OTHER ACCOMPANYING INFORMATION

Combining Schedule of Spending by Object Class

As of September 30, 2012

(in Millions)

What Money is Available to Spend?	FY 2012
Total Resources	$ 1,289,835
Less: Amount Available but Not Agreed to be Spent	75,237
Less: Amount Not Available to be Spent	8,718
Total Amounts Agreed to be Spent	$ 1,205,880

How was the Money Spent?	Grants, Subsidies and Contributions	Insurance Claims and Indemnities	Other Contractual Services	Personnel Compensation	Supplies and Materials	Personnel Benefits	Rent, Communications and Utilities	Other	FY 2012
Medicare Hospital Insurance	$ -	$ 259,207	$ 57	$ -	$ -	$ -	$ -	$ 4,591	$ 263,855
Medicaid	247,745	(50)	75	12	3,411	4	26	-	251,223
Medicare Supplementary Medical Insurance	-	230,675	34	-	-	-	-	5,246	235,955
Payments To Trust Funds	231,504	-	-	-	-	-	-	-	231,504
Medicare Prescription Drug Benefit (Medicare Part D)	-	57,580	-	-	-	-	-	380	57,960
Temporary Assistance For Needy Families	16,095	-	38	2	-	-	-	1	16,136
Children and Families Services	9,447	-	285	117	-	31	17	9	9,906
State Children's Health Insurance Program	9,054	-	12	-	-	-	-	-	9,066
Foster Care and Adoption Assistance	6,815	-	17	-	-	-	-	1	6,833
National Cancer Institute	3,113	-	1,741	393	49	103	9	26	5,434
Indian Health Services	2,589	-	696	947	440	316	41	105	5,134
Disease Control Research and Training	2,792	-	1,316	228	510	70	43	170	5,129
Allergy and Infectious Diseases	2,448	-	1,786	230	42	64	4	26	4,600
Health Resources and Services Administration	4,038	-	273	3	-	-	2	21	4,337
Child Support Enforcement and Family Support	3,154	-	806	-	-	-	-	-	3,960
Medicare Health Information Technology Incentive	-	3,822	-	-	-	-	-	-	3,822
Low Income Home Energy Assistance	3,816	-	-	-	-	-	-	1	3,817
Heart, Lung and Blood Institute	2,452	-	663	114	18	31	1	12	3,291
Child Care Entitlement To States	2,809	-	19	-	-	-	-	-	2,828
Primary Health Care	2,419	-	93	51	-	16	7	3	2,589
Health Surveillance and Program Support	1,813	-	319	53	-	15	5	3	2,208
Child Care and Development Block Grant	2,168	-	32	-	-	-	-	-	2,200
Diabetes and Digestive and Kidney Diseases	1,492	-	345	84	15	22	1	9	1,968
Early Retiree Reinsurance	-	(24)	1,949	-	-	-	-	1	1,926
General Medical Sciences	1,656	-	138	19	-	5	-	1	1,819
Mental Health	1,396	-	294	79	5	19	1	8	1,802
Public Health and Social Services	544	-	706	83	223	23	24	191	1,794
Social Services Block Grant	1,705	-	7	-	-	-	-	3	1,715
Neurological Disorders and Stroke	1,244	-	259	63	9	17	1	19	1,612
Pre-Existing Condition Insurance Plan	-	-	1,596	2	-	-	1	1	1,600
Aging Services Programs	1,453	-	20	13	-	3	3	-	1,492
Health Care Fraud and Abuse	-	-	1,440	31	-	9	7	1	1,488
National Center For Research Resources	1,426	-	46	-	-	-	-	1	1,473
Child Health and Human Development	878	-	338	80	11	22	2	15	1,346
Service and Supply Fund	-	-	748	187	59	58	252	22	1,326
National Institute On Aging	909	-	171	51	8	13	1	4	1,157
National Institute On Drug Abuse	857	-	220	50	4	13	-	7	1,151
National Institute Of Environmental Health Sciences	668	-	298	75	11	21	1	9	1,083
Substance Abuse Treatment	951	1	54	4	-	1	2	1	1,014
Other Agency Budgetary Accounts	10,274	373	10,320	4,330	562	1,297	538	1,065	28,759
Total Spending	$ 579,724	$ 551,584	$ 27,211	$ 7,301	$ 5,377	$ 2,173	$ 989	$ 11,953	$ 1,186,312
Amounts Remaining to be Spent									19,568
Total Amounts Agreed to be Spent									$ 1,205,880

