In this Section:

- Other Financial Information
- Improper Payments Information
- Management Report on Final Action
- Summary of Financial Statement Audit
- Summary of Management Assurances
- FY 2014 Top Management and Performance Challenges Identified by the OIG
- Department's Response to OIG Top Management Challenges
- Appendices

Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Office of Inspector General's FY 2014 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as acronyms and appendices to this AFR.

OTHER FINANCIAL INFORMATION

Schedule of Spending

The Schedule of Spending presents an overview of how departments or agencies are spending (i.e. obligating) money. The Schedule of Spending presents total budgetary resources and total obligations incurred for the reporting entity. The data used to populate this schedule is 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 Statement of Budgetary Resources.

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

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

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by Treasury Symbol. Those Treasury Symbols that have a material impact on the Statement of Budgetary Resources are presented separately. Other Treasury Symbols, such as Child Support Enforcement and Family Support, Child Care Entitlement to States, Affordable Insurance Exchange Grants, and Child Care and Development Block Grant, are summarized under Other Spending.

Combining Schedule of Spending

As of September 30, 2014 and 2013

(in Millions)

	FY 2014	FY 2013
Total Resources	$ 1,412,259	$ 1,323,724
Less Amount Available but Not Agreed to be Spent	29,423	32,092
Less Amount Not Available to be Spent	8,458	9,596
	$ 1,374,378	$ 1,282,036
Federal	$ 10,954	$ 30,608
Non-Federal	1,363,424	1,251,428
	$ 1,374,378	$ 1,282,036

Combining Schedule of Spending

As of September 30, 2014 and 2013

(in Millions)

	FY 2014	FY 2013
How was the Money Spent/Issued?		
Medicaid	$ 329,020	$ 286,920
Grants, Subsidies, and Contributions	325,548	283,398
Supplies and Materials	3,357	3,422
Other Contractual Services	96	72
Other	19	28
Medicare Hospital Insurance	278,971	277,109
Insurance Claims and Indemnities	272,336	266,543
Other	6,635	10,566
Payments to Trust Funds	276,792	247,702
Grants, Subsidies, and Contributions	243,361	246,922
Other	33,431	780
Medicare Supplementary Medical Insurance	264,059	252,433
Insurance Claims and Indemnities	258,024	241,977
Other Contractual Services	53	44
Other	5,982	10,412
Medicare Prescription Drug Benefit (Medicare Part D)	71,581	69,747
Insurance Claims and Indemnities	71,581	69,357
Other	-	390
Temporary Assistance for Needy Families	16,759	16,722
Grants, Subsidies, and Contributions	16,702	16,660
Other Contractual Services	57	62
State Children's Health Insurance Program	10,112	9,525
Grants, Subsidies, and Contributions	10,054	9,472
Other Contractual Services	21	20
Other	37	33
Children and Families Services	9,894	9,450
Grants, Subsidies, and Contributions	9,455	8,928
Other Contractual Services	280	344
Other	159	178
Medicare Health Information Technology Incentive	6,809	6,059
Insurance Claims and Indemnities	6,809	6,059
Foster Care and Adoption Assistance	7,428	6,634
Grants, Subsidies, and Contributions	7,393	6,489
Other Contractual Services	35	145
Indian Health Services	5,429	5,182
Grants, Subsidies, and Contributions	2,756	2,494
Personnel Compensation	971	964
Other Contractual Services	813	823
Other	889	901
Low Income Home Energy Assistance	3,401	3,255
Grants, Subsidies, and Contributions	3,375	3,248
Other Contractual Services	26	7
Primary Health Care	3,929	3,298
Grants, Subsidies, and Contributions	3,652	3,053
Other Contractual Services	199	164
Other	78	81
Allergy and Infectious Diseases	4,457	4,250
Grants, Subsidies, and Contributions	2,744	2,381
Other Contractual Services	1,336	1,504
Other	377	365
National Cancer Institue	4,997	4,825
Grants, Subsidies, and Contributions	2,981	2,915
Other Contractual Services	1,424	1,345
Other	592	565
Other Spending	80,740	78,925
Grants, Subsidies, and Contributions	44,447	44,179
Other Contractual Services	23,939	22,332
Insurance Claims and Indemnities	716	869
Other	11,638	11,545
Total Amounts Agreed to be Spent	$ 1,374,378	$ 1,282,036

Consolidating Balance Sheet by Budget Function

As of September 30, 2014

(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)	$ 9,648	$ 135,554	$ 19,189	$ 12,567	$ 176,958	$ -	$ 176,958
Investments, Net (Note 4)	-	5,614	273,286	-	278,900	-	278,900
Accounts Receivable, Net (Note 5)	84	1,538	65,810	-	67,432	(66,513)	919
Other Assets (Note 8)	-	203	25	-	228	(133)	95
Total Intragovernmental Assets	9,732	142,909	358,310	12,567	523,518	(66,646)	456,872
Accounts Receivable, Net (Note 5)	-	3,925	6,232	2	10,159	-	10,159
Inventory and Related Property, Net (Note 6)	-	8,606	-	-	8,606	-	8,606
General Property, Plant and Equipment, Net (Note 7)	-	5,561	307	-	5,868	-	5,868
Other Assets (Note 8)	-	809	1	-	810	-	810
Total Assets	$ 9,732	$ 161,810	$ 364,850	$ 12,569	$ 548,961	$ (66,646)	$ 482,315
Stewardship Property, Plant & Equipment (Note 1)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 25	$ 218	$ 66,621	$ 9	$ 66,873	$ (66,472)	$ 401
Other Liabilities (Note 13)	18	2,260	918	-	3,196	(174)	3,022
Total Intragovernmental Liabilities	43	2,478	67,539	9	70,069	(66,646)	3,423
Accounts Payable	10	439	104	2	555	-	555
Entitlement Benefits Due and Payable (Note 10)	-	33,446	57,591	-	91,037	-	91,037
Accrued Grant Liability (Note 12)	686	2,149	(47)	526	3,314	-	3,314
Federal Employee and Veterans Benefits (Note 11)	5	11,963	11	-	11,979	-	11,979
Contingencies and Commitments (Note 14)	-	10,032	1,300	-	11,332	-	11,332
Other Liabilities (Note 13)	15	1,234	1,242	10	2,501	-	2,501
Total Liabilities	759	61,741	127,740	547	190,787	(66,646)	124,141
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(100)	16,315	-	16,215	-	16,215
Unexpended Appropriations - All Other funds	8,912	86,505	-	12,010	107,427	-	107,427
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	6,756	220,795	-	227,551	-	227,551
Cumulative Results of Operations - All Other funds	61	6,908	-	12	6,981	-	6,981
Total Funds from Dedicated Collections	-	6,656	237,110	-	243,766	-	243,766
Total All Other Funds	8,973	93,413	-	12,022	114,408	-	114,408
Total Net Position	8,973	100,069	237,110	12,022	358,174	-	358,174
Total Liabilities and Net Position	$ 9,732	$ 161,810	$ 364,850	$ 12,569	$ 548,961	$ (66,646)	$ 482,315

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2014

(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	$ 11,650	$ -	$ -	$ 37,627	$ 49,277	$ (78)	$ 32	$ 49,231
ACL	1,480	-	-	-	1,480	(7)	12	1,485
AHRQ	-	30	-	-	30	(13)	369	386
CDC	-	10,034	-	-	10,034	(247)	371	10,158
CMS	-	319,698	518,066	-	837,764	(544)	15	837,235
FDA	-	2,168	-	-	2,168	(275)	16	1,909
HRSA	-	9,057	-	-	9,057	(316)	32	8,773
IHS	-	5,141	-	-	5,141	(161)	201	5,181
NIH	-	29,260	-	-	29,260	(696)	241	28,805
OS	-	3,826	-	-	3,826	(493)	764	4,097
PSC	-	966	-	-	966	(32)	543	1,477
SAMHSA	-	3,173	-	-	3,173	(73)	145	3,245
Net Cost of Operations	$ 13,130	$ 383,353	$ 518,066	$ 37,627	$ 952,176	$ (2,935)	$ 2,741	$ 951,982

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2014

(in Millions)

Responsibility Segments	Intragovernmental: Gross Cost: Combined	Gross Cost: Eliminations	Gross Cost: Consolidated	Less: Exchange Revenue: Combined	Less: Exchange Revenue: Eliminations	Less: Exchange Revenue: Consolidated	With the Public: Gross Cost	With the Public: Less: Exchange Revenue	Consolidated Net Cost of Operations
ACF	$ 229	$ (78)	$ 151	$ (53)	$ 32	$ (21)	$ 49,132	$ (31)	$ 49,231
ACL	16	(7)	9	(12)	12	-	1,476	-	1,485
AHRQ	33	(13)	20	(369)	369	-	366	-	386
CDC	865	(247)	618	(522)	371	(151)	9,718	(27)	10,158
CMS	1,344	(544)	800	(30)	15	(15)	909,711	(73,261)	837,235
FDA	1,221	(275)	946	(29)	16	(13)	2,887	(1,911)	1,909
HRSA	406	(316)	90	(32)	32	-	8,727	(44)	8,773
IHS	1,172	(161)	1,011	(264)	201	(63)	5,328	(1,095)	5,181
NIH	1,938	(696)	1,242	(356)	241	(115)	29,434	(1,756)	28,805
OS	820	(493)	327	(868)	764	(104)	3,882	(8)	4,097
PSC	187	(32)	155	(926)	543	(383)	1,761	(56)	1,477
SAMHSA	125	(73)	52	(175)	145	(30)	3,223	-	3,245
Totals	$ 8,356	$ (2,935)	$ 5,421	$ (3,636)	$ 2,741	$ (895)	$ 1,025,645	$ (78,189)	$ 951,982

Freeze the Footprint

For the Year Ended September 30, 2014

Freeze the Footprint Baseline Comparison (in Square Footage)

	FY 2012 Baseline	FY 2013 Year End	+/- Change
Total Leased	13,603,974	13,438,256	(165,718)
Total Owned	6,112,229	6,486,379	374,150
Total	19,716,203	19,924,635	208,432

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

	FY 2012 Baseline	FY 2013 Year End	+/- Change
Operation and Maintenance Costs	$ 83.3	$ 85.0	$ 1.7

Consistent with Section 3 of the OMB Memorandum - 12-12, *Promoting Efficient Spending to Support Agency Operations* and OMB Management Procedures Memorandum 2013-02, the "Freeze the Footprint" policy implementing guidance, all *CFO Act* departments and agencies shall not increase the total square footage of their domestic office and warehouse inventory compared to the FY 2012 baseline. Compared to the FY 2012 Baseline, the HHS inventory of office and warehouse space increased by 208,432 square feet in FY 2013, an overall increase of 1 percent. This is consistent with our projections in the September 2013 HHS Freeze the Footprint Plan. Because of known projects currently underway, HHS continues to project that it will be the end of FY 2016 when we can meet the FY 2012 Baseline. HHS will accomplish this through aggressively pursuing space and cost savings in office and warehouse space, through implementation of the HHS 170 useable square feet per person utilization rate policy for office space and through targeted consolidation projects for both office and warehouse space.

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

The Department of Health and Human Services' FY 2014 *Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (IPIA) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), OMB Circular A-136, and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
  - *Affordable Care Act* Risk Assessment (Section 2.10)
- Statistical Sampling Process (Section 3.0)
  - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (Section 4.0)
  - Corrective Actions for Grants (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- Progress and Achievements (Section 8.0)
  - Fiscal Year 2014 Progress (Section 8.10)
  - Fiscal Year 2014 Achievements (Section 8.20)
- Improper Payment Reduction Outlook (Section 9.0)
  - Accompanying Improper Payment Reduction Outlook Notes (Section 9.10)
- Program-Specific Reporting Information (Section 10.0)
  - Medicare Fee-For-Service (FFS) (Parts A and B) (Section 10.10)
  - Medicare Advantage (Part C) (Section 10.20)
  - Medicare Prescription Drug Benefit (Part D) (Section 10.30)
  - Medicaid (Section 10.40)
  - Children's Health Insurance Program (CHIP) (Section 10.50)
  - Temporary Assistance for Needy Families (TANF) (Section 10.60)
  - Foster Care (Section 10.70)
  - Child Care Development Fund (CCDF) (Section 10.80)
- Recovery Auditing Reporting (Section 11.0)
- The Do Not Pay Initiative (Section 12.0)
- Superstorm Sandy Reporting Information (Section 13.0)
  - Head Start (Section 13.10)
  - Social Services Block Grant (SSBG) (Section 13.20)
  - Family Violence Prevention and Services (Section 13.30)
  - Assistant Secretary for Preparedness and Response (ASPR) Research (Section 13.40)
  - Centers for Disease Control and Prevention (CDC) Research (Section 13.50)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) (Section 13.60)
  - National Institutes of Health (NIH) Research (Section 13.70)

1.10 Program Descriptions

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

OMB Determined Risk-Susceptible Programs

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

Superstorm Sandy Risk-Susceptible Programs:

9. **Head Start -** A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families
10. **Social Services Block Grant (SSBG)** – A joint federal/state program, administered by the states, which supports programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services
11. **Family Violence Prevention and Services (FVPS)** – A federal funding stream dedicated to the support of emergency shelters and related assistance for victims of domestic violence and their children
12. **Assistant Secretary for Prevention and Response (ASPR) Research** – A federal initiative to build a strong scientific research dataset and to support research that will aid in the response to, and recovery from, Superstorm Sandy
13. **Centers for Disease Control and Prevention (CDC) Research –** A federal effort to improve and enhance the emergency preparedness system to protect life and property from disasters
14. **Substance Abuse and Mental Health Administration (SAMHSA) –** A joint federal/state initiative to provide continued and enhanced mental health and substance abuse treatment to the affected parties in affected states
15. **National Institutes of Health (NIH) Research –** A federal initiative to restore investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy

2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments and those required to be measured under the *Superstorm Sandy Disaster Relief Appropriations Act* (Disaster Relief Act), HHS also reviews other programs to determine if they are susceptible to significant improper payments. In FY 2012, HHS incorporated the improper payment risk assessment requirements under IPERA and OMB Circular A-123, Appendix C, into a new risk assessment tool used for multiple purposes. This integrated approach increased efficiency for our programs without compromising the assessment process. HHS continued using this integrated risk assessment approach in FY 2014 and all of the programs that were reviewed under this integrated approach were determined not to be at-risk for significant improper payments.

2.10 *Affordable Care Act* Risk Assessment

The Department of Health and Human Services and the Department of the Treasury each have responsibilities for ensuring payment accuracy in the Marketplaces and related programs created under the *Affordable Care Act*. In fiscal year 2015, both Departments will begin to perform comprehensive risk assessments to determine areas that might affect payment accuracy. Performing comprehensive risk assessments is critical to establishing an effective program for achieving payment accuracy in future years. The status of these risk assessments will be reported in the fiscal year 2015 AFR. In the interim, both Departments have established internal controls to provide for effective program operations, reliable financial reporting, and compliance with laws and regulations.

3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 10: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy Information*. Unless otherwise stated in *Section 10 or Section 13*, all programs complied with the IPIA guidance requiring that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments. In addition, the seven programs determined by OMB to be susceptible to significant improper payments are currently using a statistical contractor to calculate improper payment estimates.

3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Table 1 in *Section 9.0: Improper Payment Reduction Outlook* presents each at-risk program's gross and net error rates. In addition, Table 8 in *Section 13.0: Superstorm Sandy Information* presents gross and net error rates for each of the Divisions that received Superstorm Sandy funding.

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

4.0 Corrective Action Plans

Each program's Corrective Action Plan (CAP) for reducing the estimated rate of improper payments can be found in *Section 10.0: Program-Specific Reporting Information* or *Section 13.0: Superstorm Sandy Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all

out-year error rate targets. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

4.10 Corrective Actions for Grants

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

- HHS worked with the programs to create subaccounts for newly awarded grants, and to transition HHS's existing grants that receive new funding to subaccounts. Previously, grantees with multiple grants "pooled" the grants into a single account. Almost all programs have ceased pooling grants and moved to subaccounts, and the remaining programs will be transitioned by the end of FY 2015. This internal policy change and the procedural adjustments will increase our financial accountability across the HHS grants community because subaccounts provide greater transparency and enhance efforts to close out grants in a timely fashion.
- HHS developed implementing guidance for OMB's "Uniform Administrative Requirements, Cost Principles, and Audit Requirement for Federal Awards" guidance, which streamlined and superseded requirements from previous OMB circulars. The regulations, both government-wide and HHS-specific, will be effective December 26, 2014. The regulations and reform activities will standardize the Department's grants activities, increasing transparency and accountability on the part of recipients and sub-recipients.
- HHS continued updating our internal grants policies in light of the government-wide grants reform effort. The updated guidance will facilitate greater financial transparency and accountability, outline consistent grants administration practices, and foster program integrity.

5.0 Accountability in Reducing and Recovering Improper Payments

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

6.0 Information Systems and Other Infrastructure

Section 10.0: Program-Specific Reporting Information details each program's information systems and other infrastructure.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Section 10.0: Program-Specific Reporting Information reports each program's statutory or regulatory barriers, if any, to reduce improper payments.

8.0 Progress and Achievements

8.10 FY 2014 Progress

As reported in the FY 2013 AFR, based on Head Start's strong internal controls, monitoring systems, and low reported error rate, OMB approved HHS's request for relief from annual improper payment reporting for Head Start. In lieu of an annual error rate measurement, HHS provided oversight through Head Start's existing internal controls and monitoring systems, and is annually reporting to OMB on its internal controls. In September 2014, HHS submitted its first report to OMB describing Head Start's policies, controls, and corrective actions to preventing and mitigating improper payments in the program, as well as any control deficiencies, risks, and trends. In the report to OMB, Head Start provided data showing that no new control deficiencies, risks or trends were identified in FY 2014, and that Head Start continued to implement and establish control mechanisms to monitor grantee performance.

8.20 FY 2014 Achievements

8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2014, HHS strengthened its efforts to reduce and recover improper payments in Medicare and Medicaid. While a few of these efforts are highlighted below, more detailed information on the FY 2014 Medicare and Medicaid programs' performance and corrective actions can be found in *Section 10: Program-Specific Reporting Information*. In addition, information on the Medicare and State Medicaid Recovery Auditor Contractor (RAC) programs can be found in *Section 11.0: Recovery Auditing Reporting*.

Affordable Care Act Provider Enrollment Moratorium

Section 6401 of the *Affordable Care Act* added new Section 1866(j)(7) to the *Social Security Act*, which provides HHS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, HHS launched the first temporary (six month) enrollment moratorium under the *Affordable Care Act* for Miami-area and Chicago-area home health agencies (HHAs) and ground ambulance suppliers in the Houston-area. On January 30, 2014, HHS extended the original moratoria for these locations and expanded the enrollment moratoria to include HHAs in the Ft. Lauderdale; Detroit; and Dallas areas. HHS also expanded the moratoria for ground ambulance suppliers into the Philadelphia-area. All of these moratoria actions were extended an additional six months with the latest notice effective July 30, 2014. The focus of these efforts is to prevent and deter fraud, waste, and abuse in problematic services and areas across the country while ensuring beneficiary access to care.

Fraud Prevention System

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

During the second implementation year of the FPS, defined in the SBJA as October 1, 2012 through September 30, 2013, HHS took administrative action against 938 providers resulting in an estimated $210.7 million in identified

savings. These savings are almost double the amount identified during the first implementation year and also resulted in more than a 5 to 1 return on investment. The FPS generated leads for 469 new investigations, and augmented information for 348 ongoing investigations. Information on these and other actions initiated through the FPS can be found in the second year FPS Report to Congress, available at: http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf. HHS continues to take action based on the FPS leads and will report updated information in the third year FPS Report to Congress in FY 2015 as required by the SBJA.

National Benefit Integrity (NBI) MEDIC

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) is tasked to perform data analysis to proactively fight fraud, waste, and abuse (FWA) in the Medicare Part C and D programs. The MEDIC identifies improper payments as a result of data analysis and assists HHS with recovering the improper payments. In FY 2013, the MEDIC conducted four projects related to the identification of improper payments. As a result of the MEDIC's analysis, in FY 2014 HHS recovered $63 million from Part D sponsors that corrected Prescription Drug Event (PDE) records.

Medicaid Integrity Program

Under the authority of Section 1936 of the *Social Security Act* as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program has two broad responsibilities:

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

HHS analyzed Medicaid recoveries, which show there has been a strong focus on Medicaid integrity since the enactment of the DRA. For example, the Medicaid Integrity Program has provided the assistance of federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance resulted in $944.4 million in total collections in FY 2014. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014—2018 is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf.

8.22 Public Assistance Reporting Information System

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

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) partnered to advance the PARIS project at no cost to states. The DOD's Defense Manpower Data Center (DMDC) provides computer resources to produce a match file, using Social Security numbers submitted by the states, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by executing Computer Matching Agreements and coordinating the quarterly matches. Since its establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, three states reported that PARIS led to reported savings or cost avoidance of approximately $93.4 million in FY 2014 alone. More information on this effective partnership can be found at: http://www.acf.hhs.gov/paris.

9.0 Improper Payment Reduction Outlook FY 2013 through FY 2017

The following table displays HHS's IPIA results for the current year (CY) FY 2014, the prior year (PY) FY 2013, and targets for FYs 2015 through 2017. The table includes the following information by year and program: fiscal year outlays, the error rate or future target (IP%), and dollars paid or projected to be paid improperly (IP$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments (CY net IP$), when available.

