Position	**$ 650,728**	**$ 650,727**	**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, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
		$ 1,338,407	***Non-Federal Costs***
			Intragovernmental Costs
		1,666	*Benefit Program Costs*
		548	*Imputed Costs*
		2,405	*Buy/Sell Costs*
		148	*Purchase of Assets*
		10	*Borrowing and Other Interest Expense*
		579	*Other Expenses (w/o Reciprocals)*
		5,355	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,201,630		
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	141,984		
Total Gross Costs	**$ 1,343,614**	**$ 1,343,762**	***Total Reclassified Gross Costs***
		(119,117)	**Non-Federal Earned Revenue**
			Intragovernmental Earned Revenue
		(1,604)	*Buy/Sell Revenue*
		(5)	*Borrowing and Other Interest Revenue*
		(148)	*Purchase of Assets Offset*
		(1,756)	**Total Intragovernmental Earned Revenue**
CMS: Exchange Revenue	(114,723)		
Other Segments: Exchange Revenue	(6,015)		
Total Exchange Revenue	**$ (120,738)**	**$ (120,874)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes	(27)	(27)	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost	**$ 1,222,849**	**$ 1,222,861**	**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, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 186,601	$ 186,601	Net Position, Beginning of Period
Appropriations Received	1,059,390	964,048	Appropriations Received as Adjusted
Other Adjustments	(95,342)		
		10	*Non-Expenditure Transfers-In of Unexpended Appropriations and Financing Sources (Federal)*
		(7)	*Non-Expenditure Transfers-Out of Unexpended*
Appropriations Transferred In/Out	3	3	Total Reclassified Appropriations Transferred In/Out
Appropriations Used	(922,246)	(922,246)	Appropriations Used (Federal)
Total Unexpended Appropriations	**$ 228,406**	**$ 228,406**	
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 260,594	$ 260,594	Net Position, Beginning of Period
Other Adjustments	(8)	(8)	Revenue and Other Financing Sources – Cancellations
Appropriations Used	922,246	922,246	Appropriations Expended
			Intragovernmental Non-Exchange Revenues
Nonexchange Revenue – Tax Revenue	281,441	281,441	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	9,771	9,771	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange)
		2,717	*Other Taxes and Receipts (RC 45)*
		817	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,533	3,534	Total Other Taxes and Receipts
	294,745	**294,746**	***Total Intragovernmental Non-Exchange Revenues***
Donations and Forfeitures of Cash and Cash Equivalents	69	69	Other Taxes and Receipts
		804	*Expenditure Transfers-In of Financing Sources*
		(3,024)	*Expenditure Transfers-Out of Financing Sources*
Transfers-In/Out Without Reimbursement (+/-) – Budgetary	(2,220)	(2,220)	Total Reclassified Transfers-In/Out w/o Reimbursement – Budgetary
Total Budgetary Financing Sources	**1,214,832**	**1,214,833**	**Total Budgetary Financing Sources**
Other Financing Sources			
Donations and Forfeitures of Property	7	7	Other Taxes and Receipts
Imputed Financing	548	548	Imputed Financing Sources (Federal)
		(1,947)	*Other Taxes and Receipts*
		1,943	*Collections transferred into a TAS Other Than the General Fund of the U.S. Government –Non-Exchange*
Other (+/-)	(4)	(4)	
Total Other Financing Sources	551	551	Total Reclassified Other
Total Financing Sources	**1,215,383**	**1,215,384**	**Total Financing Sources**
		2	*Interest Revenue - Other*
		2,805	*Other Taxes and Receipts*
		(1,090)	*Non-Entity Collections Transferred to the General Fund*
		(1,718)	*Other Taxes and Receipts*
		11	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund*
		1	*Other Non-Budgetary Financing Sources*
		11	
Net Cost of Operations	**1,222,849**	**1,222,861**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 253,128**	**$ 253,128**	**Net Position – Ending Balance**
Total Net Position	**$ 481,534**	**$ 481,534**	**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.

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 $12 million for the Statements of Net Cost and $11 million for the Statement of Changes in Net Position due to custodial activities. The remainder of the differences are due to rounding.

Note 23. 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 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 *2019 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 April 22, 2019, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that 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, required by the *Affordable Care Act*, 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, 2019, except that the projections disregard 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 2019 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2019. 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 at http://www.cms.hhs.gov/CFOReport/.[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 2019

					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]
2019	1.75	1,409,000	785.9	2.19	4.02	1.83	2.8	3.5	5.5	-1.5	1.0
2020	1.76	1,413,000	779.9	2.08	4.71	2.63	2.4	3.8	5.0	3.5	0.7
2030	2.00	1,329,000	716.5	1.29	3.89	2.60	2.0	4.2	5.6	4.9	2.5
2040	2.00	1,280,000	657.7	1.20	3.80	2.60	2.0	4.5	4.4	4.7	2.5
2050	2.00	1,251,000	606.0	1.25	3.85	2.60	2.1	4.0	4.0	4.7	2.5
2060	2.00	1,236,000	560.6	1.25	3.85	2.60	2.0	3.7	3.8	4.5	2.5
2070	2.00	1,227,000	520.6	1.19	3.79	2.60	2.0	3.8	3.7	4.4	2.5
2080	2.00	1,221,000	485.1	1.16	3.76	2.60	2.1	3.9	3.8	4.5	2.5
2090	2.00	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5

[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 pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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 2019-2015

					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]
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
2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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 24. 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 gap will continue to widen throughout the projection, and the Trustees 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. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians 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.

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.

The table on the next page 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.

[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.

Medicare Present Value

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 24,359	$ 24,420
Part B	39,652	46,342
Part D	11,232	11,232
Expenditures		
Part A	29,843	34,890
Part B	39,652	46,342
Part D	11,232	11,232
Income less expenditures		
Part A	(5,484)	(10,470)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2019 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 and Part B expenditures would each be higher than the current-law projections by roughly 17 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 17 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 25. 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, 2018 to the period beginning on January 1, 2019, and the reconciliation from the period beginning on January 1, 2017 to the period beginning on January 1, 2018. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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, any 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 Statement of Changes in Social Insurance Amounts are, in order:

- 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 Statement of Changes in Social Insurance Amounts 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 Statement of Changes in Social Insurance Amounts are for the current and prior year 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 23 summarizes these assumptions for the current year.

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 a present value 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.

Period beginning on January 1, 2017 and ending January 1, 2018

Present values as of January 1, 2017 are calculated using interest rates from the intermediate assumptions of the 2017 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2018. 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 2017 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 2018 Trustees Report.

Change in the Valuation Period

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, 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 (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 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.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2017-91) to the current valuation period (2018-92) 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 2017, replaces it with a much larger negative net cash flow for 2092, and measures the present values as of January 1, 2018, 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 (made more negative) when the 75-year valuation period changed from 2017-91 to 2018-92. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2017 are realized. The change in valuation period resulted in a very 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 $168 billion.

Change in Projection Base

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

Actual income and expenditures in 2018 were different than 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.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Actual income and expenditures in 2017 were different than what was anticipated when the 2017 Trustees Report projections were prepared. Part A payroll tax income in 2017 was lower attributable to lowered wages and expenditures were higher than anticipated based on actual experience. Part B total income and expenditures were

higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease of $926 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, 2017 and January 1, 2018 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

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 Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (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 National Center for Health Statistics (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 value 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.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2018), with the exception of a small decrease of 10,000 lawful-permanent-resident (LPR) immigrants per annum in the future, 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.

- Final birth rate data for 2016 indicated slightly lower birth rates than were assumed in the prior valuation.

- Recent fertility data suggests that the short-term increase in the total fertility rate used in the prior valuation to account for an assumed deferral in childbearing (resulting from the recent economic downturn) was no longer warranted. The observed persistent drop in the total fertility rate in recent years is now assumed to be a loss of potential births rather than just a deferral for this period.
- Incorporating 2015 mortality data obtained from the National Center for Health Statistics for ages under 65 and preliminary 2015 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.
- More recent LPR and other-than-LPR immigration data and historical population data were included.

There was one notable change in demographic methodology:

- Improved the method for projecting mortality rates by marital status by utilizing recent data from NCHS and the American Community Survey.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated income and expenditures are both lower for Part A and Part B but higher for Part D. Overall, these changes increased the present value of the estimated future net cash flow by $434 billion.

Changes in Economic and Health Care Assumptions

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 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, 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 (BEA) 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 resulted in 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 also income). Overall, these changes decreased the present value of the estimated future net cash flow by $402 billion.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The economic 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).

The ultimate economic assumptions for the current valuation (beginning on January 1, 2018) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The estimated level of potential GDP was reduced by about 1 percent in 2017 and throughout the projection period, primarily due to the slow growth in labor productivity for 2010 through 2017 and low unemployment rates in 2017. This lower estimated level of potential GDP means that cumulative growth in actual GDP is 1 percent less over the remainder of the projected recovery than was assumed in the prior valuation.
- Near-term interest rates were decreased, reflecting a more gradual path for the rise to the ultimate real interest rate than was assumed in the prior valuation.
- New data from the Bureau of Economic Analysis (BEA) indicated lower-than-expected ratios of labor compensation to GDP for 2016 and 2017, while new data from the Internal Revenue Service (IRS) indicated lower-than-expected ratios of taxable payroll to GDP for 2016 and 2017. This new data led to assumed extended recoveries in these ratios to the unchanged ultimate ratios.

There was one notable change in economic methodology:

- Improved the method for projecting educational attainment among women in age groups 45-49 and 50-54 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.

- Utilization rate assumptions for inpatient hospital were decreased.
- Utilization rate and case mix for skilled nursing facilities services were decreased.
- Payment rates to private health plans are higher than projected in last year's report primarily due to higher risk scores and increased coding by plans.
- Higher projected drug manufacturer rebates.

The net impact of these changes resulted in a small increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, these changes decreased the present value of estimated expenditures (and also income). Overall, these changes increased the present value of the estimated future net cash flow by $14 billion.

Changes in Law

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.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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 *Disaster Tax Relief and Airport and Airway Extension Act of 2017* (Public Law 115-63, enacted on September 29, 2017) included one provision that affects the HI and SMI Part B programs.
    - The funding amount of $270 million previously provided to the Medicare Improvement Fund, for services provided during and after fiscal year 2021, is decreased to $220 million. (This fund was intended to be available for improvements to the original fee-for-service program under Parts A and B.)
- An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Public Law 115-97, enacted on December 22, 2017, and also referred to as the *Tax Cuts and Jobs Act of 2017*) included three provisions that affect the HI program.
    - Federal income tax rates for individuals are reduced, effective for taxable years beginning after December 31, 2017 and ceasing to apply after December 31, 2025. In addition, the inflation index applied to the tax bracket thresholds and standard deductions is changed, effective for taxable years beginning after December 31, 2017, such that these amounts will permanently grow more slowly than under prior law.
    - The requirement that most individuals be covered by a health insurance plan or pay a financial penalty, commonly referred to as the individual mandate, is repealed, effective January 1, 2019. Accordingly, the percentage of people without health insurance is expected to increase. Because the change in this percentage is a factor used in determining payments to Medicare disproportionate share hospitals for uncompensated care, these payments are expected to increase as well. In addition, in light of this repeal, it is expected that some individuals will drop their employer-sponsored health insurance, thereby slightly increasing HI covered wages and taxable payroll.
    - Temporary tax changes for certain small businesses are made that will affect reported self-employment income and, in turn, HI covered wages and taxable payroll.
- An Act Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes (Public Law 115-120, enacted on January 22, 2018) included one provision that affects the HI and SMI programs.
    - A moratorium for calendar year 2019 is placed on the annual fee to be paid by health insurance providers. This fee is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D.

- The *Bipartisan Budget Act of 2018* (BBA 2018; Public Law 115-123, enacted on February 9, 2018) included provisions that affect the HI and SMI programs.
    - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines, as described in previous annual reports, is extended by 2 years, through fiscal years 2026 and 2027.
    - The Independent Payment Advisory Board (IPAB) and all related provisions are repealed, effective upon enactment. (The IPAB was established by the *Affordable Care Act* to develop and submit proposals aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries.)
    - For Medicare Advantage plans and stand-alone Part D plans that undergo a contract consolidation approved on or after January 1, 2019, the star rating (and any quality bonus payment) for the surviving contract is to reflect an enrollment-weighted average of the ratings for the continuing and closed contracts.
    - The authority for Medicare Advantage Special Needs Plans (SNPs), which was due to expire on December 31, 2018, is permanently extended. A number of reforms to dual-eligible SNPs and chronic-condition SNPs are also mandated.
    - For Medicare Advantage plans, certain provisions are enacted, effective January 1, 2020, which permit plans to offer to chronically ill enrollees (i) a broader range of supplemental benefits (which may include services that are not primarily health care services), as long as the benefit offers a reasonable expectation of improving or maintaining health or overall function, and (ii) expanded telehealth services as supplemental benefits, subject to certain specified requirements. In addition, the Value-Based Insurance Design (VBID) Model, which is a pilot program allowing certain plans to offer supplemental benefits or reduced cost sharing to enrollees with certain chronic conditions, is expanded, effective no later than January 1, 2020, to allow plans in all States the opportunity to participate in it. The VBID program is also made exempt, through December 31, 2021, from certain spending and quality-of-care testing to which it would otherwise be subjected.
    - For Medicare Accountable Care Organizations (ACOs), certain provisions are enacted to (i) provide more opportunities for beneficiaries to be assigned to, or voluntarily align with, ACOs; (ii) allow for the use of beneficiary incentive programs; and (iii) allow for expanded use of telehealth services. The specific types of ACOs to which each of these changes apply, as well as the effective dates, vary.
    - Funding for the National Quality Forum is provided from the HI and SMI trust funds for the remainder of fiscal year 2017 and for fiscal years 2018 and 2019.
    - Funding for certain low-income outreach and assistance programs is extended 2 years, through September 30, 2019.
    - Certain existing civil and criminal penalties are substantially increased for providers and suppliers who violate health care fraud and abuse laws, effective upon enactment.
    - For home health agencies serving beneficiaries in rural areas, the 3-percent add-on payment is extended 1 year, through December 31, 2018. Then, for services furnished in rural areas from 2019 through 2022, three separate tiers of add-on adjustments are established, based on Medicare home health utilization and low-population density; these adjustments diminish over varying periods of time (and become 0 percent no later than 2020). Also, for services furnished on or after January 1, 2019, home health agencies are required to report the county in which the services are furnished.
    - For the Medicare home health prospective payment system (PPS), the annual update for calendar year 2020 is set at 1.5 percent.

- Under the home health PPS, the unit of payment for home health services is changed from a 60-day to a 30-day episode of care, beginning in 2020. This change must be made in a budget-neutral manner, but adjustments to offset anticipated behavior changes that could result from the modified methodology are allowed. Also beginning in 2020, therapy thresholds are removed from the home health case mix adjustment.
- To demonstrate home-bound and medical-necessity status when determining if a patient is eligible for home health services, documentation in the medical records of home health agencies can be used as supporting material, in addition to documentation in the medical records of the certifying physician, effective January 1, 2019.
- For telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, the geographic restriction that limits originating sites to rural areas is eliminated, provided that all other Medicare telehealth coverage requirements are satisfied. In addition, no originating site facility fee is to be paid to sites that do not meet the current geographic and site type requirements. This provision is effective beginning on January 1, 2019.
- For the Medicare electronic health records incentive program, the provision requiring more stringent measures of meaningful use, over time, is eliminated, effective upon enactment.
- The funding amount of $220 million previously provided for the Medicare Improvement Fund (as noted above) is eliminated.
- The Medicare-Dependent Hospital (MDH) program is extended for 5 fiscal years, through September 30, 2022. In addition, the program is extended to certain rural hospitals that are located in all-urban States and that otherwise meet the MDH criteria.
- Medicare inpatient hospital add-on payments for low-volume hospitals are extended for 5 fiscal years, through September 30, 2022. In addition, for fiscal years 2019 through 2022, changes are made to the qualifying criteria (which are to be based on total discharges or Medicare discharges, depending on the year, and on the distance from another inpatient hospital) and to the add-on adjustments (which are to be based on a sliding scale ranging from 25 percent to 0 percent).
- Two changes are made to the long-term care hospital (LTCH) site-neutral provision. First, the originally mandated 2-year transition period is extended for 2 additional years, covering fiscal years 2018 and 2019. Second, the inpatient hospital PPS comparable amount used in the site-neutral payment rate calculations for fiscal years 2018 through 2026 is to be reduced by 4.6 percent.
- For the inpatient hospital diagnosis-related groups (DRGs) subject to the post-acute care transfer policy, hospice is added as a setting of care, effective October 1, 2023.
- For the Medicare skilled nursing facility PPS, the annual update for fiscal year 2019 is set at 2.4 percent.
- Physician assistants are added to the types of providers who may serve as attending physicians for the purposes of hospice care, effective January 1, 2019. (Previously, only physicians and nurse practitioners could serve.) Like nurse practitioners, physician assistants are not permitted to provide the written certification of terminal illness required for hospice services.
- A new income-related premium threshold is established. Specifically, beginning in calendar year 2019, individuals with incomes at or above $500,000 (and couples with incomes at or above $750,000) will pay premiums covering 85 percent (rather than 80 percent) of the average program cost for aged beneficiaries. These new threshold levels will not be inflation-adjusted until 2028 and later.
- The 1.00 floor on the geographic index for physician work is extended for 2 additional years, through December 31, 2019.

- The physician fee schedule update for 2019, which had been set at 0.5 percent, is decreased to 0.25 percent.
- A number of changes are made to the merit-based incentive payment system (MIPS) for physicians, including that it be applied only to covered professional services instead of to items and services (thereby excluding, most prominently, physician-administered Part B drugs) and that its transition period be extended by 3 years (such that the post-transition period now begins in 2022, not 2019). Certain additional changes to the system are mandated for the extended transition period, and others are mandated for the period thereafter. Effective dates vary.
- The annual payment limits on therapy services are permanently repealed, beginning on January 1, 2018. The threshold for the targeted manual medical review process is lowered, from $3,700 to $3,000, effective as of the same date and until 2028, after which the threshold is to be increased by a specified formula.
- Outpatient physical and occupational therapy services furnished by a therapy assistant are paid at 85 percent of the amount that otherwise would have been paid under the fee schedule, effective January 1, 2022.
- The freeze on coding and valuation of certain radiation therapy services reimbursed under the fee schedule, in place for 2017 and 2018, is extended through 2019.
- For qualified home infusion therapy suppliers, a temporary transitional payment for administering home infusion therapy is established, beginning on January 1, 2019. Payment rates in three categories will apply during the transition period, which will end on December 31, 2020, after which a new payment methodology will begin.
- Certain ground ambulance add-on payments are extended 5 additional years, through December 31, 2022. (These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.) The development of a system to collect certain data from providers and suppliers of ground ambulance services is also mandated.
- For non-emergency ground ambulance transports of beneficiaries with end-stage renal disease (ESRD) to and from renal dialysis services, the reduction in payments is increased from 10 percent to 23 percent for transports furnished on or after October 1, 2018.
- For beneficiaries with ESRD who receive home dialysis, all monthly physician visits can be provided via telehealth, beginning on January 1, 2019, as long as the beneficiary receives one in-person visit monthly for the initial 3 months and at least one every 3 months thereafter. (Previously, at least one in-person visit per month was required.) Also, the originating site requirements are modified in several ways, and no site facility fee is to be paid if the beneficiary's home is the originating site.
- Conditions are added to those that allow a beneficiary who qualifies for cardiac rehabilitation services to qualify for the more intensive set of services, effective upon enactment. Also, the supervision requirements for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation are changed to allow physician assistants, nurse practitioners, and clinical nurse specialists (in addition to physicians) to supervise these programs, effective January 1, 2024.
- A provision of the *Steve Gleason Act of 2015*, requiring that Medicare payment for rental or lump-sum purchase of speech-generating devices and accessories be made without a cap on the amount, is made permanent.
- Enforcement is delayed an additional year, through December 31, 2017, for the instruction that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure. (In the 2018 outpatient hospital PPS rule, CMS extended these non-enforcement instructions for 2018 and 2019 and noted that, for 2017, while there was not a non-enforcement

instruction in place, Medicare administrative contractors were directed not to prioritize enforcement of this requirement for these hospitals. This legislation provides the non-enforcement instruction that had been lacking for 2017.)

- Under the Part D standard benefit structure, the coverage gap closes 1 year earlier than previously scheduled for brand-name drugs only; that is, for brand-name drugs, beneficiaries in the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will pay 25 percent of drug costs beginning on January 1, 2019 (instead of 30 percent in 2019 and 25 percent thereafter). Also beginning on that date, these beneficiaries will receive a 70-percent manufacturer discount (instead of 50 percent) and a 5-percent benefit (instead of 20 percent in 2019 and 25 percent thereafter) from their Part D plans for applicable prescription drugs. (For purposes of drug discounts while beneficiaries are in the Part D coverage gap, applicable drugs are generally covered brand-name Part D drugs, while non-applicable drugs are generally covered generic Part D drugs.) For generic drugs, the law remains the same, with beneficiaries paying 37 percent of drug costs in 2019 and 25 percent thereafter.
- For purposes of drug discounts while beneficiaries are in the Part D coverage gap, the definition of applicable drugs is expanded to include biosimilars, effective January 1, 2019. (Applicable drugs previously included biologics but not biosimilars.)

Overall these provisions resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and a slight decrease to the present value of estimated future income, with an overall net decrease of $535 billion in the present value of the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

Required Supplementary Stewardship Information

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2019

Responsibility Segment Program	2019	2018	2017	2016	2015
National Institutes of Health					
Research Training and Career Development	$ 943	$ 883	$ 1,807	$ 1,745	$ 1,631
Health Resources and Services Administration					
Health Workforce Grants, Scholarships and Loans	940	1,058	1,047	935	828
Other HRSA Training Investments	87	89	88	90	-
Other Investments in Human Capital					
Other	22	23	21	17	14
Totals	**$ 1,992**	**$ 2,053**	**$ 2,963**	**$ 2,787**	**$ 2,473**

Investments in Human Capital are expenses incurred by federal education and training programs for the public, intended to maintain or increase national productive capacity. The following OpDivs conduct education and training programs under this category:

National Institutes of Health

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. NIH's major research training and career development programs include: institutional research training grants for graduate students and post-doctoral scholars; individual pre- and post-doctoral fellowships; individual and institutional research career development awards for advanced post-doctorates and early-stage faculty; loan repayment programs; and research education awards that promote research experiences, curriculum development, and other related activities. In addition, as part of implementing the *21st Century Cures Act* (Cures Act), NIH launched the Next Generation Researchers Initiative (NGRI) in August 2017 to address the challenges faced by early career researchers trying to embark upon and sustain independent research careers. In FY 2019, NIH funded at least 1,287 early-stage investigators. Going forward, NGRI will continue to prioritize meritorious applications to support early-stage investigators that have never received an independent research award, as well as current NIH-funded researchers at risk of losing support.

Within the Intramural Research Program at NIH, investments in the next generation of researchers may offer the biggest dividends yet. NIH has enlarged its world-famous training program. We now have approximately 1,500 recent college graduates in the NIH Postbaccalaureate (Postbac) Program working in NIH labs across the country as they explore scientific career opportunities. Complementing the Postbac program is the Medical Research Scholars Program, in which 50 highly qualified medical, dental, and veterinary students pause their university studies to conduct basic, clinical, or translational research work at the NIH for a year.

Health Resources and Services Administration

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. In FY 2019, BHW made more than 1800 awards worth a total of $1.1 billion to organizations and individuals for scholarships and grants. HRSA continues to invest in expanding access to substance use disorder treatment in rural and underserved areas. In Academic Year 2018-2019, BHW also supported more than 850 residents in 56 Teaching Health Centers through the Teaching Health Center Graduate Medical Education program. Teaching Health Centers trained more than 500 future Family Medicine physicians, 200 future Internal Medicine physicians, and 50 future Psychiatrists. For more information, visit HRSA Health Workforce.

Other HRSA human capital investments are primarily in the form of grants and cooperative agreements. HRSA Maternal and Child Health (MCH) Workforce Development awarded grants to educate and train the current and future generations of MCH professionals through interdisciplinary undergraduate, graduate, and post-graduate training programs, and through continuing education to practicing MCH professionals. AIDS Education and Training Centers Program supports a network of eight regional centers with more than 130 local affiliated sites, as well as two national centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people with HIV. The PHS Act family planning service program provided clinical and programmatic training and technical assistance to clinical providers, Title X family planning grantees, as well as to help support Title X clinical service sites.

Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants and contracts are awarded to public and private nonprofit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. As of September 30, 2019, 25 grants (totaling $9.1 million) and 8 contracts (totaling $2.3 million) were awarded in FY 2019. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

ACL's National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) administers the Advanced Rehabilitation Research and Training (ARRT) Program to increase capacity for high-quality rehabilitation research by supporting grants to institutions to provide advanced research training to individuals with doctorates or similar advanced degrees who have clinical or other relevant experience. As of September 30, 2019, ACL has awarded 19 ARRT grants (totaling $2.8 million). These grants were made to institutions to recruit qualified persons, including individuals with disabilities, and to prepare them to conduct independent research related to disability and rehabilitation, with particular attention to research areas that support the implementation and objectives of the Rehabilitation Act and that improve the effectiveness of services authorized under the Act.

In addition, AHRQ provides an array of pre-doctoral and postdoctoral educational and career development grants and opportunities in health services research training. Research training and career development activities are administered by the Division of Research Education in the Office of Extramural Research, Education, and Priority Populations.

Investment in Research and Development (in Millions)

For the Year Ended September 30, 2019

Responsibility Segments	Basic	Applied	Develop-mental	2019 Total	2018	2017	2016	2015	Grand Total
AHRQ	$ -	$ 189	$ -	$ 189	$ 187	$ 217	$ 213	$ 167	$ 973
CDC	60	334	76	470	424	509	502	490	2,395
FDA	193	-	7	200	188	142	170	129	829
NIH	19,020	17,909	217	37,146	35,468	29,465	28,258	28,093	158,430
Other	3	203	-	206	34	108	32	26	406
Totals	**$ 19,276**	**$ 18,635**	**$ 300**	**$ 38,211**	**$ 36,301**	**$ 30,441**	**$ 29,175**	**$ 28,905**	**$ 163,033**

The research and development programs in HHS include the following:

Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making. In FY 2019, AHRQ released a Question Builder mobile app to help prepare and organize questions and other helpful information prior to medical visits.

Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Injury Prevention and Control, and Emerging and Zoonotic Diseases were the primary areas where CDC's research and development was invested. CDC works with partners around the country and world to protect Americans from infectious diseases; prevent the leading causes of disease, disability, and death; ensure global disease protection; keep Americans safe from environmental and work-related hazards; protect Americans from natural and bioterrorism threats; monitor health; and ensure laboratory excellence. CDC programs provide partners and Americans with the essential health information and tools they need to protect and advance their health.

CDC received appropriations of $168 million in FY 2019 for Antibiotic Resistance (AR). AR has the potential to impact all Americans at every stage of life. CDC is a leader in the fight against this global threat. Through its AR Solutions Initiative, CDC works with partners to drive aggressive action and empower the nation to comprehensively respond.

CDC's AR Solutions Initiative invests in national infrastructure to detect, respond, contain, and prevent resistant infections across healthcare settings, food, and communities. CDC funding supports all 50 state health departments, six local health departments, and Puerto Rico and the U.S. Virgin Islands. Through these investments, CDC is transforming how the nation and world combat and slow antibiotic resistance at all levels. For more information, visit AR Solutions Initiative.

Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Designation (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct

scientific studies, FDA does not consider this type of research as "research and development" because it supports FDA's regulatory policy and decision-making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. The *Orphan Drug Act* also created the Orphan Product Clinical Trials Grants Program to stimulate the development of promising products for rare diseases and conditions. Orphan product grants are a proven method of fostering and encouraging the development of new, safe, and effective medical products for rare diseases and conditions. Since Orphan Products Clinical Trials Grants Program's inception in 1983, FDA has received over 2,500 applications (generally, about 100 applications each year), reviewed over 2,200, and funded over 590 studies. In contrast, fewer than 10 such products supported by industry came to market between 1973 and 1983. The program has bought more than 60 products to marketing approval. Approximately 10 percent of the studies that received developmental support from the OPD Grants Program utilized to facilitate the marketing approval of those drugs, biologics, and medical devices. The Humanitarian Use Device Program has been the first step in approval of 70 Humanitarian Device Exemption approvals. For more information about the Orphan Products Clinical Trials Grants Program, including grants funded to date, visit Orphan Products Clinical Trials Grants Program.

The FDA Research Grants Program is a grants program whose purpose is to assist public and non-public institutions and for-profit organizations to establish, expand, and improve research, demonstration, education, and information dissemination activities concerned with a wide variety of FDA areas.

National Institutes of Health

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. To push forward the frontier of knowledge and achieve this mission, 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.

Congress passed and the President signed into law the Cures Act in December 2016 authorizing $1.8 billion in funding for the Cancer Moonshot℠ over 7 years. An initial $300 million has been appropriated in fiscal year (FY) 2017 to fund Moonshot initiatives. The law provides NIH with critical tools and resources to advance biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials of promising new therapies. The Cures Act provides multiyear funding to four highly innovative scientific initiatives. The All of Us Research Program aims to collect one million or more volunteers' medical history, lifestyle information, and genetic information to support advances in medical research. The Brain Research through Advancing Innovative Neurotechnologies Initiative seeks to better understand how the brain encodes, stores, and retrieves information, which will transform the ability to diagnose and treat neurological/mental disorders. The Cancer Moonshot℠ to accelerate cancer research aims to make more therapies available to more patients, while also improving the ability to prevent cancer and detect it at an early stage. The Regenerative Medicine Innovation Project will support clinical research in coordination with the FDA using adult stem cells to further the field of regenerative medicine. For more information, visit the Cures Act.

NIH continues to implement provisions of the Cures Act relevant to the overall conduct of biomedical and behavioral research. This includes, but is not limited to, reducing administrative burdens for investigators, strengthening protections for participants involved with clinical research, bolstering the next generation of biomedical scientists,

enhancing the rigor of meritorious peer-reviewed research, ensuring persons across the lifespan are included in clinical research, and requiring sharing of data resulting from NIH funded clinical trials.

NIH continues the aggressive, trans-agency effort launched in 2018 to speed scientific solutions to stem the national opioid public health crisis. The HEAL (Helping to End Addiction Long-term) Initiative builds on extensive, NIH-supported research on understanding the complex neurological pathways involved in pain and addiction, developing and testing new treatment models, and integrating behavioral interventions with medication-assisted treatment.

The Accelerating Medicines Partnership (AMP) is a public-private partnership between the NIH, FDA, multiple biopharmaceutical and life science companies and non-profit organizations to transform the current model for developing new diagnostics and treatments. The ultimate goal is to increase the number of new diagnostics and therapies for patients and reduce the time and cost of developing them. Since its launch in 2014, AMP projects have focused on Alzheimer's disease, type 2 diabetes, rheumatoid arthritis, lupus, and Parkinson's Disease. For each project, scientists from NIH and industry developed research plans aimed at characterizing effective molecular indicators of disease, called biomarkers, and distinguishing biological targets most likely to respond to new therapies. NIH and industry partners are sharing expertise and resources — over $350 million, which includes in-kind contributions — in an integrated governance structure that enables the best-informed contributions to science from all participants. All partners have agreed to make the AMP data and analyses publicly accessible to the broad biomedical community.

For intramural research activities, investments in infrastructure, equipment, and talent have yielded significant dividends. NIH is one of the few institutions in the United States that houses gnotobiotic mice, which are born in germ-free conditions. NIH investigators can study the impact of the microbiome — benign microorganisms residing in and on our bodies — by inoculating these mice with specific microorganisms. As a result, we have learned, among many things that native microorganisms on our skin can help facilitate rapid healing through chemical signaling with immune cells called T cells. NIH investigators have found new connections between the microbiome and tumor development and obesity as well. Related to this, NIH investigators have created a new mouse model that utilizes "wildling," that is, exposing laboratory-bred genetically modified mice to a broad range of the microbes and pathogens of wild mice, which makes them even more useful for research.