OTHER FINANCIAL INFORMATION

Consolidating Balance Sheet by Budget Function

As of September 30, 2012

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 8,946	$ 152,622	$ 23,254	$ 12,526	$ 197,348	$ -	$ 197,348
Investments, Net (Note 4)	-	5,572	300,809	-	306,381	-	306,381
Accounts Receivable, Net (Note 5)	11	1,602	55,151	5	56,769	(55,949)	820
Advances (Note 8)	1	274	31	-	306	(258)	48
Total Intragovernmental Assets	8,958	160,070	379,245	12,531	560,804	(56,207)	504,597
Accounts Receivable, Net (Note 5)	1	3,334	7,606	2	10,943	-	10,943
Inventory and Related Property, Net (Note 6)	-	8,072	-	-	8,072	-	8,072
General Property, Plant and Equipment, Net (Note 7)	-	5,050	351	-	5,401	-	5,401
Advances (Note 8)	-	56	1,188	-	1,244	-	1,244
Other Assets	-	396	-	-	396	-	396
Total Assets	$ 8,959	$ 176,978	$ 388,390	$ 12,533	$ 586,860	$ (56,207)	$ 530,653
Stewardship PP&E (Note 1)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 7	$ 61	$ 56,381	$ -	$ 56,449	$ (55,790)	$ 659
Other Liabilities (Note 13)	38	1,048	760	1	1,847	(417)	1,430
Total Intragovernmental Liabilities	45	1,109	57,141	1	58,296	(56,207)	2,089
Accounts Payable	7	418	-	-	425	-	425
Entitlement Benefits Due and Payable (Note 10)	-	26,057	46,436	-	72,493	-	72,493
Accrued Grant Liability (Note 12)	643	2,544	(63)	624	3,748	-	3,748
Federal Employee and Veterans Benefits (Note 11)	5	10,993	10	-	11,008	-	11,008
Contingencies and Commitments (Note 14)	-	5,332	1,434	-	6,766	-	6,766
Other Liabilities (Note 13)	21	1,820	1,113	8	2,962	-	2,962
Total Liabilities	721	48,273	106,071	633	155,698	(56,207)	99,491
Net Position							
Unexpended Appropriations - Earmarked funds (Note 21)	-	(101)	20,519	-	20,418	-	20,418
Unexpended Appropriations - Other funds	8,241	115,635	-	11,892	135,768	-	135,768
Unexpended Appropriations, Total	8,241	115,534	20,519	11,892	156,186	-	156,186
Cumulative Results of Operations - Earmarked funds (Note 21)	-	5,209	261,800	-	267,009	-	267,009
Cumulative Results of Operations - Other funds	(3)	7,962	-	8	7,967	-	7,967
Cumulative Results of Operations, Total	(3)	13,171	$ 261,800	8	274,976	-	274,976
Total Net Position	8,238	128,705	282,319	11,900	431,162	-	431,162
Total Liabilities and Net Position	$ 8,959	$ 176,978	$ 388,390	$ 12,533	$ 586,860	$ (56,207)	$ 530,653