Table 1

Improper Payment Reduction Outlook

FY 2013- FY 2017

(in Millions)

Program or Activity	PY Outlays $	PY IP %	PY IP $	CY Outlays $	CY IP %	CY IP $	CY Over payment $	CY Under payment $	CY Net IP %	CY Net IP $	CY+1 Est. Outlays $	CY+1 IP %	CY+1 IP $	CY+2 Est. Outlays $	CY+2 IP %	CY+2 IP $	CY+3 Est. Outlays $	CY+3 IP %	CY+3 IP $
Medicare FFS	357,397 Note (a)	10.1	36,033	360,173 Note (b)	12.7 Note (1)	45,754	44,214	1,540	11.8	42,673	380,772 Note (c)	12.5	47,597	396,314	11.5	45,576	416,378	8.5	35,392
Medicare Part C	123,696 Note (d)	9.5	11,767	135,513 Note (e)	9.0	12,229	8,098	4,131	2.9	3,967	161,965 Note (f)	8.5	13,767	180,486	8.1	14,619	180,761	8.1	14,642
Medicare Part D	57,056 Note (g)	3.7	2,091	58,493 Note (h)	3.3	1,931	1,549	382	2.0	1,168	77,172 Note (i)	3.5	2,701	95,840	3.4	3,259	94,935	3.3	3,133
Medicaid	246,931 Note (j)	5.8	14,376	261,613 Note (k)	6.7 Note (2)	17,492	16,783	733	6.1	16,072	305,937	6.7	20,498	328,593	6.4	21,030	351,493	6.2	21,793
CHIP	9,065 Note (l)	7.1 Note (3)	646	9,469 Note (m)	6.5 Note (4)	612	603	10	6.3	594	11,486	6.5	747	12,711	6.4	814	12,609	6.2	782
TANF	16,521 Note (n)	N/A	N/A	16,327 Note (o)	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	17,305	N/A	N/A	16,797	N/A	N/A	16,736	N/A	N/A
Foster Care	1,326 Note (p)	5.3	70	1,198 Note (q)	5.5	66.2	62.5	3.7	4.9	58.8	1,049	5.3	55.6	868	5.1	44.3	878	4.9	43.0
Child Care	5,188 Note (r)	5.9	306	5,239 Note (s)	5.7	299	274	25	4.8	250	5,278	5.6	296	5,326	5.4	288	5,311	5.2	276

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

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

9.10 Accompanying Improper Payment Reduction Outlook Notes

a) Medicare FFS PY outlays are from the FY 2013 Medicare FFS Improper Payments Report (based on claims from July 2011 – June 2012).
b) Medicare FFS CY outlays are from the FY 2014 Medicare FFS Improper Payments Report (based on claims from July 2012 – June 2013).
c) Medicare FFS CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays current law (CL)).
d) Medicare Part C PY outlays reflect 2011 Part C payments, as reported in the FY 2013 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY outlays reflect 2012 Part C payments, as reported in the FY 2014 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays (CL)).
g) Medicare Part D PY outlays reflect 2011 Part D payments, as reported in the FY 2013 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2012 Part D payments, as reported in the FY 2014 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (Medicare Benefit Outlays (CL)).
j) Medicaid PY outlays (based on FY 2012 expenditures) are from the FY 2014 Midsession Review and exclude CDC Vaccine for Children program funding.
k) Medicaid CY (based on FY 2013 expenditures) and CY+1, CY+2, CY+3 outlays (Medicaid - Outlays (CL) exclude CDC Vaccine for Children program funding), are from the FY 2015 Midsession Review.
l) CHIP PY outlays (based on FY 2012 expenditures) are from the FY 2014 Midsession Review.
m) CHIP CY (based on FY 2013 expenditures) and CY+1, CY+2, CY+3 outlays (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL)), are from the FY 2015 Midsession Review.
n) TANF PY outlays amount is based - on the FY 2014 Midsession Review.
o) TANF CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
p) Foster Care PY outlays are based on the FY 2014 Midsession Review, and reflect the federal share of maintenance payments.
q) Foster Care CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2015 Midsession Review, and reflect the federal share of maintenance payments.
r) Child Care PY outlays are based on the FY 2014 Midsession Review.
s) Child Care CY, and CY+1, CY +2, CY+3 outlays are based on the FY 2015 Midsession Review.

1. Beginning in FY 2012, in consultation with OMB, HHS 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 (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology in FY 2013 and FY 2014. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.9 percentage points to 12.7 percent or $45.8 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166-167 of HHS's FY 2012 AFR (available at: http://wayback.archive-it.org/3922/20131030171234/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

On August 29, 2014, HHS announced that, to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, HHS is offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68 percent of the net allowable amount). The settlement is intended to ease the administrative burden for all parties. Any claims in the sample that are included in a settlement will still be considered improper for the measurement.

2. HHS calculated and is reporting the national Medicaid error rate based on measurements that were conducted in FYs 2012, 2013 and 2014. The national Medicaid error component rates are: Medicaid FFS: 5.1 percent; Medicaid managed care: 0.2 percent; and Medicaid eligibility: 3.1 percent.
3. Information presented in the CHIP prior year (PY) columns represents measurement results from the 34 states reviewed in 2012 and FY 2013.
4. HHS calculated and is reporting the first baseline measurement for CHIP based on the measurement of 50 states and the District of Columbia over a three-year period (FYs 2012, 2013 and 2014). The national CHIP error component rates are: CHIP FFS: 6.2 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 4.2 percent.
5. The TANF program is not reporting an error rate for FY 2014. Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. Please see *Section 10.60* for additional information on statutory limitations to establishing a TANF improper payment measurement.

10.0 Program-Specific Reporting Information

10.10 Medicare Fee-for-Service or FFS

10.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a stratified random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the error category. Approximately 50,544 claims were sampled during the FY 2014 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on page 165 of HHS's FY 2013 AFR, available at: http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf.

The Medicare FFS gross improper payment estimate for FY 2014 is 12.7 percent or $45.8 billion. The FY 2014 net improper payment estimate is 11.8 percent or $42.7 billion.

The factors contributing to improper payments are complex and vary from year to year.

The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 17.3 percent in FY 2013 to 51.4 percent in FY 2014 due to the implementation of documentation requirements to support the medical necessity of the services.

Another reason for the increase is attributed to medical necessity errors for inpatient hospital claims, particularly short stays determined to not be medically necessary in an inpatient setting (i.e., services should have been billed as outpatient).

10.12 Medicare FFS Corrective Action Plan

The primary cause of improper payments is Administrative and Documentation errors (67 percent), in large part due to insufficient documentation. The other cause of improper payments is classified as Authentication and Medical Necessity errors (33 percent), caused by medically unnecessary services, and to a lesser extent, incorrect coding errors. HHS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources is used to reduce or eliminate improper payments through various corrective actions. Each year, HHS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation. HHS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

Of particular importance are four corrective actions that HHS believes will have a considerable effect in preventing and reducing improper payments:

- First, HHS issued a final rule, Centers for Medicare & Medicaid Services (CMS) CMS-1611-F (79-FR 66031, issued on November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. This final rule also included three changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. Since implementation of the face-to-face requirements in April 2011, HHS observed that the provider community had difficulty complying with the documentation requirements and these errors have increased the improper payment rate. HHS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program.
- Second, HHS implemented two major policies in CMS 1599-F (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims that are expected to reduce improper payments:
    - HHS allowed all hospital participants to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.
    - HHS clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A.
- Third, HHS is expanding the use of prior authorization in the Medicare FFS program for durable medical equipment prosthetics orthotics and supplies (DMEPOS) items in two areas:
    - On September 1, 2012, HHS instituted a prior authorization demonstration program in seven states with the expectation of reducing improper payments for power mobility devices. This

demonstration project led to a decrease in the expenditures for power mobility devices in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of September 17, 2014, monthly expenditures for the power mobility devices included in the demonstration project decreased from $20 million in September 2012 to $5 million in March 2014 in the non-demonstration states; and from $12 million to $2 million in the demonstration states. Prior authorization reviews are being performed timely, industry feedback has been positive, and HHS has received no complaints from beneficiaries. HHS is leveraging this success by extending the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19.

- HHS also proposed to establish a prior authorization process for certain DMEPOS items that are frequently subject to unnecessary utilization. Through a proposed rule, HHS has solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization.

- Fourth, in FY 2015 HHS will further test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care by launching two demonstration projects to test prior authorization for certain non-emergent services. HHS will implement a prior authorization demonstration program for: 1) non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey; and 2) repetitive, scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina. Using a prior authorization process will ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

In addition to these four major efforts and the ongoing corrective actions reported on pages 165- 167 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS has implemented additional efforts in specific areas to reduce improper payments in the Medicare FFS program as outlined below.

Corrective Actions: Administrative and Documentation Errors

- Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify many inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, we are paying the claims correctly as they are submitted nearly 100 percent of the time. For example, HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program $530 million in FY 2013.
- The *Affordable Care Act* required HHS to revalidate all 1.5 million existing Medicare suppliers and providers under new risk-based screening requirements. Since March 25, 2011, more than 930,000 providers and suppliers have been reviewed under the new screening requirements. Since the implementation of these requirements, HHS has revoked 20,219 providers' and suppliers' ability to bill the Medicare program as a result of felony convictions, practice locations that were determined to be non-operational at the address HHS had on file, or non-compliance with HHS rules, such as licensure requirements.
- HHS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including federal and state partners, private payers, associations, and law enforcement exchange data and anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.

- HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims.

Corrective Actions: Authentication and Medical Necessity Errors

- HHS contracted with a Supplemental Medical Review/Specialty Contractor to perform medical reviews focused on vulnerabilities identified by HHS internal data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2014 this contractor performed post payment reviews on five home health claims from every HHA, specifically to identify the presence of an adequate face-to-face encounter. The contractor also reviewed physician claims for the more expensive level 4 and 5 evaluation and management services. The results of these reviews are used by HHS and providers to improve billing accuracy.
- HHS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, HHS announced a number of changes to the Medicare FFS Recovery Auditing Contractor (RAC) program that will take effect with the new contract awards as a result of stakeholder feedback. HHS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.
- HHS issues Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the state and across the nation.
- HHS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. For Medicare, effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries to be a Medicare participating provider. These items and services include the following: home health, clinical laboratory, imaging and DMEPOS. Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

10.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified by the CERT program during the FY 2014 report period were $53,725,898. The identified overpayments are recovered by the Medicare Administrative Contractors (MACs) via standard payment recovery methods. As of the report publication date, MACs reported collecting $44,243,005 or 82 percent of the actual overpayment dollars identified in the report.

10.14 Medicare FFS Information Systems and Other Infrastructure

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

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

HHS has identified a statutory barrier that could limit Medicare FFS' corrective actions: current law limits HHS authority to conduct prior authorization on services that account for a large portion of the overall improper payments. Section 1834(a)(15) of the *Social Security Act* authorizes the Secretary to develop and periodically update a list of DMEPOS determined, on the basis of prior payment experience, to be subject to unnecessary utilization and to develop a prior authorization process for these items. However, current law does not allow for prior authorization of any other claim types or services. As a result, the FY 2015 President's Budget proposed amending Section 1893 of the *Social Security Act* to give the Secretary the discretion to select items or services for prior authorization without rulemaking where the items or services involve high cost, high utilization, patient risk, and/or high improper payment rates.

10.16 Medicare FFS Best Practices

HHS has incorporated the following best practices to ensure the highest degree of efficiency:

- HHS made significant progress in identifying fraud with the opening of the CMS Program Integrity Command Center in 2012. The Command Center is focused on driving innovation and improvement in reducing fraud and improper payments by providing a collaborative environment for multi-disciplinary teams to develop consistent approaches for investigation and action.
- HHS works with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). HHS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. HHS analyzes matched data to identify potential fraud, waste, and abuse patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud and improper payments.
- HHS conducts re-reviews of certain claims that have been medically reviewed by the MACs to ensure accurate decisions are being made and that Medicare policies are being applied consistently across the program.
- CERT collaborates with other review contractor entities, such as the MACs and Medicare FFS RACs, to clarify unclear policies, in an effort to ensure review consistency.
- HHS provides interim improper payment rate data to the MACs to help them focus on problematic areas and identify emerging vulnerabilities.

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

- HHS coordinates provider outreach and education task forces. These task forces consist of MAC medical review professionals who meet regularly to develop provider education strategies and materials addressing areas prone to improper payments. The task forces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public at the MLN website: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo.

- HHS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- HHS revises medical record request letters, as needed, to clarify the components of the medical record required for CERT review. The letter serves as a checklist for the provider or supplier to ensure their record submission is complete. Follow-up medical record request letters have also been developed to explain what missing documentation needs to be submitted.
- When a supplier is contacted for documentation, the CERT program notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, the CERT program contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a hospital that possesses the record for professional services provided by a billing physician while the beneficiary was hospitalized.

10.20 Medicare Advantage or Part C

10.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2014 Medicare Part C gross improper payment estimate is 9.0 percent or $12.2 billion. The FY 2014 net improper payment estimate is 2.9 percent or $4.0 billion. The primary factor that drove the program's decrease from the prior year's reported error estimate was more accurate diagnoses submitted by Medicare Advantage (MA) organizations for payment.

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

The FY 2014 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2012, where the strata are high, medium, and low risk scores,
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries,
- Calculation of beneficiary-level payment error for the sample, and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

10.22 Medicare Advantage Corrective Action Plans

The root cause (100 percent) of FY 2014 Medicare Part C improper payments resulted from Administrative and Documentation errors due to insufficient documentation to support diagnoses submitted by the MA organizations.

HHS has implemented two key corrective actions to address the Part C improper payment rate: contract-level audits and new regulatory provisions.

- *Contract-Level Audits*: HHS is proceeding with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA

organizations for risk adjusted payment. RADV audits are HHS's primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. HHS expects to conduct RADV audits for approximately 30 MA contracts annually. RADV audits of payment year 2011, which began in FY 2014, will be the first HHS reviews to recoup funds based on extrapolated estimates.

- *New Regulatory Provisions*: In CMS-4159-F, "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program" (79 FR 100), HHS codified the *Affordable Care Act* requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-FC, "The Calendar Year 2015 OPPS/ASC Proposed Rule" (79 FR 134), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by an MA organization.

10.23 Medicare Advantage Program Improper Payment Recovery

The Part C error estimate is based on a national sample of beneficiaries across all MA plans. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery had been initiated until FY 2012, when HHS recovered approximately $3.4 million for the first five plans involved in the 2007 RADV audits (the pilot audits). Payment recovery for the pilot audits has been completed and totaled $13.8 million ($5.4 million was recovered in FY 2014, $5.0 million in FY 2013, and $3.4 million in FY 2012). In addition, HHS began the 2011 RADV audits in FY 2014, and expects payment recovery of audited plans to begin in FY 2016.

10.24 Medicare Advantage Information Systems and Other Infrastructure

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

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

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

10.26 Medicare Advantage Program Best Practices

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

10.30 Medicare Prescription Drug Benefit or Part D

10.31 Medicare Prescription Drug Statistical Sampling Process

The Medicare Part D gross improper payment estimate for FY 2014 is 3.3 percent or $1.9 billion. The FY 2014 net improper payment estimate is 2.0 percent or $1.2 billion. The primary factor that drove the program's decrease from the prior year's reported error estimate was a decrease in each component measure. This improvement was driven, in part, by a reduction in the eligibility component of the FY 2012 Payment Error Rate Measurement (PERM) Medicaid eligibility component error rate and a change in the Part D benefit design that has reduced government liability for some claims.

The FY 2014 Part D Composite Payment Error Rate combines four component payment error measures:

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

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

The FY 2014 national Part D improper payment rate for each component is:

- *PELS*: 0.11 percent
- *PEMS*: 0.26 percent
- *PEPV*: 2.76 percent
- *PEDIR*: 0.11 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from previous years. A description of the methodology may be found on pages 173-175 of HHS's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

10.32 Medicare Prescription Drug Corrective Action Plan

The root cause of all FY 2014 Part D improper payments (100 percent) is Administrative and Documentation errors. HHS conducted the following corrective actions to address errors:

- *Training:* HHS will continue its national training sessions for Part D sponsors on Part D payment and data submission.
- *Outreach:* Formal outreach to plan sponsors will continue for invalid/incomplete documentation, including errors due to missing provider signatures on Long Term Care medication orders.
- *New Regulatory Provisions:* HHS codified the *Affordable Care Act* requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor (See *Section 10.22* for more information on the rules).

10.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2014 for each error rate component:

- *PELS Component*: Further investigation must be done to better determine how to conduct payment recovery.
- *PEMS Component*: Application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify beneficiary-level payments that HHS could recover.
- *PEPV Component*: The FY 2014 PDE validation is based on a national sample of PDEs and the imputation of these results onto the Part D population; therefore, payment errors cannot be linked to specific beneficiaries for payment recovery purposes.

- *PEDIR Component*: The data used to develop the FY 2014 error rate was based on 2012 audits. Plans submit updates to their reported DIR amounts throughout the year. HHS will, therefore, address payment recovery through the 2012 Part D reconciliation.

10.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

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

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

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

10.36 Medicare Prescription Drug Benefit Program Best Practices

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

10.40 Medicaid

10.41 Medicaid Statistical Sampling Process

The national FY 2014 Medicaid improper payment rate is based on measurements conducted in FYs 2012, 2013, and 2014. Medicaid improper payments are estimated on a federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components and states perform the eligibility component measurement.

The PERM program uses a 17 state three-year rotation for measuring Medicaid improper payments. For information on how HHS grouped states into each of the three cycles, please see pages 177-179 of HHS's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 260 and 966 claims per state and the managed care sample size was between 231 and 286 payments per state. The sample sizes were based on each state's historical FFS and managed care improper payment rate data. When a state's FFS component or managed care component accounted for less than two percent of the state's total Medicaid expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in seven states.

Eligibility Component

States conducted an eligibility review on a randomly selected sample of between 144 and 972 active cases and between 132 and 792 negative cases. The difference in sample sizes is based on the state's historical eligibility improper payment rate data.

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

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

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

In August 2013, HHS released guidance announcing temporary changes to future PERM eligibility reviews, in light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act* that started in January 2014. These changes will impact Medicaid and CHIP improper payment rates and associated reporting starting with the FY 2015 AFR.

Calculations and Findings

The national Medicaid program improper payment rate represents the combination of each state's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national improper payment rates for each component. National component improper payment rates and the Medicaid program improper payment rate are weighted by state size, so that a state with a $10 billion program "counts" 10 times more toward the national rate than a state with a $1 billion program. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2012 and FY 2013 into the national Medicaid improper payment rate. Two state-level FFS error rates were recalculated subsequent to FY 2013 reporting and are incorporated into FY 2014 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2014 is 6.7 percent or $17.5 billion. The FY 2014 net improper payment estimate is 6.1 percent or $16.1 billion. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 10.42.* Both the eligibility and managed care components of the rate decrease from the prior year estimate.

The FY 2014 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 5.1 percent
- *Medicaid managed care*: 0.2 percent
- *Medicaid eligibility*: 3.1 percent

Within the Medicaid eligibility case error rate, the active case error rate is 2.8 percent and the negative case error rate is 4.8 percent.

10.42 Medicaid Corrective Action Plans

States reviewed for the FY 2014 AFR measurement were the same states reviewed in FY 2011.

The improper payment rate for these states increased from 6.7 percent in FY 2011 to 8.2 percent in FY 2014, causing an increase in the FY 2014 national Medicaid error rate. The FFS component reported the greatest increase, rising from 3.6 percent to 8.8 percent. However, the eligibility component reported a decrease, dropping from 4.0 percent to 2.3 percent, and the managed care component dropped from 0.5 percent to 0.1 percent.

Overall, the largest reason for the FY 2014 improper payments (by dollar amount) was Verification errors (80 percent), which were mostly caused by errors related to state claims processing systems not being fully compliant with new requirements. These new requirements include: all referring or ordering providers must be enrolled in Medicaid, states must screen providers under a risk-based screening process prior to enrollment, and attending providers must include their National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, they require systems changes that many states have not fully implemented. The second largest cause of improper payments was Authentication and Medical Necessity errors (11 percent), which were mostly due to provider billing errors. The remaining improper payments were attributed to Administrative and Documentation errors (10 percent), and were mostly due to insufficient documentation errors.

HHS works closely with all states to develop State-specific Corrective Action Plans (CAPs). All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states whose Medicaid programs were previously measured, and all states measured in FY 2014 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement.

Since the Medicaid FFS improper payment rate was primarily driven by state systems having difficulty complying with new requirements, State CAPs will focus on systems changes to reduce these errors. Methods will include implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program. Because much of the Medicaid FFS improper payment rate in the past was due to missing or insufficient documentation, State CAPs have also focused on provider communication and education to reduce errors related to these categories. These methods included holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions. State CAPs also target eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPs and the ongoing corrective actions reported on pages 173-174 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS has implemented additional efforts to lower improper payments rates:

- HHS completed a "mini-PERM audit" in one state and continued a mini-PERM audit in one state. Mini-PERM audits are voluntary state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease Medicaid improper payments.
- As of September 30, 2014, 47 states and the District of Columbia have implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs. The remaining three states have HHS-approved exceptions.
- HHS made available via a website (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html) a variety of educational tool kits which include videos, fact sheets, and checklists that were made specifically for providers and beneficiaries. These educational resources are intended to educate providers, beneficiaries, and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse.
- HHS worked with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicare and HHS data for program integrity purposes.

10.43 Medicaid Program Improper Payment Recovery

Through the PERM program, HHS identified $1,570,419; $152,968; and $631,595 in Medicaid overpayments eligible for recovery for FYs 2012, 2013 and 2014, respectively. The decrease in Medicaid overpayments eligible for recovery in FY 2013 compared to FY 2012 was due to a decrease in the dollar value of overpayments that were identified in the sample. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2012 and 2013 was amended from information previously reported in HHS's FY 2013 AFR to reflect changes made during state-level error rate recalculations.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at 42 CFR Part 433, Subpart F under which states must return the federal share of overpayments. States reimburse HHS for the federal share of overpayments on the Medicaid CMS-64 expenditure report. Section 6506 of the *Affordable Care Act* amended Section 1903(d)(2) to allow states up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.

10.44 Medicaid Information Systems and Other Infrastructure

Since Medicaid payments occur at the state level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the state level. In addition to errors caused by state systems non-compliance with new requirements, PERM faced many challenges with state payment systems that had paper only and aggregate claims, changes in information systems at the state level during the course of the measurement cycle, and a wide variation of system designs and capabilities. HHS has encouraged and supported states in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in the PERM measurement and strengthen program integrity. In addition, HHS has approved enhanced federal funding for five states to implement predictive analytics technologies that are integrated with State MMIS. 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 also developed a methodology to measure aggregate claims and this has been incorporated into the PERM processes.

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

HHS is also developing the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of State MSIS submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce state data requests. States will move from MSIS to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format in 2015.

10.45 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions

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

10.46 Medicaid Program Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states. In addition to the ongoing measures reported on page 175 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf) HHS incorporated the following efforts into the Medicaid measurement process:

- HHS continues to offer training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2014, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through over 5,100 enrollments in 114 courses and 8 workgroups at no cost to the states.
- HHS developed a PERM Standard Operating Procedure to provide consistent direction and instruction to state Medicaid and CHIP agencies regarding responsibilities during a PERM cycle. During periods of high staff turnover within the states, this document will prevent delays or issues in complying with the PERM program by providing detailed instructions to new staff.
- HHS issues quarterly PERM Newsletters to keep all states up-to-date on important information regarding the PERM program.
- HHS hosts http://www.medicaid.gov/ as a one-stop-shop for federal policy, guidance, data, and program information about Medicaid and CHIP.
- HHS continues the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and reduce improper coding which may result in improper payments of Medicaid claims.