Investments in imaging have opened new windows into organs such as the brain and into the microscopic, subcellular world. Research highlights include greater resolution of tissue imaging with less radiation and near-atomic-level resolution of proteins via cryo-electron microscopy. At the NIH Clinical Center, physician-investigators appear to have cured a major form of sickle cell disease through experimental gene therapy. To further advance such gene replacement therapies, as well as cancer immunotherapy and immunotoxin therapy, both also pioneered at the NIH Clinical Center, we soon will open the Center for Cellular Engineering and a tumor infiltrating lymphocytes facility, situated very close to the Clinical Center. The two facilities will immensely improve the capacity to safety and rapidly create cell-based medicines and will lead to future cures.

Other Investments in Research and Development

ACL, through the NIDILRR, conducts research to generate new knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. One such NIDILRR research effort is the monthly analysis and reporting of national trends in the employment rates of people with disabilities, coinciding with the Monthly Jobs Report provided by the U.S. Bureau of Labor Statistics.

ACF oversees research and evaluation programs that contribute to a better understanding of how to improve the economic and social well-being of families and children so that they may lead healthier and more productive lives.

HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision-making. MCH research is to support the MCH field, improving the health and well-being of women, children, and families. The Federal Office of Rural Health Policy funds the Rural Health Research Center Program which supports policy oriented health services research on key rural health issues. Healthcare Systems Bureau (HSB) Division of Transplantation supports applied research to identify successful model interventions designed to increase deceased organ donation registration and family consent; to educate the public about living organ donation; and to remove financial barriers to living organ donation. The Division of Poison Control and Healthcare Facilities, also under HSB, conducts survey research to assess overall awareness and use of the Poison Help Phone Line, poison centers and the services they provide. HRSA's basic research supports the diagnosis, transmission, prevention, and treatment of Hansen's disease.

Required Supplementary Information

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2019

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Fund	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 11	$ 55	$ 18,722	$ 60,625	$ 41,436	$ 120,849
Appropriations (Discretionary and Mandatory)	331,476	371,498	402,347	406,923	265,446	1,777,690
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	5	5
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,182	24,439	25,621
Total Budgetary Resources	**$ 331,487**	**$ 371,553**	**$ 421,069**	**$ 468,730**	**$ 331,326**	**$ 1,924,165**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 331,487	$ 371,553	$ 373,052	$ 454,051	$ 284,637	$ 1,814,780
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	29,312	62	20,982	50,356
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	172	172
Unapportioned, Unexpired Accounts	-	-	-	14,617	16,359	30,976
Unexpired Unobligated Balance, End of Year	-	-	29,312	14,679	37,513	81,504
Expired Unobligated Balance, End of Year	-	-	18,705	-	9,176	27,881
Unobligated Balance, End of Year	-	-	48,017	14,679	46,689	109,385
Total Status of Budgetary Resources	**$ 331,487**	**$ 371,553**	**$ 421,069**	**$ 468,730**	**$ 331,326**	**$ 1,924,165**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 327,856	$ 367,587	$ 358,881	$ 404,899	$ 247,091	$ 1,706,314
Distributed Offsetting Receipts	(35,733)	(454,676)	-	-	(2,283)	(492,692)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 292,123**	**$ (87,089)**	**$ 358,881**	**$ 404,899**	**$ 244,808**	**$ 1,213,622**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 65,152	$ 55,435
ACL	2,254	2,023
AHRQ	400	322
CDC	15,191	12,251
CMS	155,778	111,886
FDA	7,540	2,795
HRSA	12,896	11,569
IHS	9,912	5,455
NIH	45,970	34,815
OS	7,751	3,341
PSC	2,438	587
SAMHSA	6,044	4,329
Totals	**$ 331,326**	**$ 244,808**

Deferred Maintenance and Repairs

For the Years Ended September 30, 2019 and 2018

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	2019	2018
General PP&E		
Buildings	$ 2,533	$ 2,392
Other Structures	17	21
Total	**$ 2,550**	**$ 2,413**

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 *2019 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 projections in this year's report 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); and the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2027 and by 4 percent from April 1, 2027 through September 30, 2027. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2027.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from specific provisions of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010* (referred to collectively as the *Affordable Care Act* or ACA) and the *Medicare Access and*

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

CHIP Reauthorization Act of 2015 (MACRA). These ACA and MACRA provisions 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 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. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law 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 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 MACRA[14] and ACA[15] 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 24 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 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/.

[14]Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced APMs or MIPS, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

[15]Under the ACA, 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 in economy-wide productivity (1.0 percent over 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.

Prior to the ACA, Medicare payment rates for most non-physician provider categories were 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.[18] To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the ACA were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The ACA requires that many of these Medicare payment updates be 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—a lower rate than that of 1.1 percent assumed in the 2018 report. 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 per capita increases for these provider services start at 4.0 percent in 2043, or GDP plus 0.1 percent, declining gradually to 3.6 percent in 2093, or GDP minus 0.2 percent.[19]

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[16]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which the Trustees estimated 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 and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel. The Panels' final reports are available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdfand at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.

[18]Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices.

[19]These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X 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 per capita growth rates for physician payments are assumed to be 3.4 percent in 2043, or GDP minus 0.5 percent, declining to 2.8 percent in 2093, or GDP minus 1.0 percent.

(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,[20] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.2 percent in 2043, or GDP minus 0.7 percent, declining to 2.8 percent in 2093, 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 21 percent of total Part B expenditures in 2027 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.[21] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.7 percent in 2043, or GDP plus 0.8 percent, declining to 4.3 percent by 2093, or GDP plus 0.5 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 3.7 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2093 is 3.7 percent or GDP minus 0.1 percent.

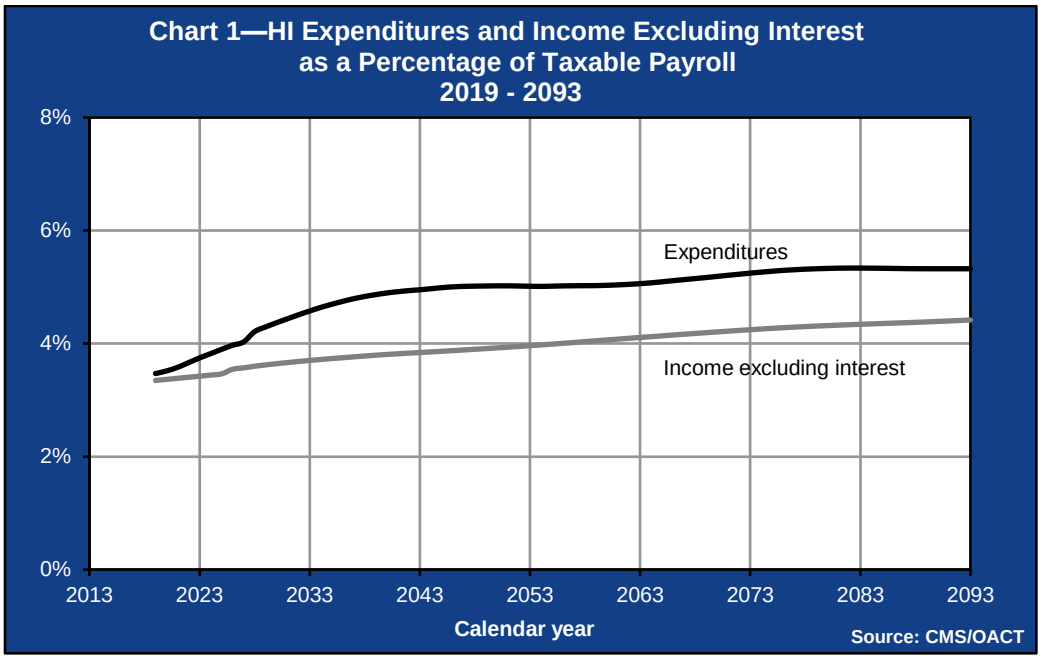
HI Cash Flow as a Percentage of Taxable Payroll

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

[20]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.

[21]For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

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 2019 report are higher than those from the 2018 report for all years largely due to higher spending and lower taxable payroll in all projected years.



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 these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional 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, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

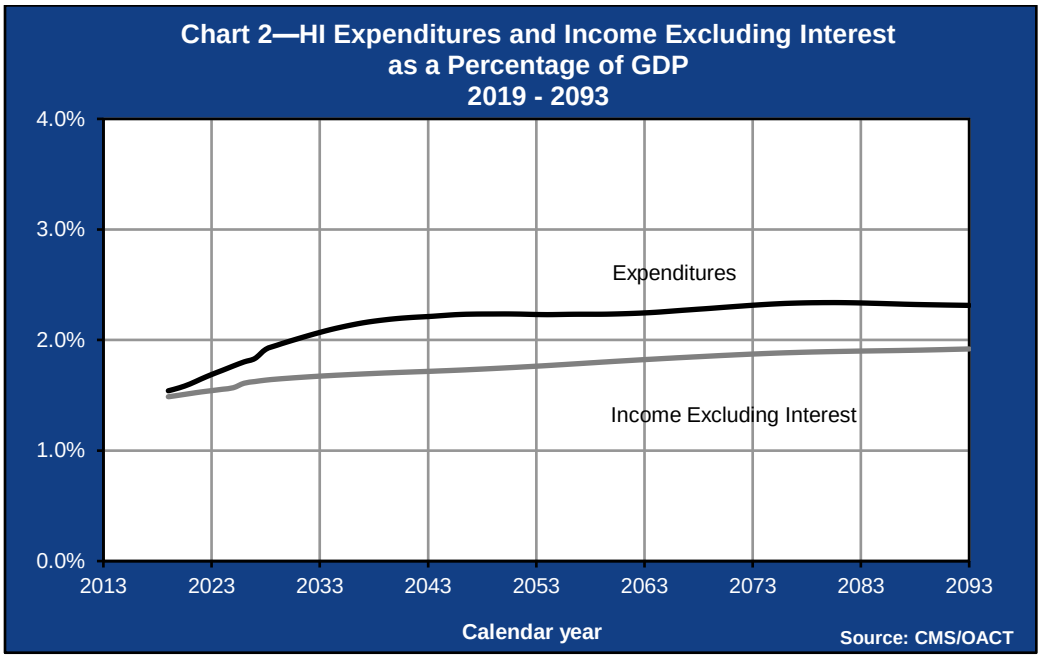
In 2019 and beyond, as indicated in Chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2028 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2044 and 7.9 percent in 2093.

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

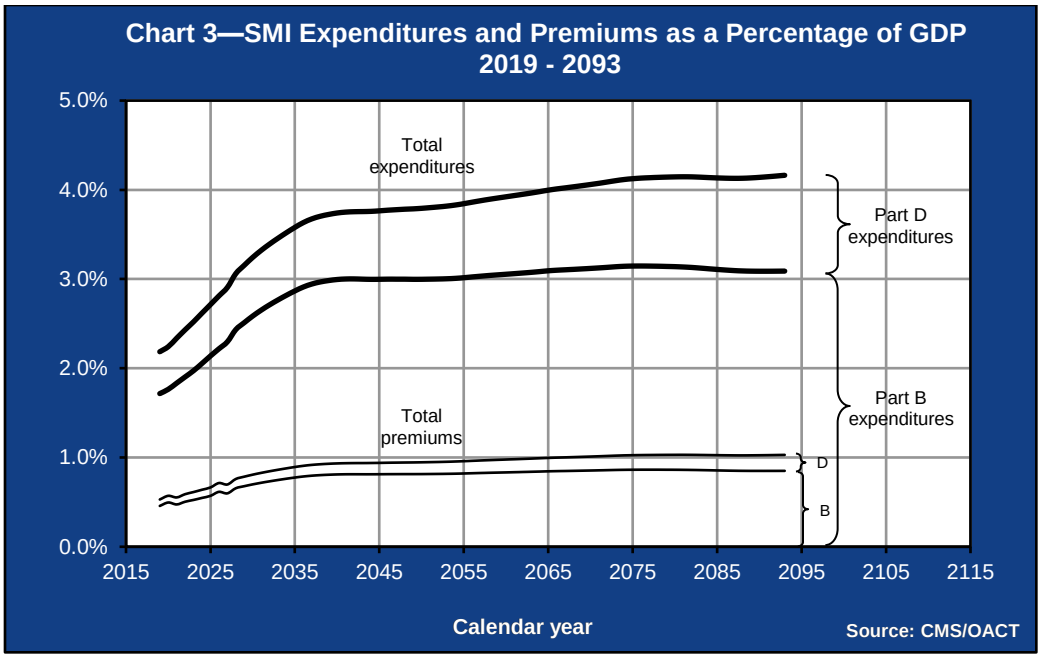
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2018, the expenditures were $308.2 billion, which was 1.5 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain 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 3.4 percent in 2093.



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.



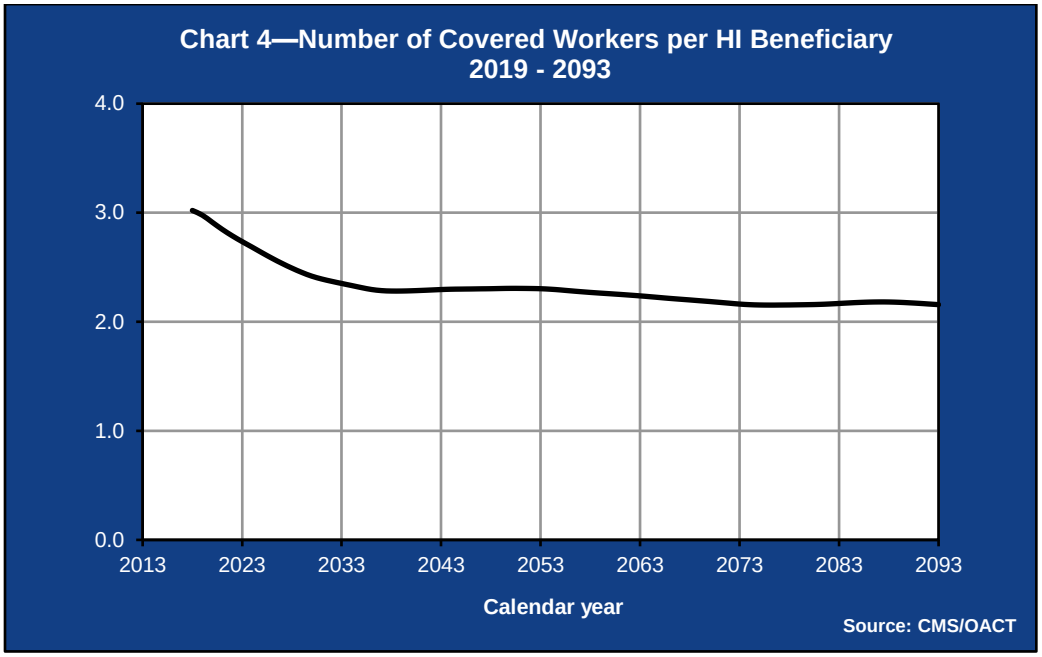
In 2018, SMI expenditures were $432.4 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.8 percent of GDP within 25 years and to 4.2 percent by the end of the projection period, as demonstrated in Chart 3. (Under the illustrative alternative, total SMI expenditures in 2093 would be 5.6 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 2018 by about 4.4 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 2018, 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 2.4 workers for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.2 workers per beneficiary by 2093.

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. [22] The assumptions varied are the health care cost factors, real wage differential, CPI, real interest rate, fertility rate, and net immigration.[23]

For this analysis, the intermediate economic and demographic assumptions in the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s 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, 2019 and are based on estimates of income and expenditures during the 75-year projection period.

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

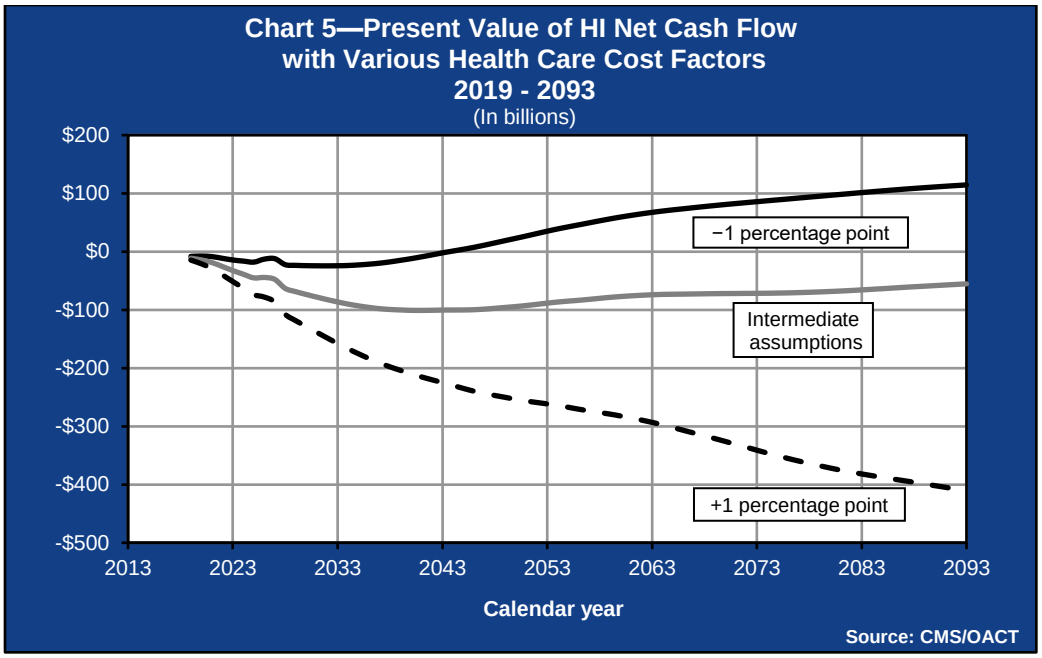
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$3,122	-$5,484	-$19,321

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,606 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 $13,837 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.

[22]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.

[23]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.



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 ACA. 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

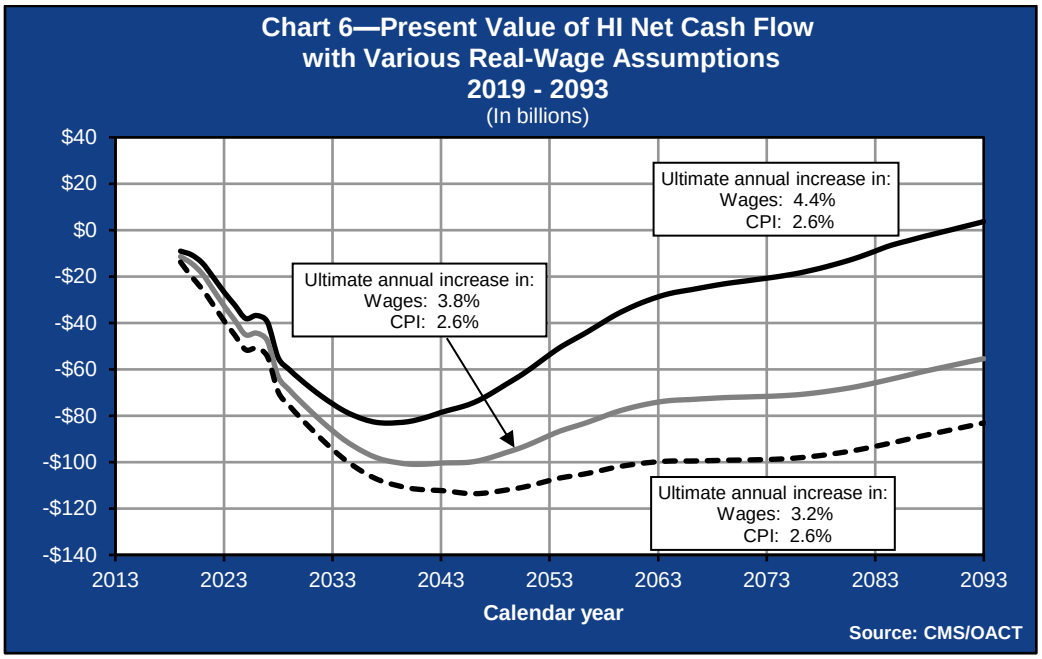
Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[24] In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions			
Ultimate percentage increase in wages - CPI	3.2 – 2.6	3.8 – 2.6	4.4 – 2.6
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	−$6,887	−$5,484	−$2,898

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 $2,155 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,170 billion.

[24]The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

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.



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 ACA and MACRA 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.

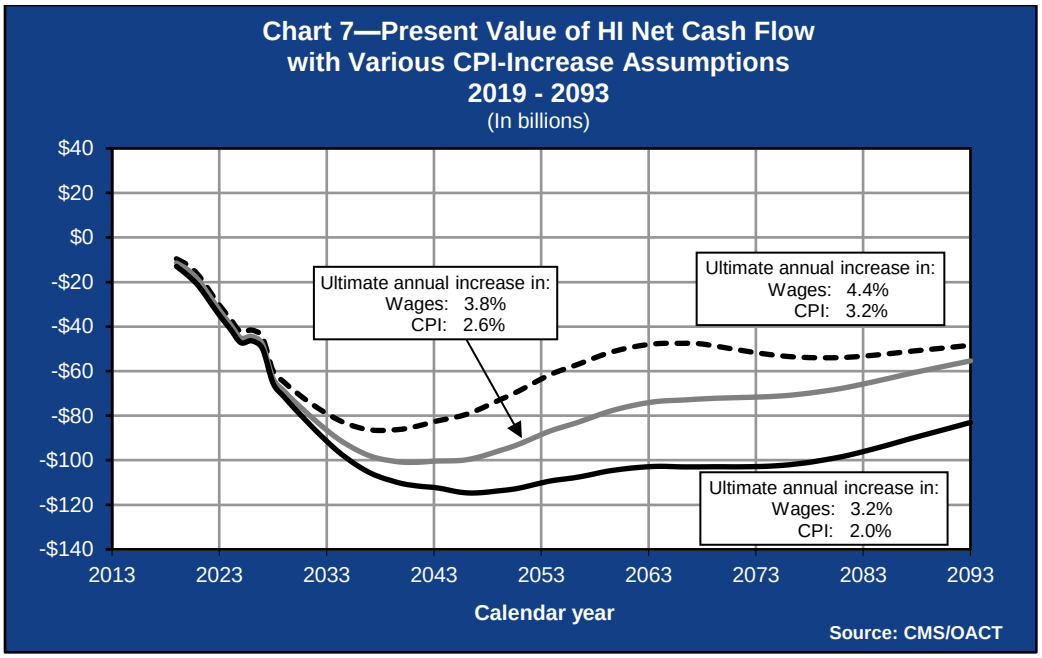
Consumer Price Index

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: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.4, 3.8, and 3.2 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in wages - CPI	4.4 – 3.2	3.8 – 2.6	3.2 – 2.0
Income minus expenditures (in billions)	−$4,331	−$5,484	−$6,946

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by $1,153 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,462 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 results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the ACA 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

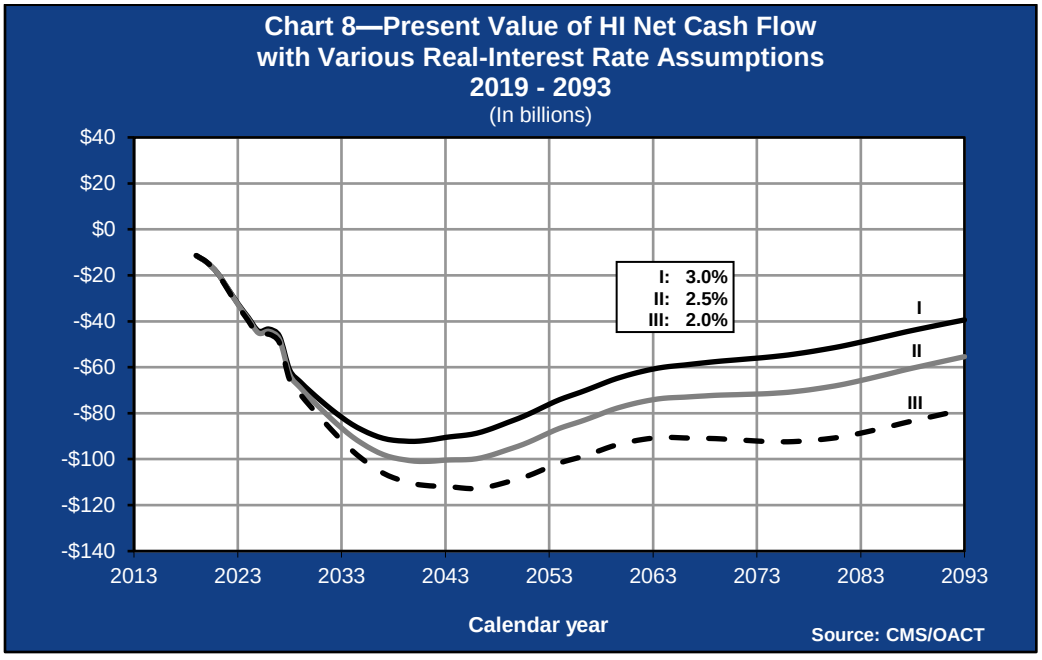
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.0, 2.5, and 3.0 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.6, 5.1, and 5.6 percent, respectively.

Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.0 percent	2.5 percent	3.0 percent
Income minus expenditures (in billions)	-$6,534	-$5,484	-$4,664

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $185 billion.

Chart 8 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

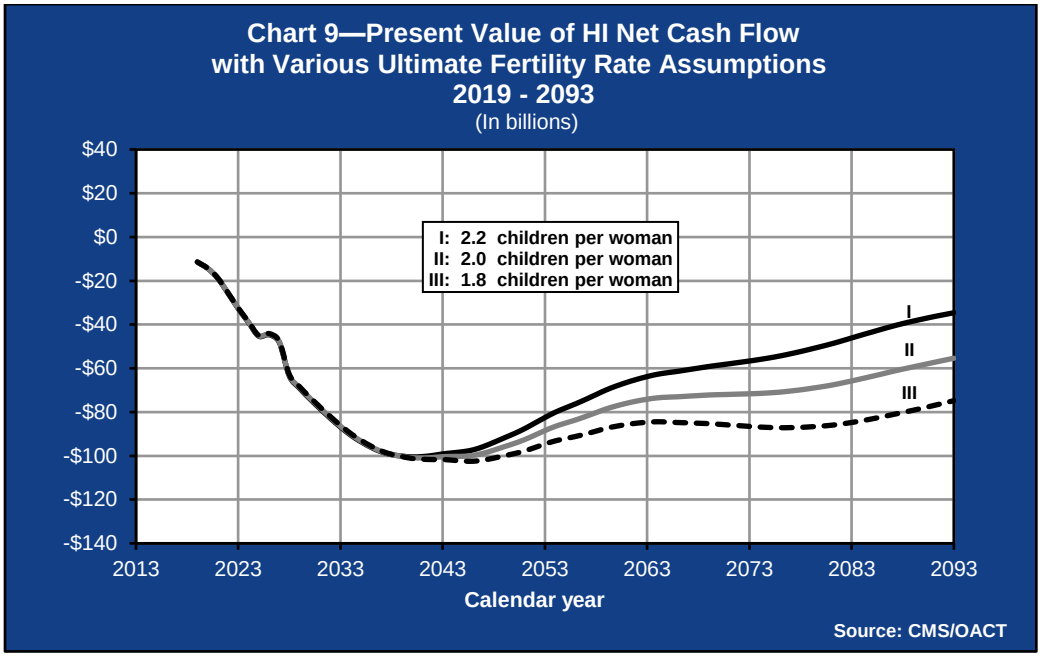
Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions			
Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures (in billions)	−$6,105	−$5,484	−$4,851

[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 $625 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.

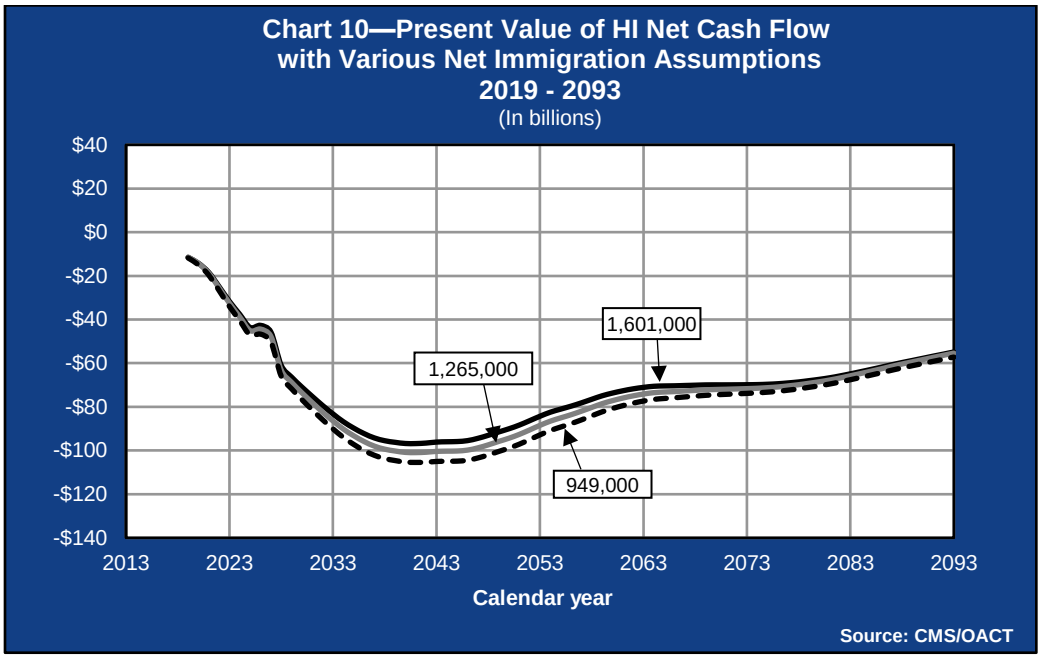
Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 949,000 persons, 1,265,000 persons, and 1,601,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions			
Average annual net immigration	949,000	1,265,000	1,601,000
Income minus expenditures (in billions)	−$5,705	−$5,484	−$5,299

As indicated in Table 6, if the average annual net immigration assumption is 949,000 persons, the deficit—expressed in present-value dollars—increases by $222 billion. Conversely, if the assumption is 1,601,000 persons, the deficit decreases by $185 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 2018 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 and lower income from the taxation of Social Security benefits. HI expenditures are projected to be slightly higher than last year's estimates because of higher-than-projected 2018 spending and higher projected provider payment updates, factors that are mostly offset by the effect of lower assumed utilization of skilled nursing facility services.

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, once again expenditures exceeded income, and there was a trust fund deficit of $1.6 billion. 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[25] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2019-2025). For the 2019 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 2021 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 report. 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 2019 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."