Consolidated Balance Sheet by Operating Division

As of September 30, 2012

	ACF	ACL	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental Assets															
Fund Balance with Treasury (Note 3)	$ 20,798	$ 683	$ 438	$ 7,442	$ 109,006	$ 2,867	$ 7,787	$ 2,073	$ 33,500	$ 9,138	$ 431	$ 3,185	$ 197,348	$ -	$ 197,348
Investments, Net (Note 4)	-	-	-	-	302,904	-	3,452	-	25	-	-	-	306,381	-	306,381
Accounts Receivable, Net (Note 5)	8	8	4	20	505	12	2	39	10	170	262	7	1,047	(227)	820
Advances (Note 8)	-	1	-	28	38	-	34	1	177	7	1	20	307	(259)	48
Total Intragovernmental Assets	20,806	692	442	7,490	412,453	2,879	11,275	2,113	33,712	9,315	694	3,212	505,083	(486)	504,597
Accounts Receivable, Net (Note 5)	3	-	-	11	10,569	222	6	116	4	6	7	(1)	10,943	-	10,943
Inventory and Related Property, Net (Note 6)	-	-	-	2,857	-	1	2	6	32	5,165	9	-	8,072	-	8,072
General Property, Plant and Equipment, Net (Note 7)	-	-	-	1,447	378	351	1	1,009	2,087	123	5	-	5,401	-	5,401
Advances (Note 8)	-	-	-	12	1,188	-	-	1	2	41	-	-	1,244	-	1,244
Other Assets	-	-	-	-	54	10	332	-	-	-	-	-	396	-	396
Total Assets	$ 20,809	$ 692	$ 442	$ 11,817	$ 424,642	$ 3,463	$ 11,616	$ 3,245	$ 35,837	$ 14,650	$ 715	$ 3,211	$ 531,139	$ (486)	$ 530,653
Stewardship PP&E (Note 1)															
Liabilities (Note 9)															
Intragovernmental Liabilities															
Accounts Payable	$ 7	$ -	$ 2	$ -	$ 646	$ 12	$ 13	$ 4	$ 32	$ 15	$ 1	$ 4	$ 736	$ (77)	$ 659
Other Liabilities (Note 13)	38	2	122	105	957	14	13	302	44	41	103	98	1,839	(409)	1,430
Total Intragovernmental Liabilities	45	2	124	105	1,603	26	26	306	76	56	104	102	2,575	(486)	2,089
Accounts Payable	7	-	6	48	-	5	25	23	262	29	16	4	425	-	425
Entitlement Benefits Due and Payable (Note 10)	-	-	-	-	72,493	-	-	-	-	-	-	-	72,493	-	72,493
Accrued Grant Liability (Note 12)	1,169	98	20	260	(190)	5	425	26	1,736	166	-	33	3,748	-	3,748
Federal Employee and Veterans Benefits (Note 11)	5	-	-	35	12	28	20	77	64	17	10,737	13	11,008	-	11,008
Contingencies and Commitments (Note 14)	-	-	-	-	5,291	-	475	1,000	-	-	-	-	6,766	-	6,766
Other Liabilities (Note 13)	26	3	14	172	1,160	217	130	287	724	122	90	17	2,962	-	2,962
Total Liabilities	1,252	103	164	620	80,369	281	1,101	1,719	2,862	390	10,947	169	99,491	(486)	99,491
Net Position															
Unexpended Appropriations - Earmarked funds (Note 21)	-	-	-	-	20,519	(101)	-	-	-	-	-	-	20,418	-	20,418
Unexpended Appropriations - Other funds	19,556	585	279	7,043	60,417	(2,346)	7,168	1,182	30,051	8,909	37	2,887	135,768	-	135,768
Unexpended Appropriations, Total	19,556	585	279	7,043	80,936	(2,447)	7,168	1,182	30,051	8,909	37	2,887	156,186	-	156,186
Cumulative Results of Operations - Earmarked funds (Note 21)	-	-	-	53	261,800	1,671	3,009	63	410	-	-	3	267,009	-	267,009
Cumulative Results of Operations - Other funds	1	4	(1)	4,101	1,537	3,958	338	281	2,514	5,351	(10,269)	152	7,967	-	7,967
Cumulative Results of Operations, Total	1	4	(1)	4,154	263,337	5,629	3,347	344	2,924	5,351	(10,269)	155	274,976	-	274,976
Total Net Position	19,557	589	278	11,197	344,273	3,182	10,515	1,526	32,975	14,260	(10,232)	3,042	431,162	-	431,162
Total Liabilities and Net Position	$ 20,809	$ 692	$ 442	$ 11,817	$ 424,642	$ 3,463	$ 11,616	$ 3,245	$ 35,837	$ 14,650	$ 715	$ 3,211	$ 531,139	$ (486)	$ 530,653