10.50 Children's Health Insurance Program or CHIP

10.51 CHIP Statistical Sampling Process

The national FY 2014 CHIP improper payment rate is based on measurements conducted in FYs 2012, 2013, and 2014. This is the first year that HHS is reporting a CHIP baseline improper payment rate. CHIP improper payments are estimated on a federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components and states perform the eligibility component measurement.

CHIP utilizes the same state sampling process as Medicaid. HHS determined that CHIP can be measured in the same states selected for Medicaid review each fiscal year with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid will be measured in the same states each year, each state will be measured for CHIP once every three years. For information on how HHS grouped states into each of the three cycles, please see pages 175-177 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf).

FFS and Managed Care Component

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

Under Section 601 of the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA), beginning in FY 2012 states could elect to accept or reject their previously reported CHIP improper payment rate. If a state elected to accept their previous CHIP improper payment rate, the state would utilize a state-specific sample size based on that rate. Since no states reviewed in FY 2012 accepted their previous CHIP improper payment rates and no historical improper payment rate data was available for states reviewed in FY 2013 or FY 2014, no state-specific sample sizes were utilized.

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

Eligibility Component

States conducted an eligibility review on a randomly selected sample of 504 active cases and 204 negative cases. Since no historical eligibility improper payment rate data was available for the majority of states, state-specific sample sizes were not utilized during this three-year measurement cycle except for one state measured in FY 2012. The state had a state-specific sample size of 360 active cases and 156 negative cases based on their FY 2009 eligibility improper payment rate data.

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

Calculations and Findings

The national CHIP improper payment rate represents the combination of each state's FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national component improper payment rates. National component improper payment rates and the CHIP improper payment rate are weighted by state size, so that a state with a $1 billion program "counts" 5 times more toward the national rate than a state with a $200 million program. A small correction factor ensures that CHIP eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2012 and FY 2013 into the national CHIP improper payment rate. Two state-level FFS error rates were recalculated subsequent to FY 2013 reporting and are incorporated into FY 2014 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2014 is 6.5 percent or $612 million. The FY 2014 net improper payment estimate is 6.3 percent or $594 million. This is the first baseline improper payment rate for

CHIP reflecting the measurement of all states. Comparing the baseline rate to the prior year's reported error estimate does not necessarily reflect a reduction in improper payments because this year HHS has incorporated the final cycle of states measurements into the estimate.

The FY 2014 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 6.2 percent
- *CHIP managed care* – 0.2 percent
- *CHIP eligibility* – 4.2 percent

Within the CHIP eligibility error rate, the active case error rate is 4.8 percent and the negative case error rate is 2.8 percent.

10.52 CHIP Corrective Action Plans

HHS's experience is that improper payment rates are typically higher in the early years of improper payment measurement programs because the process is new. HHS expects CHIP improper payments to decrease as states refine their outreach and documentation efforts. Overall, the majority of the FY 2014 improper payments (by dollar amount) were a result of Verification errors (70 percent), which were mostly caused by errors related to state claims processing systems. The second largest cause of improper payments was Administrative and Documentation errors (15 percent), which were mostly due to insufficient and no documentation errors. The third leading cause of errors was Authentication and Medical Necessity errors (15 percent), which were mostly due to policy violations and providers billing the wrong number of units.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states whose CHIP programs were previously measured, and all states measured in FY 2014 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement.

Since the CHIP FFS improper payment rate was primarily driven by state's systems having difficulty complying with new requirements, state CAPs will focus on systems changes to reduce these errors. Methods include: implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program. Because missing or insufficient documentation is also a contributor to the CHIP improper payment rate, the state CAPs also focused on strengthening provider communication and education to reduce errors related to these categories. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits to identify areas of vulnerability and target solutions. For eligibility errors, state corrective actions included clarifying written state policies; launching a more advanced and improved electronic client eligibility system; providing refresher training for eligibility staff; and producing informational broadcasts regarding changes to eligibility policy and procedures.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS completed a "mini-PERM audit" with two states and continued a mini-PERM audit with one state. Mini-PERM audits are voluntary, state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease CHIP improper payments.

10.53 CHIP Program Improper Payment Recovery

HHS identified $384,994; $161,764; and $691,352 in CHIP overpayments eligible for recovery for FYs 2012, 2013, and 2014 respectively. In addition, the amount of CHIP overpayments eligible for recovery for FYs 2012 and 2013 was amended from information previously reported in HHS's FY 2013 AFR to reflect changes made during state-level error rate recalculations.

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

10.54 CHIP Information Systems and Other Infrastructure

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

10.55 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

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

10.56 CHIP Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states. In addition to the ongoing measures reported on pages 178 of HHS's FY 2013 AFR (http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf), HHS incorporated the following efforts into the CHIP measurement process:

- HHS developed a PERM Standard Operating Procedure to provide consistent direction and instruction to State Medicaid and CHIP agencies regarding responsibilities during a PERM cycle. During periods of high staff turnover within the states, this document will prevent delays or issues in complying with the PERM program by providing detailed instructions to new staff.
- HHS issues quarterly PERM Newsletters to keep all states up-to-date on important information regarding the PERM program.
- HHS hosts http://www.medicaid.gov/ as a one-stop-shop for federal policy, guidance, data, and program information about Medicaid and CHIP.

10.60 Temporary Assistance for Needy Families of TANF

10.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2014.

10.62 TANF Corrective Action Plans

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

- HHS is working with states to analyze Single Audit material non-compliance findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the federal level and is working to mitigate these programmatic risks.
- HHS is monitoring a TANF Program Integrity Innovation Grant funded from OMB's Partnership Fund for Program Integrity Innovation. The state human service agency grantee is conducting a pilot project designed to reduce improper payments and improve administrative efficiency in the state's TANF program. Lessons learned from the pilot will be used to improve internal efficiency and provide guidance to other state human service agencies looking to improve TANF program integrity.
- HHS is implementing revisions to the TANF financial reporting form, which will require states to provide more accurate information about the ways states are using their TANF block grants and meeting their Maintenance-of-Effort obligations. The changes will take effect in FY 2015 and include a revised and expanded list of spending categories as well as a change to the accounting method to more accurately track actual expenditures that occur in a fiscal year.
- In February 2014, HHS published a Notice of Proposed Rulemaking regarding State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations. The proposed regulations would require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any electronic benefit transfer transaction in specified locations. The locations, specified in the *Middle Class Tax Relief and Job Creation Act of 2012*, are: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. HHS anticipates that the final regulation will be published in FY 2015.

10.63 TANF Improper Payments Recovery

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, HHS is not reporting an error rate or any results from improper payment recoveries for FY 2014.

10.64 TANF Information Systems and Other Infrastructure

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

10.65 TANF Statutory or Regulatory Barriers

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

10.66 TANF program Best Practices

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

- Conduct local office quality control reviews for eligibility and payment processes at both the initial intake and redetermination stages of the case, and perform periodic "checks" of case records, paying particular attention to documentation such as a current application and facts supporting income, household composition, participation in work activities, and cooperation with child support enforcement.
- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with child support, IEVS "hits", eligibility redeterminations, or failure to fulfill work requirements.
- Remind TANF recipients periodically of their responsibility to accurately report income, resources, and other changes in family circumstances to the local TANF agency on a timely basis; to use NDNH information to verify the eligibility of adult TANF recipients residing in the state; and to modify benefits or close the case if the individual is not eligible for assistance.
- Conduct training on investigative interviewing techniques for intake workers and case managers.
- Establish and monitor internal procedures to ensure that TANF payments are adjusted on a timely basis when family circumstances change and affect case eligibility or the amount of payment, and establish a process for the collection of TANF overpayments from the applicable recipients.

10.70 Foster Care

10.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for *Title IV-E* Foster Care in FY 2014. The Foster Care improper payment estimate is calculated each year using data collected in the most recent Foster Care Eligibility Review for each state. Under the regulatory review promulgated at *45 CFR 1356.71*, Foster Care Eligibility Reviews are conducted systematically in each state every three years. Each regulatory review identifies the number of error cases and amount of payment errors, as determined from the review of a sample drawn from the state's overall *Title IV-E* Foster Care caseload for its six-month Period Under Review (PUR). The sample is a random sample drawn from the universe of cases having at least one *Title IV-E* Foster Care maintenance payment during the PUR. Since each state is reviewed every three years, each year's data incorporates new review data for about one-third of the states. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, please see pages 189-190 of HHS's FY 2012 AFR (http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

The Foster Care gross improper payment estimate for FY 2014 is 5.5 percent or $66.2 million. The FY 2014 net improper payment rate is 4.9 percent or $58.8 million. The primary factor that drove the program's increase from the prior year's calculated error rate estimate was the performance of three large states that were reviewed in this cycle. Two of these large states reported two to three percent increases in their error rate estimates, and the third state maintained an error rate above 10 percent.

10.72 Foster Care Corrective Action Plans

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

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

HHS continues to monitor review results and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2014, the most common payment errors included:

- Underpayments (27 percent of errors),
- Provider not licensed or approved (10 percent of errors),
- Ineligible payments (e.g., therapy or unallowable transportation costs) (9 percent of errors),
- No safety documentation for institutional caregiver staff (9 percent of errors),
- Provider criminal records check not completed (8 percent of errors), and
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (8 percent of errors).

Together these six items account for 70 percent of Foster Care payment errors. Although underpayments represent just over one-quarter of all errors in terms of frequency, the dollar amount of the underpayments continued to decrease in 2014 as the underpayment rate improved from 0.5 percent in FY 2013 to 0.3 percent in FY 2014.

In FY 2014, HHS undertook the following key action to reduce improper payments:

- Based on discussions with individual states on review preparation and compliance results, HHS is working with states to emphasize and develop strategies for continuous program improvement with an emphasis on: viewing the quality assurance process as an ongoing, systematic process that is not limited to review preparations or results; and developing sound program improvements that support systemic change and sustain the improvement effort.

In addition, HHS continued the following ongoing corrective actions:

- HHS conducts onsite and post-site review activities to validate the accuracy of state claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the state agency to positively affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the state agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for states that exceed the error threshold.
- HHS requires non-compliant states (those that exceed the error threshold) to develop and execute state-specific PIPs that link corrective actions to the root cause of payment errors. The PIP identifies the specific action steps necessary to target and correct error root causes, and each action strategy is required to have a projected completion within one year from the date HHS approved the plan. PIPs are a proven and effective strategy, as reflected in the decrease of the national *Title IV-E* error rate since FY 2004.

- HHS provides training and technical assistance to states to develop and implement program improvement strategies, even when states are not required to develop a PIP. The intent of this assistance is to help states expand organizational capacity and promote more effective program operations.
- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings, including an extrapolated disallowance if the state is found not in substantial compliance. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to states to improve compliance.

10.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 15 states during the 12-month period between July 2013 and June 2014, HHS recovered over $1.4 million in Title IV-E improper payments. The recovered funds are comprised of $994,710 in disallowed maintenance payments and $449,595 in disallowed administrative payments.

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

10.74 Foster Care Information Systems and Other Infrastructure

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

10.75 Foster Care Statutory or Regulatory Barriers

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

10.76 Foster Care Best Practices

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

Concurrent with these efforts to continually refine its identification and reporting of improper payments, HHS works with state child welfare agencies to improve administrative procedures for tracking and documenting eligibility. HHS also works with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders. These efforts have yielded reductions in eligibility errors and improper payments, as well as the recovery of $19.4 million in improper payments for the FY 2004 through FY 2014 reporting periods.

In addition to the ongoing efforts to address improper payments as outlined above, the Foster Care program continues to lay the groundwork for a new methodology to review administrative payments (i.e., Administrative Cost Review or ACR). HHS has compiled the results of nine pilot tests of the ACR methodology conducted between FY 2007 and FY 2012, and is continuing to assess the feasibility of using the ACR process in the future.

10.80 Child Care or CCDF

10.81 Child Care Statistical Sampling Process

The methodology for measuring improper payments uses a case-record review process to determine if child care subsidies were properly paid for services provided to eligible families. The methodology focuses on improper payments made, and enables states to determine the types of errors and their sources. For the CCDF improper payments methodology, please see http://www.acf.hhs.gov/programs/occ/resource/program-integrity-and-accountability-improper-payments-error-rate-review.

Data reported in the previous two review cycles, based on the original implementation of the CCDF error rate methodology, measured improper authorizations for payment. After an evaluation of the review process, HHS determined that "improper authorizations for payment" was not a sufficient proxy for "improper payment." In pilot tests, substantial variances between authorizations and payments emerged, with authorizations estimated to be as much as 20 percent higher. Thus, HHS revised the methodology, enabling states to assess accuracy in payments made as a result of child care eligibility determinations, rather than authorizations for services that may or may not have actually been paid.

This review cycle, using the revised methodology, incorporates the following changes to the error rate methodology: (a) drawing samples from a universe of paid cases instead of cases with an authorization for payment, (b) measuring improper payments instead of improper authorizations for payment, and (c) requiring states with error rates exceeding ten percent to submit a CAP. The error rate methodology and reporting requirements continue to focus on administrative errors associated with client eligibility, consistent with the focus of the initial methodology.

The CCDF gross improper payment estimate for FY 2014 is 5.7 percent or $299 million. The FY 2014 net improper payment estimate is 4.8 percent or $250 million. The primary factor that drove the program's decrease from the prior year's reported error estimate was tates implementing steps to improve programs and reduce errors, including revising policies, expanding staff training, and enhancing information systems.

10.82 Child Care Corrective Action Plans

Verification errors represent approximately 70 percent of errors found in the reviews. Verification errors occur when there is a lack of information to verify portions of the case record. These errors consist of the failure to apply policy correctly, including:

- Income calculation (12 states),
- Unit of care authorized (7 states),
- Provider payment (6 states), and
- Application or redetermination forms (3 states).

Administrative and Documentation errors account for an estimated 30 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited errors due to missing or insufficient documentation include:

- Paystubs or income verification (10 states),
- Need for care (such as work or school schedules) (7 states), and
- Application or redetermination forms (3 states).

HHS and states have established corrective actions targeting both error types. States reporting in FY 2014 plan the following actions:

- Training and technical assistance: Providing technical assistance for eligibility staff on error-prone issues; clarifications of policy; or Information Technology (IT) systems training (14 states).
- Ongoing quality assurance reviews: Performing ongoing audits and reviews, and implementing CAPs for eligibility agencies with high error rates (6 states).
- Policy revisions: Reviewing and possibly revising program policy and procedures, either based on the current error review or after conferring with eligibility agencies (6 states).
- Information Technology (IT) systems: Enhancing IT systems to reduce errors; for example, implementing additional rules or warnings when questionable data is entered (5 states).

HHS's corrective actions have been consistent over time and assist states in reducing their error rates. This ongoing work includes the following activities:

- Providing technical assistance to states around policy and procedure changes that will streamline processes and reduce errors.
- Delivering technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors.
- Providing individual reporting cohort training on the methodology that allows states to learn best practices from each other as they conduct the reviews.
- Starting training early to allow states time to learn the methodology and implement in real time.

10.83 Child Care Program Improper Payment Recovery

Under the revised methodology effective in FY 2014, grantees provide information on both the estimate they expect to recover from the current review and any funds recovered from prior reviews. CCDF regulations only require states to recover misspent funds due to fraud. States have discretion whether to recover misspent funds for other reasons. All misspent funds are subject to disallowance.

The cumulative FY 2014 CCDF improper overpayment amount is $399,947. The overall improper payment estimate is comprised of three review cycles: FYs 2012, 2013, and 2014. The improper payments are as follows for each cycle:

- Year One States (reported in FY 2014) - $50,736,
- Year Two States (reported in FY 2012) - $146,914, and
- Year Three States (reported in FY 2013) - $202,297.

The estimates for the Year Two and Year Three States are based on the previous methodology, which measured improper authorizations for payment. The figures will reflect actual improper payments once the Year Two and Year Three States complete a review under the revised methodology in FYs 2015 and 2016, respectively.

The FY 2014 review cycle represents the third time that Year One States have conducted the error rate measurement. In FY 2011, the last time this cycle of states was measured, they reported an improper

overauthorization amount of $155,883, and they anticipated recovering 7.4 percent, or $11,576, of this total. States reported actual recoveries of 5.8 percent, or $9,043, of the $155,883 overauthorization amount.

Under the revised methodology implemented in FY 2014, the Year One States reported improper payments of $50,736 in FY 2014, and they anticipate recovering 23 percent, or $11,807, of these improper payments. Reports submitted in FY 2017 will address any amounts recovered based on the FY 2014 reviews.

10.84 Child Care Program Information Systems and Other Infrastructure

Since CCDF payments occur at the state level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the state level. In addition to the efforts outlined in prior HHS AFRs, states reported a range of other improvements to information systems including:

- Automating copay determinations,
- Building additional functions for payment management and tracking,
- Strengthening capabilities to assist in the recovery of improper payments, and
- Enhancing system supports for staff who audit providers.

10.85 Child Care Program Statutory or Regulatory Barriers

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

10.86 Child Care Program Best Practices

In addition to those best practices cited in prior reports, Year One States also reported:

- Updating review tools: Some states developed an electronic customized Record Review Worksheet, which helped reviewers be more consistent and thorough in their reviews (5 states).
- Clarifying policy and rules: Rules and policy that were found to be challenging during the previous cycle were clarified or updated, assisting both eligibility and review staff (4 states).
- Ongoing communication of review findings: Through regular meetings, eligibility and review staff discussed case findings and addressed concerns that could result in errors (4 states).
- Conducting secondary reviews: Secondary and tertiary-level reviews contributed to accuracy and promoted accountability for review staff (3 states).
- Upgrading IT systems: Electronic record storage and case document imaging upgrades allowed for faster reviews (2 states).

HHS best practices included:

- Revised the error rate methodology to increase precision in the error rate measurement.
- Continued implementing the Grantee Internal Controls Self-Assessment as an important mechanism to help states identify areas of strength and risk, as well as strategies to improve their programs and reduce errors.
- Continued to provide opportunities for peer-to-peer sharing to enhance learning and shared understanding about best practices in program implementation across the country.

11.0 Recovery Auditing Reporting

HHS developed a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS is focusing on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS's outlays in FY 2014. We are making substantial progress in recovering improper payments in Medicare and Medicaid, and, most importantly implementing corrective actions to prevent improper payments, as described below.

Medicare FFS RACs

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 states no later than January 1, 2010. In FY 2014, the Medicare FFS RAC program demanded approximately $1.9 billion and recovered $2.4 billion in overpayments by the end of the fiscal year. The amount of improper payments identified was lower than the amount of improper payments recovered primarily due to the cessation in RAC activities under the old Medicare FFS RAC contracts and a delay in awarding new Medicare FFS RAC contracts. This resulted in fewer reviews and less identified improper payments than in previous years. Meanwhile, amounts that were identified in previous years continued to be collected. During FY 2014, the majority of Medicare FFS RACs collections were from inpatient hospital claims and outpatient therapy services. HHS continues to monitor and make continuous improvements to the Medicare FFS RAC program activities.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2014, HHS released four Provider Compliance Newsletters that provided detailed information on 19 findings identified by the Medicare FFS RACs. Based on these findings, HHS also implemented local and/or national system edits to automatically prevent improper payments.

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

Medicare Secondary Payer RACs

The Medicare Secondary Payer (MSP) RAC began full recovery operations at the end of FY 2013 and operates as the MSP Commercial Repayment Center ("CRC"). The CRC reviews HHS information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP). When that 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). The debtors for these MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established "defense" process. In FY 2014, the CRC demanded approximately $234.2 million and collected $59.3 million in mistaken payments.

In FY 2015, the CRC will introduce a new, secure web-based tool designed to provide employers, insurers, and third-party administrators a way to electronically manage their GHP recovery activities. This tool is designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program. More information on the CRC can be found at: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html.

Medicare Part C and Part D RACs

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote (RFQ) in June 2014; however, no responses were received as a result of that solicitation. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2015.

The Part D RAC program became fully operational in FY 2012, and is currently reviewing prescription drug claims for calendar years 2008 through 2012. Since its launch, the Part D RAC identified overpayments made as a result of prescriptions written by excluded or unauthorized providers or filled at excluded pharmacies. At the end of FY 2013, HHS sent notification letters for overpayments totaling approximately $3.4 million to plans. As a result, approximately $2.7 million was recovered in FY 2014, with the remaining amount overturned on appeal. Additionally, $5.3 million in overpayments were identified in FY 2014, and recoupment is expected in FY 2015.

In FY 2015, the Part D RAC will review unauthorized prescribers, Drug Enforcement Agency (DEA) schedule drug refill errors, and duplicate payments. In the future, the Part D RAC may expand its reviews.

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

State Medicaid RACs

Section 6411(a) of the *Affordable Care Act* required states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012, so federal FY 2012 reporting encompassed nine months of results. FY 2014 was the second full federal fiscal year of reporting State Medicaid RAC recoveries. As states continue to implement their State Medicaid RAC programs, State Medicaid RAC federal-share recoveries totaled $55.1 million in FY 2014. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

HHS regulations align the State Medicaid RAC requirements to existing Medicare FFS RAC program requirements, where feasible, and provide each state the flexibility to tailor its RAC program where appropriate. As of September 30, 2014, 47 states and the District of Columbia have implemented Medicaid RAC programs. The remaining three states have time-limited HHS-approved exemptions.

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

Recovery Auditing Reporting Tables

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

Table 2
Payment Recapture Audit Reporting
FY 2014
(in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY) Note 2	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$1,894.1 Note 3	$2,394.8	126%	$0 Note 3	0% Note 3	N/A	N/A	$7,966.0 Note 4	$6,815.1 Note 4	$9,860.0	$9,210.0	$1,150.9	N/A
Medicare Secondary Payer Recovery Auditor	N/A	N/A	$234.2 Note 5	$59.3 Note 6	25%	$174.9	75%	N/A	N/A	N/A	N/A	$234.2 Note 7	$59.3 Note 7	$174.9	N/A
Medicare Part C Recovery Auditors	N/A Note 8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Part D Recovery Auditors	N/A	N/A	$5.3	$2.7	51%	$2.6	49%	N/A	N/A	$5.2	$1.8	$10.4	$4.5	$6.0	N/A
State Medicaid Recovery Auditors	N/A	N/A	N/A Note 9	$55.1	N/A	N/A	N/A	N/A	N/A	N/A	$132.1	N/A	$187.1	N/A	N/A
HHS Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.6	$0.074	$1.6	$0.074	N/A	N/A

Notes:

1. For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other cells. For example, the Amount Recovered (CY) and Amount Recovered (PYs) cells may not add to the Cumulative Amount Recovered (CY + PYs) cell.
2. The amount reported in the Amount Recovered (CY) column is the amount recovered in FY 2014, regardless of the year the overpayment was identified.
3. The transition process for new Medicare FFS recovery auditors began in FY 2014. As a result, fewer reviews were conducted which led to a smaller amount identified for recovery (CY). The smaller amount identified for recovery creates a negative number for the Amount Outstanding (CY) and % of Amount Outstanding out of the Amount Identified (CY) cells, thus HHS entered zeroes in these cells.
4. The Medicare FFS recovery auditors Prior Year (PYs) columns reflect recovery audit information reported in the FYs 2010 - 2013 AFRs.
5. The Medicare Secondary Payer recovery auditor Amount Identified for Recovery (CY) column is the amount of mistaken payments identified from when the program became fully operational in FY 2014.
6. The Medicare Secondary Payer recovery auditor maintains all debts established under prior MSP recovery programs; consequently, the reported collections is the amount recovered in FY 2014, regardless of the year the mistaken payment was identified.