[25]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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OTHER INFORMATION

SECTION 3

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Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2019

(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)	$ 13,563	$ 194,781	$ 63,442	$ 24,471	$ 296,257	$ -	$ 296,257
Investments, Net (Note 4)	-	3,971	305,378	-	309,349	-	309,349
Accounts Receivable, Net (Note 5)	129	10,227	78,180	-	88,536	(87,724)	812
Advances (Note 8)	32	308	-	52	392	(212)	180
Total Intragovernmental Assets	**13,724**	**209,287**	**447,000**	**24,523**	**694,534**	**(87,936)**	**606,598**
Accounts Receivable, Net (Note 5)	1	9,019	15,008	128	24,156	-	24,156
Inventory and Related Property, Net (Note 6)	-	10,781	-	-	10,781	-	10,781
General Property, Plant and Equipment, Net (Note 7)	-	6,408	136	-	6,544	-	6,544
Advances (Note 8)	252	728	3	1,469	2,452	-	2,452
Other Assets	-	197	-	-	197	-	197
Total Assets	**$ 13,977**	**$ 236,420**	**$ 462,147**	**$ 26,120**	**$ 738,664**	**$ (87,936)**	**$ 650,728**
Stewardship Land (Notes 19)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 27	$ 326	$ 88,520	$ 4	$ 88,877	$ (87,724)	$ 1,153
Other Liabilities (Note 13)	27	2,484	3,154	120	5,785	(212)	5,573
Total Intragovernmental Liabilities	**54**	**2,810**	**91,674**	**124**	**94,662**	**(87,936)**	**6,726**
Accounts Payable	25	1,162	28	6	1,221	-	1,221
Entitlement Benefits Due and Payable (Note 10)	-	38,509	71,591	-	110,100	-	110,100
Accrued Liabilities (Note 12)	1,056	12,242	-	2,245	15,543	-	15,543
Federal Employee and Veterans' Benefits (Note 11)	4	14,822	-	-	14,826	-	14,826
Contingencies and Commitments (Note 14)	-	16,910	173	-	17,083	-	17,083
Other Liabilities (Note 13)	19	2,864	801	11	3,695	-	3,695
Total Liabilities	**1,158**	**89,319**	**164,267**	**2,386**	**257,130**	**(87,936)**	**169,194**
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 18)	-	73	57,895	-	57,968	-	57,968
Unexpended Appropriations - Other funds	12,727	133,842	-	23,869	170,438	-	170,438
Cumulative Results of Operations - Funds from Dedicated Collections (Note 18)	-	18,407	239,985	-	258,392	-	258,392
Cumulative Results of Operations - Other funds	92	(5,221)	-	(135)	(5,264)	-	(5,264)
Total Net Position - Funds from Dedicated Collections	**-**	**18,480**	**297,880**	**-**	**316,360**	**-**	**316,360**
Total Net Position - Other Funds	**12,819**	**128,621**	**-**	**23,734**	**165,174**	**-**	**165,174**
Total Net Position	**12,819**	**147,101**	**297,880**	**23,734**	**481,534**	**-**	**481,534**
Total Liabilities and Net Position	**$ 13,977**	**$ 236,420**	**$ 462,147**	**$ 26,120**	**$ 738,664**	**$ (87,936)**	**$ 650,728**

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2019

(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations: Cost (-)	Intra-HHS Eliminations: Revenue	Consolidated Totals
ACF	$ 13,724	$ -	$ -	$ 42,465	$ 56,189	$ (122)	$ (5)	$ 56,062
ACL	2,184	-	-	-	2,184	(10)	1	2,175
AHRQ	-	328	-	-	328	(20)	18	326
CDC	-	12,296	-	-	12,296	(286)	98	12,108
CMS	-	434,128	653,143	-	1,087,271	(380)	16	1,086,907
FDA	-	3,017	-	-	3,017	(293)	22	2,746
HRSA	-	11,843	-	-	11,843	(248)	11	11,606
IHS	-	5,916	-	-	5,916	(182)	238	5,972
NIH	-	35,340	-	-	35,340	(256)	376	35,460
OS	-	3,280	-	-	3,280	(485)	424	3,219
PSC	-	1,082	-	-	1,082	(74)	762	1,770
SAMHSA	-	4,424	-	-	4,424	(51)	125	4,498
Totals	**$ 15,908**	**$ 511,654**	**$ 653,143**	**$ 42,465**	**$ 1,223,170**	**$ (2,407)**	**$ 2,086**	**$ 1,222,849**

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2019

(in Millions)

Responsibility Segments	Intragovernmental: Gross Cost: Combined	Intragovernmental: Gross Cost: Eliminations	Intragovernmental: Gross Cost: Consolidated	Intragovernmental: Less: Exchange Revenue: Combined	Intragovernmental: Less: Exchange Revenue: Eliminations	Intragovernmental: Less: Exchange Revenue: Consolidated	With the Public: Gross Cost	With the Public: Less: Exchange Revenue	Consolidated Net Cost of Operations
ACF	$ 289	$ (122)	$ 167	$ (2)	$ (5)	$ (7)	$ 55,920	$ (18)	$ 56,062
ACL	21	(10)	11	(2)	1	(1)	2,165	-	2,175
AHRQ	48	(20)	28	(19)	18	(1)	307	(8)	326
CDC	909	(286)	623	(218)	98	(120)	11,662	(57)	12,108
CMS	1,016	(380)	636	(25)	16	(9)	1,200,994	(114,714)	1,086,907
FDA	1,301	(293)	1,008	(38)	22	(16)	4,331	(2,577)	2,746
HRSA	365	(248)	117	(11)	11	-	11,538	(49)	11,606
IHS	727	(182)	545	(286)	238	(48)	7,005	(1,530)	5,972
NIH	1,496	(256)	1,240	(593)	376	(217)	34,582	(145)	35,460
OS	991	(485)	506	(609)	424	(185)	2,933	(35)	3,219
PSC	357	(74)	283	(1,736)	762	(974)	2,461	-	1,770
SAMHSA	95	(51)	44	(156)	125	(31)	4,481	4	4,498
Totals	**$ 7,615**	**$ (2,407)**	**$ 5,208**	**$ (3,695)**	**$ 2,086**	**$ (1,609)**	**$ 1,338,379**	**$ (119,129)**	**$ 1,222,849**

Reduce the Footprint

Reduce the Footprint Baseline Comparison (in Square Footage)

	2015 Baseline	2018 Year End	Change
Total Leased	13,014,210	13,757,629	743,419
Total Owned	6,273,290	5,282,841	(990,449)
Total	**19,287,500**	**19,040,470**	**(247,030)**

Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)

	2015 Baseline	2018 Year End	Change
Operation and Maintenance Costs	$ 92.2	$ 90.0	$ (2.2)

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*, require CFO Act Departments to set annual targets for reducing the total square footage (sq.) of their domestic office and warehouse space compared to the FY 2015 baseline.

In FY 2018, HHS office and warehouse space decreased by 247,030 sq.; as compared to the Reduce the Footprint baseline of 19,287,500 sq. established for FY 2015. HHS will continue the efforts to reduce the inventory of office and warehouse space through reconfiguration of office spaces, Regional Office consolidations, and warehouse consolidations, and will continue to review its warehouse inventory to identify future reduction opportunities.

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 FMFIA and compliance with FFMIA.

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Four 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*, June 28, 2019, page 105)

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	-	-	0
Total Material Weaknesses	*0*	*-*	*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	1	1	-	-	-	2
Medicare Appeals Process	1	-	-	-	-	1
Contracting	0	1	-	-	-	1
Total Material Weaknesses/ Noncompliances	*2*	*2*	*0*	*-*	*-*	*4*

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 Noncompliances Noted	0	-	0	-		0
Total Noncompliance	*0*	*-*	*0*	*-*		*0*

Compliance with Section 803(a) of the *Federal Financial Management Improvement Act* (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 and 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 Operating Divisions (OpDivs) and Staff Divisions (StaffDivs): ACF, AHRQ, HRSA, FDA, CMS, Office for Civil Rights, Office of the General Counsel, and Office of Inspector General. The tables below illustrates 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)	2018	2019	$ 1,542

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)	2018	2019	$ 15,034

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)	2018	2019	$ 5,781

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)	2018	2019	$ 12,695
Penalty for each pre-February 18, 2009 violation of the HIPAA administrative simplification provisions.	42 U.S.C. 299b-22(f)(1)	2018	2019	159
Calendar Year Cap	42 U.S.C. 299b-22(f)(1)	2018	2019	39,936
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)	2018	2019	117
Maximum	42 U.S.C. 1320(d)-5(a)	2018	2019	58,490
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2018	2019	1,754,698

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to reasonable cause and not to willful neglect.	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2018	2019	1,170
Maximum	42 U.S.C. 1320(d)-5(a)	2018	2019	58,490
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2018	2019	1,754,698
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or, by exercising reasonable diligence, would have known that the violation occurred.	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2018	2019	11,698
Maximum	42 U.S.C. 1320(d)-5(a)	2018	2019	58,490
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2018	2019	1,754,698
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was not corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or by exercising reasonable diligence, would have known that the violation occurred.	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2018	2019	58,490
Maximum	42 U.S.C. 1320(d)-5(a)	2018	2019	1,754,698
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2018	2019	1,754,698

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	2018	2019	$ 20,134
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	2018	2019	20,134
Maximum	31 U.S.C. 1352	2018	2019	201,340
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.	31 U.S.C. 1352	2018	2019	20,134
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	2018	2019	20,134
Maximum	31 U.S.C. 1352	2018	2019	201,340
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	2018	2019	20,134
Maximum	31 U.S.C. 1352	2018	2019	201,340

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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	2018	2019	20,134
Maximum	31 U.S.C. 1352	2018	2019	201,340
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	2018	2019	10,520
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	2018	2019	10,520

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)	2018	2019	$ 348,708
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)	2018	2019	697,418
Penalty per violation for committing information blocking.	42 U.S.C. 300jj-51	2018	2019	1,063,260
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)	2018	2019	20,504
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)	2018	2019	20,504
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)	2018	2019	30,757
Penalty for an excluded party retaining ownership or control interest in a participating entity.	42 U.S.C. 1320a-7a(a)	2018	2019	20,504
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.	42 U.S.C. 1320a-7a(a)	2018	2019	20,504
Penalty for employing or contracting with an excluded individual.	42 U.S.C. 1320a-7a(a)	2018	2019	20,504
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)	2018	2019	102,522
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)	2018	2019	20,504
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)	2018	2019	102,522
Penalty for knowing of an overpayment and failing to report and return.	42 U.S.C. 1320a-7a(a)	2018	2019	20,504
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)	2018	2019	102,522
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)	2018	2019	30,757
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)	2018	2019	5,126
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)	2018	2019	5,126

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.	42 U.S.C. 1320a-7a(b)	2018	2019	10,252
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	2019	10,461
Knowingly makes, uses, or causes 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	2019	52,308
Knowingly makes, uses, or causes 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	2019	52,308
Knowingly makes, uses, or causes 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	2019	52,308
Fails 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	2019	15,692
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)	2018	2019	39,121
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)	2018	2019	10,519
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)	2018	2019	52,596
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)	2018	2019	2,194
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)	2018	2019	10,967
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)	2018	2019	4,388
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)	2018	2019	39,936
Penalty for a Medicare Advantage organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	39,121
Penalty for a Medicare Advantage organization that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	39,121
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)	2018	2019	156,488
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)	2018	2019	23,473
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to Secretary.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	156,488
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to individual or other entity.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	39,121
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)	2018	2019	39,121
Penalty for a Medicare Advantage organization that employs or contracts with excluded individual or entity.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	39,121
Penalty for a Medicare Advantage organization enrolling an individual in without prior written consent.	42 U.S.C. 1395w-27(g)(2)(A)	2018	2019	39,121

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2018	2019	39,121
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)	2018	2019	39,121
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)	2018	2019	39,121
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)	2018	2019	13,669
Penalty for improper billing by Hospitals, Critical Access Hospitals, or Skilled Nursing Facilities.	42 U.S.C. 1395cc(g)	2018	2019	5,317
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)	2018	2019	109,663
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)	2018	2019	54,833
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)	2018	2019	54,833
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts	42 U.S.C. 1395mm(i)(6)(B)(i)	2018	2019	54,833
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)	2018	2019	54,833
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)	2018	2019	219,327
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)	2018	2019	31,558
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)	2018	2019	219,327
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)	2018	2019	54,833
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)	2018	2019	54,833
Penalty for HMO that employs or contracts with excluded individual or entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2018	2019	50,334
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)	2018	2019	25,372
Penalty for circumventing Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	2018	2019	169,153
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	2018	2019	10,519
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	2018	2019	10,519
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2018	2019	47,357
Penalty for someone other than issuer that sells health insurance that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2018	2019	28,413
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	2018	2019	10,519
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)	2018	2019	52,596
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1395mm(i)(5)(B)(i)	2018	2019	52,596
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395mm(i)(5)(B)(i)	2018	2019	210,386

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)	2018	2019	31,558
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.	42 U.S.C. 1396b(m)(5)(B)(i)	2018	2019	210,386
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.	42 U.S.C. 1396b(m)(5)(B)(i)	2018	2019	52,596
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)	2018	2019	47,357
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)	2018	2019	2,194
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)	2018	2019	10,967
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)	2018	2019	4,388
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)	2018	2019	189,427
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)	2018	2019	18,943
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	2018	2019	189,427
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	2018	2019	3,788
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	2018	2019	22,927
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	2018	2019	22,927

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)	2018	2019	$ 105,194
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-yr period.	21 U.S.C. 333 (b)(2)(B)	2018	2019	2,103,861
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)	2018	2019	210,386
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C. 333 (f)(1)(A)	2018	2019	28,413
Penalty for aggregate of all violations related to devices in a single proceeding.	21 U.S.C. 333 (f)(1)(A)	2018	2019	1,894,261
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)	2018	2019	79,875
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)	2018	2019	399,374
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.	21 U.S.C. 333 (f)(2)(A)	2018	2019	798,747
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)	2018	2019	12,103

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2018	2019	12,103
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)	2018	2019	302,585
Penalty for aggregate of all such above violations in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(i)	2018	2019	1,210,340
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)	2018	2019	302,585
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)	2018	2019	1,210,340
Penalty for aggregate of all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(ii)	2018	2018	12,103,404
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)	2018	2019	17,547
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(A)	2018	2019	1,169,798
Penalty per violation related to violations of tobacco requirements.	21 U.S.C. 333 (f)(9)(B)(i)(I)	2018	2019	292,450
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)	2018	2019	1,169,798
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)	2018	2019	292,450
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)	2018	2019	1,169,798
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)	2018	2019	11,697,983
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)	2018	2019	292,450
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(I)	2018	2019	1,169,798
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)	2018	2019	292,450
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)	2018	2019	1,169,798
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2018	2019	11,697,983
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)	2018	2019	302,585
Penalty for each subsequent above violation in any 3-year period.	21 U.S.C. 333 (g)(1)	2018	2019	605,171
Penalty to be applied for 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	2018	2019	292

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty in the case of a third tobacco product regulation violation within a 24-month period.	21 U.S.C. 333 note	2018	2019	584
Penalty in the case of a fourth tobacco product regulation violation within a 24- month period.	21 U.S.C. 333 note	2018	2019	2,340
Penalty in the case of a fifth tobacco product regulation violation within a 36-month period.	21 U.S.C. 333 note	2018	2019	5,849
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48-month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2018	2019	11,698
Penalty to be applied for 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	2018	2019	292
Penalty in the case of a second tobacco product regulation violation within a 12-month period.	21 U.S.C. 333 note	2018	2019	584
Penalty in the case of a third tobacco product regulation violation within a 24–month period.	21 U.S.C. 333 note	2018	2019	1,170
Penalty in the case of a fourth tobacco product regulation violation within a 24–month period.	21 U.S.C. 333 note	2018	2019	2,340
Penalty in the case of a fifth tobacco product regulation violation within a 36–month period.	21 U.S.C. 333 note	2018	2019	5,849
Penalty in the case of a fifth tobacco product regulation violation within a 36–month period.	21 U.S.C. 333 note	2018	2019	5,849
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48–month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2018	2019	11,698
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)	2018	2019	445,846
Penalty in the case of any other person (other than an individual) per above violation.	21 U.S.C. 335b(a)	2018	2019	1,783,384
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)	2018	2019	2,924
Penalty imposed for any related series of violations of requirements relating to electronic products.	21 U.S.C. 360pp(b)(1)	2018	2019	996,806
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	2018	2019	229,269
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C. 263b(h)(3)	2018	2019	17,834
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)	2018	2019	229,269

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)	2018	2019	6,417
Maximum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2018	2019	21,039
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)	2018	2019	106
Maximum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2018	2019	6,311
Failure to provide the Summary of Benefits and Coverage (SBC).	42 U.S.C. 300gg-15(f)	2018	2019	1,156
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	42 U.S.C. 300gg-18	2018	2019	116
Penalty for manufacturer or group purchasing organization failing to report information required under 42 USC 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)	2018	2019	1,156
Maximum	42 U.S.C. 1320a-7h(b)(1)	2018	2019	11,562
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(1)	2018	2019	173,436
Penalty for manufacturer or group purchasing organization knowingly failing to report information required under 42 USC 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)	2018	2019	11,562
Maximum	42 U.S.C. 1320a-7h(b)(2)	2018	2019	115,624
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(2)	2018	2019	1,156,242
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)	2018	2019	115,624
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)	2018	2019	578
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)	2018	2019	1,735
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)	2018	2019	3,468
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)	2018	2019	8,457

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for the violation of 42 USC 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)	2018	2019	7,975
Penalty for a representative payee (under 42 USC 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)	2018	2019	6,623
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)	2018	2019	231,249
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)	2018	2019	346,872
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)	2018	2019	231,249
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)	2018	2019	156
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)	2018	2019	
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	110
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	6,579
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)	2018	2019	2,194
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
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)	2018	2019	6,690
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
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)	2018	2019	2,194
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
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)	2018	2019	6,690
Per Day (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
Per Instance (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	2,194
Per Instance (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2018	2019	6,690
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
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)	2018	2019	110
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	6,579
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)	2018	2019	2,194
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2018	2019	21,933
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395l(h)(5)(D)	2018	2019	15,975
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)	2018	2019	4,208
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)	2018	2019	4,027
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(18)(B)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(b)(5)(C)	2018	2019	15,975
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 USC 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)	2018	2019	15,975
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)	2018	2019	1,692
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 USC 1395m(j)(4) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(j)(4)	2018	2019	15,975

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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 USC 1395m(k)(6) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(k)(6)	2018	2019	15,975
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 USC 1395u(b)(18)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(l)(6)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(b)(18)(B)	2018	2019	15,975
Penalty for any physician who charges more than 125% for a non-participating referral. (Penalties are assessed in the same manner as 42 USC 1320a-7a(a)).	42 U.S.C. 1395u(j)(2)(B)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(k)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(l)(3)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(m)(3)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(n)(3)	2018	2019	15,975
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 USC 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)	2018	2019	15,975
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)	2018	2019	4,208
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)	2018	2019	13,669
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(1)(B)	2018	2019	15,975
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 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(3)(B)	2018	2019	15,975

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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); 42 U.S.C. 1857(g)(3)(A)	2018	2019	39,121
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); 42 U.S.C. 1857(g)(3)(B)	2018	2019	15,649
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); 42 U.S.C. 1857(g)(3)(D)	2018	2019	145,335
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)	2018	2019	9,472
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)	2018	2019	1,542
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)	2018	2019	3,383
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)	2018	2019	1,211
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)	2018	2019	1,211
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)	2018	2019	20,134
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)	2018	2019	15,975
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)	2018	2019	54,832
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)	2018	2019	28,413
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)	2018	2019	47,357
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)	2018	2019	28,413
Penalty for issuer that sells or issues a Medicare supplemental policy without an acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2018	2019	47,357
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)	2018	2019	28,413
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)	2018	2019	47,357
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)	2018	2019	28,413

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
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)	2018	2019	47,357
Penalty for any person that fails to suspend the policy of a policyholder made eligible for medical assistance or automatically reinstates the policy of a policyholder who has lost eligibility for medical assistance, under certain circumstances.	42 U.S.C. 1395ss(q)(5)(C)	2018	2019	47,357
Penalty for any person that fails to provide refunds or credits as required by section 1882(r)(1)(B).	42 U.S.C. 1395ss(r)(6)(A)	2018	2019	47,357
Penalty for any issuer of a Medicare supplemental policy that does not waive listed time periods if they were already satisfied under a proceeding Medicare supplemental policy, or denies a policy, or conditions the issuances or effectiveness of the policy, or discriminates in the pricing of the policy base on health status or other specified criteria.	42 U.S.C. 1395ss(s)(4)	2018	2019	20,104
Penalty for any issuer of a Medicare supplemental policy that fails to fulfill listed responsibilities.	42 U.S.C. 1395ss(t)(2)	2018	2019	47,357
Penalty someone other than issuer who sells, issues, or renews a Medigap Rx policy to an individual who is a Part D enrollee	42 U.S.C. 1395ss(v)(4)(A)	2018	2019	20,503
Penalty for an issuer who sells, issues, or renews a Medigap Rx policy who is a Part D enrollee.	42 U.S.C. 1395ss(v)(4)(A)	2018	2019	34,174
Penalty for any individual who notifies or causes to be notified a home health agency of the time or date on which a survey of such agency is to be conducted	42 U.S.C. 1395bbb(c)(1)	2018	2019	4,388
Maximum daily penalty amount for each day a home health agency is not in compliance with statutory requirements.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	21,039
Penalty per day for home health agency's noncompliance (Upper Range).	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	17,883
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	21,039
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in actual harm.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	21,039
Penalty for a home health agency's deficiency or deficiencies that cause immediate jeopardy and result in potential for harm.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	18,934
Penalty for an isolated incident of noncompliance in violation of established HHA policy.	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	17,883
Penalty for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy, but is directly related to poor quality patient care outcomes (Lower Range).	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	3,157
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	17,883
Penalty for a repeat and/or condition- level deficiency that does not constitute immediate jeopardy and that is related predominately to structure or process-oriented conditions (Lower Range).	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	1,052
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	8,415
Penalty imposed for instance of noncompliance that may be assessed for one or more singular events of condition-level noncompliance that are identified and where the noncompliance was corrected during the onsite survey.	42 U.S.C. 1395bbb(f)(2)(A)(i)			
Minimum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	2,104

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Maximum	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	21,039
Penalty for each day of noncompliance (Maximum).	42 U.S.C. 1395bbb(f)(2)(A)(i)	2018	2019	21,039
Penalty for discriminating or discouraging enrollment or disenrollment of participants on the basis of an individual's health status or need for health care services.	42 U.S.C. 1396b(m)(5)(B)			
Minimum	42 U.S.C. 1396b(m)(5)(B)	2018	2019	23,473
Maximum	42 U.S.C. 1396b(m)(5)(B)	2018	2019	156,488
Penalty for a PACE organization that charges excessive premiums.	42 U.S.C. 1396b(m)(5)(B)	2018	2019	39,121
Penalty for a PACE organization misrepresenting or falsifying information to CMS, the State, or an individual or other entity.	42 U.S.C. 1396b(m)(5)(B)	2018	2019	156,488
Penalty for each determination the CMS makes that the PACE organization has failed to provide medically necessary items and services of the failure has adversely affected (or has the substantial likelihood of adversely affecting) a PACE participant.	42 U.S.C. 1396b(m)(5)(B)	2018	2019	39,121
Penalty for involuntarily disenrolling a participant.	42 U.S.C. 1396b(m)(5)(B)	2018	2019	39,121
Penalty for PACE organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1396b(m)(5)(B)	2018	2019	39,121
Penalty per day for a nursing facility's failure to meet a Category 2 Certification.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	110
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	6,579
Penalty per instance for a nursing facility's failure to meet Category 2 certification	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	2,194
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Penalty per day for a nursing facility's failure to meet Category 3 certification.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	6,690
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Penalty per instance for a nursing facility's failure to meet Category 3 certification, which results in immediate jeopardy.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	2,194
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Penalty per instance for a nursing facility's failure to meet Category 3 certification, which results in immediate jeopardy.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	2,194
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Penalty per day for nursing facility's failure to meet certification (Upper Range).	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	6,690
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Penalty per day for nursing facility's failure to meet certification (Lower Range).	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	110
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	6,579
Penalty per instance for nursing facility's failure to meet certification.	42 U.S.C. 1396r(h)(3)(C)(ii)(I)			
Minimum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	2,194
Maximum	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	21,933
Grounds to prohibit approval of Nurse Aide Training Program—if assessed a penalty in 1819(h)(2)(B)(i) or 1919(h)(2)(A)(ii) of "not less than $5,000" [Not CMP authority, but a specific CMP amount (CMP at this level) that is the triggering condition for disapproval].	42 U.S.C. 1396r(f)(2)(B)(iii)(I)(c)	2018	2019	10,967
Grounds to waive disapproval of nurse aide training program—reference to disapproval based on imposition of CMP "not less than $5,000" [Not CMP authority but CMP imposition at this level determines eligibility to seek waiver of disapproval of nurse aide training program].	42 U.S.C. 1396r(h)(3)(C)(ii)(I)	2018	2019	10,967
Penalty for each day of noncompliance for a home or community care provider that no longer meets the minimum requirements for home and community care.	42 U.S.C. 1396t(j)(2)(C)			
Minimum	42 U.S.C. 1396t(j)(2)(C)	2018	2019	2
Maximum	42 U.S.C. 1396t(j)(2)(C)	2018	2019	18,943
Penalty for a Medicaid managed care organization that fails substantially to provide medically necessary items and services.	42 U.S.C. 1396u–2(e)(2)(A)(i)	2018	2019	39,121
Penalty for Medicaid managed care organization that imposes premiums or charges on enrollees in excess of the premiums or charges permitted.	42 U.S.C. 1396u–2(e)(2)(A)(i)	2018	2019	39,121
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to another individual or entity.	42 U.S.C. 1396u–2(e)(2)(A)(i)	2018	2019	39,121
Penalty for a Medicaid managed care organization that fails to comply with the applicable statutory requirements for such organizations.	42 U.S.C. 1396u–2(e)(2)(A)(i)	2018	2019	39,121
Penalty for a Medicaid managed care organization that misrepresents or falsifies information to the HHS Secretary.	42 U.S.C. 1396u–2(e)(2)(A)(ii)	2018	2019	156,488
Penalty for Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u–2(e)(2)(A)(ii)	2018	2019	156,488
Penalty for each individual that does not enroll as a result of a Medicaid managed care organization that acts to discriminate among enrollees on the basis of their health status.	42 U.S.C. 1396u–2(e)(2)(A)(iv)	2018	2019	23,473
Penalty for a provider not meeting one of the requirements relating to the protection of the health, safety, and welfare of individuals receiving community supported living arrangements services.	42 U.S.C. 1396u(h)(2)	2018	2019	21,933
Penalty for disclosing information related to eligibility determinations for medical assistance programs.	42 U.S.C. 1396w–2(c)(1)	2018	2019	11,698
Failure to comply with requirements of the *Public Health Services Act*; Penalty for violations of rules or standards of behavior associated with issuer participation in the Federally-facilitated Exchange. (42 U.S.C. 300gg–22(b)(2)(C))	42 U.S.C. 18041(c)(2)	2018	2019	159
Penalty for providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(A)(i)(II)	2018	2019	28,906
Penalty for knowingly or willfully providing false information on Exchange application.	42 U.S.C. 18081(h)(1)(B)	2018	2019	289,060
Penalty for knowingly or willfully disclosing protected information from Exchange.	42 U.S.C. 18081(h)(2)	2018	2019	28,906

Payment Integrity Report

OVERVIEW

HHS is committed to advancing a transparent, accountable, and collaborative financial management environment to fulfill its federal requirements, as well as to provide stakeholders with accessible and actionable financial information. An important part of this commitment is the continuous improvement of payment accuracy in all HHS programs. The Department has 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.

As required by the *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA); Office of Management and Budget (OMB) Circular A-136; and Appendix C of OMB Circular A-123, HHS's Fiscal Year (FY) 2019 Payment Integrity Report includes a discussion of the following topics:

Section	Topic
1.0	Program Description
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 2019 Achievements
9.0	Improper Payment Performance FY 2018 through FY 2020
9.1	• Accompanying Notes for Table 1
10.0	Improper Payment Root Cause Categories
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	Recovery Auditing Reporting

Refer to PaymentAccuracy.gov for additional detailed information on HHS's improper payment efforts.

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 that 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.
Advance Premium Tax Credit (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.

Program-specific information on each risk-susceptible program is located throughout the Payment Integrity Report. However, since HHS is not reporting an Advance Premium Tax Credit (APTC) improper payment estimate for FY 2019, the program is not included in Section 11.0: *Program-Specific Reporting Information*. See Note 6 of Section 9.1*: Accompanying Notes for Table 1* for more detailed information on the Department's efforts to develop an APTC improper payment measurement program. 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 will begin reporting improper payment estimates in the FY 2020 Payment Integrity Report, as appropriate. HHS anticipates that three programs will establish methodologies and report improper payment estimates for disaster funding in FY 2020.

2.0 RISK ASSESSMENTS

As required by the amended IPIA and OMB implementation guidance, HHS reviews its non-risk-susceptible programs (including payment streams and activities) using the HHS IPERIA Risk Assessment Tool to determine susceptibility to significant improper payments. The HHS IPERIA Risk Assessment Tool contains:

- The seven risk factors contained in Appendix C of OMB Circular A-123, Part I.C.Step2.b (specific risk factors are listed on page 187 of HHS's FY 2018 AFR);
- Specific program-identified risks that may lead to improper payments; and
- Controls that may mitigate those risks.

By examining these areas, the HHS IPERIA 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 2019, HHS made no changes to the grouping of programs for improper payment risk assessments. However, HHS strengthened its risk assessment and reporting activities in FY 2019 by enhancing policies and procedures and improving the HHS risk assessment by applying lessons learned from the previous year. In addition, in FY 2019, HHS began efforts to update its program inventory and explore options to automate this process. For example, HHS applied the *Digital Accountability and Transparency Act of 2014* (DATA Act) information to the universe of programs to improve the process of identifying and selecting programs for review. HHS also created and leveraged an online tool to provide guidance to the Operating Divisions (OpDivs), collect information for the program risk assessments, and maintain supporting documentation. HHS will provide an additional update in the FY 2020 Payment Integrity Report.

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[26] on sampling and estimation plans. OMB updated its guidance in June 2018,[27] and, effective for FY 2019 reporting, three programs (Medicare FFS, Medicare Part C, and Medicare Part D) complied with the new 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.

The statistical sampling and estimation process is detailed in Section 11.0: *Program-Specific Reporting Information*.

[26] 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*".

[27] 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.

3.1 IMPROPER PAYMENT MEASUREMENT ESTIMATES

As discussed in Section 1.0: *Program Descriptions* and throughout the Payment Integrity Report, 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.

Finally, 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 information. Some improper payment estimation methodologies are able to discern if the insufficient documentation payment error would have resulted in the government making the payment in the assigned amount, 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 and reporting process is the identification of improper payment root causes. Once a program identifies improper payment root causes, the program staff works with stakeholders to implement corrective actions to address those root causes. Table 2: *Improper Payment Root Cause Category Matrix for HHS's Risk-Susceptible Programs* and Section 11.0: *Program-Specific Reporting Information* include program-specific root cause information and corrective actions that align with OMB 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 provides 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 Agency Financial Report (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* for each program's corrective action plan for reducing the estimated rate of improper payments.

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* details each program's information system(s) and other infrastructure. Unless otherwise stated in Section 11.0, 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* details each program's statutory or regulatory barriers to reducing improper payments. Unless otherwise stated in Section 11.0, HHS has no current statutory or regulatory barriers to reducing improper payments.

8.0 FY 2019 ACHIEVEMENTS

In FY 2019, HHS strengthened its efforts to reduce and recover improper payments in its programs. Results of the efforts are outlined here and in Section 11.0: *Program-Specific Reporting Information*. Four of the seven risk-susceptible programs that report improper payment estimates reported lower estimated improper payment rates in FY 2019 than in FY 2018. The more notable efforts are highlighted below and detailed information on program performance and corrective actions can be found in Section 11.0.

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 must 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.

In FY 2018, HHS assumed a key role in supporting the implementation of the "Getting Payments Right" CAP Goal – serving as an agency lead and contributor on multiple workgroups created under the CAP Goal. HHS's key role carried into the CAP Goal's efforts in FY 2019. HHS led and supported workgroups that focused on addressing the challenges that federal agencies face in effectively identifying monetary loss root causes and the existing limitations on prepayment checks due to the availability of data sources. These efforts produced findings and recommendations that will be used in future work groups to link the agencies' data sources to root causes and will help the government identify effective mitigation strategies to prevent monetary loss. HHS will continue to support this CAP Goal and other efforts to reduce improper payments in FY 2020.

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 error rates from FYs 2009 through 2012. In lieu of an annual error 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 2019, 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 2019, HHS assessed 190 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 seven 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.