Net Cost of Top 15 Programs

For the Years Ended September 30, 2012 and 2011
(in Millions)

HHS Program	HHS Net Cost ($) FY 2012	HHS Net Cost ($) FY 2011	Rank by ($) FY 2012	Rank by ($) FY 2011	Budget Function	HHS Responsibility Segment
Medicare	$ 477,687	$ 474,005	1	1	Medicare	CMS
Medicaid	247,508	268,116	2	2	Health	CMS
Research	32,362	34,807	3	3	Health	NIH
Temporary Assistance to Needy Families	17,131	19,003	4	4	Education, Training & Social Services / Income Security	ACF
Children's Health Insurance Program (CHIP)	9,260	8,689	5	5	Health	CMS
Head Start	7,805	8,362	6	6	Education, Training & Social Services / Income Security	ACF
Child Welfare	7,643	7,945	7	7	Education, Training & Social Services / Income Security	ACF
Infectious Diseases	5,484	5,696	8	9	Health	CDC
Child Care	4,982	5,957	9	8	Education, Training & Social Services / Income Security	ACF
Child Support Enforcement	3,955	4,285	10	12	Education, Training & Social Services / Income Security	ACF
Low-Income Home Energy Assistance	3,860	4,424	11	10	Education, Training & Social Services / Income Security	ACF
Affordable Care Act Program	3,800	4,327	12	11	Health	CDC, CMS, OS & SAMHSA
Primary Care	3,411	3,375	13	13	Health	HRSA
HIV/AIDS Programs	2,414	2,069	14	15	Health	HRSA
Clinical Services	2,402	2,285	15	14	Health	IHS
Total Top 15 Programs	829,704	853,345				
All Other HHS Programs	26,001	24,915			Various	Various
Total Combined Net Costs	$ 855,705	$ 878,260				
Eliminations	(158)	(127)				
Total Consolidated Net Costs of Operations	$ 855,547	$ 878,133				

Supplemental Statement of Net Cost

For The Years Ended September 30, 2012 and 2011
(in Millions)

	2012			
		Inter-Agency Eliminations		
Responsibility Segments	Agency Combined Totals	Costs (-)	Earned/Exchange Revenues (+) *	Consolidated Totals
ACF	$ 49,134	$ (44)	$ 36	$ 49,126
ACL	1,489	(6)	5	1,488
AHRQ	238	(17)	415	636
CDC	9,945	(179)	481	10,247
CMS	737,823	(616)	16	737,223
FDA	2,134	(242)	30	1,922
HRSA	8,782	(223)	49	8,608
IHS	5,766	(209)	173	5,730
NIH	32,362	(945)	128	31,545
OS	3,325	(223)	490	3,592
PSC	1,338	110	521	1,969
SAMHSA	3,369	(66)	158	3,461
Net Cost of Operations	$ 855,705	$ (2,660)	$ 2,502	$ 855,547

	2011			
		Inter-Agency Eliminations		
Responsibility Segments	Agency Combined Totals	Costs (-)	Earned/Exchange Revenues (+) *	Consolidated Totals
ACF	$ 54,010	$ (46)	$ 4	$ 53,968
ACL	1,572	(6)	4	1,570
AHRQ	175	(17)	398	556
CDC	10,067	(176)	388	10,279
CMS	754,145	(465)	17	753,697
FDA	2,034	(169)	36	1,901
HRSA	8,702	(256)	32	8,478
IHS	3,912	(223)	147	3,836
NIH	34,822	(888)	193	34,127
OS	4,680	(244)	469	4,905
PSC	728	83	508	1,319
SAMHSA	3,413	(56)	140	3,497
Net Cost of Operations	$ 878,260	$ (2,463)	$ 2,336	$ 878,133