7. Cumulative amounts reflect FY 2014 totals, as the MSP recovery auditor only commenced full recovery operations in the second quarter of FY 2014
8. HHS expects to award a contract for a Medicare Part C RAC program in FY 2015. Accordingly, HHS is not reporting Medicare Part C RAC results in the FY 2014 AFR.
9. For State Medicaid recovery auditor programs, states are only required to report the amount of recoveries on the CMS-64, and not amount of improper payments identified, amount of improper payments outstanding, or how the states use the recovered funds. The State Medicaid recovery auditors Amount Recovered (CY) and Amounts Recovered (PYs) columns represent the federal-share of the state recoveries as of the publication date of the Agency Financial Report.

Table 3
Payment Recapture Audit Targets
FY 2014[1]
(in Millions)

Type of Payment	CY Amount Identified	CY Amount Recovered	CY Recovery Rate (Amount Recovered / Amount Identified)	CY + 1 Recovery Rate Target	CY + 2 Recovery Rate Target	CY + 3 Recovery Rate Target
Medicare FFS Recovery Auditors	$1,894.1 Note 2	$2,394.8 Note 2	126%	85%	85%	85%
Medicare Secondary Payer Recovery Auditor	$234.2	$59.3	25%	85%	85%	85%
Medicare Part D Recovery Auditors	$5.3	$2.7	51%	85%	85%	85%

Notes:
1. The State Medicaid recovery auditors are not included in this table since states do not report information to HHS on recovery rate targets.
2. For the Medicare FFS recovery auditors, the amount of improper payments identified was lower than the amount of improper payments recovered primarily due to the cessation in recovery auditor activities under the old Medicare FFS recovery auditor contracts and a delay in awarding new contracts. This resulted in fewer reviews and less identified improper payments than in previous years. Meanwhile, amounts that were identified in previous years continued to be collected.

Table 4
Aging of Outstanding Overpayments
FY 2014[1]
(in Millions)

Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)
Medicare FFS Recovery Auditors	$90.9 Note 2 & Note 3	$223.3	0
Medicare Secondary Payer Recovery Auditor Note 4	$146.9 Note 2	$41.1	0
Medicare Part D Recovery Auditors	N/A Note 5	N/A	N/A

Notes:
1. The State Medicaid recovery auditors are not included in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts that are currently outstanding.

2. The amount of outstanding Medicare FFS and Medicare Secondary Payer recovery auditors overpayments identified in this table does not match the amount outstanding identified in Table 2 because this table includes information from FY 2014 only whereas Table 2 includes information on recoveries from multiple years.
3. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
4. The Medicare Secondary Payer 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. Recoupments of FY 2014 overpayments will not begin on the Medicare Part D recovery auditors' overpayments until the appeals process is complete. The appeals process is ongoing, but is expected to be completed during FY 2015.

Table 5
Disposition of Recaptured Funds
FY 2014[1,2]
(in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose[3]	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$186.3	$274.6	N/A	$1,760.9	N/A	N/A
Medicare Secondary Payer Recovery Auditor	$0.3	$8.4	N/A	$50.6	N/A	N/A
Medicare Part D Recovery Auditors	N/A	$0.7	N/A	$1.9	N/A	N/A

Notes:
1. The State Medicaid recovery auditors are not included in this table since states do not report information to HHS on how the state portion of recoveries are used. The federal share of recoveries is returned to the Treasury.
2. For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other tables. For example, adding the Medicare FFS Recovery Auditors cells does not add to the Amount Recovered (CY) cell in Table 2.
3. Funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors "Original Purpose" cell also takes into consideration underpayments to providers that were identified and corrected ($173.1 million).

Table 6
Overpayments Recaptured Outside of Payment Recapture Audits
FY 2014
(in Millions)[1]

Agency Source	Amount Identified (CY)	Amount Recovered (CY)	Amount Identified (PYs)	Amount Recovered (PYs)	Cumulative Amount Identified (CY+PYs)	Cumulative Amount Recovered (CY+PYs)
Medicare FFS Error Rate Measurement	$53.7	$44.2	$70.9	$58.7	$124.6	$102.9
Medicare Contractors Note 2	$12,980.1	$10,793.3	$39,087.5	$32,046.3	$52,067.6	$42,839.6
Medicare Part C	$0	$0	$1.7	$0	$1.7	$0
Medicare Part D	$0	$0	$0.2	$0	$0.2	$0
Medicare Part C RADV Audits	$5.4	$5.4	$8.4	$8.4	$13.8	$13.8
Medicaid Error Rate Measurement	$0.6	$0.3	$3.6 Note 3	$2.0	$4.2	$2.3
CHIP Error Rate Measurement	$0.7	$0.1	$0.5 Note 3	$0.2	$1.2	$0.3
Medicaid Integrity Contractors-Federal Share-FMAP rates	$15.7 Note 4	$5.9	$22.2 Note 4	$4.4	$37.9 Note 4	$10.3
Foster Care Eligibility Reviews = Post-Payment Reviews	$1.4	$1.4	$17.9	$17.9	$19.4	$19.4
Foster Care OIG Reviews	$58.3	$0.8	$207.1	$102.9	$265.4	$103.7
Foster Care Single Audits	$22.1	$28.2	$34.9	$33.4	$57.0	$61.6
Child Care Single Audits	$0	$0.5	$6.9	$5.8	$6.9	$6.2
Child Care-Error Rate Measurement Note 5	$0.05	$0.009	$0.9	$0.00	$1.0	$0.009
Head Start- OIG Reviews	$8.1	$0.5	$7.0	$5.1	$15.1	$5.6
Head Start- Single Audits	$1.6	$0.2	$3.9	$4.3	$5.5	$4.5

Notes:

1. For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other cells. For example, the Amount Recovered (CY) and Amount Recovered (PYs) cells may not add to the Cumulative Amount Recovered (CY + PYs) cell.
2. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program, which are reported in Table 3, and the Medicare FFS Error Rate Measurement program, which are reported separately in this table.
3. For the Medicaid measurements, the Amount Identified (PYs) information that was reported in the FY 2013 AFR was amended to reflect changes made during state-level error rate recalculations. The Medicaid error rate measurement's Amount Identified (PYs) was amended from $3.7 million to $3.6 million. For the CHIP measurement, the Amount Identified (PYs) information that was reported in the FY 2013 AFR was also amended to reflect changes

made during state-level error rate recalculations as discussed in *Section 10.53.* However, due to rounding the small changes did not affect reporting in this table.

4. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the federal and state shares. For the Amount Identified (CY) column and the FY 2013 data included in the Amount Identified (PYs) column, HHS has reported the actual federal share across audits. For data prior to FY 2013 included in the Amount Identified (PYs) column, HHS applied FY 2012 State FMAP rates to estimate the federal share of overpayments, although not all overpayments identified were based on FY 2012 paid claims.
5. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recovered (CY) information, states are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. This is the first year that recovery amounts are being reported for the CCDF program. Therefore, no prior year recovery amounts are indicated.

12.0 Do Not Pay Initiative

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List", which underscored that:

> "While identifying and recapturing improper payments is important, prevention of payments before they occur should be the first priority in protecting taxpayer resources from waste, fraud, and abuse. In those cases where data available to agencies clearly shows that a potential recipient of a Federal payment is ineligible for it, subsequent payment to that recipient is unacceptable. We must ensure that such payments are not made."

So as "to ensure that only eligible recipients receive Government benefits or payments," the President directed the establishment of a "single point of entry" through which agencies would access relevant data - in a network of databases to be collectively known as the "Do Not Pay List"- before determining eligibility for a benefit, grant or contract award, or other federal funding. Subsequently, the "Do Not Pay List" was codified by IPERIA, which included a requirement for agencies to check relevant databases prior to making an award or payment. The Presidential memorandum and IPERIA identified the following databases to include in the Do Not Pay portal: the Social Security Administration's Death Master File (DMF), the HHS OIG's List of Excluded Individuals & Entities (LEIE), the General Service Administration's System for Award Management (SAM) exclusion records (also referred to as the Excluded Party List System), the Department of the Treasury's Debt Check, the Department of Housing and Urban Development's Credit Alert Interactive Voice Response System (CAIVRS), and the Social Security Administration's Prisoner Update Processing System (PUPS). Treasury's "Do Not Pay" website - http://www.donotpay.treas.gov/index.htm - includes information on currently available and pending data sources in the DNP portal.

Since the Presidential memorandum was issued, and IPERIA was enacted, HHS has worked diligently to implement the "Do Not Pay" (DNP) initiative. In addition, after OMB released OMB Memorandum M-13-20, 'Protecting Privacy While Reducing Improper Payments with the Do Not Pay Initiative', HHS was one of the first agencies to establish a Computer Matching Agreement (CMA) with the Department of the Treasury under the DNP initiative in FY 2014. The CMA will allow HHS to match electronic files against restricted content (such as Social Security Number, Date of Birth, or Taxpayer Identification Number) in some of the data sources, simultaneously reducing the time to complete the matches while also producing more accurate results. In addition, several of our Divisions are now using DNP to check for recipients or potential recipients' eligibility and to prevent improper payments from being made.

In addition, Treasury-disbursed payments are matched against the DMF and the excluded parties elements of SAM in the DNP portal to identify improper payments on a monthly basis. While the Department has had several "hits" over the past year as part of these monthly matches, the number of confirmed matches is very low, as shown below in Table 7.

Table 7

Implementation of the Do Not Pay Initiative to Prevent Improper Payment

FY 2014[1]

	Number (#) of payments reviewed for improper payments	Dollars ($) of payments reviewed for improper payments	Number (#) of payments stopped[2]	Dollars ($) of payments stopped[2]	Number (#) of improper payments reviewed and not stopped[2]	Dollars ($) of improper payments reviewed and not stopped[2]
HHS's Treasury Disbursed Payments Matched Against the GSA SAM Excluded Parties List Elements	820,536[3]	$191.0 billion	N/A	N/A	9	$6,991
HHS's Treasury Disbursed Payments Matched Against the Death Master File	818,349[3]	$190.9 billion	N/A	N/A	5	$14,507

Notes:

1. In FY 2014, DNP matches were performed two months after payments were made. Therefore, data reported in this table covers data on monthly payment file matches that were available at the time of the report (October 2013 to June 2014).
2. All matches performed in FY 2014 were conducted on a post-payment basis. Therefore, HHS did not have the opportunity to stop the payments before the payment was made. Rather, HHS analyzed post-payment information to determine if any potential improper payments were made that should be recovered.
3. The number of payments reviewed for improper payments that were screened against the SAM Excluded Parties Elements and the DMF differ because some payments did not contain a name or a tax identification number in a format that could be matched against the DMF, and, therefore were excluded from the match.

13.0 Superstorm Sandy Information

Superstorm Sandy was a major hurricane that struck the United States' eastern seaboard on October 29, 2012 and caused extensive damage from Florida to Maine, with New Jersey and New York sustaining the most damage. Sandy was the second costliest hurricane in United States' history, causing $68 billion worth of damage, draining state funds and stretching limited resources.

In response to this disaster, Congress passed the *Disaster Relief Appropriations Act* (Disaster Relief Act), which was signed into law on January 29, 2013 to bring relief and funding to those areas most affected. The Disaster Relief Act provided $50.5 billion in aid for Sandy disaster victims and their communities. HHS received $747 million, allocated among multiple programs across five Divisions: the Administration for Children and Families (ACF), the Assistant Secretary for Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institutes of Health (NIH). Because funding of this type and magnitude often carries additional risk, the Disaster Relief Act states that all federal programs or activities receiving funds are automatically considered susceptible to significant improper payments, regardless of any previous improper payment risk assessment results, and are required to calculate and report an improper payment estimate. Accordingly, HHS developed methodologies to estimate improper payments in the programs that received Disaster Relief Act funding.

Table 8 describes the FY 2014 improper payment results for the programs that received Disaster Relief Act funding, and additional information on the methodologies, results, and corrective actions can be found on subsequent pages. Because FY 2014 is the first year that the Superstorm Sandy measurements were conducted, the table does

not include prior year results. In addition, because the measurements will only be conducted until the funding runs out, out-year reduction targets were not established. Accordingly, Table 8 displays results for the current year FY 2014 outlays (CY Outlays $), the error rate (CY IP%), and dollars paid or projected to be paid improperly (CY IP$); the amount of overpayments (CY Overpayments $); the amount of underpayments (CY Underpayments $); and the net error rate (CY Net IP%) and the corresponding amount of net improper payments (CY Net IP$), when available.

Table 8

Improper Payment Reporting for Superstorm Sandy Programs

FY 2014

Program Name or Operating Division	CY Outlays $	CY IP %[1]	CY IP $	CY Over payment $	CY Under payment $	CY Net IP %	CY Net IP $
ACF Head Start	3,926,931	0	0	0	0	0	0
ACF Social Services Block Grant	67,032,147	13.5	9,036,535	7,773,626	1,262,909	9.7	6,510,717
ACF Family Violence Prevention and Services	137,215	4.4	6,013	6,013	0	4.4	6,013
ASPR Research[2]	0	0	0	0	0	0	0
CDC Research	1,823,383	0	0	0	0	0	0
SAMHSA	415,329	12.7	52,735	52,735	0	12.7	52,735
NIH Research	32,047,237	0.002	741	741	0	0.002	741

Notes:

1. As part of the improper payment measurement development process, each Division establishes a 12-month time period that will be reported in the annual AFR.
2. ASPR Research's FY 2014 measurement period is based on the previous FY. ASPR Research will report $0 in CY outlays since they awarded grants late in FY 2013 and their grantees did not begin expending funds until FY 2014.

13.10 Head Start

13.11 Head Start Statistical Sampling Process and Results

Head Start received approximately $95 million in Disaster Relief Act funding to provide services, training and oversight, and construction assistance to affected grantees. Every grantee who spends Superstorm Sandy funds receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon thereafter as possible. Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. The onsite tool gathers information about project status, procurement activities, adequacy of contracts, duplication of funding, cost allocation, *Davis-Bacon Act*, cost principles, and period of availability. Payments are identified as actual erroneous payments if not fully remediated within 30 days of the monitoring visit (e.g., grantee locates missing invoice to demonstrate adequate source documentation within 30 days of the visit).

HHS used a risk-based sampling process to determine the number of grantee transactions to review. Specifically, HHS established three risk levels of transactions (high, medium, and low risk) based on input from general HHS monitoring activities, regional office experience with Sandy grantees, and subject matter experts assigned to the Sandy Head Start grants. Grantees with high-risk transactions have more transactions reviewed than grantees with low-risk transactions. Sampling is based on the highest risk class of any transaction during the previous quarter. For example, a grantee with mostly high-risk expenditures and a few low-risk expenditures will be sampled at the high-risk rate.

The FY 2014 review period consisted of transactions between August 29, 2013 (when HHS awarded its first Head Start Superstorm Sandy grants) and June 30, 2014, and future review periods will be from July 1 to June 30. During the FY 2014 review period, grantees expended $3,926,931 in Head Start Disaster Relief Act funds.

The Head Start gross and net improper payment estimate for FY 2014 is 0 percent or $0 million.

13.12 Head Start Root Causes and Corrective Action Plans

Since no improper or erroneous payments were identified during the FY 2014 review, no root causes of actual improper payments are known. In general, however, HHS believes that Administrative and Documentation errors have the greatest potential for generating improper or erroneous payments in the program. To prevent these errors from occurring in the future, the importance of maintaining adequate source documentation, including demonstrating compliance with the *Davis-Bacon Act*, has been consistently emphasized in HHS training and technical assistance and ongoing program and grants support of Superstorm Sandy grantees.

13.13 Head Start Improper Payment Recovery

No recoveries will be attempted as no improper payments were reported.

13.20 Social Services Block Grant (SSBG)

13.21 SSBG Statistical Sampling Process and Results

SSBG received $474.5 million in Disaster Relief Act funding to assist individuals and communities impacted by Superstorm Sandy. HHS developed a two-fold improper payment methodology to review SSBG Disaster Relief Act funds in Connecticut, New Jersey, and New York (the three states' allocations represent 99 percent of all SSBG Disaster Relief Act funding). The two approaches are: 1) a case record review and 2) a vendor payment review. The case record review uses specific eligibility criteria to review payments or benefits provided to or on behalf of individuals, families or households. The vendor payment review examines individual payments made to service vendors, and assesses if the vendors provided adequate documentation (e.g., applications or authorizations) necessary to be eligible for these payments.

In FY 2014, HHS implemented a risk-based measurement approach and only reviewed case records in New Jersey, where the vast majority of the SSBG Disaster Relief Act expenditures occurred during the FY 2014 review period (July 1, 2013 to June 30, 2014). In FY 2014, HHS reviewed payments made in nine of New Jersey's service areas, which included individual or household services such as housing assistance, direct child care assistance, behavioral health services, and accessibility repairs for people with disabilities. Using a sampling universe of New Jersey's cases served in the FY 2014 review period, HHS randomly selected 383 case records for review. For the FY 2015 review period (July 1, 2014 to June 30, 2015), HHS will complete case record reviews and vendor payment reviews for Connecticut, New York and New Jersey. HHS will consolidate the findings, describe the amounts and types of errors, and compute a national SSBG Disaster Relief Act funds error rate that will be published in the FY 2015 AFR.

The SSBG gross improper payment estimate for FY 2014 is 13.5 percent or $9 million. The FY 2014 net improper payment estimate is 9.7 percent or $6.5 million.

13.22 SSBG Root Causes and Corrective Action Plans

Of the 383 reviewed cases, 90 cases had an improper payment. All of the improper payment errors (100 percent) were Administrative and Documentation errors identified in payment processing or recipient eligibility.

The payment processing errors included: (1) missing or insufficient documentation confirming a client's service needs; (2) missing or insufficient documentation properly recording a payment made for a corresponding need; or (3) incorrect payment amounts for a client's documented needs (i.e., a payment amount did not equal the amount billed). The recipient eligibility errors included missing or insufficient documentation establishing: (1) a client's age requirements for service (i.e., 18 years or older); (2) a client's citizenship requirements for service (i.e., U.S. citizen or legal resident); or (3) that the applicant's primary residence was affected by Superstorm Sandy.

HHS shared the error findings with New Jersey so the state can identify strategies to monitor and provide oversight to the most error prone providers. In response to the error findings and to prevent future improper payments, New Jersey is developing a plan that includes: (1) monitoring its sub-awardees and (2) periodic reporting of the review findings and monitoring plan implementation.

13.23 SSBG Improper Payment Recovery

Of the total amount of $278,643 in improper payments identified in the sample, $239,701 are overpayments. New Jersey is completing additional actions before determining how many overpayments will be recovered. New Jersey will base the recovery estimate on those cases where there are core eligibility errors, and the benefit should not have been paid. As an example, there were cases where applicants misrepresented their eligibility for housing assistance services, or members of a household received benefits after their household benefit limit had been met. These types of improper payments are recoverable. On the other hand, for cases where the eligibility or payment documentation was missing from the case record at the time of the review, but was subsequently located or resubmitted by the recipient after the measurement review was completed, the payment would not be recovered. New Jersey will report an estimate of the amount subject to recovery in the state's corrective action plan.

13.30 Family Violence Prevention and Services (FVPS)

13.31 FVPS Statistical Sampling Process and Results

The ACF Family and Youth Services Bureau's Division of Family Violence Prevention and Services (FVPS) received $2 million in Disaster Relief Act funding to prevent domestic violence in affected states. This funding is used for multiple purposes. HHS identified the area of financial alternative housing assistance as most susceptible to improper payments, therefore, these are the payments that will be measured. Alternative housing assistance benefits are paid directly to third parties on behalf of an individual recipient by the New Jersey Department of Children and Families and the New York State Office of Children and Family Services.

HHS determined that each state grantee would sample 45 percent of its financial alternative housing payments during each review period to generate a statistically valid estimate. If the number of payments in any review period is less than 110, then 100 percent of the payments will be reviewed. Due to the low number of payments made during the first review period (July 1, 2013 to June 30, 2014), FVPS reviewed all 169 payments (139 were related to New Jersey's grants and 30 were from New York's grant).

FVPS' gross and net improper payment estimate for FY 2014 is 4.4 percent or $6,013.

13.32 FVPS Root Causes and Corrective Action Plans

Of the 169 payments that were reviewed, HHS determined 11 payments were in error. All 11 of the improper payments were overpayments by the New Jersey Department of Children and Families' subawardees due to Administrative and Documentation errors (100 percent); specifically, subawardees' failure to correctly classify ineligible or unallowable expenses. For example, two programs had unallowable expenses (purchases of household goods) due to misinterpretation of allowable expenses for "basic, essential items."

To reduce future improper payments, FVPS' corrective actions are to: (1) share the improper payment findings with New Jersey, (2) provide further technical assistance and clarification on allowable versus unallowable expenses, and (3) release a Frequently Asked Questions guidance document in early FY 2015 to further assist grantees in reducing unallowable expenditures. In addition, New Jersey will also identify internal corrective actions to prevent errors.

13.33 FVPS Improper Payment Recovery

It is estimated that all $6,013 of the identified overpayments will be recovered by New Jersey and will be reused by the state.

13.40 Assistant Secretary for Preparedness and Response Research (ASPR Research)

13.41 ASPR Research Statistical Sampling Process and Results

ASPR received approximately $11.9 million in Disaster Relief Act funding to evaluate preparedness and response activities in the affected states. ASPR's Superstorm Sandy improper payment methodology will be conducted in two stages. The first stage, for FY 2014 reporting, reviewed the eligibility of grantees that received funding in FY 2013. The second stage of the methodology will be implemented for FY 2015 and FY 2016 reporting, and will calculate an unallowable spending error rate (e.g., unallowable expenses, lack of documentation) based on a review of each grantee's expenditures during the review period. The sample for the FY 2015 reporting period will consist of expenditures made during FY 2014 (October 1, 2013 to September 30, 2014), and the sample for the FY 2016 reporting period will consist of expenditures made during FY 2015 (October 1, 2014 to September 30, 2015).