Vulnerability Collaboration Council (VCC)

To detect and combat fraud, waste, and abuse, the Centers for Medicare & Medicaid Services (CMS) 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 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 has aligned the VCC's risk-based approach with the Government Accountability Office's (GAO) "A Framework for Managing Fraud Risk in Federal Programs" (GAO-15-593SP). By aligning with the GAO framework, HHS has standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the development of measurable, verifiable, and time-bound action plans.

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 2019, HHS continued to add and refine models in FPS.

During FY 2019, the FPS generated leads that resulted in 766 new investigations and augmented information for 575 existing investigations. The Unified Program Integrity Contractors reported initiating FPS-attributable actions against 509 providers in FY 2019.

National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) and Investigations MEDIC (I-MEDIC)

In FY 2019, HHS split the Medicare Part C and Part D program integrity initiatives between two contractors, the NBI MEDIC and the I-MEDIC. The NBI MEDIC has a national focus related to plan oversight pertaining to the following Medicare Part C and Part D program integrity initiatives: identification of program vulnerabilities, data analysis, health plan audits, outreach and education, and law enforcement support which includes requests for information. As a result of the NBI MEDIC's data analysis projects, including Part D plan sponsor self-audits, HHS recovered $3.80 million from Part D sponsors during the first three quarters of FY 2019. The primary purpose of the I-MEDIC is 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:

- Hiring contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate 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 the increased focus on Medicaid program integrity. For example, the Medicaid Integrity Program provided federal staff specializing 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 $486.87 million in FY 2019.[28] The Medicaid Integrity Program works in coordination with the Medicaid program integrity activities funded by the Health Care Fraud and Abuse Control program. Such program integrity activities improve HHS's financial oversight of Medicaid and CHIP by supporting reviews of proposed Medicaid state plan amendments, financial management, and other activities.

The DRA also requires HHS to establish a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to guide the Medicaid Integrity Program's development and operations. HHS has established CMIPs since 2006. The last 5-year CMIP covered FYs 2014 through 2018. Noteworthy outcomes from FYs 2014 through 2018 have been referenced in the Medicaid section of the HHS AFR Payment Integrity Report for recent years, as well as in Section 11.4: *Medicaid* of this year's Payment Integrity Report.

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 new audits of state beneficiary eligibility determinations and audits of Medicaid managed care plans' Medical Loss Ratio calculations – will form the foundation for a new 5-year CMIP to be published in FY 2020. In June 2019, HHS celebrated the 1-year anniversary of the Medicaid Program Integrity Strategy by publishing a blog post describing HHS's successes to date.

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 an individual's eligibility and to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, child care related programs, and the Supplemental Nutrition Assistance Program. Provided to states at no cost, PARIS data helps states strengthen program administration. For example, New York used PARIS to close or remove active clients from 8,593 public assistance cases for projected cost savings of $49.35 million during the most recent full state FY (April 2018 to March 2019). 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 has 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, 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 2019, the Department screened 1.2 million payments against IPERIA-listed databases, representing $493.4 billion. While the Department identified 66 potential

[28] 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.

improper payments over the past year through these daily matches, there was 1 confirmed match in FY 2019. Lastly, CMS also checks certain payments against IPERIA-listed databases outside of the DNP portal. In FY 2019, CMS screened 1.2 billion payments against IPERIA-listed databases, representing $415 billion. Through these checks, CMS stopped 402,871 payments representing $1.7 billion.

9.0 IMPROPER PAYMENT PERFORMANCE FY 2018 THROUGH FY 2020

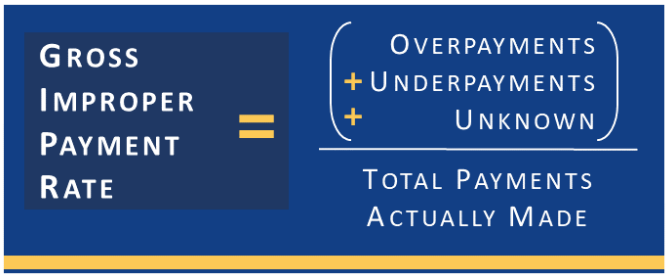
Each year, HHS reports updated improper payment estimates in the Payment Integrity Report. Table 1 displays HHS's proper and improper payment estimates for current year (CY) (FY 2019), improper payment estimates for the prior year (PY) (FY 2018), and improper payment targets for FY 2020 (CY+1). The table includes the following information by year and program, as applicable:

- FY outlays;
- Estimated improper payment rate or future target rate (IP%); and
- Estimated amount and percent paid or projected to be paid properly (PP) and improperly (IP).

In addition, for the CY, Table 1 includes:

- Estimated dollar amount of overpayments (CY Over Payments);
- Estimated dollar amount of underpayments (CY Under Payments); 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.



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 2018 – FY 2020 (in Millions)

Program or Activity	PY Outlays $	PY IP %	PY IP $	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	$389,300.05 [a]	8.12	$31,617.94	$398,623.97 [b]	92.75	$369,715.14	7.25 [1]	$28,908.83	$11,016.06	$1,343.75	$16,549.02	$450,403.00 [c]	7.15	$32,203.81
Medicare Part C	$191,923.92 [d]	8.10	$15,554.31	$212,444.68 [e]	92.13	$195,716.10	7.87	$16,728.58	$9,402.18	$6,948.36	$378.04	$295,157.00 [f]	7.77	$22,933.70
Medicare Part D	$79,559.54 [g]	1.66	$1,318.92	$80,787.84 [h]	99.25	$80,179.90	0.75	$607.94	$101.12	$272.47	$234.35	$102,231.00 [i]	0.74	$756.51
Medicaid	$370,391.00 [j]	9.79 [5]	$36,249.70	$384,996.67 [k]	85.10	$327,638.54	14.90 [2 and 5]	$57,358.13	$12,462.32	$377.82	$44,518.00	$401,681.38 [k]	N/A [4]	N/A [4]
CHIP	$16,223.92 [l]	8.57 [5]	$1,389.63	$17,280.95 [m]	84.17	$14,544.57	15.83 [3 and 5]	$2,736.38	$999.00	$12.35	$1,725.02	$17,826.03 [m]	N/A [4]	N/A [4]
APTC	$33,755.55 [n]	N/A	N/A	$47,520.58 [o]	N/A	N/A	N/A [6]	N/A	N/A	N/A	N/A	$50,869.84 [o]	N/A	N/A
TANF	$16,330.95 [p]	N/A	N/A	$16,536.29 [q]	N/A	N/A	N/A [7]	N/A	N/A	N/A	N/A	$16,218.87 [q]	N/A	N/A
Foster Care	$394.00 [r]	7.56	$29.79	$147.00 [s]	95.15	$139.87	4.85	$7.13	$6.82	$0.31	$0.00	$1,387.00 [s]	6.00 [8]	$83.22
CCDF	$7,549.78 [t]	4.00	$301.99	$7,166.95 [u]	95.47	$6,842.29	4.53	$324.66	$106.08	$19.81	$198.77	$9,697.81 [u]	N/A [9]	N/A

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 PY outlays are from the FY 2018 Medicare FFS Improper Payments Report (based on claims from July 2016 – June 2017).
b) Medicare FFS CY outlays are from the FY 2019 Medicare FFS Improper Payments Report (based on claims from July 2017 – June 2018).
c) Medicare FFS CY+1 outlays are based on the FY 2020 Midsession Review (Medicare Benefit Outlays current law [CL]).
d) Medicare Part C PY outlays reflect 2016 Part C payments, as reported in the FY 2018 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY outlays reflect 2017 Part C payments, as reported in the FY 2019 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1 outlays are based on the FY 2020 Midsession Review (Medicare Benefit Outlays [CL]).
g) Medicare Part D PY outlays reflect 2016 Part D payments, as reported in the FY 2018 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2017 Part D payments, as reported in the FY 2019 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1 outlays are based on the FY 2020 Midsession Review (Medicare Benefit Outlays [CL]).
j) Medicaid PY outlays (based on FY 2017 expenditures) are based on the FY 2019 Midsession Review and exclude CDC Vaccine for Children program funding.
k) Medicaid CY (based on FY 2018 expenditures) and CY+1 outlays (Medicaid - Outlays CL exclude CDC Vaccine for Children program funding), are based on the FY 2020 Midsession Review.
l) CHIP PY outlays (based on FY 2017 expenditures) are based on the FY 2019 Midsession Review.
m) CHIP CY (based on FY 2018 expenditures) and CY+1 outlays (total outlays from the Children's Health Insurance Fund [CL]), are based on the FY 2020 Midsession Review.
n) APTC PY outlays are comprised of FY 2017 estimated expenditures; and are based on the FY 2019 Midsession Review.
o) APTC CY outlays are comprised of FY 2018 estimated expenditures and are based on the FY 2020 Midsession Review. CY+1 outlays are based on the FY 2020 Midsession Review.
p) TANF PY outlays are based on the FY 2019 President's Budget baseline, as reported in the FY 2018 AFR.
q) TANF CY and CY+1 outlays are based on the FY 2020 President's Budget baseline (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs and excluding the TANF Contingency Fund).
r) Foster Care PY outlays are based on the FY 2019 President's Budget baseline and reflect the federal share of maintenance payments for states not operating under a demonstration waiver, as reported in the FY 2018 AFR.
s) Foster Care CY and CY+1 outlays are based on the FY 2020 President's Budget baseline, and reflect the federal share of maintenance payments. Foster Care CY+1 outlays' increase reflects an increase in the number of states reporting this data due to the expiration of the waiver authority under Section 1130 of the *Social Security Act*.
t) CCDF PY outlays are based on the FY 2019 President's Budget baseline, as reported in the FY 2018 AFR.
u) CCDF CY and CY+1 outlays are based on the FY 2020 President's Budget baseline.

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 2019. 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 0.20 percentage points to 7.25 percent or $28.91 billion in projected improper payments. Additional adjustment factor information is on pages 166-167 of HHS's FY 2012 AFR.
2. HHS calculated and is reporting the national Medicaid improper payment rate based on measurements conducted in FYs 2017, 2018, and 2019. The national Medicaid component improper payment rates are: Medicaid FFS: 16.30 percent, Medicaid managed care: 0.12 percent, and Medicaid eligibility: 8.36 percent.
3. HHS calculated and is reporting the national CHIP improper payment rate based on measurements conducted in FYs 2017, 2018, and 2019. The national CHIP component improper payment rates are: CHIP FFS: 13.25 percent, CHIP managed care: 1.25 percent, and CHIP eligibility: 11.78 percent.
4. 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 and is reporting the first updated national eligibility improper payment estimates in FY 2019. 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.
5. 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 2019 rate would adjust by up to +/- 0.27 percent based on these concerns, again well within the estimate's confidence interval. This impact on the national improper payment rate may vary again in FY 2020 depending on the results of the final cycle.
6. 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 2019. The Department is committed to implementing an improper payment measurement program as required by the IPIA, as amended. As with similar HHS programs, developing an effective and efficient improper payment measurement program requires multiple, time-intensive steps including contractor procurement timelines, 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, 2018, and 2019, HHS conducted development and piloting activities for the APTC improper payment measurement program and will continue these activities in FY 2020. The Department will continue to update its annual AFRs with the measurement program development status until the reporting of the improper payment estimate.
7. The TANF program is not reporting an error rate for FY 2019. As discussed in Section 11.6: *TANF*, statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.
8. Foster Care is reporting a higher CY+1 improper payment target than the CY improper payment rate due to the anticipated impact of the *Family First Prevention Services Act*. As discussed in Section 11.7: *Foster Care*, HHS expects that the new Title IV-E Foster Care eligibility requirements, which went into effect October 1, 2018, may contribute to an increase in improper payments as states make the necessary adjustments to comply with the law. The FY 2020 improper payment estimate for the Foster Care program will be the first year subject to the new requirements. As a result, HHS increased the Foster Care program's improper payment target for FY 2020.
9. CCDF is not reporting a CY+1 improper payment target. Rolling implementation of the new requirements will continue to affect the error rate in the FY 2020 measurement, making it challenging to determine a target rate. CCDF state grantees are implementing large-scale changes to their child care programs. 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. HHS anticipates that the error rate may continue to rise as states work to meet the new requirements and anticipates the publication of a reduction target in FY 2022.

10.0 IMPROPER PAYMENT ROOT CAUSE CATEGORIES

OMB guidance requires agencies to report the improper payment root causes for risk-susceptible programs with reported improper payment estimates. Table 2 displays HHS's FY 2019 improper payment root causes and the estimated overpayment, underpayment, or unknown amounts for each risk-susceptible program. 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.

Table 2
Improper Payment Root Cause Category Matrix for HHS's Risk-Susceptible Programs
FY 2019 (in Millions)

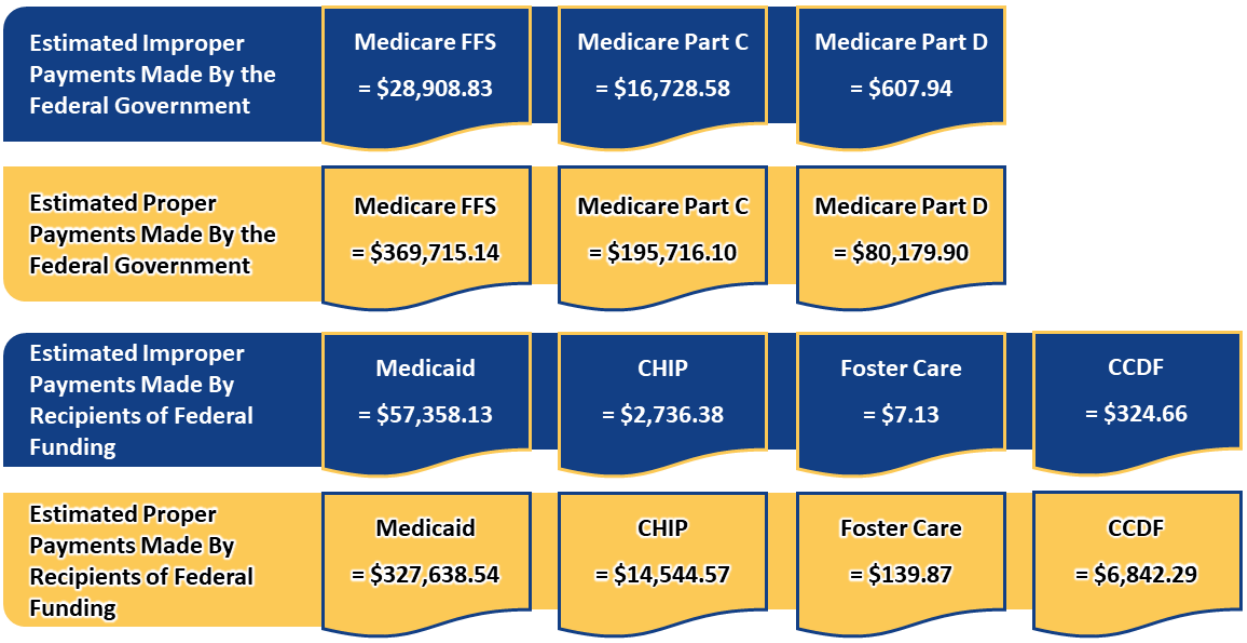
Program or Activity	Payment Type	Inability to Authenticate Eligibility: Inability to access data	Failure to Verify Death Data	Administrative or Process Error Made by: State or Local Agency	Administrative or Process Error Made by: Other Party	Medical Necessity	Insufficient Documentation to Determine	Total [2]
Medicare FFS	Overpayments				$5,620.37	$5,395.69		$11,016.06
	Underpayments				$1,343.23	$0.52		$1,343.75
	Unknown						$16,549.02	$16,549.02
Medicare Part C	Overpayments				$9,402.18			$9,402.18
	Underpayments				$6,948.36			$6,948.36
	Unknown						$378.04	$378.04
Medicare Part D	Overpayments				$101.12			$101.12
	Underpayments				$272.47			$272.47
	Unknown						$234.35	$234.35
Medicaid [1]	Overpayments	$7,093.01	$8.80	$5,071.94	$288.56			$12,462.32
	Underpayments	$326.51		$51.31				$377.82
	Unknown						$44,518.00	$44,518.00
CHIP [1]	Overpayments	$578.32		$408.66	$11.66	$0.37		$999.00
	Underpayments	$7.15		$5.21				$12.35
	Unknown						$1,725.02	$1,725.02
Foster Care	Overpayments			$6.82				$6.82
	Underpayments			$0.31				$0.31
	Unknown							
CCDF	Overpayments			$100.21	$5.87			$106.08
	Underpayments			$16.51	$3.30			$19.81
	Unknown						$198.77	$198.77

Notes:

1. As described in Sections 11.4: *Medicaid* and 11.5: *CHIP*, HHS resumed the eligibility component measurement for the first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. The national eligibility improper payment rate still includes a proxy estimate for the remaining 34 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 2019 measurement are included in the appropriate category.
2. Totals do not necessarily equal the sum of the rounded components.

OMB Circular A-136 requires agencies to report by program the estimated amount of improper payments made directly by the federal government or by recipients of federal money as shown in Figure 2. At HHS, all Medicare FFS, Medicare Part C, and Medicare Part D estimated improper payments were made by the federal government or its representatives. The estimated improper payments for the remaining programs, Medicaid, CHIP, Foster Care, and CCDF were made by recipients of federal money (e.g., state agencies or grantees).

Figure 2: FY 2019 Estimated Proper and Improper Payments Made by the Federal Government or Recipients of Federal Funding (in Millions)



OMB Circular A-136 also 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 first time, 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 2019 estimated improper payments are distributed between monetary loss, non-monetary loss, and unknown monetary loss for each program as displayed in Table 3. In addition, Table 3 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 3
Estimated Proper and Improper Payments (across Monetary Loss [ML], Non-Monetary Loss [NML], and Unknown Monetary Loss) by Program
FY 2019 (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	$369,715.14	$28,908.83	$9,757.62 [1]	34%	$9,757.62		$2,602.20	9%	$16,549.02	57%
Medicare Part C	$195,716.10	$16,728.58	$9,402.18	56%		$9,402.18	$6,948.36	42%	$378.04	2%
Medicare Part D	$80,179.90	$607.94	$101.12	17%		$101.12	$272.47	45%	$234.35	38%
Medicaid	$327,638.54	$57,358.13	$12,462.32 [2]	22%		$12,462.32 [3]	$377.82	0.7%	$44,518.00	78%
CHIP	$14,544.57	$2,736.38	$999.00 [2]	37%		$999.00 [3]	$12.35	0.5%	$1,725.02	63%
Foster Care	$139.87	$7.13	$6.82	96%		$6.82 [4]	$0.31	4%		
CCDF	$6,842.29	$324.66	$106.08	33%		$106.08 [5]	$19.81	6%	$198.77	61%
Total [6]	**$994,776.41**	**$106,671.65**	**$32,835.15**	**31%**	**$9,757.62**	**$23,077.52**	**$10,233.32**	**10%**	**$63,603.20**	**60%**

Notes:

1. The majority of monetary loss for the Medicare FFS program is due to medical necessity improper payments for home health and 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. The categorization of Monetary Loss Within versus Outside Agency Control corresponds to the distinction in Figure 2 between Improper Payments Made By the Federal Government versus Improper Payments Made By Recipients of Federal Funding (e.g., Medicaid and CHIP improper payments made by states on behalf of the federal government are considered outside the agency's control).
4. Title IV-E Foster Care is a state-administered program and therefore eligibility is determined by staff at the state and local levels.
5. 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.
6. 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 3 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 3: 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).

HHS sampled approximately 50,000 claims during the FY 2019 report period. The improper payment rate estimated from this sample reflects all claims processed by the Medicare FFS program during the report period. 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 2019 is 7.25 percent of total outlays or $28.91 billion. This year's estimate decreased from the prior year's reported 8.12 percent improper payment estimate due to a reduction in improper payments for home health, Part B, and DMEPOS claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate decreased, improper payments for SNF, hospital outpatient, IRF, and home health claims were major contributing factors to the FY 2019 Medicare FFS improper payment rate, comprising 36.01 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 SNF claims. The SNF claims improper payment rate increased from 6.55 percent in FY 2018 to 8.54 percent in FY 2019. The primary reason for the errors was missing or insufficient certification/recertification statements. Medicare coverage of SNF services requires certification and recertification for these services (42 Code of Federal Regulation [CFR] §424.20).
- Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims increased from 3.25 percent in FY 2018 to 4.37 percent in FY 2019. 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 CFR §410.32).

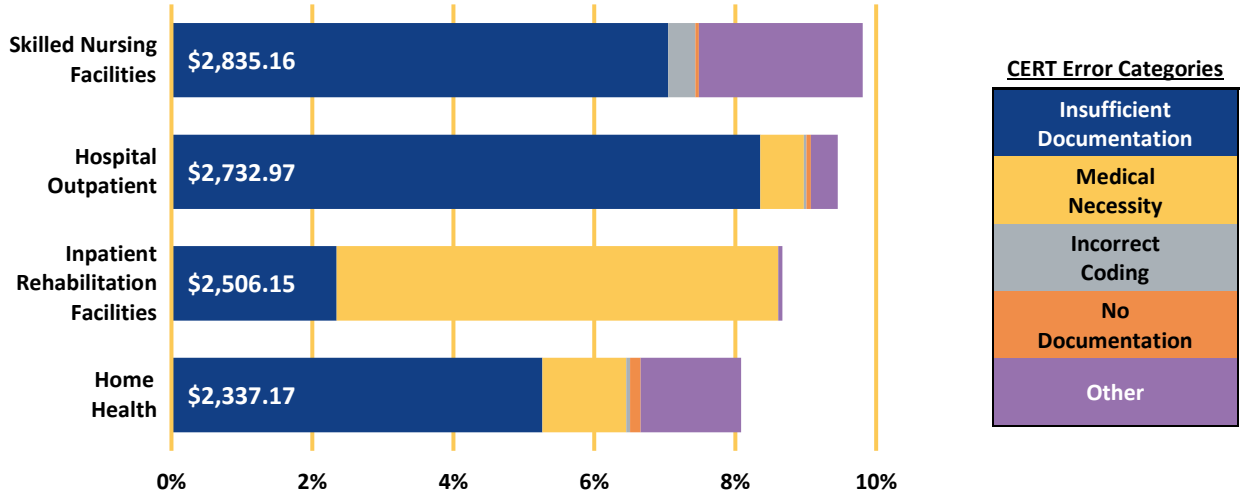
- Medical necessity (i.e., services billed were not medically necessary) continues to be the major error contributor for IRF claims. The IRF claims improper payment rate decreased from 41.55 percent in FY 2018 to 34.87 percent in FY 2019. The primary reason for these errors was that the IRF coverage 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 for home health claims continues to be prevalent, despite the improper payment rate decrease from 17.61 percent in FY 2018 to 12.15 percent in FY 2019. The primary reason for the errors was insufficient or missing 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 4 describes the CERT error categories, while Figure 5 shows the FY 2019 Medicare FFS drivers for SNF, hospital outpatient, IRF, and home health claims by CERT error category.

Figure 4: 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 a specific documentation element required as a condition of payment is missing.	59.54%
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.	18.67%
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.	13.67%
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.	6.06%
Other	These errors do not fit into the previous categories (e.g., duplicate payment error, non-covered or unallowable service, ineligible Medicare beneficiary, etc.).	2.05%

Figure 5: FY 2019 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 is 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 6, "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:

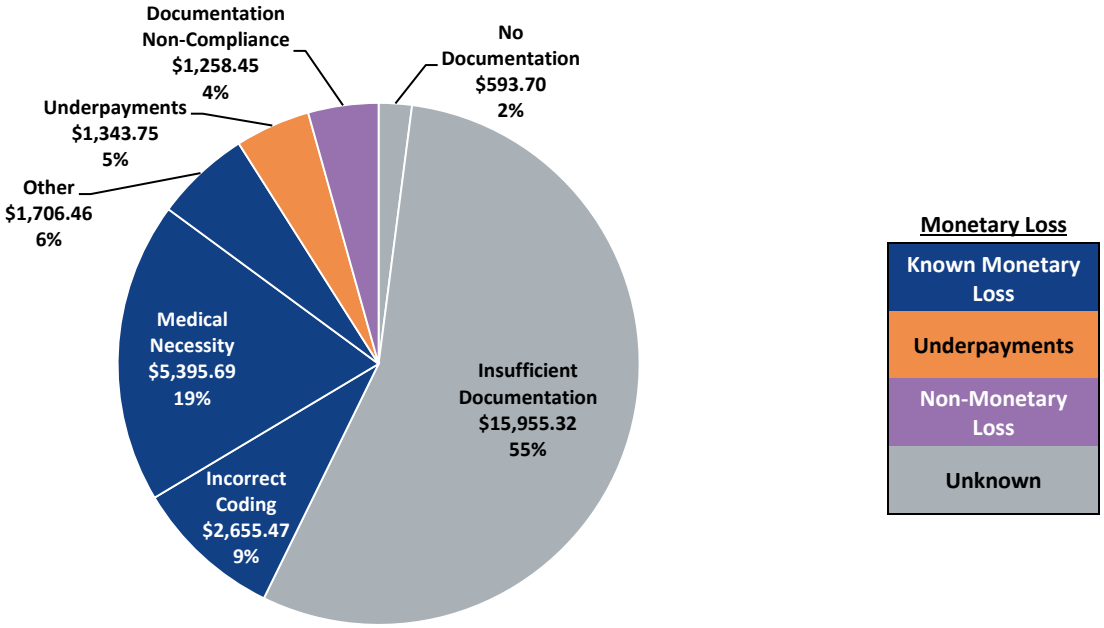
- That were covered and necessary;
- Provided/delivered to an eligible beneficiary;
- Paid in the correct amount; and
- The medical record documentation did not comply with rules and requirements per Medicare policy.

HHS determined that 4.35 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 2019 Medicare FFS improper payment rate would have been 6.94 percent, representing $27.65 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.

Figure 6 provides information on Medicare FFS improper payments that are known monetary losses, underpayments, unknown, and non-monetary losses to the program.

Figure 6: FY 2019 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 uses CERT program data and other sources of information to address improper payments in Medicare FFS through various corrective actions. The following sections discuss key corrective actions to address driver service area errors and OMB root cause categories.

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 SNF, hospital outpatient, IRF, 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: 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**
Targeted Probe and Educate (TPE) SNF Reviews	During FY 2019, HHS conducted medical review of SNF claims with high error rates under the TPE program. Under the TPE strategy, Medicare Administrative Contractors (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 2019, MACs reviewed approximately 1,000 SNF providers under the TPE program.
Supplemental Medical Review	In FY 2019, the SMRC initiated medical review activities related to post-payment review of SNF claims. The SMRC shares the results with the MACs for claim adjustment. The providers

Key SNF Corrective Actions	
Corrective Action	**Description**
Contractor (SMRC) SNF Reviews	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) SNF Reviews	During FY 2019, 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. Five percent of Medicare FFS RAC collections were from overpayments identified during SNF claim reviews.

Service Area: Hospital Outpatient

HHS implemented corrective actions for payment errors related to hospital outpatient services resulting from missing or insufficient medical record documentation. Key hospital outpatient corrective actions include:

Key Hospital Outpatient Corrective Actions	
Corrective Action	**Description**
TPE Hospital Outpatient Reviews	During FY 2019, MACs 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 2019, MACs reviewed approximately 1,400 Hospital Outpatient providers under the TPE program.
SMRC Hospital Outpatient Reviews	In FY 2019, 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, and Polysomnography services. 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.
RAC Outpatient Reviews	During FY 2019, Medicare FFS RACs continued to identify and collect improper payments related to outpatient claims for several factors, including insufficient documentation. Thirty-five percent of Medicare FFS RAC collections were from overpayments identified during hospital outpatient claim reviews.

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 IRF Reviews	During FY 2019, HHS conducted medical review of IRF claims with high error 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 2019, MACs reviewed approximately 600 IRF providers under the TPE program.

Key IRF Corrective Actions	
Corrective Action	**Description**
SMRC IRF Reviews	In FY 2019, the SMRC initiated medical review activities related to post-payment review 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 2019, HHS approved the Medicare FFS RACs to review IRF claims for several factors, including medical necessity and insufficient documentation.

Service Area: Home Health

HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services, including errors resulting from insufficient or missing 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 (HHAs)	During FY 2019, HHS continued reviewing home health agencies with high error 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. 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 2019, MACs reviewed approximately 5,500 HHA providers under the TPE program.
Review Choice Demonstration for Home Health Services	As noted in the September 27, 2018, Federal Register Notice, 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 3 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* (PRA) approval on February 28, 2019. The demonstration began for Illinois providers on June 1, 2019, and for Ohio providers on September 30, 2019.
RAC Home Health Reviews	In FY 2019, the national HHA RAC is currently approved and conducting 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.

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 2019, HHS affirmed (approved) over 65,000 items through the prior authorization process. On April 22, 2019, HHS published a Federal Register Notice requiring: • Prior authorization for seven Power Mobility Device codes effective nationwide July 22, 2019; and • Prior authorization for five Pressure Reducing Support Surface codes effective July 22, 2019, in California, Indiana, New Jersey, and North Carolina.
Ambulance Transport Prior Authorization	In FY 2019, HHS continued a prior authorization model for repetitive scheduled non-emergent ambulance transport occurring on or after December 15, 2014, in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, in accordance with Section 515 of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), HHS added five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia to the model. The model is scheduled to end in all states on December 1, 2020. Based on expenditure data, spending decreased in the initial model states from an average of $18.9 million to an average of $6.2 million per month. Based on data from the additional MACRA states, spending decreased from an average of $5.7 million to an average of $2.9 million per month.
RAC Durable Medical Equipment (DME) Reviews	During FY 2019, the national DME RAC continues to conduct complex DME reviews for medical necessity of DME items billed, insufficient documentation to support DME items billed, missing valid orders for DME items billed, and if items/services billed were rendered. The DME RAC is also conducting automated DME reviews for inappropriate unbundling and if the DME items billed were medically necessary.

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 (24.09 percent) 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 stop claims that should never be paid. For example, this program prevents payments for services such as the repair of an organ by two

Corrective Actions for Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	different methods. HHS will report FY 2019 savings from the NCCI edits in the forthcoming *Annual Report to Congress on the Medicare and Medicaid Integrity Programs*.
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 2.3 million distinct Medicare enrollments through the Provider Enrollment, Chain, and Ownership System (PECOS). In FY 2019, HHS performed approximately 222,740 initial enrollment screenings, completed 199,999 revalidations, deactivated 150,679 enrollments, and revoked 2,556 enrollments.
	New Medicare Providers and Suppliers: HHS established 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 (FCBCs) in addition to all of the requirements in the "limited" and "moderate" screening levels. In FY 2019, the initiative resulted in 30,668 site visits conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 26,438 conducted by the National Supplier Clearinghouse, which conducts site visits for Medicare DME suppliers. This work resulted in 232 revocations due to non-operational site visit determinations for all providers and suppliers. In FY 2019, HHS denied 771 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 2019, HFPP membership grew from 112 to 142 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 final rule titled "Medicare Program: Reporting and Returning of Overpayments" (81 Federal Register 7654, February 12, 2016), HHS codified a rule requiring providers and suppliers to identify, report, and return Medicare Part A or Part B overpayments. This rule implements Section 1128J(d) of the *Social Security Act* and obligates providers and suppliers to report and return self-identified 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 (59.54 percent). 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 (18.67 percent). 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 2019, HHS tasked the SMRC with performing post-payment reviews on multiple areas, such as Replacement Positive Airway Pressure Devices, DME in SNF, Emergency Ambulance Services, Hospice Services, Non-Emergency Ambulance Services, Spinal Cord Stimulator, DME and No Response Providers, and IRF Services. 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.
Medical Review Strategies	HHS implemented a 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 2019, MACs reviewed 3,647 DME and Hospice providers 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 implemented the TPE 10-Claim Preview Pilot for DMEPOS suppliers.
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 include identifying unclear and/or burdensome policy requirements that can be clarified or simplified to prevent unnecessary denials. HHS will also work to implement an accuracy review initiative for the MAC redetermination appeal units to ensure consistent medical review decisions are made at that level.