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

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2012
(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	$ 11,815	$ -	$ -	$ 37,319	$ 49,134	$ (44)	$ 36	$ 49,126
ACL	1,489	-	-	-	1,489	(6)	5	1,488
AHRQ	-	238	-	-	238	(17)	415	636
CDC	-	9,945	-	-	9,945	(179)	481	10,247
CMS	-	260,136	477,687	-	737,823	(616)	16	737,223
FDA	-	2,134	-	-	2,134	(242)	30	1,922
HRSA	-	8,782	-	-	8,782	(223)	49	8,608
IHS	-	5,766	-	-	5,766	(209)	173	5,730
NIH	-	32,362	-	-	32,362	(945)	128	31,545
OS	-	3,325	-	-	3,325	(223)	490	3,592
PSC	-	1,338	-	-	1,338	110	521	1,969
SAMHSA	-	3,369	-	-	3,369	(66)	158	3,461
Net Cost of Operations	$ 13,304	$ 327,395	$ 477,687	$ 37,319	$ 855,705	$ (2,660)	$ 2,502	$ 855,547

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2012
(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	$ 131	$ (44)	$ 87	$ (47)	$ 36	$ (11)	$ 49,056	$ (6)	$ 49,126
ACL	13	(6)	7	(4)	5	1	1,481	(1)	1,488
AHRQ	41	(17)	24	(414)	415	1	611	-	636
CDC	978	(179)	799	(593)	481	(112)	9,581	(21)	10,247
CMS	1,207	(616)	591	(23)	16	(7)	801,710	(65,071)	737,223
FDA	1,022	(242)	780	(41)	30	(11)	2,470	(1,317)	1,922
HRSA	310	(223)	87	(50)	49	(1)	8,566	(44)	8,608
IHS	558	(209)	349	(208)	173	(35)	6,377	(961)	5,730
NIH	1,749	(945)	804	(210)	128	(82)	31,030	(207)	31,545
OS	662	(223)	439	(564)	490	(74)	3,245	(18)	3,592
PSC	169	110	279	(819)	521	(298)	1,996	(8)	1,969
SAMHSA	125	(66)	59	(177)	158	(19)	3,421	-	3,461
Totals	$ 6,965	$ (2,660)	$ 4,305	$ (3,150)	$ 2,502	$ (648)	$ 919,544	$ (67,654)	$ 855,547

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

Our Fiscal Year (FY) 2012 *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), Office of Management and Budget (OMB) Circular A-136 and Appendix C of OMB Circular A-123.

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
- Corrective Action Plans (Section 4.0)
- 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)
- Improper Payment Reduction Outlook (Section 9.0)
- Program Specific Reporting Information (Section 10.0)
    - Medicare Fee-for-Service (FFS) Program (Section 10.10)
    - Medicare Advantage (Section 10.20)
    - Medicare Prescription Drug Benefit (Section 10.30)
    - Medicaid (Section 10.40)
    - Children's Health Insurance Program (Section 10.50)
    - Temporary Assistance for Needy Families (Section 10.60)
    - Foster Care (Section 10.70)
    - Head Start (Section 10.80)
    - Child Care Development Fund (Section 10.90)
- Recovery Auditing Reporting (Section 11.0)

1.10 Program Descriptions

The following is a brief description of the nine programs that will be discussed in this report.

1. Medicare FFS (Medicare 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 (Medicare 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 (Medicare 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. Head Start - A federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.
9. Child Care Development Fund (CCDF) - A joint federal/state program, administered by the States that provides child care financial assistance to low-income working families.

2.0 Risk Assessments

In addition to the nine programs deemed by OMB to be susceptible to significant improper payments, the Department of Health and Human Services (HHS or the Department) also reviews additional programs to determine if they are susceptible to significant improper payments. This year 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 increases efficiency for our programs without compromising the assessment process. Using this new integrated risk assessment approach HHS conducted risk assessments on 33 programs this year, and 33 programs were deemed non-high-risk as susceptible for significant improper payments.

3.0 Statistical Sampling Process

The statistical sampling process conducted to estimate the improper payment rate for each program is discussed in the Program-Specific Reporting Information section. For the eight programs that are currently reporting error rates, a statistical contractor was used. Unless otherwise stated in the Program-Specific Reporting Information section, 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.

3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates.