Based on a sample size of 9 grants awarded in FY 2013, no ineligible applications or awards were identified.

13.42 ASPR Research Root Causes and Corrective Action Plans

HHS has taken a number of steps to monitor and prevent improper payments from occurring in the ASPR Research program in the future. These actions include:

- Leveraging the FY 2014 OMB Circular A-123 activities, and the Department's effort to fully incorporate internal controls requirements for the Disaster Relief Act into the *Federal Managers Financial Integrity Act* (FMFIA)/A-123 assessment process, ASPR developed a Superstorm Sandy Disaster Relief Act Internal Control Plan and proactively tested controls associated with eligibility criteria.
- Requiring awardees to submit quarterly programmatic and financial reports within the Funding Opportunity Announcement (FOA) and Notice of Award (NoA) terms and conditions. The programmatic report is reviewed by the assigned Government Project Officer, while the financial report is reviewed by the Grants Management Specialist (GMS) and compared to draw downs in the payment management

system. HHS will maintain a copy of the reports in the official grant files for each Disaster Relief Act awardee. Awardees who fail to submit the reports may face disciplinary actions.

- Listing the requirements to fully expend funds within 24 months in the terms and conditions of the award. The final Federal Financial Report (FFR) lists the date of last obligation and expenditure for the award. ASPR will monitor the quarterly cash reports submitted to HHS to ensure grantees are on track to expend funding.
- Separately tracking, flagging, and expediting closeout procedures for Disaster Relief Act grantees and ensuring that all funds not expended (obligated and outlaid) by the end of the 24th month after award are recaptured. Approvals of extensions cannot be granted without obtaining OMB approval.

13.43 ASPR Research Improper Payment Recovery

No recoveries are necessary because only grantee eligibility was reviewed, and no ineligible grantees were identified.

13.50 Centers for Disease Control and Prevention Research (CDC Research)

13.51 CDC Research Statistical Sampling Process and Results

CDC received approximately $8.2 million under the Disaster Relief Act to perform environmental health studies and provide public health support. The CDC's NoA required awardees to include additional documentation to support the line items on the Federal Financial Report (FFR). This additional documentation includes grantees internally generated reports or extracts of expenses. Under its methodology, CDC reviewed these documents to identify improper payments due to causes including: 1) unallowable costs; 2) unallocable costs; and 3) goods and/or services not received. The FY 2014 sampling methodology included quarterly reviews of draw down activity and transactions from September 30, 2013 (when the grants were first awarded) through June 30, 2014 for each grantee that spent Disaster Relief Act funding (subsequent reporting period will measure transactions made between July 1 and June 30), covering 238 transactions representing approximately $1.8 million in outlays.

The CDC Research gross and net improper payment estimate for FY 2014 is 0 percent or $0 million.

13.52 CDC Research Root Causes and Corrective Action Plans

Although HHS did not identify any improper payments in the CDC Research program in FY 2014, HHS established internal controls to prevent future improper payments from occurring. Specifically, HHS developed a Risk Mitigation Plan for the CDC Research program that outlines steps to prevent improper payments in the Superstorm Sandy funding.

13.53 CDC Research Improper Payment Recovery

No recoveries will be attempted as no improper payments were identified.

13.60 Substance Abuse and Mental Health Services Administration (SAMHSA)

13.61 SAMHSA Statistical Sampling Process and Results

SAMHSA received $10 million under the Disaster Relief Act. SAMHSA awarded $6.2 million to four programs and returned approximately $3.8 million because fewer organizations applied for the funding and applications received were for amounts significantly less than expected. The four funded programs are: 1) Behavioral Health

Treatment, 2) Disaster Distress Helpline, 3) Resiliency Training for Educators, and 4) Medication Assisted Treatment of Opioid Addiction Restoration.

For FY 2014, SAMHSA's program universe subject to sampling consisted of four grants awarded to New York State ($798,339), New York City ($2,947,786), New Jersey ($329,120), and Link2Health ($2,100,000) for the four funded programs listed above. Between July 1, 2013 and June 30, 2014, SAMHSA outlaid $415,329 across 18 transactions. Due to the small number of transactions, SAMHSA reviewed all outlays for payment accuracy (e.g., examining grant expenditures and related documentation to ensure the expenditures were appropriate and accurate) and used the results to calculate the total improper payments for the program.

SAMHSA's gross and net improper payment estimate for FY 2014 is 12.7 percent or $52,735.

13.62 SAMHSA Root Causes and Corrective Action Plans

SAMHSA's improper payments identified during the review period were due to Administrative and Documentation errors (100 percent). Of the total gross improper payments of $52,735, $42,985 of the improper payments were due to errors in the calculation of direct and indirect expenses, and the remaining $9,750 were related to outlays that were incorrectly classified to a Disaster Relief Act program grant.

SAMHSA's improper payment results were discussed with each grantee and the grantees concurred with the findings. Efforts to reduce future improper payments include: (1) improving grantee processes for ensuring adequate supporting documentation is maintained, (2) ongoing examinations by SAMHSA GMSs of documentation supporting grantee draw downs, and (3) developing and disseminating additional guidance to grantees to govern the conditions under which draw downs can be made and the supporting evidence that should be maintained.

13.63 SAMHSA Improper Payment Recovery

SAMHSA has corrected the entire $52,735 in improper payments. The $42,985 in improper payments due to errors in the calculation of direct and indirect expenses were recovered through a check submitted by the grantee and the remaining $9,750 was reclassified from the Disaster Relief Act program grant to the correct grant in the payment management system.

13.70 National Institutes of Health Research (NIH Research)

13.71 NIH Research Statistical Sampling Process and Results

NIH received $148.7 million in funds under the Disaster Relief Act to support recovery efforts at eligible impacted universities and research institutions. These funds will restore NIH's investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

Due to the variable grant expenditure amounts, NIH implemented a stratified random sampling process, with the sampling frame being divided into mutually exclusive groups or "strata" based on expenditure amount. Each sampling period consists of six months. NIH selects a random sample of expenditures from the grantees quarterly reports for the respective two quarters. The sampling unit is the total quarterly expenditures for a single award, while the sampling frame is the collection of all reports filed containing expenditures during the sampling period. NIH uses a random number generator to assign random numbers to each quarterly expenditure report. The list of expenditure reports is sorted by stratum and random number, and the appropriate number of items from each stratum is reviewed. NIH's methodology examines two areas for improper payments: (1) ensuring funds are used for an allowable program use and (2) grantee eligibility. For each grant in the sample, NIH requests detailed

expenditure data and appropriate background documentation from the grantee to determine allowability. NIH also confirms grantees' continued eligibility to receive Disaster Relief Act funding in accordance with HHS requirements.

Under its methodology, NIH completed two rounds of improper payment reviews for FY 2014 covering 12-months of expenditures in two semi-annual sampling periods: July 1, 2013 to December 31, 2013 and January 1, 2014 to June 30, 2014. For this sampling period, NIH reviewed 332 expenditure reports representing 166 grant awards, and identified one improper payment of $352.

The NIH Research gross and net improper payment estimate for FY 2014 is .002 percent or $741.

13.72 NIH Research Root Causes and Corrective Action Plans

The root cause for the one improper payment identified for the review period was Administrative and Documentation Errors (100 percent). Since the grantee was unable to provide supporting documentation for this cost, NIH was unable to determine if the cost was allowable.

NIH will implement the following corrective actions for the grantee with the improper payment:

- NIH will perform an accounting system review to identify potential weaknesses in the grantee's accounting system.
- NIH will recover unallowable costs.
- NIH will counsel the grantee on the federal requirements for documenting charges to grant awards.
- NIH will include the grantee in all future improper payment testing if they report additional expenditures.

13.73 NIH Research Improper Payment Recovery

It is estimated that NIH will recover all $352 identified as an improper payment from the grantee.

MANAGEMENT REPORT ON FINAL ACTION

October 1, 2013-September 30, 2014

Background

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

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

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

Status of Audits in the Department

In general, HHS OpDivs have followed up on OIG recommendations effectively and within regulatory time limits. HHS Agencies usually reach a management decision within the 6-month period that is prescribed by the *Inspector General Act Amendments of 1988* and OMB Circular A-50, *Audit Follow-up*. Final action for single audits occurs when non-monetary and/or monetary compliance actions are completed. Achieving final action can require more than a year if the findings are complex or the grantee does not have the resources to take corrective action. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

Departmental Conflict Resolution

In the event that HHS OpDivs and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2014, there were no disagreements requiring the convening of the Conflict Resolution Council.

Final Action Tables and Departmental Findings

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

- In FY 2014, HHS initiated Recovery Action, through collection, offset or other means, on 314 reports for a total of $840,372,969.
- In FY 2014, HHS completed Recovery Action, through collection, offset or other means, on 284 reports for a total of $550,478,597.

- As of September 30, 2014, HHS identified 245 reports with outstanding balances over one year old totaling $2,001,618,350[16]. Six percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by state and local governments (128), hospital and medical related organizations (22), non-profit organizations (78), Indian tribes (15) and educational institutions (2). A detailed list of reports over one year old with outstanding balances to be collected can be found at: http://www.hhs.gov/asfr/of/finpollibrary/financialpolicies.html.

TABLE 1
Management Action on Costs Disallowed in OIG Reports
As of September 30, 2014

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period.[1]	336	$ 2,214,401,414
B. Reports on which management decisions were made during the reporting period.[2]	314	840,372,969
Subtotal (A + B)	**650**	**$ 3,054,774,383**
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of disallowed costs that was recovered through collection, offset, property in lieu of cash, or otherwise.	284	550,478,597
ii. The dollar value of disallowed costs that were written off by management.	15	8,144,846
Subtotal (i + ii)	**299**	**$ 558,623,443**
D. Reports for which no final action has been taken by the end of the reporting period.[3]	351	$ 2,496,150,940

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period (FY 2013 ending balance of $2,568,581,688 less adjustments of $354,180,274).
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS OpDivs showed a variance that represents only timing differences between the OIG's and the OpDivs' records.
3. In addition to current unresolved reports, this figure includes reports over one year old with outstanding balances totaling $2,001,618,350 (e.g., audits under current collection schedule or audits under administrative or judicial appeal).

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

- In FY 2014, HHS initiated action on $724,841,230 in OIG recommendations to put funds to better use.
- In FY 2014, HHS completed action on $11,081,763 in OIG recommendations to put funds to better use.

[16] This amount is included in Table 1, Item D (see Note 3 of the table).

TABLE 2
Management Action on OIG Reports
with Recommendations that Funds Be Put to Better Use

As of September 30, 2014

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period.	11	$ 1,110,960,466
B. Reports on which management decisions were made during the reporting period.	16	724,841,230
Subtotal (A + B)	**27**	**$ 1,835,801,696**
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of recommendations that were actually completed based on management action or legislative action.	9	11,081,763
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	-	-
Subtotal (i + ii)	**9**	**$ 11,081,763**
D. Reports for which no final action has been taken by the end of the reporting period.	18	$ 1,824,719,933

SUMMARY OF FINANCIAL STATEMENT AUDIT

As mentioned earlier in the MD&A section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

TABLE 1

Audit Opinion			Unmodified for Four Financial Statements. No Opinion Expressed on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
Financial Reporting, Systems, Analyses & Oversight	–	–	–	–	–
Financial Management Information Systems	***1***	–	–	–	***1***
Total Material Weaknesses	***1***	**-**	**-**	**-**	***1***

***Definition of Terms – Tables 1 and 2**

Beginning Balance: The beginning balance will agree with the ending balance of material weaknesses from the prior year.

New: The total number of material weaknesses that have been identified during the current year.

Resolved: The total number of material weaknesses that have 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 material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., section 2 to a section 4 and vice versa).

Ending Balance: The agency's year-end balance.

***Reference**: OMB Circular A-136, *Financial Reporting Requirements*, September 18, 2014, page 151

SUMMARY OF MANAGEMENT ASSURANCES

TABLE 2

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	*1*	-	-	-	-	*1*
Total Material Weaknesses	***1***	**-**	**-**	**-**	**-**	***1***

Effectiveness of Internal Control over Operations (FMFIA #2)						
Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	*1*	-	-	-	-	*1*
Error Rate Measurement	*1*	-	-	-	-	*1*
Total Material Weaknesses	***2***	**-**	**-**	**-**	**-**	***2***

Conformance with Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Do not conform to financial management system requirements					
Non-Conformances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	*1*	-	-	-	-	*1*
Total Non-Conformances	***1***	**-**	**-**	**-**	**-**	***1***

Compliance with Section 803(a) of the *Federal Financial Management Improvement Act* (FFMIA)		
	Agency	**Auditor**
1. System Requirements	Lack of substantial compliance noted	Lack of substantial compliance noted
2. Accounting Standards	No lack of substantial compliance noted	No lack of substantial compliance noted
3. USSGL at Transaction Level	Lack of substantial compliance noted	Lack of substantial compliance noted

FISCAL YEAR 2014 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

TO: The Secretary

FROM: Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2014

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

The OIG's top management and performance challenges for fiscal year 2014 are:

1) Implementing, Operating, and Overseeing the Health Insurance Marketplaces
2) Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid
3) Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse
4) Fighting Waste and Fraud and Promoting Value in Medicare Parts A and B
5) Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care
6) The Meaningful and Secure Exchange and Use of Electronic Health Information
7) Effectively Operating Public Health and Human Services Programs To Best Serve Program Beneficiaries
8) Ensuring Effective Financial and Administrative Management
9) Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse
10) Ensuring the Safety of Food, Drugs, and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Lisa Re, Acting Director of External Affairs, at (202) 205-9213 or Lisa.Re@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

Management Challenge 1: Implementing, Operating, and Overseeing the Health Insurance Marketplaces

Why This Is a Challenge

The new Health Insurance Marketplaces, also known as Health Insurance Exchanges, (Marketplaces) are critical components of the health insurance market reforms enacted through the *Affordable Care Act*. In 2014, The Centers for Medicare & Medicaid Services (CMS) operated Marketplace functions on behalf of 36 states. Implementation, operation, and oversight of the Marketplaces were among the most significant challenges for the Department of Health and Human Services (Department or HHS) in fiscal year (FY) 2014 and will continue to present a top management and performance challenge in FY 2015, http://oig.hhs.gov/reports-and-publications/top-challenges/2013/.

In 2015, CMS and the Health Insurance Marketplaces face new and ongoing challenges including, for example, ensuring accurate eligibility determinations; processing enrollments, re-enrollments, and qualifying life change events; and communicating timely and accurate information to health insurance issuers (issuers) and consumers. Marketplaces must also facilitate Medicaid enrollment for those who qualify. In coordination with states, CMS will implement premium-stabilization programs. To carry out these complex Marketplace functions, the Department must ensure effective communication and coordination between and among all internal and external parties with Marketplace responsibilities, including within HHS and with contractors, issuers, and partners in state and federal government. Effective coordination with, and timely provision of accurate data to, the Internal Revenue Service (IRS) will be particularly important for sound administration of the premium tax credit program. In addition, CMS will need to be attentive to state Marketplace operations to ensure state compliance with requirements, including transmitting accurate and timely data used for federal payments. Key focus areas for the federal and state Marketplaces should include:

Payments. Ensuring sound expenditure of taxpayer funds for intended purposes poses a substantial management challenge, especially given the use of manual systems. The Department must implement financial management and payment systems that produce accurate and timely payments to issuers of advance payment of premium tax credits, cost-sharing reduction amounts, and premium-stabilization payments. In addition, CMS must validate information received from issuers to ensure that it is timely, complete, and accurate for payment purposes. Given the substantial federal funds involved, the Department should undertake a thorough risk assessment and, where appropriate, develop error rates to measure the integrity of program payments.

Eligibility. Ensuring accurate eligibility determinations is critical. Recent Office of Inspector General (OIG) work addressing eligibility verification systems during the first open enrollment period found that not all internal controls at reviewed Marketplaces were effective and that Marketplaces were unable to resolve most inconsistencies between applicants' self-reported information and data obtained by the Marketplaces from other sources. Moreover, for the second open enrollment period, Marketplaces must add functionality for processing re-enrollments. Effective internal controls and timely and accurate resolution of inconsistencies are, and will continue to be, critical to ensure that eligible consumers receive appropriate benefits and that ineligible individuals are not enrolled.

Management and Administration. Following the October 1, 2013, launch of the Marketplaces, the Department acknowledged the need for improved management and oversight, including clear leadership, disciplined operations, and better communication across the Department. Challenges include selecting capable contractors and providing appropriate oversight to ensure successful operation of the federal Marketplace, including both public-facing and administrative systems. The Department must ensure, to the greatest extent possible, that the Government obtains specified products and services from its contractors on time and within budget. In addition,

problematic operations at some state Marketplaces have prompted questions regarding the use of Federal establishment grant funds, and the Department must ensure that these grants have been properly managed. (For general information about challenges associated with grants management and contract administration, see Management Challenge 9.)

Security. Protecting and ensuring the confidentiality and integrity of consumers' sensitive personal information and Marketplace information systems is paramount. Effective operation of the Marketplaces requires rapid, accurate, and secure integration of data from numerous federal and state sources, issuers, and consumers. It also requires an established large-scale means of communication among many federal and state systems. The Department must vigilantly guard against intrusions and continuously assess and improve the security of Marketplace related systems, including, among others, the Data Services Hub. OIG work found that selected Marketplaces generally protected personally identifiable information, but could improve some information security controls. The Department also must ensure that non-automated systems used to process consumer enrollment information, such as the call center and paper application processes, incorporate effective security measures.

Progress in Addressing the Challenge

Since October 1, 2013, the Department has reported improvement in the operations of the federal Marketplace, as well as substantial enrollment figures. Key progress reported by CMS includes:

- changes to CMS's management of the federal Marketplace, including closer oversight by CMS leadership, designation of a systems integrator, use of cross-functional teams, and procurement of a new contractor for federal Marketplace construction and maintenance;
- establishment of (1) an interim process for resolving data inconsistencies pending automated functionality, (2) an interim process for paying issuers that are owed financial assistance payments pending automated functionality, and (3) functionality for reporting life change events;
- an improved application on a redesigned HealthCare.gov intended to streamline the eligibility process and improve the consumer experience;
- actions taken to address OIG recommendations to improve information technology (IT) security; and
- screening of call center representatives and focused training on protecting sensitive information.

CMS also reported regular communications with the IRS to validate payment information and the provision of technical and other support to the state Marketplaces.

What Needs To Be Done

The Department must continue to improve the federal Marketplace, including the public-facing consumer functions, as well as the back-end administrative and financial management functions. The Department must ensure that alternate pathways for enrollment operate with integrity and that consumers' personal information is secure. The Department must operate a well-run second open enrollment period for individuals and small businesses, employing lessons learned, taking all steps practicable to avoid problems that marred the first open enrollment period and rapidly and effectively addressing any problems that arise. Vigilant monitoring and testing and rapid mitigation of identified vulnerabilities are essential. In addition, attention must be paid to sound operation of financial assistance and premium-stabilization programs. The Department must ensure that consumers and issuers receive accurate Marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms.

As with other new programs, the Department must continue to work with its partners to develop program integrity measures and processes. It must monitor for and address fraud, waste, and abuse risks to protect the federal investment in health care reform. If fraud schemes are identified, the Department must respond quickly

and effectively, working jointly with partners at the federal and state level to ensure program integrity and hold those involved accountable. Further, the Department must continue to coordinate closely with states and others in federal government to monitor the operations and security of the Marketplaces and to implement Marketplace programs.

Key OIG Resources

- OIG Testimony, "Failure To Verify: Concerns Regarding PPACA's Eligibility System," July 2014, http://oig.hhs.gov/testimony/docs/2014/Daly_Greenleaf_testimony_07162014.pdf
- OIG Report, *Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls*, September 2014, http://oig.hhs.gov/oas/reports/region1/181430011.asp
- OIG Report, *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements*, June 2014, http://oig.hhs.gov/oas/reports/region9/91401000.asp
- OIG Report, *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data*, June 2014, http://oig.hhs.gov/oei/reports/oei-01-14-00180.pdf
- OIG Report, *An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace*, August 2014, http://oig.hhs.gov/oei/reports/oei-03-14-00231.asp
- OIG 2015 Work Plan, http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf

Management Challenge 2: Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid

Why This Is a Challenge

CMS provides prescription drug coverage for 37.4 million Medicare beneficiaries through Part D and 59.4 million Medicaid beneficiaries. In 2012, combined Part D and Medicaid prescription drug expenditures totaled over $93 billion. Medicare Part D alone accounted for $66.9 billion of those expenditures. Maintaining the integrity of these two programs is critical to ensuring patient safety; safeguarding the quality of care; protecting the programs from fraud, waste, and abuse; and protecting taxpayer dollars.

OIG has extensively examined ongoing monitoring and oversight of the programs and the effectiveness of controls designed to ensure appropriate payment and patient safety. In both the Medicare Part D and Medicaid programs, OIG has uncovered improper and potentially harmful prescribing practices, pharmacies billing for drugs not dispensed, and diversion of prescription drugs.

Questionable Utilization and Billing Patterns. A 2014 OIG report examining questionable utilization patterns for HIV drugs by beneficiaries revealed claims on behalf of many beneficiaries with no indication of HIV in their Medicare histories, claims for excessive doses or supplies of HIV drugs, claims for HIV drugs from a high number of pharmacies or prescribers, or claims for contraindicated drugs. These patterns may indicate that beneficiaries are receiving inappropriate prescription drugs and selling them illegally, pharmacies are billing for drugs that beneficiaries never received, or that beneficiaries' Medicare identification numbers were stolen. Medicare paid $32 million for HIV drugs for beneficiaries with questionable utilization patterns in 2012.

Additional health care fraud schemes have involved providers submitting fraudulent claims to Medicare for deceased beneficiaries. A 2013 report revealed that, in 2011, Part D inappropriately paid more than $1 million for prescription drugs for 5,101 deceased beneficiaries, including some beneficiaries who had died in 2009.

Drug Diversion and Abuse of Controlled Substances. The diversion and abuse of prescription drugs is an ongoing problem. Drug diversion is the transfer of legitimate prescription drugs for unlawful purposes. Controlled substances, such as opiate pain relievers, are potentially so dangerous that they require restrictions on their manufacture, possession, or use. The Centers for Disease Control and Prevention (CDC) characterizes prescription drug abuse as an epidemic, reaching virtually all demographics and geographic locations. As abuses of these drugs have increased over the past five years, OIG has also increased its investigations of abuses in this area, many of which involve harm to individual beneficiaries. Diversion of these drugs may also result in profound public harm. In one noteworthy example, an OIG investigation found that a health care worker infected with Hepatitis C diverted a controlled prescription drug from a hospital for his own personal use. In an attempt to remain undetected, the worker inserted saline solution into the vials to replace the diverted drugs. Because the worker used his contaminated syringes to switch the fluids, several patients treated from these vials contracted the infectious disease.