Corrective Actions for Insufficient Documentation and Medical Necessity	
Corrective Action	**Description**
Provider Billing Review Evaluation	In FY 2019, HHS issued Comparative Billing Reports (CBRs) for the following topics: • Intensity-Modulated Radiation Therapy, Office Visits, New and Established Patients, Family Practitioners; • Subsequent Hospital Visit; • Vitamin D Assay Test; • Air Ambulance; • Emergency Department Services; • Modifier 25 Dermatology; • Breast Re-Excision Rate; • Venipuncture; and • Different-Day Elective Upper and Lower Endoscopy Rate, by a Physician. On November 6, 2017, HHS sent CBRs to 7,245 providers with abnormal billing practices for emergency department services. For providers who received the November 2017 and May 2019 CBRs, HHS observed an 11 percent decline in services and a 9 percent ($63.8 million) decline in allowed charges. On September 11, 2017, HHS sent CBRs to 1,536 providers with abnormal billing practices for established office visits with modifier 25 with a dermatology specialty. For providers that received the September 2017 and June 2019 CBRs, HHS observed a decline of 3.5 percent in services, 2 percent ($1.3 million) decline in allowed charges, and 4 percent decline in number of beneficiaries for several billing codes related to office visits for established patients (with modifier 25) combined.

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.

Medicare FFS Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that limit corrective actions.

11.2 Medicare Advantage (Part C)

Medicare Advantage Statistical Sampling Process

The Part C methodology estimates improper payments due to 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 will be inaccurate, ultimately resulting in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual National Improper Payment Measurement process, where HHS identifies unsupported diagnoses and calculates corrected risk scores. The National Improper Payment Measurement (see Figure 7) 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 2019, HHS selected a stratified random sample of beneficiaries with a risk adjusted payment in calendar year 2017 (where the strata are high, medium, and low risk scores) and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries.

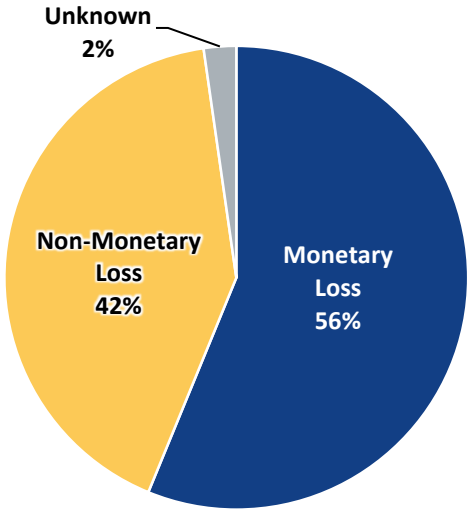
Figure 7: National Improper Payment Process

The Medicare Part C gross improper payment estimate for FY 2019 is 7.87 percent or $16.73 billion. The submission of more accurate diagnoses by Medicare Advantage (MA) organizations for payment primarily drove the decrease from the prior year's estimate of 8.10 percent.

Medicare Advantage Corrective Action Plan

The root causes of FY 2019 Medicare Part C improper payments consist of errors due to administrative or process errors made by another party (56.20 percent in overpayments and 41.54 percent in underpayments), with a smaller portion of overpayments resulting from missing documentation (2.26 percent). Monetary loss results from administrative or process errors by other party, specifically, 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 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 8.

Figure 8: FY 2019 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.

Corrective Actions to Address Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

HHS implemented three 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. HHS completed payment recovery for the 2007 pilot audits, totaling $13.7 million recovered, in FYs 2012 through 2014. The Department completed several stages of the contract-level RADV audits for payment years 2011 through 2013. In April 2019, HHS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits to prepare the audited MA organizations for RADV audits. The payment year 2014 RADV audit is currently underway and is expected to conclude in late FY 2020. HHS launched the payment year 2015 RADV audit in late FY 2019.
Overpayment Recoveries Related to Regulatory Provisions	As required by the *Social Security Act*, HHS regulations require MA organizations to report and return identified overpayments. HHS believes that this requirement will reduce improper payments by encouraging MA organizations to submit accurate payment information. In FY 2019, MA organizations reported and returned approximately $44.55 million in self-reported overpayments.
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 2019, HHS conducted: two small in-person Medicare Parts C and D Fraud, Waste, and Abuse Collaboration Missions (October 2018 and March 2019); a large in-person Fraud, Waste, and Abuse Training (July 2019); and two Opioid Missions (April 2019 and August 2019). 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.

Medicare Advantage Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that limit corrective actions.

11.3 MEDICARE PRESCRIPTION DRUG BENEFIT (PART D)

Medicare Prescription Drug Benefit Statistical Sampling Process

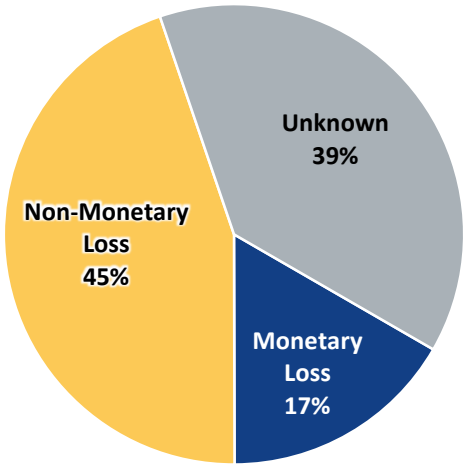
The Part D improper payment estimate measures the payment error related to prescription drug event (PDE) data, where most errors for the program exist. HHS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (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.

The FY 2019 Medicare Part D gross improper payment estimate is 0.75 percent or $607.94 million. The decrease from the prior year's estimate of 1.66 percent resulted from errors being smaller in magnitude.

Medicare Prescription Drug Benefit Corrective Action Plan

The FY 2019 Medicare Part D improper payments root causes are administrative or process errors made by other party (16.63 percent overpayments and 44.82 percent underpayments) and missing documentation (38.55 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 9.

Figure 9: FY 2019 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.

Corrective Actions to Address 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.
Overpayment Recoveries Related to Regulatory Provisions	As required by the *Social Security Act*, HHS requires Part D sponsors report and return all identified overpayments. HHS believes that overpayment statute and regulation contributed to increased attention to data accuracy by Part D sponsors. In FY 2019, Part D sponsors self-reported and returned approximately $1.54 million in overpayments.
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 2019: HHS conducted two small in-person Medicare Parts C and D Fraud, Waste, and Abuse Collaboration Missions (October 2018 and March 2019); a large in-person Fraud, Waste, and Abuse Training (July 2019); and two Opioid Missions (April 2019 and August 2019). The missions included multi-disciplinary teams of experts and decision makers from HHS and its partners, and supported collaborative efforts to protect the Medicare Part C and D programs.

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.

Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that limit corrective actions.

11.4 MEDICAID

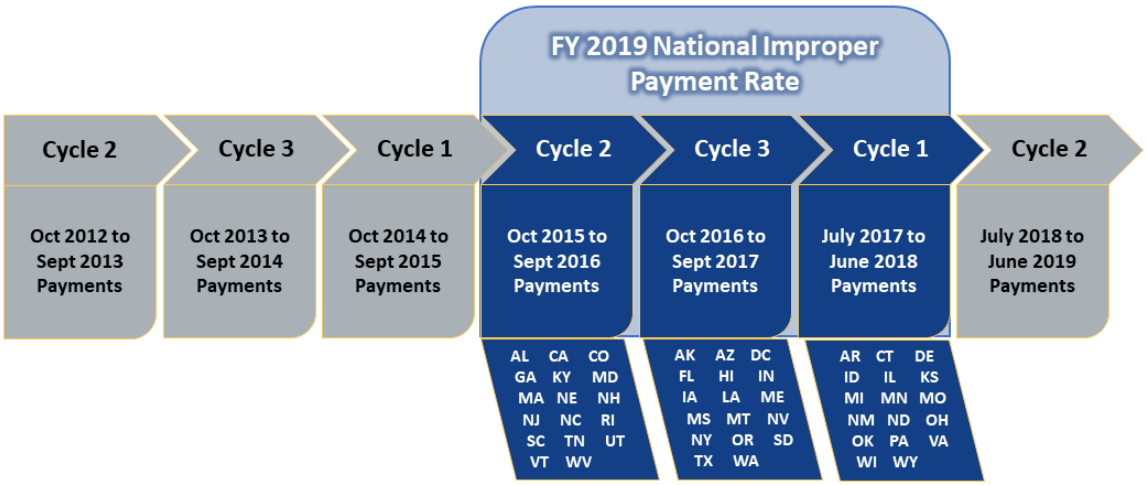
Medicaid Statistical Sampling Process

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 2019 Medicaid improper payment rate is based on FYs 2017, 2018, and 2019 measurements (see Figure 10 below).

Figure 10: FY 2019 Medicaid Cycle Measurements



To learn how HHS grouped states into three cycles, refer to pages 177 – 179 of HHS's FY 2012 AFR.

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, while managed care is a delivery system in which a state makes a monthly payment to a managed care organization, which is responsible for managing beneficiary care. 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, therefore, 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 302 and 1,570 claims per state, the managed care sample size was between 38 and 242 payments per state, the eligibility FFS sample size was between 102 and 298 per state, and the eligibility managed care sample size was between 105 and 380 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. Examples of noncompliance with eligibility requirements include a state: enrolling a beneficiary when he or she is ineligible for Medicaid or CHIP; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service being provided; not

conducting a timely beneficiary redetermination; or not performing or completing 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 first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. 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. Please note that the national eligibility improper payment rate still includes a proxy estimate for the remaining 34 states 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 Medicaid eligibility improper payments are not "double counted."

The national Medicaid improper payment estimate for FY 2019 is 14.90 percent or $57.36 billion.

The FY 2019 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 16.30 percent
- *Medicaid managed care*: 0.12 percent
- *Medicaid eligibility*: 8.36 percent

Supplemental information related to the FY 2019 Medicaid improper payment results will be published on HHS's website – www.cms.gov/PERM – in early FY 2020.

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 are those where a newly enrolled provider had not been appropriately screened by the state; a provider did not have the required NPI on the claim; or a provider was not enrolled. Although these errors remain a driver of the Medicaid rate, state compliance has improved as the Medicaid FFS improper payment rate for these errors decreased from 7.21 percent in FY 2018 to 6.28 percent in FY 2019.

While the screening errors described above are for newly enrolled providers, states also must revalidate the 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 2019, HHS measured the second 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 will complete the measurement of all states for compliance with provider revalidation requirements in FY 2020.

Another area driving the FY 2019 Medicaid improper payment estimate is the reintegration of the PERM eligibility component, mentioned above. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously states conducted the measurement and self-reported results to HHS for reporting the national rate. This allows for consistent insight into the accuracy of Medicaid eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify

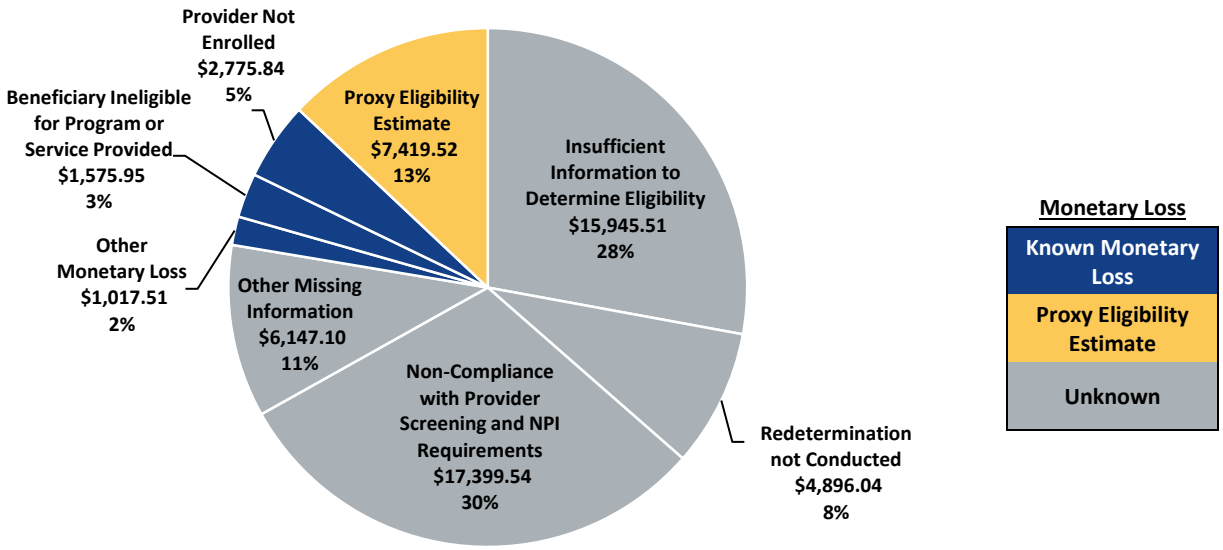
eligibility or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income or resource verification. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Unknown versus Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Improper payments also include instances where there is 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 or eligibility determination was missing from the claim or state systems and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable. Another proportion of improper payments are considered a known monetary loss to the program, which are claims where HHS determines the Medicaid payment should not have occurred or should have been made in a different amount.

Figure 11 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). In the figure, "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 11: FY 2019 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 34 states not yet measured since the reintegration of the PERM eligibility component. All eligibility improper payments from the FY 2019 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 ($51.31 million) was too small to report in Figure 11. In addition, due to rounding, amounts in this chart may not add up precisely to other tables in this document.

Medicaid Corrective Action Plan

HHS works closely with all states through enhanced technical assistance (including state-specific liaisons that will be assigned to each state and 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.

HHS also establishes corrective actions to help reduce improper payments. For example, HHS is actively engaged in:

- Conducting outreach during off-cycle PERM years to address issues identified in corrective action plans;
- Facilitating national best practice calls to share ideas across states;
- Offering ongoing technical assistance;
- Developing a notice of proposed rulemaking to strengthen the integrity of the eligibility determination process and avoid improper payments that will address several of the drivers of eligibility errors such as insufficient recordkeeping, verification of eligibility, redeterminations, and compliance with eligibility requirements when individuals experience a change in circumstances that may impact eligibility; and
- Providing additional guidance as needed.

Additional information on states' and HHS's corrective actions is provided in the following sections.

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 and failure to verify errors mainly consist of errors resulting from noncompliance with the requirement to 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 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 2019, HHS worked to establish a more robust state-specific corrective action plan process that provides enhanced technical assistance and guidance to states. Beginning with the FY 2019 state-specific corrective action plans, HHS will work with its components, in conjunction 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 will monitor and follow up with all states on their progress in implementing effective corrective actions to address the errors and deficiencies. HHS will also use lessons learned from this process to inform areas to evaluate for future guidance and education.
Enhanced Assistance on State Medicaid Provider Enrollment	HHS provides ongoing guidance, education, and outreach to states on federal requirements to enroll Medicaid providers. 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 2020.

Corrective Actions for Administrative or Process Errors Made by State or Local Agency and Failure to Verify	
Corrective Action	**Description**
	• Technical Assistance for Provider Enrollment: In FY 2016, HHS procured a state assessment contractor to assist with ongoing state technical assistance and process improvements related to provider enrollment. In FY 2019, the state assessment contractor visited Louisiana, Maine, Minnesota, Mississippi, New York, and Oregon to assess compliance with provider enrollment requirements, conduct a gap analysis, and develop strategic blueprints to help states improve processes. HHS discontinued the contract in March 2019 and all future visits will be conducted solely by HHS. • Site Visits: HHS continued state site visits during FY 2019 to assess provider enrollment compliance and provide technical assistance. In addition to the State Assessment contractor visits, HHS internally provided assistance through visits to Illinois and Michigan in FY 2019.
Medicaid Eligibility Quality Control (MEQC) Program	Under the MEQC program, states design and conduct projects, known as pilots, to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. States have great flexibility in designing pilots to focus on vulnerable or error-prone areas as identified by PERM and by the state. These MEQC pilots are conducted during the two-year intervals ("off-years") that occur between their triennial PERM review years, allowing states to implement prospective improvements in eligibility determination processes prior to their next PERM review.
Audits of State Beneficiary Eligibility Determinations	As part of the Medicaid Program Integrity strategy announced by HHS in June 2018, HHS initiated audits of beneficiary eligibility determinations in states identified as having eligibility errors in previous OIG reports. These audits have included assessments of the impact of state eligibility policies, processes, and systems. For example, HHS is reviewing if beneficiaries were found properly eligible for the correct Medicaid eligibility category. In FY 2019, HHS began eligibility reviews in New York, Kentucky, California, and Louisiana, and potential future audits will focus on states that may be at higher risk of errors, such as those that have higher eligibility improper payment rates under the PERM program.
Medicaid Integrity Institute (MII)	HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the MII. The FY 2019 course schedule included a seminar in May 2019 that focused exclusively on complying with the provider enrollment requirements. The materials from previous MII provider enrollment courses remain available to states on the Regional Information Sharing System. HHS held an additional seminar in September 2019 that focused on managed care issues, including provider enrollment. HHS is finalizing the FY 2020 course schedule but may include similar courses in the future. More information is located at the Medicaid Integrity Institute.
Technical Assistance and Education on Eligibility and Enrollment	In June 2019, HHS released an information 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 bulletin provides states technical guidance on requirements related to eligibility and enrollment systems, including systems' requirements to ensure accurate eligibility determinations, distinguish newly eligible adults from non-newly eligible adults, and capacity to conduct trend analysis for eligibility-related

Corrective Actions for Administrative or Process Errors Made by State or Local Agency and Failure to Verify	
Corrective Action	**Description**
	fraud, waste and abuse. In addition, the bulletin describes state responsibilities related to eligibility policies and procedures, included eligibility verification plans, and staff training.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine errors mainly 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 mainly 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, described 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	In FY 2019, HHS worked to establish a state-specific corrective action plan process that provides enhanced technical assistance and guidance to states. Beginning with the FY 2019 state-specific corrective action plans, HHS will work with its components, in conjunction 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 will monitor and follow up with all states on their progress in implementing effective corrective actions to address the errors and deficiencies. HHS will also use lessons learned from this process to inform areas to evaluate for future guidance and education.
Education	In FY 2019, HHS provided training opportunities to state Medicaid agencies at the MII to address common errors, best practices, and challenges to implementing corrective actions. In addition, historically HHS published a variety of educational toolkits, which include presentations, fact sheets, and booklets made specifically for providers or beneficiaries. These educational resources help educate providers, beneficiaries, and other stakeholders in promoting best practices and raising awareness of Medicaid fraud, waste, and abuse. Lastly, a state technical assistance work group also helps educate states on working with providers to understand the causes of documentation errors and provide recommendations for methods to reduce errors.
State Medicaid Provider Screening and Enrollment Data and Tools	HHS shares Medicare data to assist states 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 offered a data compare service 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. Using the data

Corrective Actions for Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	compare service, a state provides a Medicaid provider enrollment data extract to HHS, and then HHS returns information indicating which of these providers have undergone a Medicare screening on which the state can rely (thus reducing the state's work load). The following states and territories participated in the data compare service in FY 2019: Hawaii, Maine, New Hampshire, New York, Puerto Rico, and Vermont. HHS is working to expand the data compare service to additional states. In addition to the data compare service, HHS will pilot 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 will screen these two states' Medicaid-only providers and produce a report of the providers found with licensure issues, criminal activity, and Do Not Pay activity. HHS will evaluate the results and impact of the pilot and assess the value of expanding the service to more states in the future.
Enhanced Technical Assistance and Site Visits Relating to Medicaid Provider Screening and Enrollment	HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid enrollment and screening. 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 2020. • Technical Assistance for Provider Screening and Enrollment: In FY 2016, HHS procured a state assessment contractor to assist with ongoing state technical assistance and process improvements related to provider screening and enrollment. In FY 2019, the state assessment contractor visited Louisiana, Maine, Minnesota, Mississippi, New York, and Oregon to assess compliance with provider screening and enrollment requirements, conduct a gap analysis, and develop strategic blueprints to help states improve processes. HHS discontinued the contract in March 2019 and all future visits will be conducted solely by HHS. • Site Visits: HHS continued state site visits during FY 2019 to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities. In addition to the State Assessment contractor visits, HHS internally provided screening and enrollment assistance through visits to Illinois and Michigan in FY 2019.
Death Master File (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 the DMF to states. In May 2017, HHS made DMF data available to pilot states via the same file server where states currently also 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. As of March 2019, all 50 states, the District of Columbia, and Puerto Rico have access to DMF data through the Data Exchange.
MEQC Program	Under the MEQC program, states design and conduct projects, known as pilots, to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. States have great flexibility in designing pilots to focus on vulnerable or error-prone areas as identified by PERM and by the state. These MEQC pilots are conducted during the two-year intervals ("off-years") that occur between their triennial PERM review years, allowing states to

Corrective Actions for Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	implement prospective improvements in eligibility determination processes prior to their next PERM review.
Conduct Audits of State Beneficiary Eligibility Determinations	As part of the Medicaid Program Integrity strategy announced by HHS in June 2018, HHS initiated audits of beneficiary eligibility determinations in states identified as having eligibility errors in previous OIG reports. These audits included assessments of the impact of state eligibility policies, processes, and systems. For example, HHS is reviewing if beneficiaries were found properly eligible for the correct Medicaid eligibility category. In FY 2019, HHS began eligibility reviews in New York, Kentucky, California, and Louisiana, and potential future audits will be focused on states that may be at higher risk of errors, such as those that have higher eligibility improper payment rates under the PERM program.
MII	HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the MII. The FY 2019 course schedule included a seminar in May 2019 that focused exclusively on complying with the provider screening and enrollment requirements. The materials from previous MII provider enrollment courses remain available to states on the Regional Information Sharing System. An additional seminar was held in September 2019 that focused on managed care issues, including provider enrollment. HHS is finalizing the FY 2020 course schedule but may include similar courses in the future. More information is located at the Medicaid Integrity Institute.
Technical Assistance and Education on Eligibility and Enrollment	In June 2019, HHS released an information 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 bulletin provides states technical guidance on requirements related to eligibility and enrollment systems, including systems' requirements to ensure accurate eligibility determinations, distinguish newly eligible adults from non-newly eligible adults, and capacity to conduct trend analysis for eligibility-related fraud, waste and abuse. In addition, the bulletin describes state responsibilities related to eligibility policies and procedures, included eligibility verification plans, and staff training.

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 that HHS can provide more effective oversight of its programs. 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 data requests to the states. As of August 30, 2019, 50 states, the District of Columbia, Puerto Rico, and the US Virgin Islands are submitting T-MSIS data. More information on states' overall data submission progress can be found at T-MSIS. HHS closely monitors monthly T-MSIS data submissions, with a focus on assessing and improving the quality of the data. HHS is also preparing analytics files, tools, and reports aimed at enabling use of the data 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 an Information 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 their T-MSIS data and to ensure changes to state systems or operations will not degrade T-MSIS data submission quality, completeness, and/or timeliness.

Medicaid Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS is working to address statutory and regulatory barriers that could potentially limit corrective actions. As identified in the Spring 2019 Unified Agenda of Regulatory and Deregulatory Actions, HHS plans to issue new regulations to address barriers that limit corrective actions related to beneficiary eligibility. Regulations will clarify the Medicaid eligibility determination process, including income verification and redetermination processes, and address limitations on HHS's ability to recoup eligibility-related improper payments. In addition, the FY 2020 President's Budget included legislative proposals that would provide HHS with greater flexibility to prevent future improper payments. Specifically, the Budget proposed to modify Section 1903(u) of the *Social Security Act* (42 U.S.C. 1396a) to give HHS broader flexibility in developing actions to address errors associated with ineligible beneficiaries, and sought statutory authority for HHS to conduct centralized screening of Medicaid and CHIP providers.

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 IPIA, as amended, required confidence and precision levels. For information on how HHS grouped states into three cycles for CHIP, refer to page 183 of HHS's FY 2012 AFR.

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, while managed care is a delivery system in which a state makes a monthly payment to a managed care organization, which is responsible for managing beneficiary care. 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. Based on each state's expenditures and historical FFS and managed care improper payment data, the FFS sample size was between 172 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 76 and 324 per state, and the eligibility managed care sample size was between 43 and 317 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. Examples of noncompliance with eligibility requirements include a state: enrolling a beneficiary when he or she is ineligible for Medicaid or CHIP; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service being provided; not conducting a timely beneficiary redetermination; or not performing or completing 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 first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. 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. Please note that the national eligibility improper payment rate still includes a proxy estimate for the remaining 34 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 CHIP eligibility improper payments are not "double counted."

The national CHIP gross improper payment estimate for FY 2019 is 15.83 percent or $2.74 billion.

The FY 2019 national CHIP improper payment rate for each component is:

- *CHIP FFS:* 13.25 percent
- *CHIP managed care:* 1.25 percent
- *CHIP eligibility*: 11.78 percent

Supplemental information related to the FY 2019 CHIP improper payment results will be published on HHS's website – www.cms.gov/PERM – in early FY 2020.

One area driving the FY 2019 CHIP improper payment estimate is the FY 2019 reintegration of the PERM eligibility component, mentioned above. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously states conducted the measurement and self-reported results to HHS for reporting the national rate. This allows for consistent insight into the accuracy of CHIP eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income verification. The CHIP improper payment rate was also driven by claims where the beneficiary was ineligible for CHIP, but was eligible for Medicaid, again, mostly related to beneficiary income. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

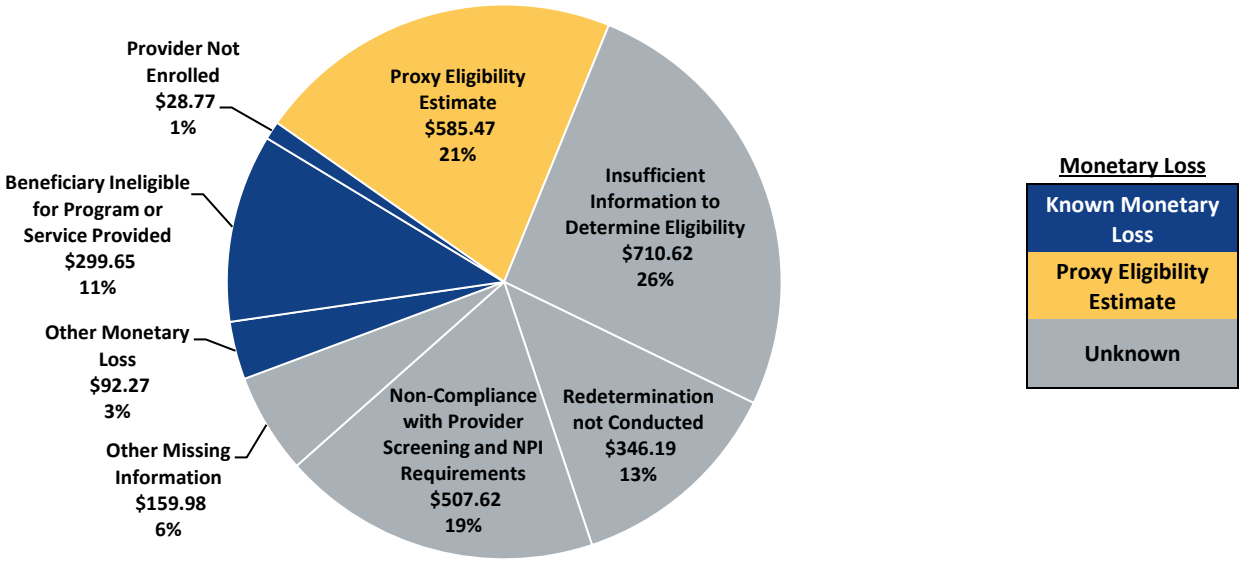
Additionally, since FY 2014, improper payments cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately enrolled and screened by the state or a provider did not have the required NPI on the claim have also driven the CHIP rate (see Section 11.4 for further description of HHS's review of these errors). Although these errors remain a driver of the CHIP rate, state compliance with the newly enrolled provider requirements has improved as the CHIP FFS improper payment rate for these errors decreased from 7.73 percent in FY 2018 to 6.02 percent in FY 2019.

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. A majority of CHIP improper payments were due to instances where information required for payment or eligibility determination was missing from the claim or state systems and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or ineligible beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable in whole or in part. A smaller proportion of improper payments are claims where HHS determines that the CHIP payment should not have happened or should have been made in a different amount and are considered a known monetary loss to the program.

Figure 12 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). In the figure, "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 12: FY 2019 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 34 states not yet measured since the reintegration of the PERM eligibility component. All eligibility improper payments from the FY 2019 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 ($5.21 million) was too small to report in Figure 12. In addition, due to rounding, amounts in this chart may not add up precisely to other tables in this document.

CHIP Corrective Action Plan

HHS works closely with all states through enhanced technical assistance (including state-specific liaisons that will be assigned to each state and 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 corrective action plan effectiveness, with assistance and oversight from HHS. When developing corrective action plans, states focus efforts on the major causes of improper payments.

HHS also establishes corrective actions to help reduce improper payments. For example, HHS is actively engaged in:

- Conducting outreach during off-cycle PERM years to address issues identified in corrective action plans;
- Facilitating national best practice calls to share ideas across states;
- Offering ongoing technical assistance;
- Developing a notice of proposed rulemaking to strengthen the integrity of the eligibility determination process and avoid improper payments that will address several of the drivers of eligibility errors such as insufficient recordkeeping, verification of eligibility, redeterminations, and compliance with eligibility requirements when individuals experience a change in circumstances that may impact eligibility; and
- Providing additional guidance as needed.

Additional information on states' and HHS's corrective actions is provided in the following sections.

Corrective Actions to Address Root Causes:

Root Causes: Administrative or Process Errors Made by State or Local Agency

Administrative or process errors made by states or local agencies mainly consist of errors resulting from noncompliance with the requirement to 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.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine errors mainly 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 mainly 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.

Root Cause: Medical Necessity

Although medical necessity has been identified as a minor issue in a few states, HHS works closely with those states to develop state-specific corrective actions to address such errors when they arise. In addition to state-specific corrective action plans, many HHS corrective actions listed in Section 11.4 also address medical necessity errors.

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.

CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

Refer to Section 11.4 for information on statutory or regulatory barriers that could potentially limit corrective actions.

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 2019.

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. 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 2020 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 2019. However, in FY 2018, the program modified the formula used to calculate the state-level standard error as recommended by the OIG. 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.

As stated in the FY 2015 AFR, an increasing number of time-limited child welfare waiver demonstration projects (which all terminated as of September 30, 2019) have 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 with non-statewide 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 2019 estimate is based on review data for 34 states or territories operating traditional Title IV-E programs. The FY 2019 estimate excludes data for 18 states operating statewide waiver demonstrations: 3 states that were due for a review this year (Illinois, Maine, and Tennessee) and 15 states that were due for a review in prior years (Arkansas, Colorado, the District of Columbia, Florida, Hawaii, Indiana, Kentucky, Maryland, Nebraska, Oklahoma Oregon, Utah, Washington, West Virginia, and Wisconsin).

The Foster Care gross improper payment estimate for FY 2019 is 4.85 percent or $7.13 million. The error rate decreased from 7.56 percent in FY 2018 to 4.85 percent in FY 2019 in part because one state with a large program and a high error rate was removed from the national error rate calculations in FY 2019 due to the state's operation of a statewide child welfare waiver demonstration project. During the FY 2019 error rate reporting cycle, one small state had a significant increase in its state-level error rate, 7 of the 12 states reviewed either decreased their error rates or remained about the same, and 4 states had small increases. Overall, 11 of the 12 states had low error rates of less than 3 percent.

Foster Care Corrective Action Plan

All payment errors (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 payment errors that contribute most to Title IV-E improper payments.