The gross error rate is calculated by adding the sample's overpayments and underpayments and dividing by the total dollar value of the sample. The gross error rate is the official program error rate.

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

Table 1 in Section 9.0 presents each program's gross and net error rates.

4.0 Corrective Action Plans

Corrective Action Plans for reducing the estimated rate of improper payments for each program are included in the Program-Specific Reporting Information section. There are two important aspects to the corrective action plans - setting aggressive, but realistic targets and achieving the targets according to the timetable in the plan. All out-year error rate targets are approved by OMB. Corrective action plans are reviewed each year to ensure that they are focused on the root causes of the errors and that the targets are being met. If targets are not being met, remediation will take place that may include employing new strategies, adjusting staffing and other resources and possibly revising targets.

4.10 Corrective Actions for Grants

Beyond government-wide grants circulars, requirements outlined in HHS regulations and HHS' internal policies, the Department has taken the following actions to strengthen the stewardship of grant funds:

- Over the course of FY 2011 and FY 2012, launched an "Accelerated Closeout Team" to increase Departmental focus on grants closeout and improve progress on closing inactive grant accounts. While grant closeout focuses on the stewardship of funds at the "prime" recipient level, closeout activities entail reconciliation of expenditures by the prime, as well as the sub-recipient if the grantee uses sub-awards to carry out its mission.
- Participated in a number of risk reviews that identified areas of grantee and sub-grantee risk and help to mitigate these programmatic risks.
- Initiated an effort to update HHS' existing grants policy manual, completing more than 60 draft chapters including new guidance to specifically address monitoring, sub-awards, program integrity and high-risk grantees.
- Launched an intra-Departmental work group to examine HHS' internal practices and processes related to indirect costs. This work group will ensure that the Department clearly articulates the appropriate composition of grantees' indirect costs and the methodology for making that decision and holds grantees accountable for charging the appropriate expenditures to indirect costs.

5.0 Accountability in Reducing and Recovering Improper Payments

HHS has shown tremendous leadership in the improper payments arena. HHS has published an error rate for Medicare FFS since FY 1996, which was one of the first error rates published across government. HHS has also reported Foster Care and Head Start error rates since FY 2004. This year, HHS is reporting an error rate for CHIP for

the first time since FY 2008. As discussed in Section 10.51, HHS did not report a CHIP error rate in FYs 2009 through 2011 due to a statutory prohibition. In addition, the annual performance plan objectives for HHS managers include critical elements for achieving progress on this initiative. As part of the semi-annual and annual performance evaluation, HHS Senior Executives and program officials are evaluated on the progress the agency achieves toward this and other goals.

6.0 Information Systems and Other Infrastructure

Reporting requirements related to information systems and other infrastructure is discussed within the Program-Specific Reporting Information sections.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Reporting requirements related to whether there are any statutory or regulatory barriers to reducing improper payments are discussed within the Program-Specific Reporting Information sections.

8.0 Progress and Achievements

8.10 FY 2012 Progress

HHS currently has nine programs that have been deemed risk-susceptible: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, TANF, Head Start, Child Care and Foster Care.

HHS worked with OMB to put approved measurement plans and corrective action plans in place for all risk-susceptible programs. In addition, out-year error rate targets have been identified for all programs that have established a baseline measurement.

8.20 FY 2012 Achievements

8.21 Improving Program Integrity in Medicare and Medicaid

Medicare. HHS has implemented a number of efforts to prevent and reduce improper payments in Medicare FFS. Of particular importance are three demonstrations that HHS launched in FY 2012 to prevent and reduce improper payments:

- First, HHS is expanding the use of Recovery Audit Contractors in the Medicare program. Over the past several years, Recovery Audit Contractors have recovered billions of taxpayer dollars by finding improper payments that have already been paid by the Medicare FFS program. HHS is now allowing the Recovery Audit Contractors to review claims before they are paid, which will prevent improper payments from occurring. This demonstration project began on August 27, 2012.
- Second, HHS is testing a change in hospital billing policies that allows some hospitals to re-bill for inpatient claims that should have been billed as outpatient. These errors traditionally have accounted for over 20 percent of all Medicare improper payments. This demonstration project began on January 1, 2012.
- Third, HHS is testing a change in payment policies requiring prior authorization for power mobility devices that have historically had a high improper payment rate. HHS instituted a demonstration program in seven states with the expectation of reducing improper payments for power mobility devices. This demonstration project began on September 1, 2012.