Drug Diversion and Abuse of Non-Controlled Substances. A rapidly growing trend is the illegal billing and diversion of non-controlled medications (e.g., anti-psychotics), which presents a substantial financial vulnerability to federal health care programs. Many cases involve pharmacies billing federal programs for expensive brand-name medications that were never dispensed. Other common cases involve Medicare or Medicaid beneficiaries combining prescribed drugs with opioids to create an enhanced euphoria; such drugs are called "potentiators." Some HIV drugs are examples of non-controlled substances that can be used as potentiators.

Progress in Addressing the Challenge

CMS has taken steps to strengthen oversight of appropriate drug utilization in Medicare Part D. For example, CMS responded to an OIG recommendation that it strengthen the Medicare Drug Integrity Contractor's (MEDIC) monitoring of pharmacies and its ability to identify pharmacies with questionable billing patterns and develop pharmacy risk scores. In June 2013, CMS and the MEDIC developed pharmacy risk scores and released a list of "high risk" pharmacies to Part D plans. CMS instructed Part D plans to use the risk score information in conjunction with their own data analysis to combat fraud, waste, and abuse. CMS suggested that plans use the list of high risk pharmacies to target pharmacies for audits and further review.

Moreover, OIG recommended that CMS require Part D sponsors to verify that prescribers have the authority to prescribe drugs. Beginning June 1, 2015, physicians and eligible professionals must be enrolled in Medicare to prescribe Part D drugs. In addition, to identify the prescribing physician or eligible professional, CMS will require that a pharmacy claim for a Part D drug contain the National Provider Identifier. This will enable CMS, Part D plans, and the MEDIC to verify that prescribers have the authority to prescribe Part D drugs before the claims are paid.

What Needs To Be Done

In addition to taking the steps described above, CMS must increase Part D plan sponsors' abilities to limit questionable utilization of drugs, particularly drugs that are vulnerable to diversion and recreational abuse. For example, CMS should expand sponsors' drug utilization review programs and use of beneficiary-specific controls. CMS should also restrict certain beneficiaries with questionable utilization patterns to a limited number of pharmacies or prescribers.

Additionally, CMS should improve existing safeguards to prevent improper payments in Part D. CMS needs to ensure that the MEDIC routinely analyzes billing data to detect pharmacies and providers with questionable billing patterns, including billing for deceased beneficiaries.

Key OIG Resources

- OIG Report, *Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs*, August 2014, http://oig.hhs.gov/oei/reports/oei-02-11-00170.pdf
- OIG Testimony, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse," June 2014, https://oig.hhs.gov/testimony/docs/2014/cantrell_testimony_06252014.pdf
- OIG Report, *Medicare Payments Made on Behalf of Deceased Beneficiaries*, October 2013, http://oig.hhs.gov/oei/reports/oei-04-12-00130.pdf

Management Challenge 3: Protecting an Expanding Medicaid Program From Fraud, Waste, and Abuse

Why This Is a Challenge

Protecting the integrity of Medicaid takes on heightened urgency as the program continues to grow in spending and in the number of people it serves. As of October 2014, 27 states and the District of Columbia (28 states) are expanding Medicaid coverage to include qualifying adults earning up to 133 percent of the federal poverty level, pursuant to *Affordable Care Act* and Medicaid waivers. Further, states that have not expanded eligibility have seen increases in Medicaid enrollment. In addition to facing the challenges in implementing expanded eligibility in the 28 states, Medicaid programs face long-standing program integrity challenges. These include improving the effectiveness of Medicaid data; preventing and addressing fraud, waste, and abuse, including avoiding or recovering Medicaid improper payments; ensuring access to care in Medicaid managed care programs; and curbing state Medicaid policies that inflate federal costs. (See Management Challenge 5 for more information on Medicaid issues related to nursing homes and benefits provided in home- and community-based settings.)

Expansion of Medicaid Eligibility. As of August 2014, CMS reported that enrollment in Medicaid and the Children's Health Insurance Program (CHIP) had increased by 8.7 million people since individuals became eligible to apply under the *Affordable Care Act's* expanded eligibility criteria in October 2013. For individuals in expansion states who are "newly eligible" under the *Affordable Care Act's* expanded income limits, the Federal Government will pay the full costs of medical assistance through 2016, after which the federal share gradually falls to 90 percent by 2020 and continues at 90 percent thereafter. For Medicaid beneficiaries who are not "newly eligible," the Federal Government will continue to share costs with states according to its standard Federal Medical Assistance Percentage (FMAP), which currently ranges by state from 50 to 74 percent. Updating eligibility systems and ensuring appropriate eligibility determinations and FMAP designations for each beneficiary present implementation challenges.

Improving the Effectiveness of Medicaid Data. As Medicaid expands, implementing a functional, national Medicaid database is essential to effective oversight of Medicaid payments and services. OIG continues to find that the existing national Medicaid data are not complete, accurate, or timely and that additional data are needed to conduct national Medicaid program integrity activities. CMS has attempted to improve the access and quality of Medicaid data, most recently through the Transformed Medicaid Statistical Information System (T-MSIS) initiative. OIG found that as of January 2013, CMS and 12 volunteer states had made some progress in implementing T-MSIS; however, early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation.

Identifying and Recovering Improper Payments. In 2013, CMS reported that Medicaid's improper payment rate was 5.8 percent. The projected federal share of the $24.9 billion improper payments was $14.4 billion; almost 97 percent of these improper payments were overpayments. Payments made on behalf of individuals who should not have been enrolled in the program were the main source of error. CMS is developing a Unified Program Integrity Contractor model in which program integrity work at the federal level will be consolidated so that each contractor

will conduct Medicare, Medicaid, and Medicare-Medicaid Data Match (Medi-Medi Program) work within designated geographic areas; CMS expects to implement this strategy starting in FY 2015. OIG has found that CMS's national Medicaid integrity programs—Medicaid Audit Program and Medi-Medi Program—have had limited success identifying Medicaid overpayments and potential fraud. (See Management Challenge 8 for more information on error rate measurement and reporting.)

Program Integrity and Beneficiary Access in Managed Care Programs. CMS reports that, as of 2011, almost three-quarters of all Medicaid beneficiaries were enrolled in some type of managed care system. The private plans and Medicaid share financial risk from fraud, waste, and abuse by health care providers or beneficiaries. Such fraud, waste, and abuse drives up costs for both the plans and Medicaid. Fraud or abuse by the managed care plan (e.g., manipulating its bids) can further increase Medicaid costs. In a 2011 report, OIG work revealed that the predominant concerns of both states and plans were provider fraud—billing for services that were not provided, were medically unnecessary, or were upcoded—and beneficiary fraud, including prescription drug abuse.

Ensuring that beneficiaries enrolled in managed care plans have sufficient access to providers and services is paramount. OIG has found that standards for access to care vary widely across states. For example, standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 enrollees. States do not commonly use "direct tests," such as making calls to providers, to identify whether plans are meeting access-to-care-standards. Further, CMS provides limited oversight of state access standards.

State Policies That Inflate Federal Costs. OIG has raised long-standing concerns, as noted in our Compendium of Priority Recommendations, about states' Medicaid policies that result in the Federal Government's paying a greater share of Medicaid costs than the FMAP percentages would dictate. Medicaid permits states to provide enhanced payments that qualify for federal reimbursement to non-state-owned government providers, such as county or local publicly owned nursing facilities and hospitals. But some states have required such facilities to transfer the funds to the states to be put to other uses, leaving the facilities underfunded. Misalignment of costs and payments at certain state-operated facilities can also inflate federal costs; for example, in New York, Medicaid payments to state-run developmental centers exceeded actual costs by more than $1 billion during New York's State FY 2009. In another example, Pennsylvania used a state tax on Medicaid managed care plans to draw down almost $1 billion in federal funds over a three-year period.

Progress in Addressing the Challenge

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

CMS has taken action to improve its data and technology capabilities with respect to Medicaid program integrity. Beginning in July 2014, all states were expected to demonstrate operational readiness to submit T-MSIS files to CMS. As of October 2014, CMS stated that over 38 states are engaged in testing with CMS regarding the transfer of their T-MSIS files. CMS stated that it will continue to monitor, evaluate, and improve the quality and consistency of T-MSIS data submissions.

CMS has also reported actions to improve the Medicaid Audit Program and the Medi-Medi Program consistent with OIG recommendations, such as assigning more Medicaid audits through a collaborative process, which showed greater success than the traditional process. In addition, CMS stated that it will continue working with states and third parties to address problems identified by states with identification and collection from liable third parties.

In a June 2014 status update to OIG, CMS indicated that it is working with states to protect against fraud, waste, and abuse in managed care. Specifically, CMS is working to update guidelines to states on program integrity in Medicaid managed care. In addition, CMS indicated that it will advise states to work with their managed care entities to identify and implement effective strategies for verifying billed services in managed care settings. CMS also agreed with OIG's recommendations to strengthen oversight of managed care access standards, and it described plans to provide guidance and technical assistance to states.

CMS is continuing to work with New York to revise its methodology for Medicaid payments to state-run developmental centers to better align them with costs. CMS has approved a State Plan Amendment, issued a disallowance letter to New York for $1.25 billion for 2010-2011, and plans to review two subsequent fiscal years. Finally, CMS has issued guidance on Medicaid upper payment limits and is requiring all states to demonstrate annually the upper payment liability to the Federal Government for services that are subject to these limits. In addition, CMS recently issued a State Health Officials letter on the treatment of health-care-related taxes and their effect on federal matching funding, following OIG's audit work in Pennsylvania.

What Needs To Be Done

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

CMS should continue to work with states to ensure the submission of complete, accurate, and timely T-MSIS data. If states fail to submit timely T-MSIS data, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel state participation.

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

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

OIG has long recommended that Medicaid payments to public providers be based on the costs of providing services. In 2008, CMS issued a final rule that, among other things, would limit Medicaid payments to public providers to their costs of providing care, but the rule was ultimately vacated by Federal District Court.

Key OIG Resources

- OIG Report, *State Standards for Access to Care in Medicaid Managed Care*, September 2014, http://oig.hhs.gov/oei/reports/oei-02-11-00320.asp
- OIG *Compendium of Priority Recommendations*, March 2014, http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2014.pdf
- OIG Testimony, "Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes," July 29, 2014, http://oversight.house.gov/wp-content/uploads/2014/07/Hagg-HHS-OIG-Final.pdf
- OIG Report, *Early Outcomes Show Limited Progress for the T-MSIS*, September 2013, https://oig.hhs.gov/oei/reports/oei-05-12-00610.asp

- OIG Testimony, "Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid," June 14 2012, http://oig.hhs.gov/testimony/docs/2012/Maxwell_testimony_06142012.pdf
- OIG Testimony, "Examining the Administration's Failure to Prevent and End Medicaid Overpayments," September 20, 2012, https://oig.hhs.gov/testimony/docs/2012/Hagg_testimony_09202012.pdf
- OIG Report, *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*, December 2011, https://oig.hhs.gov/oei/reports/oei-01-09-00550.asp

Management Challenge 4: Fighting Waste and Fraud and Promoting Value in Medicare Parts A and B

Why This Is a Challenge

To secure the future of health care for Medicare beneficiaries, the Department must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. The Institute of Medicine estimated that 30 percent of U.S. health spending (public and private) in 2009—roughly $750 billion—was wasted.[17]

Waste in health care programs is a multi-dimensional problem. Key areas of focus for reducing waste in Medicare Parts A and B include reducing improper payments, fighting fraud, fostering economical payment policies, and transitioning from volume to value in health care. HHS faces challenges—and opportunities—in each of these areas.

Reducing Improper Payments. CMS reported an error rate of 10.1 percent for Medicare fee for service (Parts A and B), corresponding to an estimated $36 billion in improper payments in FY 2013. This measure includes payments for unnecessary services, billing or coding errors, and payments for claims that did not meet documentation or other Medicare coverage requirements. Medicare's pending transition to a new system of diagnosis codes, the ICD-10, may bring implementation challenges or potential increases in improper billing as providers transition to the new codes. (See Management Challenge 8 for more information on error rate measurement and reporting.)

Challenges affect every stage of the payment process, from making the initial payment accurately to adjudicating overpayment recoveries. OIG has documented high Medicare improper payment rates for various services, including home health services and evaluation and management services. OIG audits of hospitals have uncovered and sought to remedy improper billing and payments for a myriad of issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes. Accurate billing by hospitals for short inpatient stays versus outpatient observations has been an area of considerable challenge and concern for the Department, hospitals, and beneficiaries.

CMS relies on contractors for most of these crucial functions; however, OIG has identified deficiencies in contractor performance and in CMS's oversight of contractors that process Medicare claims and that audit and recover overpayments. Finally, the Department is facing significant challenges in adjudicating provider appeals of Medicare overpayment recoveries, including (1) a substantial backlog of appeals at the administrative law judge (ALJ) level (third level of appeals), (2) inconsistent determinations among the ALJs and between the ALJs and Qualified Independent Contractors (second level of appeals), and (3) insufficient CMS participation in the appellate process.

Preventing and Responding to Fraud. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain Medicare services have been consistent targets. For example, OIG investigations continue to uncover fraud schemes and questionable billing patterns by durable medical equipment (DME) suppliers, home health agencies, community mental health centers, clinical

[17] Institute of Medicine, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," September 6, 2012.

laboratories, ambulance transportation suppliers, and outpatient therapy providers. CMS's contractors play a key role in fighting Medicare fraud. However, CMS is not realizing the full potential of this oversight tool. For example, OIG found that CMS contractors' program integrity efforts were limited with respect to home health and community mental health services, even though these services are known as fraud risk areas.

Fostering Economical Payment Policies. As a result of certain payment policies that OIG has identified, Medicare pays significantly different amounts for the same services for similar patients in different settings. For example, Medicare pays significantly more for services performed in an outpatient hospital department than for the same services performed in an ambulatory surgical center (ASC). While not all patients can safely receive services in an ASC, for low-risk patients that do not need hospital-level care at an outpatient hospital department, Medicare could save billions of dollars by paying for their services at ASC rates. In another example, Medicare generally reduces payments to hospitals for patients with early discharges to post-acute care, such as care provided in a skilled nursing facility, to avoid overlapping payments for the hospital care and the post-acute care. However, Medicare does not reduce hospital payments if a patient's early discharge is to hospice care.

Transitioning From Volume- to Value-Based Payment. Experts generally agree that the incentives created by paying for health care on the basis of the volume of items or services furnished, as in Medicare's fee-for-service program, contribute to waste by encouraging unnecessary utilization and fragmented, poor quality care. HHS is transitioning to value-based payments in Medicare, which are intended to produce better quality of care at lower costs by rewarding high-quality care, penalizing low-quality care, or enhancing care coordination. Models involve, for example: accountable care organizations (ACOs), value-based payments for hospitals, penalties for hospital readmissions, pay-for-performance systems, shared savings programs, gainsharing, care coordination payments, and bundled payments.

Designing bundled payment methodologies that reimburse for items and services across separate provider settings will pose additional challenges. Many value-based payment mechanisms rely on complex data, electronic health information, and sophisticated quality and performance measures. To be effective, the data must be correct and timely, the metrics meaningful, and the information usable.

Progress in Addressing the Challenge

Overall, the Department has implemented many of OIG's recommendations for combating waste and fraud in Medicare, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In FY 2013, OIG audits and investigations resulted in expected recoveries of $5.8 billion in stolen or misspent funds across Department programs. In addition, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations. The Health Care Fraud and Abuse Control Program (a joint program of the Department, CMS, OIG, and the Department of Justice (DOJ) to fight waste, fraud, and abuse in Medicare and Medicaid) returned more than $8 for every $1 invested. Medicare Fraud Strike Forces, led by OIG and DOJ, have demonstrated success in investigating and prosecuting fraud and shutting down criminal networks.

CMS has taken actions intended to improve the integrity and accuracy of billing for numerous types of services. For example, CMS implemented (1) a provision of the *Affordable Care Act* that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients and (2) a demonstration project that requires prior authorization for scooters and power wheelchairs in seven states with high incidences of fraud and improper payments for these items. CMS is working with home health service providers and practitioners to improve the low initial rates of compliance with this requirement. CMS continues to work to address hospital billing for short inpatient stays and outpatient observation stays, which has significant impacts on Medicare spending, beneficiary cost-sharing, and hospital revenue.

OIG has also noted reductions in Medicare billing and payments for certain services and geographic areas with known fraud risks. For example, following high-intensity law enforcement activities and administrative actions by CMS, billing and payments for home health services and community mental health services declined significantly in fraud hot spots. CMS has also instituted temporary moratoria on the enrollment of new home health agencies in the Miami, Chicago, Fort Lauderdale, Detroit, Dallas, and Houston areas and ambulance transportation suppliers in the Houston and Greater Philadelphia areas. Additionally, CMS continues to develop its Fraud Prevention System (FPS). OIG certified CMS's reported $54 million in actual savings and $210 million in unadjusted savings resulting from year 2 of the FPS, representing a positive return on investment of $1.34 for every $1.

CMS has reported improvements to its oversight and measurement of its contractors' performance and its follow-up on improper payment vulnerabilities that contractors identify. The Department also continues to focus on resolving the backlog of Medicare appeals by providers.

CMS has implemented and is administering ACO programs, value-based purchasing programs, the Bundled Payment for Care Improvement initiative, the Health Care Innovation Awards program, the State Innovation Model program, and others. In September 2014, CMS reported first performance year results for the Medicare Shared Savings Program (MSSP) showing that 53 MSSP ACOs earned shared savings payments of more than $300 million and held spending $652 million below their targets; in total, the Medicare Trust Fund will save approximately $345 million.

What Needs To Be Done

Despite progress in key areas, further actions are needed to protect Medicare from waste and fraud. CMS needs to better ensure that Medicare makes accurate and appropriate payments. When Medicare improper payments occur, CMS needs to identify and recover them in a timely manner. CMS must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve issues about improper payments efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

With respect to promoting value in Medicare, the Department should continue to prioritize the effective transition to value-based payment mechanisms and the development and refinement of quality, outcomes, and performance metrics. Data systems supporting programs that link payment to quality and value must be scrutinized for timeliness, accuracy, and completeness. CMS should continue to strengthen its program integrity tools and apply them as needed to ensure integrity in new models. As demonstration programs continue to unfold, the Department should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems—including inefficiencies, misaligned incentives, or abuses. As with any innovation and experimentation, missteps may occur; it is critical that the Department take effective and appropriate actions to address such missteps and prevent their recurrence.

Key OIG Resources

- OIG Testimony, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse," June 2014, https://oig.hhs.gov/testimony/docs/2014/cantrell_testimony_06252014.pdf
- OIG Testimony, "Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds," May 2014, http://oig.hhs.gov/testimony/docs/2014/Ritchie_testimony_05202014.pdf
- OIG *Compendium of Priority Recommendations*, March 2014, http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2014.pdf

Management Challenge 5: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care

Why This Is a Challenge

As the median age of Americans continues to rise and as more Americans live with chronic medical conditions, the Department faces challenges in ensuring that beneficiaries who require nursing home, hospice, or home- and community-based services (HCBS) receive high quality care. It is critical that these services be available, allowing beneficiaries to receive the care they need in the setting that best serves their needs and preferences. High quality nursing home and HCBS programs are important for the continued well-being of people who need ongoing assistance with daily living, as well as those who need additional help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries by reducing pain and addressing physical and other needs. High quality nursing home, hospice, and HCBS personal care services can often prevent the need for disruptive and costly hospitalizations.

OIG continues to identify various problems with nursing home and hospice care. For example, in reports on nursing homes, OIG raised concerns about the frequency of preventable adverse events due to substandard care, the extent to which nursing homes comply with federal regulations for reporting abuse and neglect, and the lack of monitoring of nursing homes' resident hospitalization rates. With respect to hospice care, OIG has raised concerns about insufficient monitoring of hospice service use, as well as inadequate oversight of hospice certification surveys and hospice-worker licensure requirements.

It is critical to ensure effective oversight of HCBS programs and Medicaid-paid personal care services. HCBS programs are important, in part, because they allow beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid or delay institutionalization. These programs offer many advantages for promoting beneficiary choice and preferences, but OIG efforts have revealed persistent payment, compliance, and quality vulnerabilities.

Progress in Addressing the Challenge

The Department continues to take steps to improve the quality of nursing home, hospice, and HCBS programs. Through its Web site and in various outreach strategies, CMS is providing guidance to nursing homes on how to meet newly expanded quality assessment and performance improvement (QAPI) activities required under the *Affordable Care Act*. Adding to this effort is a recent proposed rule that outlines actions CMS intends to take to remove obsolete or unnecessary provisions affecting nursing homes' ability to carry out these and other requirements. CMS also published rules strengthening nursing home requirements in areas such as emergency preparedness, dementia care, and infection control.

The Department has also taken steps to improve the quality of services beneficiaries receive in hospice settings and from HCBS programs. To improve hospice care, CMS proposed rules that would update the hospice quality reporting program and reform hospice payment methodologies. For HCBS programs, CMS finalized rules covering minimum quality expectations for providers, new administrative flexibilities for states running HCBS programs, requirements for person-centered planning in these services, and enforcement actions CMS can take against HCBS programs out of compliance with requirements. The Department also entered into a contract with the National Quality Forum to begin work on the development of a national quality measure set for HCBS.

OIG continues to pursue enforcement actions against nursing homes, hospices, and HCBS providers that render substandard care. CMS and OIG work closely with law enforcement partners at DOJ and through the federal Elder Justice Interagency Working Group to promote better care for older adults and to prosecute providers committing abuse or neglect. Additionally, state Medicaid Fraud Control Units (MFCUs), which receive oversight and funding

from OIG, devote substantial resources to the investigation and prosecution of abuse and neglect in Medicaid-funded facilities, such as nursing homes and board-and-care homes.

The decision to force a nursing home to shut down or stop serving federal health care program beneficiaries is never taken lightly, as the experience of being transferred is traumatic to displaced beneficiaries, and locating nearby facilities to adequately serve them can be challenging. Therefore, OIG invests substantial efforts in helping facilities improve. OIG has developed an innovative quality-oriented corporate integrity agreement process to work with nursing home providers so they may better serve beneficiaries. OIG has placed nearly 40 nursing home companies (covering more than 750 facilities) under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

What Needs To Be Done

The Department should continue to prioritize quality of nursing home, hospice, and HCBS. OIG has offered recommendations to assist the Department in this mission. For example, OIG recommended that the Department monitor how often nursing home residents are hospitalized and develop resources that can be used to help nursing home staff reduce the incidence of adverse events in nursing homes. OIG has also recommended that the Department seek to link payments for services to meeting quality-of-care requirements and work with OIG to hold providers that have rendered substandard care accountable, thereby preventing additional harm to vulnerable beneficiaries. Further, the Department should promulgate the regulations mandated under section 6102 of the *Affordable Care Act* concerning compliance and ethics programs for nursing homes. Such regulations could assist nursing homes in preventing and detecting fraud, waste, and abuse and promoting quality of care.