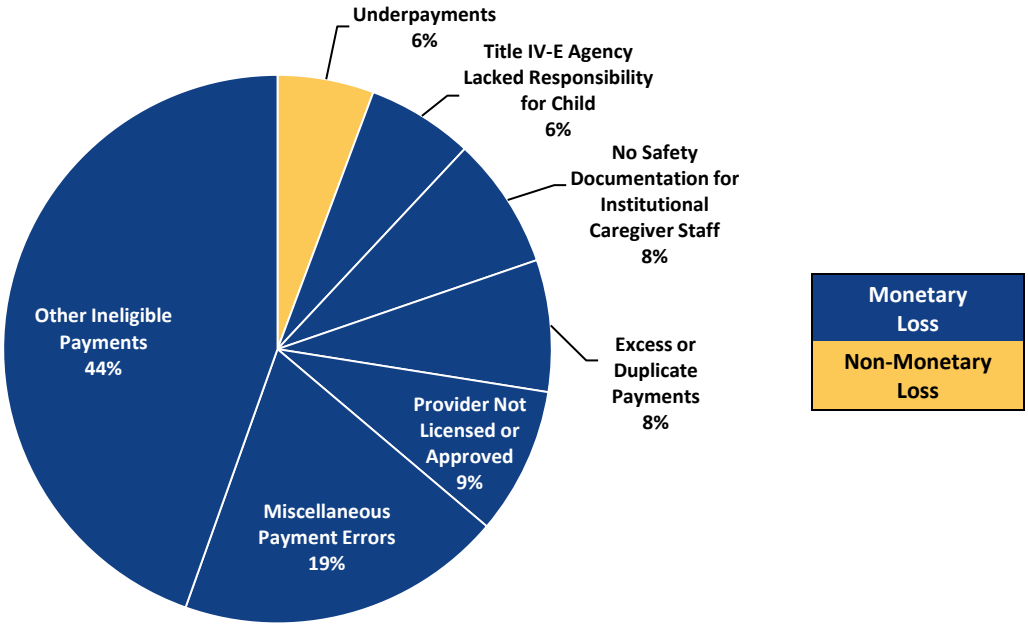
Corrective Actions to Address Root Cause:

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. 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 13 presents the most common administrative or process payment errors in FY 2019.

Figure 13: Root Causes for FY 2019 Title IV-E Foster Care Improper Payments across All States



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

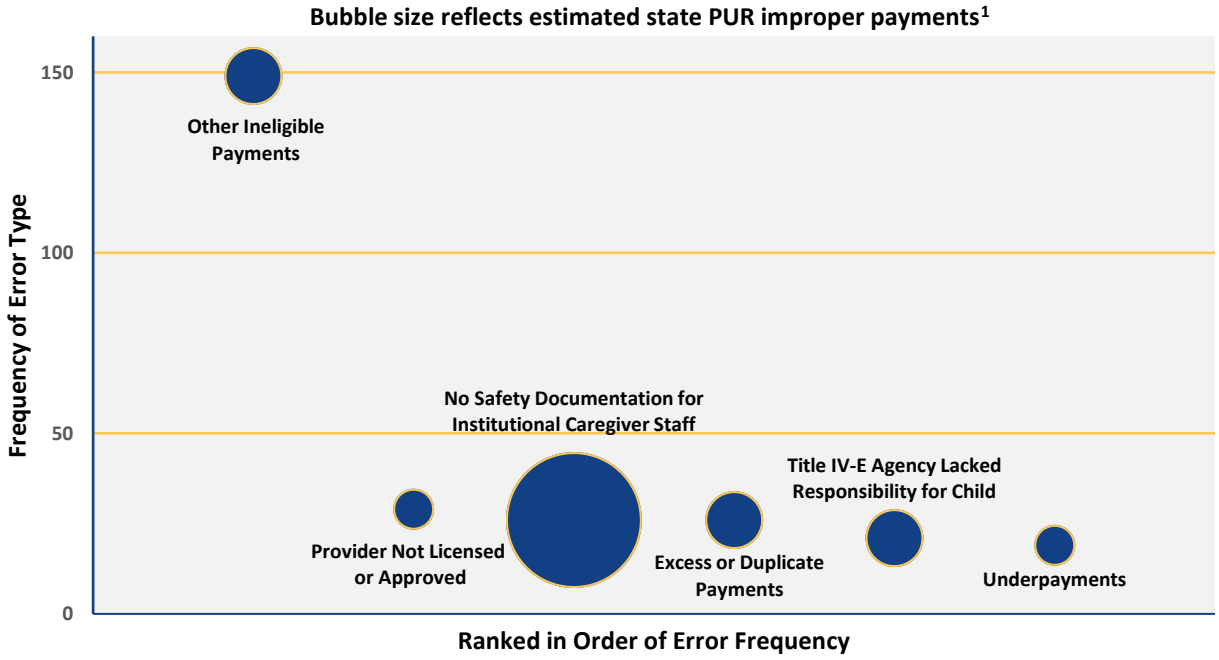
As shown in Figure 13, the six most frequent error types (except for miscellaneous payment errors) account for 80 percent of Foster Care's payment errors.[29] The general pattern of frequency and cost of errors continues from FY 2018 reporting. Of the six most frequent error types, "Other ineligible payments" continues to constitute the largest number of errors, accounting for 44 percent of errors. Two states reviewed in earlier years account for about 80 percent of "Other ineligible payments," which are payments for services such as child health support that are not eligible for Title IV-E funding. Because these states have taken corrective action to address the accounting issues

[29] 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.

that resulted in systemic incorrect claiming of certain costs not allowable as 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 cases with "No safety documentation for institutional caregiver staff" were only 8 percent of improper payment errors, they accounted for over half of all improperly paid dollars due to the high cost of institutional care relative to foster care placements. None of the states reviewed in FY 2019 had these types of errors; the majority occurred in two states that were last reviewed in earlier years and are being reviewed again as part of the FY 2020 error rate reporting cycle at which time it is expected they will have completed corrective action and demonstrate improved performance. Figure 14 provides more information on the relative contribution of these top six payment error types.

Figure 14: Reasons for Title IV-E Foster Care Program Improper Payments across All States – FY 2019 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 2019, 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 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.

Corrective Actions to Address Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
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 payment errors involving inadequate or missing documentation of safety checks.
	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 issued written guidance to federal and state staff and conducted a series of webinars in FY 2018 to instruct all staff on the new federal safety check requirements and other provisions of the new federal law. Additional guidance and instructional tools are planned for early FY 2020 to further 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 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 safety 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 onsite 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 state exceeded the error threshold in a review and must develop a performance improvement plan (PIP).

Corrective Actions to Address Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
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 of an eligibility review conducted following PIP completion. States must complete each action strategy within 1 year from the date HHS approved the plan. In FY 2019, one of the 12 states reviewed must 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 2019, HHS trained all 12 states reviewed on the federal eligibility and payment requirements and provided technical assistance prior to, during, and after the Foster Care Eligibility Reviews. Furthermore, because they are operating under a capped allocation, states and jurisdictions that are excluded from regulatory Title IV-E reviews while their child welfare waiver demonstration is operational may participate in a Title IV-E Technical Assistance Review. The Technical Assistance Review ensures that as waiver demonstration projects end for all states on September 30, 2019, states are prepared to submit accurate claims and perform successfully on future Title IV-E reviews. At the conclusion of the Technical Assistance Review, HHS reports cases that did not meet Title IV-E eligibility requirements and any other improper payments, discounting the waivers provided in the agency's demonstration terms and conditions. HHS has conducted 17 Technical Assistance Reviews since FY 2017.
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). One state reviewed in the FY 2019 cycle will undergo a secondary review. 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 in accordance with federal regulations at 45 CFR §1355.50 through §1355.59. Comprehensive Child Welfare Information System 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* 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 will be the first to include review data from states be subject to the new child care institution safety check requirements. 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 error rates in some states. In light of this concern, HHS has set an improper payment target of 6 percent for FY 2020.

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 eligibility 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 error rates.

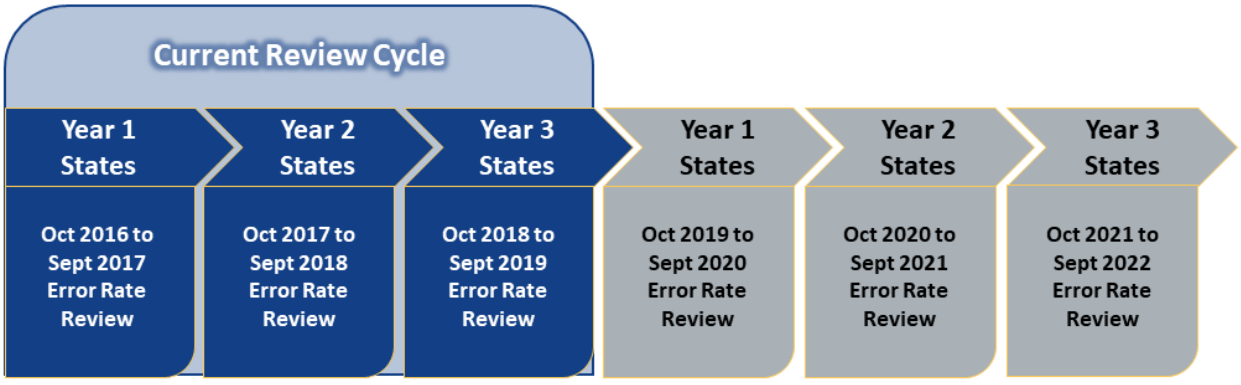
While cognizant of the challenges ahead, HHS remains committed to working with all states to ensure that they have a clear understanding of changes in federal eligibility requirements and are prepared to successfully manage Title IV-E eligibility determinations for their Foster Care programs.

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 are divided into three cohorts and conduct the error rate review once every 3 years (as shown in Figure 15).

Figure 15: CCDF Error Rate Review Cycle



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 payment errors 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 2019, the Year Three states implemented the revised methodology for review for the first time. Over the next 2 years, HHS will gather data from each of the other state grantee cohorts (Years One and Two) to determine the impact of the revisions.

The CCDF gross improper payment estimate for FY 2019 is 4.53 percent or $324.66 million. HHS attributes the increase in the improper payment estimate, from 4.00 percent in FY 2018 to 4.53 percent in FY 2019, 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 in their attempts 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 staff.

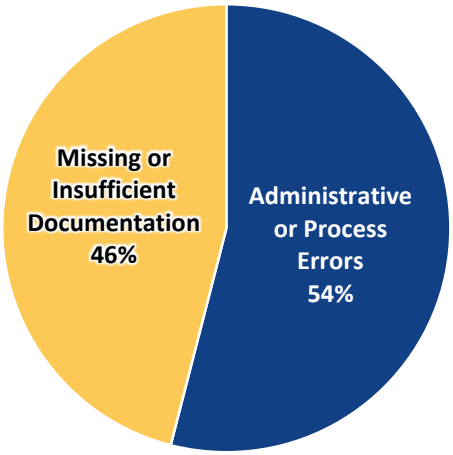
CCDF Corrective Action Plan

As reflected in Figure 16, CCDF program errors can be categorized as (1) non-payment errors and (2) payment errors. 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. A payment error or 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. The HHS Payment Integrity Report data only reflects payment errors. States have flexibility in the administration of Child Care programs and state-level policies and procedures reflect this variety.

Figure 16: CCDF Program Error Categories

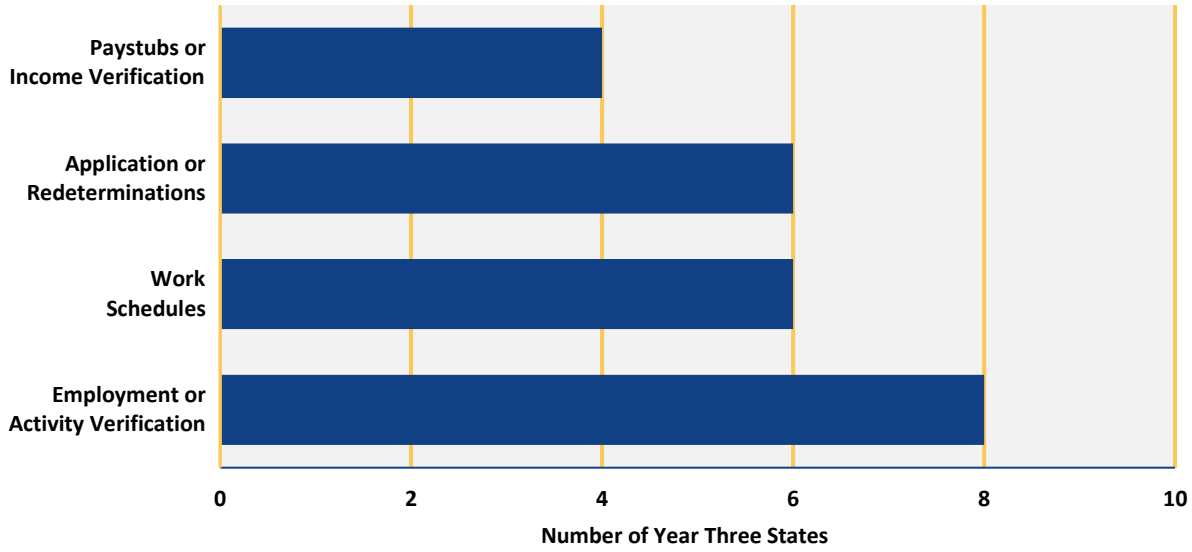
Historically, CCDF improper payments have been divided evenly between administrative or process errors and missing or insufficient documentation. Figure 17 shows there were fewer errors from missing and insufficient documentation (about 45.54 percent) than administrative or process errors (54.46 percent) for Year Three reviews.

Figure 17: Root Causes of FY 2019 CCDF Improper Payments



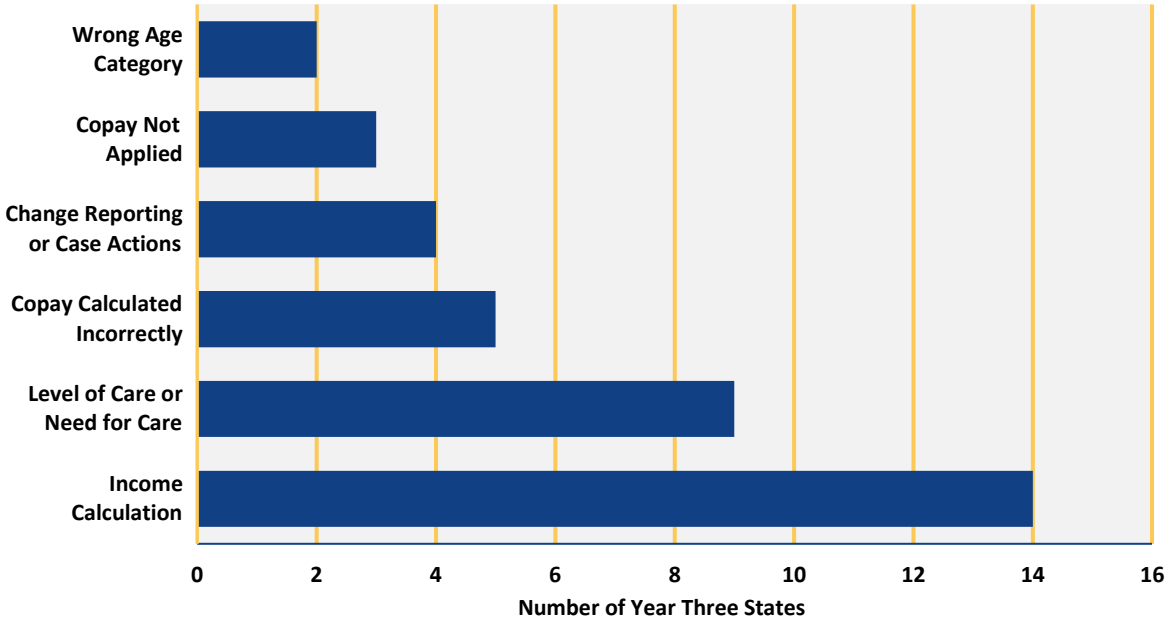
Missing or insufficient documentation errors account for an estimated 45.54 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. Figure 18 presents the most frequently cited errors.

Figure 18: Most Frequently Cited Errors Due to Missing or Insufficient Documentation for CCDF



Administrative or process errors represent approximately 54.46 percent of errors noted in the Year Three 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 Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by State or Local Agency

Insufficient documentation to determine and administrative or process errors made by a state or local agency 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 2019 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	Fifteen states plan to conduct training with eligibility staff on CCDF policies and procedures.
Oversight	Reviews: Nine states plan to conduct ongoing case reviews or audits.
State Policies and Procedures	Policy Review: Seven states plan to review and possibly update state eligibility policies.
	Eligibility Procedures: Four states plan to make changes to the eligibility determination procedures.
Information Systems	Six states plan to upgrade or implement new IT systems.
Technical Assistance	Eligibility Agencies: Five states plan to provide technical assistance to eligibility agencies.
	Regulations: Four states plan to issue policy guidance, memoranda, or briefs.

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. 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.
	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 that were not reported. The following categories include the information systems and infrastructure capabilities some states chose to report for FY 2019:

- 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 identifies the Year Three states and the capabilities applied for FY 2019 to improve information systems and infrastructure.

Figure 20: FY 2019 CCDF Capabilities to Improve Information Systems and Infrastructure

Capabilities and Improvements to:		CCDF Year Three States																	Total
		CT	DC	HI	ID	KY	ME	MD	MI	MN	MO	MT	NE	NJ	NM	NC	SC	WY	
Eligibility Determination and Authorization	Part or All of Eligibility Automated	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓				✓	✓	12
	Flags/Blocks for Avoiding Eligibility Errors	✓		✓	✓						✓	✓			✓		✓		7
	Integrated with Other Agency/State Systems	✓		✓		✓			✓	✓				✓					6
	Data Imaging			✓		✓		✓	✓								✓		5
Information on Providers or Provider Payments	Issues Payments	✓								✓		✓				✓	✓		5
	Flags/Blocks for Avoiding Duplicate/Erroneous Payments									✓	✓						✓	✓	4
	Provider and Licensing Information			✓						✓		✓		✓					4
Information on Active Cases to Assist in Case Management	Reports and Data on Case Accuracy	✓			✓								✓	✓	✓	✓	✓		7
	Integrated with Other Agency/ State Systems	✓		✓		✓			✓	✓				✓					6
	Case Action Alerts			✓			✓		✓										3
	Case Audits						✓						✓						2
Information Systems and Infrastructure	Updates, Enhancements, or New Systems	✓	✓	✓	✓	✓	✓									✓	✓		8
	Planned Updates/System Replacements		✓				✓			✓	✓		✓		✓				6
	Systems Limitations			✓				✓				✓					✓	✓	5

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 staff 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.

12.0 RECOVERY AUDITING REPORTING

HHS developed a risk-based strategy to implement IPERA'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 2019. 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 below. In addition, in FY 2019 HHS continued reviewing and cataloging potential opportunities to utilize RACs outside of Medicare and Medicaid. 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 2019, the Medicare FFS RAC program identified approximately $219.98 million in overpayments and recovered $162.03 million. During FY 2019, the majority of Medicare FFS RAC collections were from Diagnosis Related Group validations and outpatient therapy reviews.

HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2019, 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 Medicare FFS RAC program.

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, when the CRC initiates recovery of these conditional payments. In October 2017, HHS awarded the CRC contract to a new RAC. The contract transition completed in February 2018, and the previous contractor entered a wind-down period that ended in February 2019.

In FY 2019, the CRC identified approximately $409.66 million and collected $168.43 million in mistaken payments. More information can be found at CRC.

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 has been 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 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 2020 budget included a proposal 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 and abuse incidents and corrective actions. Given that the functions of the Part C RAC program are being performed through other program integrity mechanisms, the proposal creates programmatic and administrative efficiencies while strengthening fraud and abuse reporting.

The functions of the Part C RAC are being performed by the RADV program. The proposed scope of the Part C RAC has been subsumed by an updated RADV methodology that addresses recommendations in the GAO report, "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (GAO-16-76). The new methodology targets payment error using historical payment error data. In January 2019, HHS hosted an industry-wide training providing an overview of the RADV program for MA organizations' representatives, Programs of All-Inclusive Care for the Elderly, Cost Plans, Demonstration Projects, and Third Party Submitters. In April 2019, HHS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits. The purpose of the training was to prepare the MA industry for the selection of audited MA organizations for RADV audits. The payment year 2014 RADV audit is currently underway and is expected to conclude in late FY 2020. HHS launched the payment year 2015 RADV audit in late FY 2019.

To more efficiently use program integrity resources, the FY 2020 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 MEDIC. The MEDIC's primary focus is to conduct program integrity activities aimed to reduce fraud, waste, and abuse in Medicare Part C and Part D. The MEDIC's workload is substantially like that of the Part D RAC, and the MEDIC has a robust program to identify improper payments. After the 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. In FY 2019, the MEDIC will launch new self-audits and national audits that identify potentially improper payments. Additionally, continued education and outreach will be conducted 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 or recovered by the Part D RAC in FY 2019. See Medicare Part C and Part D RAC programs 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. States must implement RAC programs by January 1, 2012. Thus, FY 2019 is the seventh full federal FY of reporting State Medicaid RAC recoveries. In FY 2019, State Medicaid RAC federal-share recoveries totaled $57.72 million and include overpayments collected, adjusted, or refunded to HHS, as reported by states on the Form CMS-64, Medicaid Statement of Expenditures.

Recovery Auditing Reporting Tables

OMB Circular A-136 requires agencies to provide detailed information on agency recovery auditing programs, and other efforts to recapture improper payments. Some Department programs have results to report in this area (see Tables 4, 5A, and 5B). If HHS excluded a program from a table, the program does not have results in that area.

Table 4
Overpayments Recaptured with and without Payment Recapture Audit Programs
FY 2019 (in Millions)

	Overpayments Recaptured through Payment Recapture Audits			Overpayments Recaptured Outside of Payment Recapture Audits		
Program or Activity	Amount Identified	Amount Recaptured [1]	CY Recapture Rate	Amount Identified	Amount Recaptured [1]	CY Recapture Rate
CMS Error Rate Measurements [2]				$22.44	$15.85	71%
Medicare FFS Recovery Auditors	$219.98	$162.03	74%			
Medicare Secondary Payer Recovery Auditor	$409.66	$168.43	41%			
Medicare Contractors [3]				$13,331.39	$11,626.18	87%
Medicare Part C and Part D [4]				$46.09	$46.09	100%
Medicare Part D Recovery Auditors	N/A	$0.00	N/A			
Medicaid Integrity Contractors - Federal Share [5]				$9.66	$9.55	99%
State Medicaid Recovery Auditors - Federal Share [6]	N/A	$57.72	N/A			
ACF Error Rate Measurements and Eligibility Reviews [7]				$0.82	$0.74	90%
ACF OIG Reviews [8]				$6.71	$0.30	4%
ACF Single Audits [9]				$57.69	$35.12	61%
HRSA National Health Service Corps				$10.84	$4.66	43%
TOTAL[10]	**$629.64**	**$388.18**	**62%**	**$13,485.64**	**$11,738.49**	**87%**

Notes:

1. The amount reported in the Amount Recaptured column is the amount recovered in FY 2019, 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 2019 report period were $18,527,397.95. The MACs recovered the identified overpayments via standard payment recovery methods. As of the report publication date, MACs reported collecting $14,347,495.08 or 77.44 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 2019 report period were $2,390,430.43 for Medicaid and $1,521,584.21 for CHIP. The amounts recovered were $1,136,160.00 for Medicaid and $363,656.00 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. The values in the Medicare Part C and Medicare Part D row represent overpayments reported and returned by Medicare Advantage organizations and Part D sponsors. The actual overpayments identified and recovered during the FY 2019 report period were $44.55 million for Medicare Part C and $1.54 million for Medicare Part D.
5. For Medicaid, the Medicaid Integrity Contractors identified total overpayments that include both the federal and state shares. However, HHS reports only the actual federal share across audits.
6. For the State Medicaid Recovery Auditor row, the amount of recoveries are the only items states must return, not the amount of improper payments identified or recovery rates. The State Medicaid Recovery Auditors Amount Recaptured cell represents the federal share of the state recoveries as of the publication date of the AFR. The FY 2019 Annual Report to Congress on the Medicare and Medicaid Integrity Programs will report the final amount recaptured for FY 2019 as a result of activities by State Medicaid Recovery Auditors.
7. The ACF Error 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 12 states between July 2018 and June 2019, HHS recovered $0.71 million in Title IV-E improper payments (comprised of $0.39 million in disallowed maintenance payments and $0.32 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 2019 represent improper payments recovered in FYs 2017 through 2019 by the Year Three states based on improper payments identified in FY 2016. States reported identifying $0.11 million and recovering $0.03 million.

8. The ACF OIG row includes Amount Identified information for all ACF programs for which the amounts from an OIG Report were sustained in FY 2019.
9. 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 2019 reporting period.
10. Totals do not necessarily equal the sum of the rounded components.

Table 5A
Disposition of Funds Recaptured Through Payment Recapture Audit Programs
FY 2019 (in Millions) [1]

Program or Activity	Amount Recaptured	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Original Purpose[2]	Returned to Treasury
Medicare FFS Recovery Auditors	$162.03	$34.64	$25.58	$59.67	N/A
Medicare Secondary Payer Recovery Auditor	$168.43	$3.10	$21.06	$144.27	N/A
Medicare Part D Recovery Auditors	$0.00	N/A	$0.00	$0.00	N/A
State Medicaid Recovery Auditors - Federal Share[3]	$57.72	N/A	N/A	$57.72	N/A
Total	**$388.18**	**$37.74**	**$46.64**	**$261.66**	**$0.00**

Notes:

1. HHS did not have any amounts used for financial management improvement activities or the OIG.
2. Funds under the Original Purpose column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors Original Purpose cell also takes into consideration identified and corrected underpayments to providers ($18.3 million) and amounts collected in prior years but overturned on appeal in FY 2019 ($23.8 million).
3. The state Medicaid recovery auditors' row only includes information on the federal share of recoveries returned to the Treasury. States do not report information to HHS on how the recoveries' state portions are used.

Table 5B
Aging of Outstanding Overpayments Identified by Payment Recapture Audit Programs
FY 2019 (in Millions) [1 and 2]

Program or Activity	CY Amount Outstanding (0 to 6 months)	CY % Outstanding (0 to 6 months)	CY Amount Outstanding (6 months to 1 year)	CY % Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)	CY % Outstanding (over 1 year)
Medicare FFS Recovery Auditors[3]	$60.00	3%	$70.71	4%	$1,787.38	96%
Medicare Secondary Payer Recovery Auditor[4 and 5]	$260.94	87%	$38.61	13%	$0.00	0%
Medicare Part D Recovery Auditor[6]	N/A	N/A	N/A	N/A	N/A	N/A
Total	**$320.94**	**14%**	**$109.32**	**5%**	**$1,787.38**	**81%**

Notes:

1. The state Medicaid recovery auditors are omitted in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts currently outstanding.
2. HHS had no amount that was determined not to be collectable.
3. Under the Medicare FFS Recovery Auditors Program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
4. The MSP recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
5. The MSP recovery auditor amount of outstanding payments included in this table reflects the outstanding balances on debts identified in FY 2019.
6. The Medicare Part D RAC contract ended in December 2015, but an administrative and appeals option period allowed the RAC to complete work on outstanding audit issues until the end of December 2018. Because the option period does not permit new audit work, the Part D RAC identified no new improper payments during FY 2019.

FY 2019 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: NOV 01 2019

TO: Alex M. Azar II, Secretary

THROUGH: Ann C. Agnew, Executive Secretary

FROM: Joanne M. Chiedi, Acting Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2019

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 2019 are:

1. Ensuring the Financial Integrity of HHS Programs
2. Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid
3. Protecting the Health and Safety of HHS Beneficiaries
4. Safeguarding Public Health
5. Harnessing Data To Improve Health and Well-Being of Individuals
6. Working Across Government To Provide Better Service to HHS Beneficiaries

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

2019

TOP MANAGEMENT AND PERFORMANCE

CHALLENGES FACING HHS

2019
TOP MANAGEMENT AND PERFORMANCE
CHALLENGES FACING HHS

Introduction

The 2019 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) facing the Department 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." This year, OIG synthesized new and past challenges and reorganized them into six TMCs. These top six challenges reflect overarching issues that affect multiple HHS programs and responsibilities. These are not the only challenges that face HHS, and OIG reports are a key resource that highlight specific opportunities to improve HHS programs and operations.

HHS is responsible for a portfolio of more than $1 trillion, and its programs impact the lives of virtually all Americans. To identify the six TMCs, we integrated OIG's oversight, risk analysis, data analytics, and enforcement work. For each TMC, we describe the dimensions of the challenge, highlight the progress that the Department has made in addressing the challenge, and identify what remains to be done.

Management and performance challenges are inherently cross-cutting and the TMCs reflect how multiple HHS Operating Divisions (OpDivs) may be affected by these pressing issues. For example, the challenge of financial integrity highlighted in TMC 1 has natural intersections with the challenge of delivering value, quality, and improved outcomes in Medicare and Medicaid, the subject of TMC 2. This document identifies those intersections. Given that challenges cross both internal HHS boundaries and sometimes externally across Departments at the Federal and State levels, 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, in OIG's view, would most positively affect HHS programs in terms of cost savings, program effectiveness and efficiency, and public health and safety.[1]

More information on OIG's work, including the reports mentioned in this publication, is available on our website at https://oig.hhs.gov.

2019
TOP MANAGEMENT AND PERFORMANCE

CHALLENGES FACING HHS

1 Ensuring the Financial Integrity of HHS Programs

2 Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid

3 Protecting the Health and Safety of HHS Beneficiaries

4 Safeguarding Public Health

5 Harnessing Data To Improve Health and Well-Being of Individuals

6 Working Across Government To Provide Better Service to HHS Beneficiaries

CHALLENGE 1

1: Ensuring the Financial Integrity of HHS Programs

RELEVANT OPDIVS

All HHS

KEY ELEMENTS

- Controlling costs by ensuring proper payment for goods and services
- Reducing improper payments
- Combating fraud, waste, and abuse in HHS programs
- Monitoring and reporting on the integrity of HHS programs

The Department of Health and Human Services (HHS or the Department) is the largest civilian agency in the Federal Government, with a $1.2 trillion budget in fiscal year (FY) 2019, representing more than one-third of the total Federal budget. HHS's Medicare program is the Nation's largest health insurer, handling more than 1 billion claims per year. Medicare and Medicaid, the Department's largest programs, comprise 49 percent of the U.S. health care insurance economy. More than 136 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.[2] CMS bears the responsibility at HHS for administering these programs. Federal Medicare expenditures totaled $644.8 billion in FY 2019; Federal Medicaid spending totaled $418.7 billion in FY 2019 (with an additional $18.6 billion for the Children's Health Insurance Program (CHIP)).[3]

HHS is also the largest grant-making and fourth-largest contracting agency in the Federal Government. In FY 2018, HHS awarded $109 billion in grants (excluding CMS) and $25 billion in contracts. 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,[4,5] the expansion of Medicaid services to a larger population, and the increased use of grants as funding tools to achieve program results. HHS should take steps to control costs by ensuring proper pricing for goods and services; reducing improper payments; and preventing, detecting, and prosecuting fraud in HHS programs. The Department must not only manage both the efficient and effective use of funds internally but also oversee the thousands of external funding recipients' use of Federal funds to fulfill HHS's mission.

Controlling costs by ensuring proper payment for goods and services

Whether HHS is paying for medical services, prescription drugs, or complex information technology (IT) solutions, managing what the Department pays and recognizing and remedying payment policies that inadvertently incentivize improper billing or inflate prices are critical to controlling costs.