In addition, Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS Recovery Audit program in all 50 states no later than January 1, 2010. In February 2009, HHS awarded contracts to four Recovery Auditors, each of which is responsible for identifying and correcting improper payments in approximately 25 percent of the country.

In FY 2012, the Medicare FFS Recovery Audit program demanded approximately $2.634 billion and recovered $2.291 billion in overpayments. FY 2012 recoveries continued to grow and were 187 percent higher than recoveries in FY 2011.

During FY 2012, the Recovery Auditors focused their reviews on short hospital stays and claims for Durable Medical Equipment (DME). This approach is consistent with HHS' focus to lower the Medicare error rate. HHS expects that implementation of certain corrective actions will lower collections for some types of claims because the corrective actions will prevent future improper payments from being made. HHS continues to monitor and make continuous improvements to Recovery Audit program activities.

HHS also takes the findings identified by the Recovery Auditors and puts actions into place to prevent future improper payments. For example, in FY 2012, HHS released four Provider Compliance Newsletters that provided detailed information on 36 findings identified by the Recovery Auditors. HHS also implemented local and/or national system edits to automatically prevent improper payments. More information on the Medicare FFS Recovery Audit program can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/.

Section 6411(b) of the *Affordable Care Act* (ACA) expanded the Recovery Audit program to Medicare Parts C and D. Part D of the Recovery Audit Contractor (RAC) program became fully operational in FY 2012, and the first audits identified overpayments made as a result of prescriptions written by excluded providers or filled at excluded pharmacies. Future audits will include additional areas of review such as duplicate payments and Direct and Indirect Remuneration. Data for the Medicare Part D RAC program will not be reported in this fiscal year's Agency Financial Report, as the Part D RAC program is still in the initial stages for collecting improper payments. HHS is expected to begin recoupment in the second quarter of FY 2013. HHS is still exploring options for implementing the Medicare Part C RAC program, and a date for its implementation has not been determined. 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/.

Lastly, HHS launched the Fraud Prevention System (FPS), which is a state-of-the-art predictive analytics technology system designed to identify fraudulent or questionable Medicare FFS claims. The FPS, which was launched on June 30, 2011, now runs predictive algorithms and other sophisticated analytics nationwide against all Medicare FFS claims prior to payment. For the first time in the history of the program, HHS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis.

Medicaid. Under the authority of the *Deficit Reduction Act of 2005* (DRA), HHS has two broad responsibilities under the Medicaid Integrity Program (MIP). The first responsibility is to hire contractors to review Medicaid provider activities, audit claims, identify overpayments and educate providers and others on Medicaid program integrity issues. The second responsibility is to provide effective support and assistance to States in their efforts to combat Medicaid provider fraud, waste and abuse.

In an effort to determine the effectiveness of the MIP, HHS performed data analysis on Medicaid recoveries and expenditures over the years, which indicated that, since the enactment of the DRA, there has been an increased focus on Medicaid integrity. For example, the MIP has provided direct support to State activities that have led to increases of recoveries from $1.3 billion in FY 2007 to $2.3 billion in FY 2009, as overall Medicaid expenditures on

program integrity activities increased from $181 million in FY 2007 to $393 million in FY 2009 during that time. HHS is also positioned to achieve additional savings with the implementation of innovative technology and is continuing to refine an approach to measuring the impact of initiatives that achieve cost avoidance.