Recently, Congress passed two laws that gave the Department new tools to improve the quality of care in nursing homes and other post-acute care providers. The *Protecting Access to Medicare Act of 2014* (PAMA) establishes a value-based payment program for nursing homes under which incentive payments will be made to high performing providers. The *Improving Medicare Post-Acute Care Transformation Act of 2014* (IMPACT) includes new reporting requirements for nursing homes and other post-acute care providers, including standardized admission and discharge patient assessments. IMPACT also includes requirements that hospice programs be surveyed at least once every 36 months and that oversight entities perform chart reviews, in some cases, of hospice episodes longer than 180 days. The Department should use these tools to improve the care people receive in these settings.

Lastly, the Department should ensure the integrity of Medicaid-funded personal care services by establishing minimum federal qualification standards for providers; improving CMS's and states' ability to monitor billing and care quality; and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of personal care attendants. The Department should also issue guidance to states regarding adequate prepayment controls and help states access data necessary to identify overpayments.

Key OIG Resources

- OIG Report, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, February 2014, http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf
- OIG Portfolio, *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement*, November 2012, http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

Management Challenge 6: The Meaningful and Secure Exchange and Use of Electronic Health Information

Why This Is a Challenge

The American health care system increasingly relies on health information technology (health IT) and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. The *Health Information Technology for Economic and Clinical Health Act of 2009* (HITECH) provided for Medicare and Medicaid incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) for adopting, implementing, upgrading, or demonstrating meaningful use of EHRs and established a variety of grant programs to encourage widespread adoption of EHRs. HITECH also included requirements for public reporting of breaches of unsecured protected health information. Although participation in the Medicare and Medicaid EHR Incentive Programs is high and has led to widespread adoption among eligible providers, significant challenges exist with respect to overseeing the EHR Incentive Programs, achieving interoperability of EHRs, and keeping sensitive health information secure. Additionally, as the Department works to link payments with care quality, health outcomes, or performance as part of health care delivery system reforms, it will need to ensure that EHR and other health information data are accurate and reliable and are protected from misuse. (For more information on linking health care payments to value, see Management Challenge 4.)

Medicare and Medicaid EHR Incentive Programs. As of September 2014, the EHR Incentive Programs have paid out $25.4 billion in incentive payments. Although program interest has been high among those eligible, recent data suggest that not all those currently participating will continue in the programs. If the number of program participants were to decrease, fewer eligible professionals, eligible hospitals, and CAHs would progress to Stage 2 meaningful use, which includes a focus on health information exchange. For example, a recent Office of the National Coordinator for Health Information Technology (ONC) report, http://dashboard.healthit.gov/quickstats/pages/FIG-Medicare-Professionals-Stage-One-Meaningful-Use-Attestation-Cohort-2011.php, shows that a substantial number of the first cohort of participants may be dropping out of the Medicare EHR Incentive Program. Of those that received a payment in 2011, 16 percent did not return for 2012. Further, 19 percent of participants dropped out of the Medicare EHR Incentive Program in 2013.

Challenges in program oversight also leave the EHR Incentive Programs vulnerable to inappropriate payments to participants that do not meet program requirements. OIG work has demonstrated vulnerabilities in oversight controls for EHR incentive payments, as well as the accuracy of EHR incentive payment calculations. OIG also found that CMS and states did not implement strong prepayment controls and relied primarily on postpayment audits of high-risk participants to confirm that payments were appropriate. Additionally, OIG found that CMS and states lacked adequate data to verify participants' self-reported attestations about their eligibility and meaningful use of EHRs. ONC requires EHRs to generate audit reports for some, but not all, meaningful use measures; this requirement may create some oversight obstacles for CMS to verify payment during postpayment audits.

An OIG audit of Medicaid EHR incentive payment accuracy in Louisiana found that the state did not always pay Medicaid EHR incentive payments, in accordance with federal and state requirements. OIG found incorrect incentive payments including both overpayments and underpayments, totaling $4.4 million.

Interoperability. Those who adopt health IT must be able to use their systems to exchange and meaningfully use health information in order to achieve the broader policy objectives and cost savings to the health care system. Health information is still not commonly exchanged between groups of health care providers that use different EHR products. For example, most Health Resources and Services Administration (HRSA) health centers had the capability to capture data, but few were able to meet the Stage 1 meaningful use standard for sharing data. As of

September 2014, only 93 hospitals and 2,282 doctors had successfully progressed to Stage 2 meaningful use, which includes functionalities related to exchanging data, including for transitions of care between inpatient, outpatient, and postacute care providers. This may mean that patients' electronic health information is not shared across organizational, vendor, and geographic boundaries. A June 2014 study, http://jamia.bmj.com/content/21/6/1060.full.pdf+html?sid=30b4ae26-1916-4b0d-ac5a-0afd31e2cc95, published in the Journal of the American Medical Informatics Association found that customized health history documents in certified EHRs lead to errors in transmissions between EHR systems, often necessitating manual data entry—a counterproductive outcome. Sharing of data may be impeded by several factors, including costs to establish the capability to share data, complex federal and state privacy and security rules, and system variation.

Further, many health care delivery system reform initiatives envision providers, suppliers, and others coming together in new or enhanced ways to better coordinate patient care and increase efficiency. These reform initiatives include the Medicare Shared Savings Program, the Pioneer ACO Model, and the Bundled Payments for Care Improvement initiative, among others. To improve care coordination and meet performance goals, many participants in these and other reform initiatives will share data across settings and use data received from outside their own systems. A lack of data exchange and incompatibility across systems presents challenges to achieving the benefits promised by EHRs and other health IT and could undermine the goals of some reform initiatives. Data created, maintained, or transmitted using EHRs or other health IT are used to ensure correct Medicare and Medicaid payments, including value-based payments. Participants in some of these payment initiatives also receive Departmental data for their use in improving the care they furnish. Those data similarly must be accessible and accurate.

Protecting Sensitive Information. Safeguarding privacy and data security is, and should remain, a top priority in health IT adoption and health data exchange, storage, and use efforts. Health care data breaches can have serious consequences, including medical identity theft, misdiagnoses, delays in treatment, and mistreatment of illness. Following HITECH's enhancements of breach notification requirements, HHS's database of major breach reports affecting 500 people or more has tracked nearly 950 incidents affecting the personal information of about 30.1 million people. OIG consistently finds gaps in adherence to security standards set by the *Health Insurance Portability and Accountability Act* and the National Institute of Standards and Technology. During our audits of hospitals and covered entities, we identified weaknesses that included inadequacies in access controls, patch management, encryption of data, and Web site security vulnerabilities. Such weaknesses could result in unauthorized access to sensitive health information.

Safeguarding EHRs From Fraud. Some of the beneficial characteristics of EHRs, including efficiency and ease of storage and access, may also make them tools for fraud. OIG work in examining fraud safeguards in EHRs found that protections designed to improve validity, accuracy, and integrity in EHRs were not being used to their full extent. Only about one-quarter of hospitals have policies regarding the use of copy-paste, a feature that could be used inappropriately to add documentation to a patient's record to support a fraudulent bill for services that were never provided. Deleting or disabling audit logs could make it harder to prevent and detect fraud. Furthermore, CMS and its program integrity contractors have done little to update their practices to address EHR vulnerabilities.

Progress in Addressing the Challenge

The Department has made great strides in developing a foundational health IT infrastructure by making inroads with EHR adoption, establishing privacy and security guidance and standards, and offering services to support health information exchanges (HIE) and interoperability. As of September 2014, 95 percent of eligible hospitals and CAHs and 92 percent of physicians and other eligible professionals have registered to participate in the EHR Incentive Programs, amounting to more than 500,000 eligible professionals, eligible hospitals, and CAHs.

With respect to oversight of the EHR Incentive Programs, CMS has audited Medicare providers who received EHR incentive payments to gauge the accuracy of, among other things, attestations that risk analyses designed to protect electronic health information were conducted. CMS also reports that it began conducting pre-payment audits in 2013. If the Department continues to takes steps to ensure that meaningful use requirements include necessary safeguards, these audits will be a helpful oversight and enforcement tool.

ONC has issued a document entitled "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" (10-Year Vision Paper), http://healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf, which describes future efforts to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide interoperable health information infrastructure.

What Needs To Be Done

The 10-Year Vision Paper states that, "[b]y 2024, individuals, care providers, communities, and researchers should have an array of interoperable health IT products and services that allow the health care system to continuously learn and advance the goal of improved health care." The desired "learning health system" should, according to the 10-Year Vision Paper, also enable lower costs, improved population health, and other benefits. To fully realize the value of an over $24 billion investment, the Department must do more to ensure that systems are interoperable in order to realize these goals.

As the Department progresses through the development and implementation of meaningful use stages, it should continue to consider feedback from stakeholders to ensure that adopted policies advance the Nation towards the Department's stated goals, while appropriately reflecting the changing health IT landscape. Guidance and technical assistance should be issued to address adoption, meaningful use, and interoperability barriers and program integrity safeguards. It is also essential that privacy, security, and fraud prevention remain at the forefront of the Department's, ONC's, and CMS's health IT efforts.

Finally, given the magnitude of the investment in EHRs and other health IT programs, it will become increasingly important to demonstrate and measure the extent to which EHRs and health IT have actually achieved the Department's goals, which include improved health care and lower costs. Ongoing OIG work is examining the accuracy of Medicare and Medicaid EHR incentive payments for the first stage of meaningful use and attempting to determine whether Medicaid safeguards prevent improper payments. Future work may examine health IT interoperability across providers, across HHS, and between providers and patients, as well as examine outcomes from health IT investments.

Key OIG Resources

- OIG Reports on EHR Incentive Program Oversight, January 2014, http://oig.hhs.gov/oei/reports/oei-09-11-00380.pdf; August 2014, http://oig.hhs.gov/oas/reports/region6/61200041.pdf; November 2012, http://oig.hhs.gov/oei/reports/oei-05-11-00250.pdf; July 2011, http://oig.hhs.gov/oei/reports/oei-05-10-00080.pdf; December 2013, http://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf
- OIG Report, *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology*, December 2013, http://oig.hhs.gov/oei/reports/oei-01-11-00570.pdf
- OIG Report, *CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs*, January 2014, http://oig.hhs.gov/oei/reports/oei-01-11-00571.pdf
- OIG Report, *The Office of the National Coordinator for Health Information Technology's Oversight of the Testing and Certification of Electronic Health Records*, August 2014, http://oig.hhs.gov/oas/reports/region6/61100063.pdf

Management Challenge 7: Effectively Operating Public Health and Human Services Programs To Best Serve Program Beneficiaries

Why This Is a Challenge

The Department funds and operates public health and human services programs that promote health and economic and social well-being. These include, among others, programs to prevent, track, and treat acute and chronic diseases; respond to natural and man-made disasters; and protect, care for, and educate children. Many of these programs target vulnerable populations. Effective management of these programs is essential to ensure that they achieve their goals and best serve the programs' intended beneficiaries. Key challenges include (1) ensuring effective preparedness and response to current and future public health emergencies, (2) protecting the health and safety of America's vulnerable populations, and (3) ensuring access for intended beneficiaries and delivery of quality services such that beneficiaries' needs are met.

Public Health Preparedness and Emergency Response. Recent natural disasters, such as Hurricane Sandy, and disease outbreaks, such as the Ebola virus outbreak, highlight the importance of an agile public health infrastructure that can rapidly and capably respond to emergencies at home and abroad. The ability to effectively communicate and coordinate with federal, state, local, tribal, and private entities, as well as with international partners, is critical. OIG's recent review of hospitals' experiences during Hurricane Sandy revealed that the vast majority of hospitals in affected areas reported substantial challenges, including infrastructure breakdown and communication failures. The recurrence of similar problems as experienced during prior disasters highlights the need to apply knowledge gained from past experience to anticipate and prepare for new problems going forward.

The Department is also responsible for ensuring that select agents (e.g., anthrax and smallpox), which have the potential to pose a severe threat to human, animal, or plant health, are handled safely and stored securely. Earlier work by OIG identified security vulnerabilities at many Department research facilities, and recent testimony and news accounts attest to continuing problems with how these agents are inventoried and handled.

Access to and Quality of Services. To achieve program goals, the Department must ensure that qualified beneficiaries have access to high quality services. OIG work has uncovered situations in which beneficiaries could not access key services and situations in which beneficiaries received substandard services. For example, OIG found that many HRSA-funded health centers, which provide primary care for millions of patients, failed to fully adopt CDC-endorsed practices for routine HIV testing that are recommended to help combat spread of the virus. In another example, OIG found that vaccines intended for use in the Vaccines for Children (VFC) program had expired or had been improperly stored in ways that could compromise their safety or efficacy. Additional challenges arise in ensuring that children in foster care receive required health screenings.

Protecting Vulnerable Populations. OIG work has revealed potential threats to the health and safety of children served by the Child Care and Development Fund (CCDF) program of the Administration for Children and Families. CCDF provides financial assistance for child care, each month serving approximately 1.45 million children from low income families. OIG work identified vulnerabilities in states' standards for and monitoring of child care providers and suggested efforts the Department should undertake to better serve this vulnerable population.

Since first assuming responsibility for unaccompanied children in 2003, the Office of Refugee Resettlement (ORR) has cared for more than 100,000 such children, through the end of FY 2013. This year, the number of unaccompanied children arriving in the United States without lawful immigration status has dramatically increased. In 2014, the Department estimates that the total number of such unaccompanied children will reach nearly 60,000, more than double the number from the prior year. ORR faces substantial demands in adequately caring for this influx of children in an environment of heightened public and media scrutiny.

Progress in Addressing the Challenge

The Department reports that it has made progress in improving physical security and employee training related to secure storage and safe handling of select agents; however issues related to inventory control in HHS laboratories remain.

CMS is developing more comprehensive emergency preparedness requirements for Medicare providers and suppliers. The Department is currently undertaking several initiatives, including a technical assistance center, to support collaboration among federal, state, and community entities in disaster response. Similarly, in response to OIG's recommendations, the Department has established new training materials for its grantees and providers to ensure that VFC vaccines are stored according to requirements.

What Needs To Be Done

The Department must effectively deploy its resources and expertise to combat communicable diseases, such as Ebola. The Department should continue to promote federal, state, tribal, and community collaboration in major disasters and public health exigencies. While it may not be possible to predict when and where disasters will strike, the Department should prepare for a range of potential emergency scenarios and be ready to rapidly and effectively respond. Similarly, the Department must plan for, and meaningfully assist health care providers in planning for, a range of public health emergencies. Additionally, improvements in adoption and interoperability of health IT can facilitate medical care for displaced patients or patients with communicable diseases by ensuring continuity of access to health records. (For additional discussion on issues related to the secure exchange of health care information, see Management Challenge 6.)

The Department should also fully implement OIG recommendations to ensure that HRSA-funded health centers follow CDC recommendations regarding routine HIV testing to prevent disease transmission. Improved program operation will better serve beneficiaries and help prevent future public health emergencies.

Given the recent unprecedented surge in unaccompanied children, the Department must be prepared to meet future demand for services for additional children. OIG continues to recommend that the Department establish a memorandum of understanding with the Department of Homeland Security to clearly delineate the roles and responsibilities of each Department and facilitate gathering and exchange of information regarding unaccompanied children.

The Department should also fully implement OIG recommendations regarding CCDF to ensure compliance with state requirements related to the health and safety of children, implementation of controls for determining eligibility for receiving assistance payments, and ensuring that states implement better controls for regulating and monitoring childcare providers. OIG has also recommended strengthened health and safety requirements and use of provider background checks to reduce health and safety risks to children served by the programs.

The Department will need to take swift action to significantly improve its inventory control policies and procedures for select agents in light of recent news reports identifying significant issues with inventory controls, which the Department has confirmed.

Key OIG Resources

- OIG Report, *Hospital Emergency Preparedness and Response During Superstorm Sandy*, November 2014, http://oig.hhs.gov/oei/reports/oei-06-13-00260.asp
- OIG Testimony, "The Foundation for Success: Strengthening the Child Care and Development Block Grant Program," March 25, 2014, http://oig.hhs.gov/testimony/docs/2014/jarmon-testimony-0314.pdf
- OIG Report, *HIV Testing in HRSA-Funded Health Center Sites*, November 2013, http://oig.hhs.gov/oei/reports/oei-06-10-00290.asp

- OIG Report, *Vaccines for Children: Vulnerabilities in Vaccine Management*, April 2012, http://oig.hhs.gov/oei/reports/oei-04-10-00430.asp
- OIG Report, *Division of Unaccompanied Children's Services: Efforts To Serve Children*, March 2008, http://oig.hhs.gov/oei/reports/oei-07-06-00290.pdf

Management Challenge 8: Ensuring Effective Financial and Administrative Management

Why This Is a Challenge

The Department manages health care insurance, public health, social services, and research programs designed to enhance the health, safety, and well-being of all Americans. Responsible stewardship of these programs is vital. Underpinning such stewardship should be a financial management and administrative infrastructure that employs appropriate internal controls to minimize risk to the programs and safeguard resources.

Financial statement audits. Financial statement audit results provide an important assessment of financial management challenges an agency faces. For FY 2013, independent auditor Ernst & Young identified a material weakness in the Department's financial management systems related to IT security and a significant deficiency in its financial reporting systems, analyses, and oversight. Specifically, Ernst & Young recommended that the Department bolster IT security in its financial management systems and take steps to improve internal control deficiencies that impact HHS's ability to report accurate financial information on a timely basis.

The financial statement audit also revealed challenges the Department continues to face in addressing violations of certain provisions of the *Anti-Deficiency Act*. These violations highlight weaknesses in an agency's control over budgetary resources. Prior OIG audits of National Institutes of Health contracts revealed instances of improper funding in 11 of 18 contracts reviewed. Follow-up work is underway to assess the effectiveness of the remedial actions outlined by the Department in its 2011 report of *Anti-Deficiency Act* violations.

Improper payments. Improper payments cost federal programs billions of dollars annually. For FY 2013, the Department reported improper payments totaling almost $50 billion in the Medicare program and $65 billion overall. Pursuant to the *Improper Payments Information Act of 2002* (IPIA), as amended, federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. Inspectors General are required to report annually to Congress and The President regarding agency compliance with IPIA. Although the Department met many requirements of the IPIA in FY 2013, it did not fully comply. The greatest challenges in this area are to report on all programs deemed susceptible to significant improper payments and minimize improper payments to acceptable levels. The Department has not published an improper payment estimate and other required information for the Temporary Assistance for Needy Families (TANF) program. For the Medicare fee-for-service program, the Department reported an improper payment rate that exceeded 10 percent of program outlays in FY 2013.

Administrative Oversight. Careful coordination of Departmental staff, contract staff, grantees, and other partners is essential to achieve mission objectives in accordance with federal, departmental, and agency requirements. Many grantees receive multiple awards from HHS. The discontinuation of the Department-wide Alert List in 2007 may pose challenges for awarding agencies to share concerns with one another regarding grantees' abilities to handle federal funds. Moreover, OIG found that only one of four agencies within HHS that awarded Small Business Innovation Research (SBIR) funds checked for duplicative funding within the Department, and none of the four completed a required check for duplicative awards across other federal agencies. OIG is currently evaluating the extent to which HHS programs maintain and share information about grantees vulnerable to fraud, waste, and abuse. (For more information on specific issues associated with grantee and contractor oversight and effectiveness, see Challenge 9.)

Progress in Addressing the Challenge

The Department has been taking steps to address outstanding financial management challenges. Most significantly, to help address a number of shortcomings, it has scheduled an upgrade of its accounting systems, which the Department expects to complete in 2016, to alleviate internal control deficiencies it has reported in the financial statement audits.

With respect to *Anti-Deficiency Act* violations related to systemic contract funding problems, the Department continues to provide its contracting workforce with an online reference tool for contract funding, formation, and appropriations law compliance. The Department conducts appropriations law compliance reviews of all contract actions exceeding certain thresholds, depending on the type of requirement reviewed and the awarding Operating Division (OpDiv) or Staff Division (StaffDiv). HHS has also revised its contract funding guidance to more accurately describe appropriations law and policy; these revisions incorporated best practices and lessons learned. Further, in its FY 2013 *Agency Financial Report*, the Department stated that it released a major update to its internal grants policies, featuring enhanced guidance on grants closeout, suspension and debarment, grants systems, and grants payments.

With regard to improper payments, the Head Start program had reported a consistently low improper payment rate which has been below the mandated threshold for reporting, and Office of Management and Budget (OMB) granted the Department relief from reporting annual error rate estimates in FY 2013. Further, between FY 2012 and FY 2013, the Department reduced the improper payment rate for Medicare Advantage from 11.4 percent to 9.5 percent, for Medicaid from 7.1 percent to 5.8 percent, for the Child Care and Development Fund from 9.4 percent to 5.9 percent, and for the Foster Care program from 6.2 percent to 5.3 percent.

HHS is drafting regulations to implement OMB's new Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, commonly referred to as the Uniform Guidance. The Uniform Guidance consolidates eight federal regulations into a single guide to ease administrative burdens and strengthens oversight of federal awards to reduce the risk of fraud, waste, and abuse.

What Needs To Be Done

To ensure better financial management across all program areas, the Department should resolve weaknesses identified across all financial management systems currently in operation, as recommended by internal and external auditors. To bring the Department into full compliance with the IPIA, it should continue to reduce error rates in all programs via appropriate corrective action plans. However, full compliance would also require the Department to publish an improper payment estimate for the TANF program. To do this for TANF, the Department reports it needs legislative changes to require states to report information necessary to calculate and report improper payment estimates for TANF. The Department should actively seek such legislative changes. CMS should work to improve its oversight of corrective action plans to ensure their relevance to contractors' error measurement.

Grant-making agencies, including HHS, are scheduled to implement OMB's new Uniform Guidance by the end of calendar year 2014. In accordance with the new guidance, the Department will need to implement robust new processes, including enhancements to processing the Single Audit reports. OIG will monitor the Department's implementation of these new processes and future reform efforts. OIG will also continue to examine existing administrative controls and grants management practices across the Department.

The Department should continue to leverage technology to further prevent improper payments and ensure responsible program stewardship. The Department should also continue to expand its education efforts for providers, grantees, staff, contractors, and other partners. Implementation of planned program integrity efforts, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues, resolving reported grantee

audit findings, and sharing best practices across HHS, will help the Department integrate program integrity into all aspects of its operations and culture and fortify the financial and administrative infrastructure.