CHALLENGE 1

Medicare

Medicare should act as a prudent payer on behalf of taxpayers and beneficiaries, including instituting payment policies delivering greater value. (See TMC 2 for more information on value-based payment models.) In certain contexts, Medicare payment policies, which are generally set by statute, 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).[6] Likewise, Medicare pays hospitals different amounts for the same care depending on whether the hospital admits beneficiaries as inpatients or treats them as outpatients. Some payment policies create financial inequities that actually may drive up Medicare costs without improving care for beneficiaries.[7,8] For example, the OIG found that Medicare payments to SNFs for therapy greatly exceeded SNFs' costs for that therapy, creating an environment that provides incentives to bill for unnecessary therapy.[9]

Prescription drug programs

Vulnerabilities exist in HHS's payment strategies for prescription drugs and biologicals. HHS programs accounted for 40 percent ($136 billion) of the total U.S. prescription drug expenditures in 2017. Increases in prescription drug prices have contributed to the growth in total prescription drug spending. Increases in drug prices may limit patients' access to needed prescription drugs if the out-of-pocket costs become unaffordable. The way that Medicare and Medicaid pay for drugs, in addition to fundamental differences in how the Medicare Part B and Part D programs are structured, 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.[10] 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.[11] 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 noncovered versions when setting payment for two Part B drugs, Medicare and beneficiaries paid an extra $366 million from 2014 through 2016.[12] 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, such as biosimilars and gene therapies like chimeric antigen receptor T-cell therapy.

Contracts

Better controls in HHS's contracting process could strengthen competition and pricing for HHS-purchased goods and services. OIG has identified vulnerabilities in acquisition planning and monitoring of procurement and contracts. For instance, key HHS contracts may not always undergo Contract Review Board oversight before being awarded, and when awarding contracts, CMS has not always performed thorough reviews of contractors' past performance.[13] Similarly, in the past, CMS and other OpDivs have frequently chosen contract types that place the risk of cost increases solely on the Government.[14]

Reducing improper payments

CHALLENGE 1

Due to their size, HHS programs account for some of the largest estimated improper payments in the Federal Government. Medicare, Medicaid, and CHIP accounted for $86.1 billion, or 99.6 percent, of the $86.4 billion in improper payments that HHS reported in its FY 2018 Agency Financial Report.[15] Furthermore, insufficient HHS oversight of grant programs and contracts poses risks of significant improper payments and payments for unallowable costs.

Medicare

Traditional Medicare fee-for-service (FFS) accounted for $31.6 billion, or about 37 percent, of the improper payments that HHS reported. Notably, this improper payment rate decreased from 9.5 percent, or $36.2 billion, in FY 2017 to 8.1 percent in FY 2018.[16] 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.[17] For instance, OIG and CMS have identified especially high rates of improper payments for home health, hospice, and SNF care, durable medical equipment (DME), chiropractic services, and certain hospital services.[18] HHS and CMS have taken corrective actions for the Medicare FFS program focusing on specific service areas with high improper payment rates. Although this year's reduction in the improper payment rate was driven by a reduction in improper payments for home health and SNF claims, 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.

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 using a 17-State 3-year rotation. In FY 2018, the improper payment rate for the Medicaid program was 9.8 percent.[19] OIG audits have 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.[20] CMS has engaged with State Medicaid agencies to develop corrective action plans that address State-specific reasons for improper payments identified through the PERM program. OIG work has also identified that States are not always correctly determining eligibility of individuals to receive Medicaid benefits, resulting in potential improper payments. Given that CMS will resume the Medicaid eligibility component measurement and report updated national eligibility estimates for FY 2019, the improper payment rate may significantly increase for this fiscal year.

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.

CHALLENGE 1

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;[21] and States not sufficiently overseeing their Child Care and Development Fund (CCDF) program payments.[22]

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 *Improper Payments Information Act of 2002.*[23] 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. States receive block grants ($16.5 billion annually) to design and operate TANF programs. 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 needed 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. However, OIG has identified problems with the Department's processes for contract closeouts. CMS relies extensively on contractors to carry out its mission and spends billions of dollars each year in contracts. Because improper payments may be identified and recovered during the closeout process, it is imperative that contracts are closed in accordance with Federal Acquisition Regulation (FAR) requirements. The closeout process, generally, is the last chance for improper contract payments to be detected and recovered, and delayed closeout poses a financial risk to agency funds. OIG found that a large backlog of unfinalized indirect cost rates may have contributed to the untimely closeout of CMS contracts totaling $25 billion.[24] Although CMS has taken steps to improve its closeout and contract management processes, the Department needs to take additional actions to ensure that it is meeting FAR requirements.

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 and to detect and prevent fraud. The Department should also apply a robust program integrity strategy to protect current and future HHS programs.

FRAUD SCHEMES

- Billing for Services Not Provided
- Identity Theft
- Kickbacks
- Improper Prescribing
- Deceptive Marketing
- Money Laundering

CHALLENGE 1

Program integrity strategies

HHS programs must be designed with program integrity in mind. These strategies must take into account the various methods that HHS uses to implement its programs, including how public and private partners can help in meeting the Department's mission. Additionally, these strategies must include systems and processes to detect and prevent fraud, as well as plans for addressing fraud when it occurs.

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.[25]

In the Medicare and Medicaid programs, States must keep bad actors intent on committing fraud from participating in the programs. With respect to Medicaid in particular, significant problems remain for ensuring all high-risk Medicaid providers undergo criminal background checks. Further, States are not sharing provider enrollment data with Federal and State partners to streamline the Medicaid enrollment process. Sharing these data would reduce the chance for error within any one of the State and Federal databases and help in identifying fraud schemes and other vulnerabilities that cross State lines.[26] CMS should continue to work directly with States to implement tools such as fingerprint-based criminal background checks for high-risk providers. Further, CMS should develop a central repository or "one-stop shop" with provider information that all States and Medicare can use.

Medicare and Medicaid

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 individuals with no prior experience in the health care industry to organized criminal enterprises.

Managed care continues to play an increasingly important role in Medicare and Medicaid. Unlike in FFS, where CMS (Medicare) or the State (Medicaid) pays providers directly for each covered service received by a beneficiary, under managed care, CMS or the State pays a population-based fee 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 or the State. Managed care is the primary delivery system for Medicaid, covering at least some services for more than 80 percent of all enrollees.[27] In Medicare, one-third of beneficiaries are enrolled in Medicare Advantage organizations (MAOs). HHS faces a significant challenge in protecting managed care programs and other non-traditional models against fraud, waste, and abuse.

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OIG has found weaknesses in MAOs' and Medicaid managed care organizations' (MCOs) efforts to identify and address fraud and abuse by their providers.[28] CMS requires MAOs and Medicaid MCOs 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 MCOs. This makes effective oversight by CMS more complex and challenging.

CMS is working to validate the completeness and accuracy of MAO and Medicaid MCO encounter data and recently has released best practices guidance for MAOs to improve encounter data submission. CMS is also working with States to provide technical assistance and education to identify and share best practices for improving Medicaid MCO identification and referral of cases of suspected fraud or abuse. CMS should take further actions to ensure the completeness, validity, and timeliness of Medicaid encounter data. Further, CMS should work with its contractors and with States to make improvements in 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, grants and contracts are vulnerable to fraud schemes, including embezzlement.[29] HHS has worked to strengthen some of its program integrity efforts focused on grant programs. For instance, it issued guidance to HHS awarding OpDivs about facilitating a review of prospective grantees prior to awarding grants.[30] 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 opioid use disorders (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 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 the Indian Health Service (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.[31] In addition, the Department must guard against fraud in OUD treatment

programs, including, for example, the submission of fraudulent insurance claims for purported OUD treatment and testing services.[32]

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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 that culminate the results of their programs, addressing weaknesses in financial management systems and meeting the requirements of the *Digital Accountability and Transparency Act (DATA Act) of 2014* remain challenges for HHS.

Addressing weaknesses in financial management systems

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.[33] 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.[34]

Meeting the requirements of the DATA Act of 2014

The DATA Act required agencies to use Government-wide data standards to report financial and award information into USAspending.gov. For FYs 2017, 2019, and 2021, the DATA Act also requires the Inspector General of each agency to determine the accuracy, completeness, timeliness, and quality of these data. In FY 2018, OIG performed an additional audit to follow-up on prior issues and monitor and provide feedback on the progress made by the Department. For FY 2018, OIG's audit of compliance with the DATA Act found that HHS complied with data standards but continued to rely on a manual, labor-intensive process.[35] HHS needs to continue to automate the standardization and transmission of data to the Department of Treasury.

2: Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid

CHALLENGE 2

The transition to innovative, value-based, consumer-empowered care is a top Administration[36] and Departmental priority. HHS continues to enact reforms in Medicare and Medicaid to promote quality, efficiency, and value of care. These reforms come with an array of operational and program integrity challenges, as well as promising opportunities for better health outcomes, lower costs, improved transparency and choices for consumers, and reduced administrative burden on providers.[37]

RELEVANT OPDIVS

CMS, ONC, OS

KEY ELEMENTS

- Aligning program incentives with health outcomes
- Addressing integrity problems across models
- Delivering on the promise of innovative technology to improve health outcomes

Medicare and Medicaid, the two largest programs in the Department, are also among the most complex. 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. Increasingly, beneficiaries are enrolling in Medicare and Medicaid managed care options.

The transition to value in the Medicare and Medicaid programs is well underway, with continued growth expected. The Health Care Payment Learning & Action Network, an HHS-sponsored public-private partnership, estimated that for FY 2017, 90 percent of providers in Medicare FFS were paid based, at least in part, on quality and value, with 38 percent being paid under an alternate payment model or a population-based payment; the comparable numbers for Medicaid were 32 percent and 25 percent, respectively.[38] HHS has introduced, and continues to introduce, a range of new models, including accountable care organizations (ACOs), medical homes, bundled payment models, primary care models, and others. Many of these models are designed as all-payer models to align with developments in the private sector. Most recently, HHS announced a major set of initiatives to reform payment and delivery of kidney care, including new payment models, technologies, and care options for patients.

Both Medicare (FFS, Part C, and Part D) and Medicaid have proven susceptible to fraud, waste, and abuse, with estimates of improper payments ranging from 8.1 percent (Medicare FFS) to 9.8 percent (Medicaid) of total expenditures, totaling $86 billion in FY 2018.[39] For the past 16 years, the Government Accountability Office (GAO) has included both programs on its list of high-risk Government programs. OIG work has long demonstrated a range of vulnerabilities in both Medicare and Medicaid:

- Flaws in program design and administration (e.g., improper payments) (see TMC 1),
- Misaligned program incentives and confusing or insufficient program guidance,

- Deficiencies in how providers deliver care to beneficiaries (e.g., poor quality and unsafe care (see TMC 3) or inappropriate utilization),
- Gaps in provider enrollment systems and available data needed for proper oversight (see TMCs 1 and 5), and
- Problems in ensuring that eligible beneficiaries have adequate access to covered services in both FFS and managed care.

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There are three specific elements of this challenge: (1) aligning program incentives with improved health outcomes, (2) strengthening program integrity, and (3) delivering on the promise of innovative technology. Each element is integral to delivering greater value (including savings), quality, and improved outcomes for Medicare and Medicaid, their beneficiaries, and taxpayers.

Aligning program incentives with health outcomes

Developing effective incentives and policies to drive better health outcomes is difficult given the complexities of medicine, the programs themselves, and the populations served by these programs. HHS faces obstacles in correctly measuring the value of care. Designing measures that effectively incentivize high-quality care 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.[40] Where applicable, CMS must clearly define actionable and meaningful quality measures and ensure their reliability, accuracy, and utility. CMS and other OpDivs currently using quality measurements should continue to align efforts to reduce unnecessary provider burden and strengthen quality measurement. Moving forward, HHS will need to ensure that its programs use effective, evidence-based measures for quality improvement. Under the new Executive Order on Health Care Price Transparency and Quality, HHS is producing a health quality roadmap in coordination with the Secretaries of Defense and Veterans Affairs that will include a strategy for developing common quality measures, aligning inpatient and outpatient measures, and eliminating low-value quality measures. The Department is also exploring—via a Regulatory Sprint to Coordinated Care led by the Deputy Secretary—whether better care coordination and value-based care can be fostered through changes to existing regulations that some view as barriers to care coordination, including certain fraud and abuse regulations administered by CMS and OIG, as well as certain Substance Abuse and Mental Health Services Administration (SAMHSA) and Office for Civil Rights (OCR) regulations.

OIG work examining the Medicare Shared Savings Program over the first 3 years of the program revealed that ACOs participating in the Medicare Shared Savings Program reduced Medicare spending and achieved a net spending reduction of nearly $1 billion for 9.7 million beneficiaries. ACOs improved their performance on most (82 percent) of the individual quality measures and outperformed FFS providers on most (81 percent) of the quality measures. ACOs participating in the program longer were more likely to reduce spending and by greater amounts than other ACOs. This suggests that more established ACOs can achieve greater cost savings and quality over time.[41] OIG conducted site visits to successful ACOs and identified strategies used by ACOs to reduce Medicare spending and improve quality of care. Examples of these strategies include 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

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and social determinants of health, and using technology to increase information sharing among providers.[42] Based on this work, OIG recommended—and CMS concurred—that CMS take steps to support and share successful ACO strategies. These strategies may be adaptable in other value-based models.[43]

New payment structures, business arrangements among providers, and incentives all give rise to risk-management challenges. In pursuing innovative models to improve the health care system—whether in FFS or managed care—CMS must take steps to prevent unintended consequences, such as misaligned incentives or abusive practices. Moreover, notwithstanding identified successes, CMS must maintain a steady focus on quality. For example, an OIG review of Medicare Part B dialysis services at a health care group in Puerto Rico found noncompliance with Federal requirements for which the deficiencies could have had a significant impact on the quality of care provided to Medicare beneficiaries and could have resulted in the provision of inadequate or unnecessary dialysis services. OIG provided recommendations for strengthening policies and procedures to meet quality requirements.[44] (See TMC 3 for further discussion of quality-of-care challenges.)

Addressing integrity problems across models

The transition to a value-driven health system could mitigate some of the fraud and abuse vulnerabilities resulting from volume-based incentives and poorly coordinated care. However, familiar risks will continue to exist and new risks will likely emerge. Examples of risks in a value-based system (e.g., one where providers assume financial risk for patients' cost of care) could include providers inappropriately reducing costs by stinting on care, discriminating against expensive patients, or manipulating or falsifying data used to measure performance, outcomes, or acuity. Managed care suffers from similar program integrity problems. More will need to be done across FFS and managed care programs to assess and identify emerging risks so that they can be mitigated.

As health care transitions from paying for procedures to paying for outcomes, the programs will concurrently face risks associated with volume-driven and value-driven payment and care. Indeed, many providers will be paid under models that combine multiple types of incentives, such as a shared savings payment in combination with FFS payments, and some providers will continue to be paid primarily or exclusively on a volume-basis. Managed care programs also are not immune from risks created by mixed incentives. OIG's oversight and enforcement work addressing program integrity in managed care demonstrate the opportunities for "downstream" fraud and abuse, such as by providers paid on an FFS basis, notwithstanding that the Government pays on a population basis (e.g., a capitated payment). (See TMC 1 for further discussion of program integrity in managed care.)

A further, significant program integrity concern arises in connection with services furnished in home- and community-based settings, which patients often prefer and can be less costly. Value-based care models are expected increasingly to promote care in these settings through home visits by practitioners and care managers, remote monitoring, and other technologies. CMS is expanding beneficiaries' access to telehealth. OIG work in areas such as hospice care, home health, and personal care services consistently demonstrates that patients and the programs may be vulnerable to fraud and abuse in home- and community-based settings. Moreover, there is heightened risk that new technologies, when misused, could enable wrongdoers to commit broader and new types of fraud.

Managing and mitigating multifaceted risks to ensure that patients, providers, and taxpayers realize the full benefits of innovative value-based care will require sustained effort, resources, flexibility, and continual prioritization by CMS

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and the Department. In testing and implementing value-based care models, CMS must continue to focus on program integrity risks, incorporate safeguards to reduce them, and promptly correct identified issues. Focusing on these risks is especially important for models that introduce new payment incentives, which might lead to new fraud schemes, and for models for which waivers of payment, coverage, or fraud and abuse laws may have been issued.

Across Medicare and Medicaid, whether in the traditional FFS, managed care, or emerging new models, CMS must remain attentive to tailoring effective program integrity strategies that prevent and detect problems and hold wrongdoers accountable. Attention must be paid to the range of fraud, waste, and abuse risks, 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. These risks are covered in more detail in TMCs 1, 3, 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, recent OIG work examining how Medicare Shared Savings Program ACOs use health IT showed that, although ACOs have used health IT to aid in care coordination in a variety of ways, the full potential of health IT has not been realized.[45]

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 them to choose reliable apps and technologies to assure themselves that providers they may be engaging with via an app or technology are trustworthy. (See TMC 5.)

Artificial intelligence and machine learning are introducing new paradigms that will likely require fresh thinking about compliance and fraud prevention.

HHS also faces challenges in ensuring that evolving technologies achieve their intended results, enhancing patient access to quality care and providers' ability to furnish such care. The recent billion-dollar law enforcement action known as Operation Brace Yourself illustrated how telehealth technology used for 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 range of program integrity risks their inventions may face. These new participants in the health care ecosystem will need education, guidance, and appropriate oversight.

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HHS faces a growing challenge in understanding and, as appropriate, overseeing providers' use of artificial intelligence 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. Artificial intelligence and machine learning are introducing new paradigms that will likely require fresh thinking about compliance and fraud prevention. Relatedly, HHS will need to assess how it can use artificial intelligence, machine learning, and other technologies to foster program integrity, value, and quality of care in Medicare, Medicaid, and other HHS programs. Finally, HHS will need to ensure that rural beneficiaries and underserved populations are not left out of a technology-enriched, value-driven health system. (See TMC 4 for further information about the Food and Drug Administration's (FDA's) role in emerging technology.)

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.

3: Protecting the Health and Safety of HHS Beneficiaries

CHALLENGE 3

HHS programs provide critical services to diverse populations across a broad range of care settings. Some such 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 services, educational services, child care services, and even physical custody for select populations. Ensuring that intended beneficiaries receive appropriate services and are not subjected to abuse or neglect represents a major challenge for the Department.

RELEVANT OPDIVS

ACF, CMS, IHS, SAMHSA

KEY ELEMENTS

- Ensuring safety and quality of health care paid for by Federal health insurance programs
- Protecting the health and safety of children served by HHS programs
- Preventing abuse and

Ensuring safety and quality of health care paid for by Federal health insurance programs

HHS operates the Medicare program to insure about 60 million elderly or disabled Americans. In partnership with the States, the Medicaid and CHIP programs insure about 75 million and 7 million beneficiaries, respectively. IHS serves about 2.6 million members of 573 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.[46] 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.[47] Additionally, fixed daily payment structures may incentivize hospices to enroll beneficiaries for longer time periods but scrimp on care. Oversight work also 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, and that harm rates were even higher for post-acute settings: 29 percent in rehabilitation hospitals, 33 percent in skilled nursing facilities, and 46 percent in long-term-care hospitals.[48] In addition

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to the high harm rates, OIG 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.[49] OIG is currently conducting a study to update the harm rate for Medicare beneficiaries in hospitals. This review will assess progress made in reducing harm in the decade since the prior study was released in 2010.[50] OIG also has work underway to measure the rate of adverse events for patients at IHS Hospitals. (See TMC 6 for more information on challenges associated with adverse events.)

The Department continues efforts to improve the quality of covered services. The Department has worked to improve 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. CMS has announced plans to revamp its Hospital Quality Star Rating System to enable better informed decision-making for beneficiaries seeking hospital care.

Also, CMS enforcement actions have stopped some poor-performing nursing homes from rendering worthless 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.[51] Further, after a series of OIG reports about quality of care problems in IHS-operated hospitals,[52] IHS created a new Quality Framework and Office of Quality to provide better guidance and oversight to its facilities and clinical staff.[53]

Although the Department has made progress, more work remains to be done 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,[54] and improving the health and safety of nursing home residents by ensuring facility correction of deficiencies.[55] To continue improvements at IHS, OIG has recommended that IHS prioritize developing and implementing a staffing program to ensure 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.[56]

Protecting the health and safety of children served by HHS programs

HHS operates or funds many programs providing additional services beyond health care for children, including child care, education, and residential care. The Head Start program promotes school readiness for nearly 1 million children from low-income families and the CCDF provides child care for about 1.3 million children from low-income families. The importance of properly vetting staff for these programs is discussed below.

Operating the UAC Program

Through the UAC Program, ORR assumes custody of children who enter the United States without immigration status and have no parent or guardian in the United States able to provide for their physical and mental well-being. The child may have arrived in the United States alone, or in certain circumstances, may have been separated from their parents or legal guardians at the border. This 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

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unaccompanied or separated children in 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 175,000 children.

In recent years, ORR has been called upon to care for more children, including children who did not come to the United States 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. OIG reported in January 2018 that possibly thousands of children had been separated and released by ORR before the court order and that children had been separated from their parents for longer than had previously been reported. ORR had not been tracking this figure and the exact number of separated children is still not known, although HHS and DHS are now working to identify all of the children separated from their parents since July 2017. OIG also reported that children continue to be separated by DHS from their parents, and ORR does not always receive adequate information.[57] Lack of data about separated children complicates HHS's ability to ensure appropriate placement and reunite children with their families in a timely manner. 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. Also, at one influx care facility, OIG found failures in conducting required staff background checks and insufficient clinical staff to serve children's mental health needs.[58]

The Department must work to ensure that UAC Program-funded facilities meet all safety requirements and provide adequate 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 are in a position of trust and in close contact with beneficiaries, often behind closed doors and at especially-vulnerable times in the beneficiary's life. 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 in prison in one State and standing trial in another State for sexually assaulting boys he treated as patients. That incident 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.[59] The Task Force is charged with examining IHS systems that may have failed in the past and recommending improvements to better protect children from abuse. Better attention to protecting vulnerable beneficiaries of all ages in all HHS care settings is also needed.

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

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conduct required background checks for UAC facility staff whose jobs entail access to children.[60] Failure to conduct adequate background checks has been a problem in domestic 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.[61] Implementation of background checks for long-term-care providers remains a challenge as well.[62] 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. 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 many care settings are at risk of abuse and neglect. About 1.8 million Medicare beneficiaries receive care in SNFs each year.[63] 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 work found extensive failures to properly handle critical incidents, including suspected abuse and neglect, of group home residents.[64] OIG has also identified substantial failures to report incidents of potential abuse or neglect of Medicare beneficiaries living in SNFs who require treatment in hospital emergency departments.[65] 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.[66]

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.[67]

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.[68] 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.

4: Safeguarding Public Health

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As HHS pursues its mission of enhancing the health and well-being of all Americans, there are challenges to ensuring public health and safety. These include opioid abuse and misuse, risks associated with public health emergencies caused by communicable diseases and natural disasters, dangers from unsafe food, and medical devices vulnerable to cyberattacks. To best serve the American public, the Department must leverage the skills and tools it has at its disposal to reduce the ill-effects of opioid use disorders (OUDs) through prevention, treatment, and recovery support, prioritize emergency planning and response, and ensure that food, drugs, and devices are safe. Additionally, Americans rely on HHS to recognize and respond to emerging issues such as concerning trends and evidence of detrimental health impacts associated with the use of e-cigarettes and other electronic nicotine delivery systems ("vaping"). Because challenges to public health are often complex, the Department must ensure that operating divisions coordinate with each other, as well as partners within and outside of Government, to effectively promote public health and safety. (See TMC 6 for more information on the Department's challenge of coordinating with internal and external partners.)

RELEVANT OPDIVS

ASPR, CDC, CMS, FDA, HRSA, IHS, SAMHSA

KEY ELEMENTS

- Tackling the opioid epidemic while ensuring access to treatment
- Strengthening emergency preparedness and response capabilities
- Safeguarding the Nation's food supply
- Providing adequate oversight of medical device safety and security

Tackling the opioid epidemic while ensuring access to treatment

The Nation is struggling with an opioid crisis that is, at least partially, fueled by opioids prescribed by licensed medical professionals, dispensed by licensed pharmacies, and paid for by Federal funds. Approximately 2 million people have an OUD,[69] and two out of three overdose deaths involve an opioid.[70] In 2017 alone, there were an estimated 47,600 opioid-related overdose deaths in the United States.[71] Although the opioid epidemic is pervasive nationally, data suggest that the Appalachian region, in particular, has higher opioid prescribing rates and overdose death rates,[72] and that the American Indian/Alaska Native (AI/AN) population is disproportionately harmed by opioid misuse[73, 74] and overdose deaths.[75] Additionally, synthetic opioids such as fentanyl and tramadol present a significant, growing threat and have been associated with more deaths than other types of opioids.[76]

Two out of three overdose deaths involve an opioid.

In 2017, the President directed the Acting HHS Secretary to declare the opioid crisis a national public health emergency, authorizing the Department to use emergency authority to address the opioid epidemic. The

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Department plays a critical role in ensuring that opioids are prescribed and dispensed appropriately and according to program policies.[77] HHS developed a five-point strategy to combat the opioid crisis[78] and must continue working toward addressing the problem, adjusting its approach as appropriate. HHS OpDivs should continue to use the tools available in their 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.

Although opioid misuse and abuse remains a problem, OIG found some potential improvements in utilization patterns and access to treatment for substance abuse in Medicare Part D, including a decrease in Medicare beneficiaries receiving opioids, an increase in beneficiaries receiving medication-assisted treatment (MAT) for OUD, and an increase in prescriptions for naloxone—a drug that can prevent overdose deaths.[79] Ensuring access to appropriate pain management therapies and combating opioid abuse remains a high priority. CMS and Part D sponsors should implement effective drug management programs for at-risk beneficiaries.

Further, IHS could improve the quality of care for prescribing and dispensing opioids to the AI/AN population by fully utilizing States' prescription drug monitoring programs. A 2019 OIG report[80] identified that IHS hospitals did not fully use the States' prescription drug monitoring programs when prescribing or dispensing opioids at certain IHS hospitals. In addition, the hospitals did not use available data to identify risks in their prescribing and dispensing practices, such as giving patients (1) opioid doses of as high as 500 daily morphine milligram equivalents; and (2) opioids and benzodiazepines at the same time, which puts patients at greater risk of a potentially fatal overdose. Making data-supported decisions and conducting data analysis will be crucial to identifying risks and reducing the occurrence of adverse events. (See TMC 5.)

Additionally, through the FDA, the Department approves new drugs before they are marketed in the United States and takes into account benefits and risks to assure safety and efficacy.[81] FDA also monitors the safety of marketed drugs as new information becomes available. Through this framework, the FDA can encourage the development of abuse-deterrent formulations of opioids that may be less susceptible to abuse; employ tools, including the Risk Evaluation and Mitigation Strategy program, to mitigate risks associated with approved drugs; and pursue measures that include withdrawal from the market when there are serious safety concerns.[82]

The treatment of OUDs is a priority. Only a fraction of the 2.1 million people with OUDs received specialty treatment in 2018 (19.7 percent).[83] It is important for the public to be able to access effective, quality treatments. Research suggests that MAT medications, in combination with counseling and behavioral therapies, can be an effective treatment for OUDs. Three drugs—methadone, buprenorphine, and naltrexone—are approved to treat OUDs. Access to MAT is a priority as patients suffering from an OUD are at risk for withdrawal and relapse and may seek out illicit opioids, such as heroin. As such, the Department must work diligently to ensure access to these medications.[84]

The Department continues to manage and oversee investments to address OUDs. SAMHSA awarded more than $930 million[85] through the State Opioid Response grants to support a comprehensive response to the opioid epidemic and expand access to treatment and recovery support services; HRSA awarded nearly $400 million for community health centers, rural organizations, and academic institutions to establish and expand access to OUD treatment.[86] Although treatment must be prioritized nationally, the Department should ensure that resources are devoted to areas disproportionately affected by the opioid epidemic, including the AI/AN population and rural

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communities. Recognizing the potential danger of abrupt opioid withdrawal and the patient safety imperative of tapering or discontinuing opioids thoughtfully, the Department released a *Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*.[87]

The Department can also help save lives through enabling people to access medications that reverse the effects of opioids and illicit drugs. Research shows policies that make it easier to access naloxone may be saving lives.[88] HHS is in the process of implementing the *SUPPORT for Patients and Communities Act of 2018* that proposes several strategies to combat the opioid crisis, including reducing improper opioid prescribing and expanding access to prevention, treatment, and recovery services. For example, it requires CMS to recommend ways to lower consumer prices for opioid overdose-reversal medications such as naloxone and requires HHS to establish a grant program to implement best practices regarding treatment for individuals who experience an overdose, including emergency treatment and the use of recovery coaches. (See TMC 1 for more information on program integrity considerations associated with grants.)

Strengthening emergency preparedness and response capabilities

HHS has a lead role in preventing, preparing for, and responding to the adverse health effects of public health emergencies. (See TMC 6 for more information about HHS's role in the Federal Government's emergency preparedness and response efforts.) Communicable diseases, outbreaks, and natural disasters constitute public health emergencies that can severely strain public health and medical infrastructure and lead to serious illness and loss of life. Prior to and during a public health emergency, it is important to have adequate planning (such as preparing for a medical surge) and mechanisms in place to efficiently and rapidly deploy assets and provide relief to those in need of vital health and human services resources in the aftermath of an emergency. Prior OIG work has identified gaps in emergency preparedness and response planning for health care facilities during disasters and pandemics.[89] The Department's continued efforts to improve preparedness and response are important as it is uniquely positioned with the opportunity to continuously assist communities throughout the United States so that they can respond to and deliver health services in the immediate aftermath of natural disasters, as well as support sustained recovery efforts.

Prior OIG work has identified gaps in emergency preparedness and response planning for healthcare facilities during disasters and pandemics.

Additionally, recent outbreaks of communicable diseases (e.g., measles, hepatitis, and Ebola) are an ongoing challenge and demonstrate the need for the Department to rapidly detect, diagnose, and assess these threats. A 2019 OIG report determined whether HHS's response efforts to the 2014 Ebola outbreak were effective and efficient and found that HHS (1) had no strategic framework in place to coordinate global health security at the international or departmental levels before the Ebola outbreak, (2) was not prepared to deploy the resources needed for such a large-scale international response, and (3) did not have in place internal or external communication channels for responding to an international public health emergency.[90] It is important for HHS to have the ability to readily develop, distribute, and administer medical countermeasures (i.e., vaccines, therapeutics, and diagnostics) to

effectively prevent and treat infectious diseases. States and localities should ensure planning and preparedness in areas including medical surge and vaccine and antiviral drug distribution and dispensing.[91]

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Safeguarding the Nation's food supply

An estimated 1 in 6 Americans get sick from contaminated foods each year, and 3,000 die.[92] Individuals with weakened immune systems, such as older and younger populations, may be particularly susceptible to foodborne illnesses. Foodborne illnesses are largely preventable, and the American public relies on FDA, working with partners including the Centers for Disease Control and Prevention (CDC), to ensure that the food we eat is safe.[93] The passage of the *FDA Food Safety Modernization Act* (FSMA) placed renewed emphasis on the importance of preventing foodborne illnesses and FDA has made progress in implementing that statute. FDA has prioritized creating a more effective and efficient food safety system. One means by which it aims to do this is by increasing the role of the States in improving produce safety.[94] Still, with an increasingly global food supply, keeping food safe presents a constant challenge.

The Department must ensure that FDA continues to modernize the food safety system and responds effectively when issues are identified. FDA should use the array of tools at its disposal to protect the American public. It should conduct risk-based inspections of domestic and foreign food facilities within the timeframes required by FSMA, 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.[95] 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 optimize its ability to protect the public from outbreaks of foodborne illnesses.

Providing adequate oversight of medical device safety and security

FDA is responsible for approving new medical devices that it determines are safe and effective, and assuring that approved products remain safe and effective.[96] As technology advances, FDA performs this task in an increasingly complex environment. Beneficial aspects of innovative medical devices, such as the ability to communicate widely with other devices, may increase the risk of cybersecurity threats. (See TMC 5 for more information on cybersecurity.) FDA has the difficult task of staying at the forefront of emerging technology, amassing the technical knowledge to understand the science that supports advances in medical device function, and anticipating the potential impacts of new technologies. FDA reports that it has undertaken several initiatives to enhance the Agency's approach to medical device safety, and is working closely with patients, providers, and device developers to make sure that it is appropriately balancing risk and benefit.