Key OIG Resource

- OIG Report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2013, April 2014, https://oig.hhs.gov/oas/reports/other/171452000.asp
- OIG Report, Medicare Claims Administration Contractors' Error Rate Reduction Plans, January 2014, http://oig.hhs.gov/oei/reports/oei-09-12-00090.asp

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

Why This Is a Challenge

HHS is the largest grant-making organization in the Federal Government; over 79,000 grants totaling $389 billion were awarded in FY 2014. That amount comprised $47 billion in discretionary awards and the remaining amount in formula/block grant and entitlement awards.

HHS is also the third largest contracting agency in the Federal Government. In FY 2013, HHS awarded over $20 billion in contracts across all program areas. The Government Accountability Office (GAO) and OIG both have identified weaknesses in HHS contracting processes and contract management throughout the Department. Oversight is a particular concern. An OIG audit of CDC contracts revealed poor execution of required contractor performance assessments by HHS. A recent GAO report, http://www.gao.gov/products/GAO-14-694, identified ineffective contract planning and management as one cause of the problematic rollout of HealthCare.gov. In addition, recent OIG work identified the large number of contractors responsible for aspects of the federal Marketplace and requiring appropriate oversight and management. Under the *Affordable Care Act*, contractors have a vital role in building, maintaining, and fixing the systems that underpin the federal Marketplace. HHS faces a challenge to ensure proper management and oversight of these and other contracts. (See Management Challenge 1 for more information on management and oversight of the Marketplaces.)

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

A common problem uncovered by our reviews at the grantee level is that grantees have lacked robust financial management systems. Many grantees still do not account for specific costs on a grant-by-grant basis, making it difficult to reliably monitor and account for costs associated with specific grant awards. When combined with frequent findings of significant unallowable expenses, these conditions support the need for more purposeful and consistent oversight.

HHS is the second largest payer under the SBIR and Small Business Technology Transfer (STTR) programs. HHS awarded $13 million in SBIR contracts and $463,000 in STTR contracts in FY 2013. OIG has noted two significant issues with the programs: inconsistent collection of information needed to evaluate commercial success and failures to check for duplicative funding within the Department and across other agencies. (See Management Challenge 8 for more information on administrative oversight of HHS grants and contracts.)

Progress in Addressing the Challenge

HHS has strengthened its program integrity efforts by working with OpDivs and StaffDivs to implement a uniform risk management approach that encompasses developing strategies, plans, and metrics. The Department has established a Program Integrity Coordinating Council, which identifies common program challenges and explores solutions.

The Department has sponsored training for HHS grant and contracting officials to aid them in identifying potential fraud, waste, and abuse, including encouraging contractors to self-report contract fraud and overpayments. Training has also taken place on best practices for investigating fraud in HHS grants and contracts.

The Department has made progress in its Suspension and Debarment program by conducting training, finalizing the HHS Suspension and Debarment Guidance and accompanying Desk Reference, creating a Department-wide referral tracking system, and working with the Office of the General Counsel to streamline the referral review process. The total number of suspension and debarment referrals according to the Office of Recipient Integrity Coordination (ORIC) has increased from 22 in FY 2012 to 42 in FY 2013, and the total number of actions taken by the Suspension and Debarment Officer (SDO) has increased from 0 suspensions or debarments in FY 2012 to 8 debarments and 8 suspensions in FY 2013. The Department is on track to increase the number of suspensions and debarments in FY 2014.

What Needs To Be Done

Sustained focus by the Department is needed to address vulnerabilities in its grant programs and contract administration. For instance, although the Department designed internal controls with features specified by OMB Memorandum M-13-07, this effort must be followed by diligent monitoring to ensure that qualified individuals have access to grants and that recipients use the funds according to the award terms and in a manner consistent with the *Disaster Relief Appropriations Act of 2013*.

HHS could improve federal contracting by aligning more closely with the Office of Federal Procurement Policy (OFPP) strategy of improving contractor source selection decisions. A key part of OFPP's strategy is contractor performance monitoring. HHS has improved its rate of monitoring from 10 percent to 24 percent in the last two years. However, according to a recent GAO report, http://www.gao.gov/products/GAO-14-707, that rate is less than half the FY 2014 government-wide rate of 49 percent.

OpDivs must be vigilant in monitoring grant resources and take appropriate actions, including: implementing planned program integrity efforts, such as evaluating and mitigating risks and identifying and addressing cross-cutting issues; resolving grantee audit findings; and sharing best practices across the Department to better position HHS to integrate program integrity into all aspects of its operations and culture.

Training on identifying and pursuing misconduct in HHS grants and contracts should continue. HHS contract and grant officers should more actively coordinate with, and refer potential grant and contract fraud to, OIG for investigation. The Department needs to implement a program to actively pursue fraud under the *Program Fraud Civil Remedies Act* (PFCRA). The Department also needs to continue to refine its suspension and debarment procedures by further streamlining the referral and decision process, continuing to provide training and decreasing the processing time of referrals. Although HHS has begun to take suspension and debarment actions largely in response to conviction-based actions, OpDivs, StaffDivs, OIG, and the SDO need to make effective use of fact-based debarments and suspensions.

Key OIG Resources

- OIG Hurricane Sandy Grants and Contracts Training Videos, http://oig.hhs.gov/newsroom/podcasts/2014/sandy/
- OIG Report, *The Department of Health and Human Services Designed Its Internal Controls Over Hurricane Sandy Disaster Relief To Include Elements Specified by the Office of Management and Budget*, July 2014, http://oig.hhs.gov/oas/reports/region2/21302010.asp
- OIG Report, *Vulnerabilities in the HHS Small Business Innovation Research Program*, April 2014, http://oig.hhs.gov/oei/reports/oei-04-11-00530.asp

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

Why This Is a Challenge

The Department, through the Food and Drug Administration (FDA), is responsible for protecting public health by ensuring the safety, efficacy, and security of drugs, medical devices, biologics, dietary supplements, tobacco, and much of our Nation's food supply. The Department must ensure that once a drug, biologic, or device has been approved for use, it conducts effective post-market monitoring. During a food emergency, the Department is responsible for finding the contamination source and overseeing the removal of these products from the market. However, OIG work has revealed weaknesses in FDA's ability to adequately oversee the safety of drugs, biologics, medical devices, and food. It has also revealed failures by industry participants to follow processes designed to ensure the safety and efficacy of food, drugs, biologics, and medical devices. These high risk areas include:

Drug Compounding. A fall 2012 nationwide fungal meningitis outbreak associated with contaminated compounded sterile drug injections raised major concerns about the quality of drugs supplied by compounders and FDA's ability to effectively oversee these entities. OIG reviewed hospitals' use of compounded drugs and found that in 2012, 92 percent of hospitals used compounded sterile preparations (CSPs). Additionally, we found that 56 percent of hospitals made changes or planned to make changes to CSP sourcing practices in response to the 2012 outbreak. After the meningitis outbreak, in November 2013, President Obama signed the *Drug Quality and Security Act* (DQSA), Public Law 113-54. Among other things, the DQSA added a new section to the *Federal Food, Drug, and Cosmetic Act*, section 503B, that provides a new pathway for entities called "outsourcing facilities" to legally compound human drugs. FDA also continues to identify serious deviations from acceptable practices for the production of compounded sterile drugs, as evidenced by the lists of inspectional observations issued to compounders at the conclusion of FDA inspections; the numerous recalls of compounded drugs because of contamination or lack of sterility assurance; and the warning letters issued to compounders addressing, in part, unsanitary conditions at their facilities. Implementation of the DQSA poses new challenges for the Department.

Imported Drugs. Medications imported from foreign or unlicensed suppliers may be unapproved by FDA and may be ineligible for reimbursement by Medicare, Medicaid, and other federal health care programs. Such drugs may also be counterfeit, contaminated, ineffective, and/or unsafe. FDA's Office of Criminal Investigations (OCI), OIG, and our law enforcement partners have investigated many instances in which physician practices, drug distributors, and suppliers have imported such drugs. Among other consequences, importation of such drugs can lead to patient safety issues, the submission of improper claims to federal health care programs, and the circumvention of FDA drug approval and facility inspection processes.

Food Safety. Protecting the American public from food-borne illness, such as those caused by salmonella and E. coli, is an ongoing challenge. In the past, OIG has found that food facilities' failures to comply with FDA's requirements impede the Department's ability to ensure the safety of the Nation's food supply. Since September 2009, FDA has required food facilities to report to a new registry all instances when there is a reasonable probability that a food might cause serious adverse health consequences and to investigate the causes of any

adulteration reported if the adulteration may have originated with the food facility. The *Food Safety Modernization Act* (FSMA), signed into law in January 2011, provides FDA important authorities to better protect the Nation's food supply. However, implementing these authorities could prove difficult given the broad preventive controls framework envisioned in FSAM, including establishing the new import oversight program and the training needed to ready both FDA and the states to conduct preventive control inspections.

Marketing Requirements. Manufacturers of drugs, biologics, and medical devices gain approval for sale of their products for specific uses once FDA determines that the products are safe and effective for those uses. Once approved for sale, qualified medical providers may prescribe them for any use on the basis of their medical judgment. However, manufacturers are prohibited from promoting products for uses for which FDA has not specifically approved them (known as off-label uses). OIG, in conjunction with its law enforcement partners, including FDA's OCI, has investigated many instances in which manufacturers illegally promoted products for off-label uses. Off-label promotion can undermine the system intended to ensure that drugs are safe and effective and can put patients at risk. Additionally, this illegal off-label promotion may lead to fraudulent claims for payment submitted to federal health care programs, including Medicare and Medicaid. (See Management Challenge 2 for more information on drug diversion and appropriate use of prescription drugs in Medicare and Medicaid.)

FDA faces ongoing concerns regarding dietary supplements and the structure/function claims made by manufacturers. Structure/function claims describe the role of a dietary supplement in the structure and function of human bodies, but the claims may not explicitly or implicitly claim to prevent, treat, mitigate, cure, or diagnose a disease. Manufacturers must have competent and reliable scientific evidence to show that dietary supplement claims are truthful and not misleading, but they do not have to submit the substantiation to FDA, and FDA has only voluntary standards for it. OIG found that substantiation documents for the supplements reviewed were inconsistent with FDA guidance on competent and reliable scientific evidence. OIG also found that FDA could not readily determine whether manufacturers had submitted the required notification for their claims. These results raise questions about the extent to which structure/function claims are truthful and not misleading.

Progress in Addressing the Challenge

To address risks associated with imported drugs, FDA has engaged in both outreach and enforcement actions. FDA has undertaken significant efforts to warn consumers, medical practitioners, and others about the risks associated with buying drugs from foreign sources. In addition, FDA has continued to work with OIG and other law enforcement partners to investigate and prosecute individuals and businesses (e.g., physicians and drug suppliers) that import unapproved drugs. In July 2013, three physicians previously associated with McLeod Cancer and Blood Center entered into civil settlement agreements and agreed to pay more than $4.25 million to resolve allegations that they purchased misbranded, unapproved chemotherapy drugs from foreign sources; used the drugs to treat their Medicare, Medicaid, and other patients; and billed federal health care programs for the drugs. Dr. William Kincaid, the managing partner, pled guilty to receiving misbranded drugs with intent to defraud and mislead. Dr. Kincaid was sentenced to 2 years in prison and was excluded from participating in federal health care programs for 10 years.

With regard to drug compounding, FDA increased inspection and enforcement efforts, while developing the regulatory framework to implement the DQSA. In FY 2014, FDA conducted over 85 inspections of compounding pharmacies and outsourcing facilities and issued 29 warning letters. FDA's inspection and enforcement efforts are continuing. In addition, since the DQSA was enacted in November, 2013, FDA issued numerous policy documents to implement both section 503A (concerning pharmacy compounding) as well as the new section 503B (concerning outsourcing facilities) and continues to work on additional rules and guidance. FDA has made progress in addressing OIG recommendations. For example, as a result of OIG's identifying vulnerabilities in FDA's oversight of

regulatory decisions, FDA implemented new operating procedures for resolving scientific disagreements. In response to OIG recommendations regarding oversight of dietary supplements, FDA stated that it is considering whether to seek explicit statutory authority to review substantiation for structure/function claims beyond its pre-existing authorities.

What Needs To Be Done

The Department and FDA will need to continue issuing rules and guidance documents to fully implement the various provisions in the July 2012 *Food and Drug Administration Safety and Innovation Act* (FDASIA) and in DQSA. FDA will need to continue to conduct inspections of compounding pharmacies and pursue regulatory action, as needed to protect public health, when deficiencies are identified. In addition, FDA will need to continue its efforts to fully implement FSMA to better protect the Nation's food supply. FSMA addresses many of OIG's recommendations; however, we continue to recommend that FDA remedy identified weaknesses in its inspections and recall procedures. FDA should also ensure that states properly conduct contracted food facility inspections. The Department also needs to continue its efforts to eliminate off-label promotion and reduce the importation of unapproved drugs from foreign sources to protect patients and HHS health care programs. Moreover, the Department and FDA will need to continue implementing the provisions under the 2009 *Family Smoking Prevention and Tobacco Control Act* to protect public health.

Key OIG Resources

- OIG Report, *High-Risk Compounded Sterile Preparations and Outsourcing by Hospitals That Use Them*, April 2013, https://oig.hhs.gov/oei/reports/oei-01-13-00150.asp
- OIG Report, *Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements*, October 2012, http://oig.hhs.gov/oei/reports/oei-01-11-00210.asp
- OIG Report, *Vulnerabilities in FDA's Oversight of State Food Facility Inspections*, December 2011, http://oig.hhs.gov/oei/reports/oei-02-09-00430.asp
- DOJ press release, sentencing of William Kincaid, M.D., June 11, 2013, http://www.justice.gov/usao/tne/news/2013/June/061113%20Kincaid%20Sentencing%20Misbranded%20Drugs.html#top

DEPARTMENT'S RESPONSE TO OIG TOP MANAGEMENT CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: William V. Corr, Deputy Secretary

Subject: FY 2014 Top Management and Performance Challenges Identified by the Office of Inspector General (OIG)

Thank you for your memorandum "Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2014" issued November 12, 2014. We remain committed to enhancing the financial and operational effectiveness of HHS and appreciate OIG's role in the effort.

We concur with OIG's findings concerning HHS. We appreciate the cooperation and work conducted by OIG to help us address the Department's major management and performance challenges. Our management is committed to resolving these challenges to help us achieve our mission of improving the health and well-being of the American people.

Many thanks to you and your staff for your continued commitment in helping us improve our management environment. We look forward to working with you to further address these challenges.

/William V. Corr/

William V. Corr
Deputy Secretary
November 13, 2014

APPENDIX A: ACRONYMS

3D	Three-dimensional
AA	Associate of Arts
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ACR	Administrative Cost Review
ADA	*Anti-Deficiency Act*
ADRCs	Aging and Disability Resource Centers
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
AIDD	Administration for Intellectual and Development Disabilities
ALJ	Administrative Law Judge
AOA	Administration on Aging
APP	Application
APTC	Advance premium tax credits
ASA	Office of the Assistant Secretary for Administration
ASC	Ambulatory Surgical Center
ASFR	Office of the Assistant Secretary for Financial Resources
ASL	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BA	Bachelor of Arts
BARDA	Biomedical Advanced Research and Development Authority
BHPR	Bureau of Health Professions
CAHs	Critical Access Hospitals
CAIVRS	Urban Development's Credit Alert Interactive Voice Response System
CAP(s)	Corrective Action Plan(s)
CAUTI	Catheter-Associated Urinary Tract Infections
CBRs	Comparative Billing Reports
CCDF	Child Care Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CEAR	*Certificate of Excellence in Accountability Reporting*
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	*Children's Health Insurance Program Reauthorization Act of 2009*
CIO	Chief Information Officer
CISO	Chief Information Security Officer
CL	Current Law
CLABSI	Central Line-associated Bloodstream Infections
CMA	Computer Matching Agreement
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
COLA	Cost of Living Adjustment
COTS	Commercial Off the Shelf
CPI	Consumer Price Index
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
CPIM	Consumer Price Index-Medical
CRADA	Cooperative Research and Development Agreement
CRC	Commercial Repayment Center
CSPs	Compounded Sterile Preparations
CSR	Cost-sharing reductions
CSRS	Civil Service Retirement System
CUSP	Comprehensive Unit-Based Safety Program
CY	Current Year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DEA	Drug Enforcement Agency
DHS	Department of Homeland Security
DIR	Direct and Indirect Remuneration
DMDC	DOD's Manpower Date Center
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics Orthotics and Supplies
DNP	Do Not Pay
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*
DQSA	*Drug Quality and Security Act*
EHR	Electronic Health Records
ESRD	End-Stage Renal Disease
FASAB	Federal Accounting Standards Advisory Board
FBIS	Financial Business Intelligence System
FBIP	Financial Business Intelligence Program
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FDASIA	*Food and Drug Administration Safety and Innovation Act*
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees' Retirement System
FETP	Field Epidemiology Training Program
FFM	Federally Facilitated Marketplace
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFR	Federal Financial Report
FFS	Fee-for-Service
FGB	Financial Governance Board
FICA	*Federal Insurance Contributions Act*
FIFO	First-in/first-out
FISMA	*Federal Information Security Management Act of 2002*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FOA	Funding Opportunity Announcement
FPS	Fraud Prevention System
FR	Final Rule
FSMA	*Food Safety Modernization Act*
FMAP	Federal Medical Assistance Percentage
FSIP	Financial Systems Improvement Program
FVPS	Family Violence Prevention and Services
FWA	Fraud, waste, and abuse
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GMRA	*Government Management Reform Act of 1994*
GMS	Grants Management Specialist
GSA	General Services Administration
HAIs	Healthcare-Associated Infections
HCBS	Home-and community-based- services
HCS	Health Care System
HEAL	Health Education Assistance Loan
HEW	Department of Health, Education and Welfare (now HHS)
HFPP	Healthcare Fraud Prevention Partnership
HHAs	Home Health Agencies
HHS	Department of Health and Human Services

HI	Hospital Insurance
HIE	Health Information Exchange
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HITECH	*Health Information Technology for Economic and Clinical Health Act*
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HSOPS	Hospital Survey of Patient Safety
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
ICUs	Intensive Care Units
IDDA	Intra-Departmental Delegation of Authority
IEA	Office of Intergovernmental and External Affairs
IEVS	Income Eligibility Verification System
IG	Inspector General
IHS	Indian Health Service
IMPACT	*Improving Medicare Post-Acute Care Transformation Act of 2014*
IOS	Immediate Office of the Secretary
IP	Improper Payments
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPERIA	*Improper Payments Elimination and Recovery Improvement Act of 2013*
IPIA	*Improper Payments Information Act of 2002*
IRS	Internal Revenue Service
IT	Information Technology
LEIE	List of Excluded Individuals & Entities
LLP	Limited Liability Partnership
LPR	Legal Permanent Resident
J&J	Johnson & Johnson
MA	Medicare Advantage or Part C
MACS	Medicare Administrative Contractors
MARX	Medicare Advantage Prescription Drug
M.D.	Medical Doctor
MD&A	Management's Discussion and Analysis
MEDIC	Medicare Drug Integrity Contractors
MFCUS	Medicaid Fraud Control Units
MIC	Medical Integrity Contractors
MII	Medicaid Integrity Institute
MLN	Medicare Learning Network
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MMIS	Medicaid Management Information Systems
MSIS	Medicaid Statistical Information Systems
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Saving Program
NAMD	National Association of Medicaid Directors
NBI	National Benefit Integrity
NBS	NIH Business Systems
NCCI	National Correct Coding Initiative
NEI	National Eye Institute
NDNH	National Directory of New Hires
NHSC	National Health Service Corps
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
NOA	Notice of Award
NPI	National Provider Identifier
OACT	Office of the Actuary
OASDI	Old-Age Survivors and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCI	Office of Criminal Investigations
OCR	Office for Civil Rights
OFPP	Office of Federal Procurement Policy
OGA	Office of Global Affairs
OGC	Office of the General Counsel

OHR	Office of Health Reform
OI	Other Information
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Development
OpDiv	Operating Division
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
PAMA	*Protecting Access to Medicare Act of 2014*
PARIS	Public Assistance Reporting Information System
PDE	Prescription Drug Event
PEDIR	Payment Error related to Direct and Indirect Remuneration
PELS	Payment Error related to Low-Income Subsidy Status
PEMS	Payment Error related to Medicaid Status
PEPV	Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PFCRA	Program Fraud Civil Remedies Act
PHD	Doctor of Philosophy
PHS	Public Health Service
PIP	Program Improvement Plan
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PUPS	Social Security Administration's Prisoner Update Processing System
PUR	Period Under Review
PY	Prior Year
QAPI	Quality Assessment and Performance Improvement
QIO	Quality Improvement Organization
QRIS	Quality Rating and Improvement Systems
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
RFQ	Request for Quote
RMFOB	Risk Management and Financial Oversight Board
RSI	Required Supplementary Information
SAM	General Service Administration's System for Award Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SBJA	*Small Business Jobs Act of 2010*
SDO	Suspension and Debarment Officer
SE	Salmonella Enteritidis
SECA	*Self Employment Contribution Act of 1954*
SF	Standard Form
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SIR	Standard Infection Ratios
SMI	Supplementary Medical Insurance
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSBG	Social Service Block Grant
SSF	Service and Supply Fund
StaffDiv	Staff Division
STEM	Science, Technology, Engineering and Mathematics
STEMM	Science, Technology, Engineering, Mathematics, and Medicine
STTR	Small Business Technology Transfer
TANF	Temporary Assistance for Needy Families

TeamSTEPPS	Team Strategies and Tolls to Enhance Performance and Patient Safety
T-MSIS	Transformed Medical Shared Information Saving Program
TREASURY	Department of the Treasury
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	U.S. Code
USDA	U.S. Department of Agriculture
USSGL	U.S. Standard General Ledger
VA	Department of Veterans Affairs
VFC	Vaccines for Children

APPENDIX B: CONNECT WITH HHS

Secretary Burwell gives remarks at the Pan American Health Organization Directing Council, September 29, 2014.

Thank you for your interest in the HHS FY 2014 *Agency Financial Report*. Electronic copies of this report and related budgetary reports are available through HHS's website at http://www.hhs.gov/budget.

We would like to hear from you about our FY 2014 *Agency Financial Report*. Did we present information in a way you could use? What did you like best and least about our report? How can we improve our report in the future?

You can send written comments to:

U.S. Department of Health and Human Services
Office of Finance/OFPR
Mail Stop 549D
200 Independence Avenue, S.W.
Washington, DC 20201

Or, if you prefer, e-mail your comments to hhsafr@hhs.gov.

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