The *21st Century Cures Act* (the Cures Act) aims to help accelerate medical product development and bring new innovations and advances to patients.[97] Among the expedited product development programs established by the Cures Act is the Breakthrough Devices program. Under that program, manufacturers of medical devices that meet certain criteria may obtain priority review by FDA. For example, a medical device designed to provide more effective treatment or diagnosis of a life-threatening or irreversibly debilitating disease or condition may be eligible for "Breakthrough Device" designation.[98] Recently, FDA granted breakthrough status to an artificial intelligence-enabled medical device intended to diagnose and improve clinical management of patients with Type 2 diabetes with fast-progressing kidney disease.[99]

CHALLENGE 4

The speed at which science and technology are evolving means that the development and regulation of medical devices presents new safety and effectiveness concerns. For example, artificial intelligence-enabled devices that communicate with other medical devices may be subject to cybersecurity risks[100] or interoperability difficulties, which could adversely affect patient safety and medical device performance. (See TMC 5.) One area of challenge for FDA thus will be to review medical device applications as expeditiously as possible while being mindful of factors that could adversely affect the safety and effectiveness of medical devices. (See TMC 2 for HHS's challenges in overseeing evolving technologies in Medicare and Medicaid.)

Post-market surveillance of medical devices continues to be a management challenge for FDA.[101] Each year, the agency receives several hundred thousand reports of medical devices suspected of being associated with death, injury or malfunction. By regulation, these reports must be submitted in a timely manner to FDA.[102] In 2009, OIG reported that manufacturers and medical device user facilities often submitted tardy and incomplete adverse event reports and that FDA failed to employ adverse event reports in a systematic manner to detect and address safety concerns.[103] FDA reports that it is evolving beyond its current passive post-market surveillance system and moving to an active surveillance system that relies on real-world evidence and timely receipt of robust safety information, which it believes will better protect patients and help enable the Devices Program to act quickly with manufacturers and health care providers to make timelier decisions to keep patients safe. A key element of implementing this strategy will be the multi-stakeholder effort to establish the new national system for gathering real world evidence through the National Evaluation System for health Technology (NEST). Implementing a national surveillance system would also not be possible without the FDA's establishment in recent years of a unique device identification (UDI) system, in which medical devices are marked on their labels with a unique code that can be used to track the device through its distribution and use in patients.

5: Harnessing Data To Improve Health and Well-Being of Individuals

CHALLENGE 5

Improving how the Federal Government manages, shares, and secures its data is a priority for both Congress and the Administration.[104] HHS is prioritizing "Leveraging the Power of Data" as one of its six strategic shifts for its *ReImagine HHS* effort.[105] Collectively, these initiatives recognize the significant value of Federal data and the importance of having a coordinated approach to use "data to deliver on mission, serve the public, and steward resources while respecting privacy and confidentiality."[106] Additionally, HHS's authorities and influence that shape how an individual's data are used and protected by other private and public entities are increasingly important in a technology-enriched health and human service delivery system. Failure to modernize HHS data practices will limit the capability of HHS and its OpDivs to fulfill their missions. HHS and its 11 OpDivs and associated programs have made progress in doing so, but challenges remain in how it manages, shares, and secures data.

RELEVANT OPDIVS

All HHS

KEY ELEMENTS

- Expanding HHS's capacity to use data in policy making, program management, and deployment of emerging technologies
- Providing data to HHS partners and promoting the public data access and sharing
- Protecting data from misuse or unlawful disclosure

Expanding HHS's capacity to use data in policy making, program management, and deployment of emerging technologies

Data play a central role in every HHS program or policy mission.[107] 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, which are vital to improving the health and welfare of individuals in the Nation. The Department and its programs are increasingly digitally oriented and able to generate, receive, and transmit data in large volumes associated with important programmatic functions.

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 in 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.[108] These silos may limit the capability of HHS to use data for evidence-based decision making and better manage its programs and OpDivs. 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. When OpDivs and programs cannot access data from each other, they miss opportunities to improve the effectiveness of programs. For example, OIG recommended that CMS provide its Medicare Drug

Integrity Contractor with centralized access to Medicare Part C encounter data to enable the contractor to more effectively and proactively identify potential fraud, waste, and abuse.[109] 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.

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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. The need to improve data governance is not unique to the Department and is a priority and a requirement for Federal agencies.[110] It is also part of HHS Strategic Plan and the Digital Strategy at HHS.[111] The Department is taking steps to improve its data governance and more effectively use the data it has. Under the *ReImagine HHS* "Leveraging the Power of Data" initiative and implementation of the Foundations for Evidence-Based Policymaking Act of 2018, the Department is developing an enterprise-wide data sharing strategy to increase combined analysis of disparate data sets to achieve better insights.[112] Although progress has been made, 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. Without quality data that can provide visibility on how its programs are operating, HHS will have limited capabilities to improve its program management. For example, OIG raised concerns about the national Medicaid data set named the Transformed Medicaid Statistical Information System (T-MSIS).[113] CMS made progress by ensuring that all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands report data and work with States to improve the quality of data submissions. However, concerns still exist about the completeness and reliability of the T-MSIS data. Most recently, OIG found a national review of opioid prescribing in Medicaid using T-MSIS is not yet possible because not all at-risk beneficiaries and providers can be identified. Because existing T-MSIS data do not allow identification of all at-risk beneficiaries and potentially inappropriate providers, data enhancements are needed to enable a national review of opioid prescribing in Medicaid.[114] Further, limitations of T-MSIS data impede identification of individual beneficiaries for national opioid analysis.[115] Similar data quality and governance challenges exist across other Departmental programs that collect external data from grantees or other organizations.[116]

Building Advanced Capacity To Use Data

Improving how HHS, its programs, and its employees use data is a critical component of the 2018 HHS's Data Strategy. 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.[117]

In certain areas, the Department made progress. For example, in response to OIG work related to improving Departmental oversight of grantees, HHS established the Audit Tracking and Analysis System, a Department-wide source of adverse information from grantee audits and facilitated Department-wide information sharing about grantees with past performance issues.[118] However, HHS struggles to use and

leverage its own data to improve its program management in several areas, such as financial and payment systems information and reporting operations. (See TMC 1.)

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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. Technologies such as machine learning and artificial intelligence 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.[119] The Department is making progress by exploring solutions through several recent pilots, demonstrations, and other limited scope projects.[120] These use cases can help HHS learn how data can be used in a short-time frame and that can serve as quick feedback loop to inform the next pilot or demonstration.

In December 2017, HHS hosted a "Opioid Code-a-Thon" to develop data-driven solutions to combat the opioid epidemic. The Code-a-Thon involved use and analysis of 10 HHS databases from 5 different OpDivs, and more than 70 data sets in total from other Federal agencies, State and local governments, and publicly available data. The competition resulted in the development of new tools to address the opioid crisis.[121] According to HHS, the Code-A-Thon also provided insights into the data it has and what other steps it should take to improve its data governance that might facilitate development of other solutions to the opioid crisis.[122]

The challenge for HHS will be to go from strategies and pilot tests to fully incorporating lessons learned into the Department's operations. There are significant barriers—legal, cultural, and resource limitations—that strategies and pilots 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 undertake multiyear efforts and implement sustained change management across its OpDivs.

Increasing Data Access and Sharing with HHS Partners and the Public

There is an increasing recognition that Federal agency stakeholders[123] and the public can also use Federal data assets for the public good.[124] Much of HHS's data are publicly available but may not be easy to use or may have other barriers that limit stakeholders' and the public's access or use. Those barriers present a challenge to providing increased access of HHS data that could lead to innovation and improvement in health and welfare. 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 and 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. However, most public access to HHS data does not benefit from 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 attempting to expand access to these important assets, but progress has been slow. In January 2018, FDA announced a pilot to provide more

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access to summary portions of the clinical study report for pivotal drug trials establishing the safety and effectiveness of the drug. However, only one drug sponsor agreed to participate in the FDA pilot program.[125] The CMS *Blue Button 2.0* initiative to improve beneficiaries' access to their Medicare information through apps has made progress by adding more app developers to the program, but widespread use by beneficiaries has yet to take off.[126] (See TMC 2 for more information on the challenge of using technology to improve health outcomes for patients.)

In other areas, the Department sustained progress. Through the National Institutes of Health (NIH) initiative *All of Us*, HHS is leading an effort to collect 1 million or more volunteers' medical history, lifestyle information, and genetic information to support advances in medical research. These data will be shared with research partners to advance breakthroughs in precision medicine.[127] To realize the full potential of these data, NIH utilized modern approaches to collect and then disseminate data to its research partners.[128] At CMS, OIG found that almost all the Open Payments program data reported by CMS met requirements. These data help to promote transparency by making available to the public the financial relationships that providers (physicians and teaching hospitals) have with certain other entities (applicable drug manufacturers and group purchasing organizations).[129] Additionally, OIG created a data toolkit that stakeholders, like State Medicaid programs, can use to identify their beneficiaries at high risk of opioid misuse and facilitate intervention to prevent harm.[130] These successes 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 and patients have not realized the benefits of 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.[131]

Routine and robust health information exchange between providers remains a challenge. Less than half of physicians using an electronic health record (EHR) to electronically send or receive patient health information.[132] Only 14 percent of physicians electronically send patient health information to behavioral health and long-term-care providers.[133] The factors limiting increased interoperability and exchange 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 2.) 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 2019, the Office of the National Coordinator for Health Information Technology (ONC) proposed rules directly related to improving interoperability and helping cement data standards and data exchange mechanisms.

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For example, ONC is incorporating Fast Health Interoperability Resource (FHIR) standards into its health IT certification program. ONC also proposed standardized use of APIs for certified health IT. In a coordinated effort, CMS proposed rules to improve the interoperability of health information at many entities it regulates through the use standard, open APIs.[134] This was a significant step to improving data exchange. CMS is also piloting novel approaches to provide Medicare claims data to providers through the *Data at the Point of Care* initiative.[135]

Challenges with the flow of electronic health information can also impede patient access to their own data. In 2018, only 51 percent of patients were offered access to their data through online patient portals; of those patients who were offered access, only 30 percent viewed their medical record.[136] These challenges related to improving the flow of electronic health information to providers and patients may also affect other Departmental coordinated care initiatives. (See TMC 2.)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. Outside of the Department's systems, many of the HHS's partners, grantees, and the health care system at large are subject to an increasing amount of cyber threats. Any doubts the public may have about HHS's ability to protect sensitive, personal health data may hinder the full potential of Federal initiatives that seek to leverage technology to create medical treatments of the future.

Challenges with the flow of electronic health information can also impede patient access to their own data. In 2018, only 51% of patients were offered access to their data through online patient portals and only 30% of of them viewed their medical record.

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 the Department's enterprise-wide information security program was not effective but had improved in some areas.[137] Other OIG work that examined eight Departmental OpDivs identified vulnerabilities in configuration management, access control, data input control, and software patching.[138] 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 4 for more information about FDA's role regarding cybersecurity of medical devices.)

HHS also faces other 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

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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.[139] The Department has made progress recognizing the threats, studying the potential impact on its programs, and exploring recommendations to improve its security posture.[140]

Promoting the security and privacy of the health care system

HHS's responsibilities for ensuring cybersecurity also extend to the health care system. The statistics on the impact and persistence of cyberattacks demonstrate the magnitude of the problem facing HHS and the health care industry. HHS reported that in 2016, $6.2 billion was lost in the U.S. health care system due to data breaches and that 4 in 5 U.S.-based physicians have experienced some form of cyberattack.[141] Despite continued calls for action and additional awareness related to improving the health care system's cybersecurity, 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. OIG found cybersecurity weakness at Medicaid managed care organizations and several State agencies.[142] Additionally, OIG made recommendations on how FDA could integrate cybersecurity issues into its premarket review process for medical devices.[143]

The Department made some progress to bolster cybersecurity in the health care industry. HHS launched the Health Sector Cybersecurity Coordination Center to increase the amount and frequency of cybersecurity information sharing between the Federal Government and the Healthcare and Public Health (HPH) sector.[144] HHS also worked with industry partners to publish a cybersecurity principles and practices document to educate health care entities on cybersecurity threats and practical steps they could take to mitigate risks.[145] ONC and OCR developed a security risk assessment tool designed to help providers identify where health information might be a risk within their organization.[146] FDA entered into an agreement with DHS to encourage greater coordination between the agencies to identify, address, and mitigate cybersecurity vulnerabilities in medical devices.[147] The Department also proposed rules to protect donations of cybersecurity technology within the health care industry to promote increased adoption of cybersecurity. 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 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 individual privacy concerns with health information. For example, an individual's electronic health information that is on the patient's personal electronic device and not in the possession of a HIPAA-covered entity or business associate is not subject to the privacy protections of the HIPAA Privacy Rule. At the same time, individual demand to have easy access to their health information where and when they want it is increasing. This demand creates a challenge for HHS to create and promote better access for patients while reconciling the limits of existing privacy protections.

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Patient health information that falls outside of the typical framework covered by the Privacy Rule may be at risk of being misused. The Department's challenge is to keep up with changes in the health care industry and with non-traditional 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.

6: Working Across Government To Provide Better Service to HHS Beneficiaries

CHALLENGE 6

RELEVANT OPDIVS

All HHS

KEY ELEMENTS

- Building and sustaining effective partnerships
- Managing greater integration and efficiency among HHS partners
- Ensuring that HHS and its partners are accountable for ongoing coordination

Big problems require big solutions. HHS faces some of the largest and most complex problems that challenge our Government and the American public. These problems commonly transcend a single HHS program. Often, HHS's mission is only one piece of a larger puzzle, and HHS shares responsibility with multiple entities, including other Federal departments, States, and industry partners. Nearly all HHS programs require strong partnership from multiple entities, within and outside of HHS. This coordination can add complexity to HHS's work but also provides greater gains, marshalling all available resources to improve the Nation's health and well-being.

The potential benefits of effective collaboration are great, both in ensuring program efficiency and providing better service to HHS beneficiaries and the public. HHS and the Administration recognize that complex issues require coordinated solutions and see the Department as a leader in forging these partnerships. The Administration pre-designated HHS as the Quality Service Management Office for grants management across Federal Government in response to its Cross-Agency Priority Goal 5 (Sharing Quality Services).[148] Pending final approval by OMB, HHS will be called upon to provide leadership and best practices to other Federal agencies in the area of grants management. Likewise, HHS responded to the Administration's 2017 directive to reorganize Government[149] to make it more efficient, effective and accountable through its *ReImagine HHS* effort. *ReImagine HHS* outlined several core objectives for the Department, including Optimizing Coordination across HHS. The *ReImagine HHS* initiative also laid out specific shifts in strategy across the Department, several of which highlight the need for greater coordination and information sharing across HHS and with partner agencies and Departments.[150] To achieve these goals and optimize its operations, HHS must prioritize coordination and work to identify opportunities, overcome barriers, and seek accountability and improved outcomes. The need for coordinated responses will only grow in the years to come as health care and other human services become more complex and intertwined with other Federal, State, and private-sector programs. For example, CMS estimates that national health expenditures will grow rapidly during 2020–2027, reaching nearly $6 trillion by 2027.[151] Given that much of this growth is expected to be in the Medicare and Medicaid programs, HHS will continue to lead in managing policy that affects publicly and privately funded health care. Coordination is so integral to success at HHS that it crosses many of the programs discussed in each TMC. Several TMCs highlight the broad and complex nature of HHS's work and the need to consider related issues outside of a single program or mission of a single agency. For example, the quality of care for HHS beneficiaries, described in TMC 3, is affected by not only the availability and quality of health

services but also human services such as child care and health care education. Likewise, delivery of quality care through Medicaid depends on accurate and complete data from States, as referenced in TMC 5.

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Building on HHS coordination efforts

Recent OIG work reveals the importance of effective and collaborative management within HHS and with HHS partners. In some areas, HHS has focused on collaboration and brought substantial gains, such as its extensive work within the Department and with law enforcement to combat opioid misuse and fraud. In other areas, HHS must work urgently to improve its coordination efforts, such as its management of ORR's UAC Program and programs to promote patient safety.

Confronting the opioid crisis

The need for coordinated responses will only grow in the years to come as healthcare and other human services become more complex and intertwined with other Federal, State, and private-sector programs.

Fighting the Nation's opioid epidemic is an example of a collaborative and coordinated activity across many Federal, State, and local agencies. HHS has multiple programs and offices involved in fighting the opioid epidemic: CDC sets opioid equivalent dosage guidelines; CMS gives guidance to providers on prescribing opioids; SAMHSA issues grants for OUD treatment; and OIG investigates and excludes providers who illegally prescribe and distribute opioids. (See TMCs 3 and 4 on HHS's efforts to combat the opioid epidemic.) HHS's external partners in the fight include the Department of Justice's (DOJ's) Criminal Division, the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), as well as State and local law enforcement agencies.

This is a collaborative effort for which HHS and its partners have enjoyed some success. For the first time in 30 years, the number of opioid-related deaths is decreasing.[152] In 2018, there was a significant decrease in the number of Part D beneficiaries who were prescribed opioids.[153] These improvements are due in part to better and more available anti-overdose drugs,[154] as well as aggressive law enforcement action to stop bad actors from providing opioids to people addicted to opioids.

A 2019 OIG study found that 36 percent of Medicare Part D beneficiaries in 5 Appalachian-region States received a prescription opioid in 2017; almost 49,000 beneficiaries received high amounts of opioids; and nearly 6,000 beneficiaries were at serious risk of opioid misuse (received extreme amounts of opioids or appeared to be doctor shopping).[155] OIG has worked with HHS, DOJ, and other law enforcement partners to prosecute people who illegally prescribe, dispense, or divert opioids. In October 2018, DOJ, in partnership with OIG, FBI, and DEA, launched the Appalachian Regional Prescription Opioid (ARPO) Strike Force.[156] As part of this Strike Force effort, OIG worked in cooperation with DEA, U.S. Attorneys, the FBI, and State Medicaid Fraud Control Units to investigate prescribing practices of physicians in the Appalachian Region.[157] These investigations have resulted in numerous indictments and arrests of doctors and nurse

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practitioners who were illegally prescribing opioids. In 2019, enforcement actions targeting the Appalachian Region yielded charges against 60 people, including 53 medical professionals, for allegedly illegally prescribing and distributing more than 32 million opioid pills to over 24,000 people.[158] In addition to taking bad providers off the street, the Strike Force team worked with CDC, DOJ, and State public health officials to ensure that patients received access to needed medical care and did not experience interruption of care due to the law enforcement operation.

The UAC Program

One of the most visible examples of HHS program activities requiring coordination and information sharing among multiple agencies is ORR's UAC Program. (See TMC 3 for more information.) HHS is not the only Department with responsibility for children served by the UAC Program. These children usually are referred to ORR by the DHS, Customs and Border Patrol, and transported to ORR-funded facilities by Immigration and Customs Enforcement. Much attention is focused on the lack of coordination between HHS and these DHS programs regarding the identification, transfer, case management, and placement of unaccompanied children, particularly unaccompanied children who were separated from their parents at the border.[159] Without strong and collaborative planning, coordination, and execution, HHS faces challenges in effectively providing care and identifying sponsors for these unaccompanied children. HHS must continue to improve its information gathering and communication practices to ensure that separated children are reunited with their families in a timely manner. Enhanced communication and cooperation with DHS, DOJ, and other Government partners are critical.

Emergency preparedness and response

Although assistance in responding to natural disasters and other public health emergencies is widely recognized as the responsibility of the Federal Emergency Management Agency (FEMA) within DHS and the Department of Housing and Urban Development (HUD), HHS provides important emergency preparedness and response services. (See TMC 4 for more on HHS's emergency preparedness challenges.) It is the lead Federal department responsible for providing medical support and coordination during public health emergencies, such as disease outbreaks.[160] Three OpDivs share this responsibility: Office of the Assistant Secretary for Preparedness and Response (ASPR), CDC, and CMS. ASPR coordinates HHS's response to public health emergencies with other Federal agencies, such as FEMA.[161] ASPR also coordinates and oversees Healthcare Coalitions, which are groups of providers and public health entities that work together to prepare for, respond to, and recover from emergencies and maintains the Strategic National Stockpile for vaccines, medicines, and supplies.[162] CDC conducts research about emergencies, provides critical guidance to providers, Government, and the public.[163] CMS oversees health care facilities participating in Medicare and Medicaid by requiring a set of minimum health and safety standards, including recently updated standards for emergency preparedness.[164, 165]

OIG studies have repeatedly identified the need for improved coordination in emergency preparedness and response, both within and outside the Department. A 2019 OIG report determined whether HHS's response efforts to the 2014 Ebola outbreak were effective and efficient and found that HHS (1) had no strategic framework in place to coordinate global health security at the international or departmental levels before the Ebola outbreak, (2) was not prepared to deploy the resources needed for such a large-scale

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international response, and (3) did not have in place internal or external communication channels for responding to an international public health emergency.[166] Similarly, a 2018 OIG report assessed hospital preparedness for infectious diseases in the years since the 2014 Ebola outbreak, and found that coordination between ASPR, CDC, and CMS was sometimes lacking.[167] Hospital administrators reported that their staff had difficulty interpreting guidance from multiple government entities and understanding their role in serving the public during a crisis.

Patient safety

As described in TMC 3, OIG has conducted extensive work regarding protecting the safety of patients undergoing medical care, including a 2008–2018 series of reports that found alarming rates of patient harm as the result of medical care.[168] HHS's responsibility for making health care safe and avoiding adverse events lies with CMS in overseeing facility compliance with health care standards and with the Agency for Healthcare Research and Quality (AHRQ) in conducting patient safety research and issuing guidance to providers. In these reports, OIG recommended that AHRQ and CMS work more closely together, and work with providers, to identify patient harm and develop technical assistance for the facilities and clinicians providing care. In response, AHRQ and CMS took action together, and with other HHS operating divisions, to develop new quality and safety measures and revise guidance to providers.

Federal Marketplace

Another example of a lack of coordination within HHS and with multiple stakeholders occurred during the roll-out of the Federal Marketplace under the *Patient Protection and Affordable Care Act of 2010*.[169] In a case study released in 2016, OIG found poor coordination and communication between the HHS Office of the Secretary (OS) and CMS contributed to the failed launch of the Federal Marketplace website HealthCare.gov.[170] The website project was transferred early in its development from a division within OS to CMS, and the transfer occurred without proper planning and coordination or a clear handoff of leadership. As the project progressed, CMS officials failed to adequately convey to OS that they were encountering deep and widespread problems with the policy, technology, and contracts associated with the website build.

As a result, the Department did not intervene and continued to plan for a website release date and functionality that CMS could not effectively meet. The website could not accommodate the volume of traffic it received and was plagued by performance problems in the first months of its operation. The OIG report identified lessons learned from this project and core management principles to apply to all Government programs, technological or otherwise: clear leadership; effective communication; willingness to adjust; and accountability for performance and meeting objectives. Attention to these areas helped CMS recover from the failed launch, develop a functioning system, and salvage the first open enrollment period. Better collaboration allowed CMS to leverage Departmental expertise and other resources, identify and address problems more quickly, make informed decisions, and provide clearer direction to the public. Going forward, CMS will continue to need close coordination with other Federal agencies and with States to ensure that marketplaces operate in accordance with requirements and meet emerging challenges.

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Indian Health Service

OIG found similar themes in a 2019 case study of the IHS closure and reopening of the Rosebud Hospital Emergency Department (ED), an IHS-run facility in South Dakota.[171] IHS has many partners in providing health care to AI/AN communities, including CMS (requiring that hospitals maintain basic standards), the AI/AN tribes, and the surrounding (often rural) communities. (See TMC 3 for more information on quality standards.) CMS found Rosebud Hospital was not in compliance with its ED standards, and CMS planned to terminate the hospital's certification to receive Medicare and Medicaid reimbursements. The hospital was unable to bring its ED operations back into compliance, so IHS closed the ED temporarily. The closure proved highly problematic for other hospitals in the area, in that IHS did not adequately notify them of the closure, and the hospitals were ill-prepared to receive Rosebud Hospital's emergency patients. After failed attempts to resolve the issues, IHS entered into a Systems Improvement Agreement with CMS and sought additional resources and support from the Department, including the Health Resources and Services Administration (HRSA). The Rosebud ED reopened following these collaborative efforts but has continued to struggle in maintaining compliance with CMS standards. The success of rural IHS services will depend on ongoing collaboration within and outside HHS, including Federal departments and agencies responsible for AI/AN programs, such as the Bureau of Indian Affairs in the Department of the Interior. A 2017 report by the Council of the Inspectors General on Integrity and Efficiency outlined management deficiencies that Inspectors General from HHS, Interior, and other Departments found in AI/AN programs, some of which were similar to Rosebud's problems with staffing and infrastructure.[172] (See TMC 3 for more on concerns regarding quality of care at IHS facilities.)

Improving coordination in ongoing and future multi-agency efforts

HHS cannot accomplish its mission to enhance and protect the health and well-being of all Americans without strong partnerships and improved coordination. As HHS continues to find solutions to the Department's many challenges, it should draw on its prior accomplishments and failures in coordinating complex, multi-agency projects and develop a roadmap for success. In developing this roadmap, HHS should focus on three key areas: (1) sustaining effective partnerships, (2) managing and planning for greater integration and efficiency among its partners, and (3) ensuring that all partners are accountable for ongoing coordination and information sharing.

To fully assess these areas, HHS must address some difficult questions: What information does HHS need from its partners? How do all entities develop a common plan and communicate effectively? What barriers to collaboration exist, including competing interests and practical issues such as IT compatibility? Which agency is responsible for which part, and how do agencies hold themselves and each other accountable?

After developing this path, HHS should aspire to leverage effective coordination to address problems and reach for new, ambitious goals, such as raising standards for health and well-being, improving holistic outcomes for beneficiaries served by multiple programs, and developing more effective preventive care and other health management programs. HHS recognizes the need for coordination and higher shared goals. Such goals are achievable and would allow HHS to best serve its mission and the American public.

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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: Joanne Chiedi, Acting Inspector General

From: Eric D. Hargan, Deputy Secretary

Subject: FY 2019 Department's Response to the OIG Top Management and Performance Challenges

On behalf of the Department of Health and Human Services (HHS), thank you for the Office of Inspector General's (OIG) annual report identifying the top management and performance challenges facing the Department. The audits and investigations conducted by OIG during this past year strengthen the Department's efforts to ensure responsible stewardship of scarce taxpayer resources in the execution of HHS's mission.

The HHS mission is dynamic and far-reaching, and the evolving challenges are wide-ranging and complex. Senior leadership continues to appreciate OIG's independent perspective on HHS performance challenges and shares this valuable insight throughout the Department. Leadership at every level evaluates the risks and works diligently to prioritize resources and oversight efforts.

We are committed to addressing these challenges and adjusting to the evolving operating environment.

/Eric D. Hargan/

Eric D. Hargan
Deputy Secretary
November 13, 2019

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APPENDICES

SECTION 4

IN THIS SECTION

// Acronyms

// Connect with HHS

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Appendix A: Acronyms

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/AN	American Indian and Alaska Native
AMP	Accelerating Medicines Partnership
API	Application Programming Interfaces
APG	Agency Priority Goal
APM	Alternative Payment Model
APTC	Advance Premium Tax Credit
AR	Antibiotic Resistance
ARPO	Appalachian Regional Prescription Opioid
ARRT	Advanced Rehabilitation Research and Training
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
BBA	*Bipartisan Budget Act of 2018*
BEA	Bureau of Economic Analysis
BHW	Bureau of Health Workforce
CAP	Cross-Agency Priority
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
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*
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIB	CMCS Informational Bulletin
CIO	Chief Information Officer
CL	Current Law
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 the Chief Technology Officer
Cures Act	*21st Century Cures Act*
CY	Current Year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DEA	Drug Enforcement Administration
DCI	Data Collection Instructions
DHS	Department of Homeland Security
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*
ED	Emergency Department
EHR	Electronic Health Record
ES	The Executive Secretariat
ESRD	End-stage Renal Disease
FAR	Federal Acquisition Regulation
FASAB	Federal Accounting Standards Advisory Board
FBI	Federal Bureau of Investigation
FBIP	Financial Business Intelligence Program
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*
FEMA	Federal Emergency Management Agency
FEP	First Episode of Psychosis
FERS	Federal Employees Retirement System
FETP	Field Epidemiology Training Programs
FFATA	*Federal Funding Accountability and Transparency Act of 2006*
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFRDC	Federally Funded Research and Development Centers
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FHIR	Fast Health Interoperability Resource
FICA	*Federal Insurance Contributions Act*
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
FRDAA	*Fraud Reduction and Data Analytics Act of 2015*
FSIP	Financial Systems Improvement Program
FSMA	*FDA Food Safety Modernization Act*
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*
GRRT	Global Rapid Response Team
GSA	General Services Administration
GTAS	Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HCBS	Home and Community Based Services
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
HPH	Healthcare and Public Health
HRSA	Health Resources and Services Administration
HSB	Healthcare Systems Bureau
HUD	Department of Housing and Urban Development
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
IPAB	Independent Payment Advisory Board
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPERIA	*Improper Payments Elimination and Recovery Improvement Act of 2012*
IPIA	*Improper Payments Information Act of 2002*
IPPS	Inpatient Prospective Payment System
IPT	Integrated Project Team
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology
LIS	Low Income Subsidy
LPR	Lawful Permanent Resident
LTCH	Long-Term Care Hospital
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACRA	*Medicare Access and CHIP Reauthorization Act of 2015*
MAO	Medicare Advantage Organizations
MARx	Medicare Advantage Prescription Drug
MAT	Medication-assisted Treatment
MCH	Maternal and Child Health
MCO	Medicaid Managed Care Organization
MDH	Medicare-Dependent Hospital
MEDIC	Medicare Drug Integrity Contractor
MEQC	Medicaid Eligibility Quality Control
MHBG	Mental Health Block Grant
MII	Medicaid Integrity Institute
MIPS	Merit-based Incentive Payment System
MMA	*Medicare Modernization Act of 2003*
ML	Monetary Loss
MSP	Medicare Secondary Payer
NBI	National Benefit Integrity
NBS	NIH Business System
NCCI	National Correct Coding Initiative

NCHS	National Center for Health Statistics
NEST	National Evaluation System for Health Technology
NGHP	Non-Group Health Plan
NGRI	Next Generation Researchers Initiative
NIDILRR	National Institute for Disability, Independent Living, and Rehabilitation Research
NIH	National Institutes of Health
NML	Non-Monetary Loss
NPI	National Provider Identifier
NPRM	Notice of Proposed Rulemaking
OASDI	Old-Age, Survivors, and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCR	Office for Civil Rights
OGA	Office of Global Affairs
OGC	Office of the General Counsel
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Designation
OpDiv	Operating Division
OPM	Office of Personnel Management
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
OUD	Opioid Use Disorders
PARIS	Public Assistance Reporting Information System
Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage
Part D	Medicare Prescription Drug Benefit
PDE	Prescription Drug Event
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PIP	Performance Improvement Plan
PMA	President's Management Agenda
PP	Paid Properly
PPACA	*Patient Protection and Affordable Care Act*
PPS	Prospective Payment System
PRA	*Paperwork Reduction Act*
PSC	Program Support Center
PTF	Payments to the Trust Funds
PY	Prior Year
QHP	Qualified Health Plan
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
RDS	Retiree Drug Subsidy
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
SNP	Special Needs Plan
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
StaffDiv	Staff Division
T-MSIS	Transformed Medicaid Statistical Information System
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
TMC	Top Management and Performance Challenge
TNC	Treasury Nominal Coupon
TPE	Targeted Probe and Educate
Treasury	U.S. Department of the Treasury
UAC	Unaccompanied Alien Children
UDI	Unique Device Identification
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	United States Code
VFC	Vaccines for Children
VBID	Value-Based Insurance Design
VCC	Vulnerability Collaboration Council

Appendix B: Connect with HHS

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.

The FY 2019 AFR was prepared with the talent, time, and energy of many employees across the Department of Health and Human Services. On behalf of the Department, we would like to offer our sincerest gratitude and acknowledgement to all those individuals that helped produce this report.

Thank you for your interest in HHS's FY 2019 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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