Section 6411(a) of the ACA required States to establish Medicaid RAC programs by submitting State plan amendments, attesting that their programs meet the statutory requirements, by December 31, 2010. HHS published a Final rule titled, "Medicaid Program: Recovery Audit Contractors" in the *Federal Register* on September 16, 2011, that implemented Section 6411(a) of the ACA. The Final rule, effective January 1, 2012, requires States to implement RAC programs in an effort to identify and recover improper payments in their Medicaid programs. The Final rule aligns the Medicaid RAC requirements to existing Medicare Recovery Auditor FFS program requirements, where feasible and provides each State the flexibility to tailor its RAC program where appropriate. As of September 30, 2012, 36 States have implemented Medicaid RAC programs. Additional information on the State Medicaid RAC programs can be found at http://w2.dehpg.net/RACSS/.

8.22 Head Start Signed Statement Template Form and Monitoring Visit Procedure Changes

HHS developed a standard signed statement template form for Head Start, which was made available to all grantees in FY 2009. Although the use of the form is optional, grantees are strongly encouraged to use it. The standard signed statement form helps guide grantees on the type of information they need to collect from prospective families during the enrollment process and provides them with a structure for recording this information. Even though the retention of source documentation is not required, HHS has noted that the percentage of Head Start programs retaining source documents for eligibility is increasing annually as more programs are using the standard signed statement template form. HHS is currently revising the signed statement template form to enhance the collection of data in order to better understand how grantees are determining eligibility and identify areas where grantees could benefit from additional guidance and targeted technical assistance.

In addition, HHS published proposed regulations requiring programs to keep copies of eligibility documents and enhance training by Head Start programs. HHS expects those rules to be finalized in FY 2013.

Lastly, in the past, HHS has typically provided grantees with notice before conducting monitoring or other onsite visits. HHS is now increasing its use of unannounced visits in an effort to ensure the reviewers are seeing how the programs normally operate.

8.23 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 assist them in maintaining program integrity and detecting and deterring improper payments in their TANF, Medicaid, Workers' Compensation, Child Care and Supplemental Nutrition Assistance Program (formerly known as Food Stamps) programs.

PARIS has a Board of Directors comprised of a key technical support representative from HHS (*ex-officio* non-voting member) and nine elected State technical and program representatives. The Board provides support to State public assistance agencies by disseminating information, processes, techniques and activities to maximize the technical abilities of States' systems and staff performing PARIS-related activities.

HHS, the Department of Veterans Affairs (VA) and the Department of Defense (DOD) have formed a partnership to further the goals of the PARIS project. The Department of Defense's Manpower Data Center (DMDC) provides computer resources to support PARIS development and operation. HHS contributes to this effort by establishing

Computer Matching Agreements and coordinating the quarterly matches (November, February, May and August) with all participating parties.

There is no cost to states to participate in PARIS. DMDC produces a match file using the social security numbers submitted by the States, VA and DOD as the key match indicator. States are expected to verify the matched individual's continued eligibility for benefits in their state and take the appropriate case action. As a result of these PARIS matches, three states have reported savings or cost avoidance of approximately $60 million in FY 2012 alone. More information on this partnership can be found at http://www.acf.hhs.gov/paris.

9.0 Improper Payment Reduction Outlook FY 2011 through FY 2015

The table on the following page shows HHS' IPIA results for the Current Year (CY) FY 2012, the prior year (PY) FY 2011, as well as the targets for FYs 2013 through 2015. The table includes the following information by year and program: outlays for that FY, the error rate or future target (IP%) and the dollars paid or projected to be paid improperly (IP$). In addition, for the CY HHS also included the amount of overpayments (CY Overpayments) and underpayments (CY Underpayments), as well as the net error rate (CY Net IP%) and the corresponding overpayments, when available. Table notes are defined in Section 9.1.

Table 1
Improper Payment Reduction Outlook
FY 2011- FY 2015
(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	336,378 Note (a)	8.6 Note (1)	28,810	349,673 Note (b)	8.5 Note (1)	29,571	28,503	1,068	7.8	27,435	375,859 Note (c)	8.3	31,196	398,920	8.0	31,913	433,393	7.5	32,504
Medicare MC	112,215 Note (d)	11.0	12,390	115,183 Note (e)	11.4	13,100	9,824	3,276	5.7	6,548	141,444 Note (f)	10.9	15,417	138,861	10.4	14,442	127,329	9.9	12,605
Medicare Drug	53,162 Note (g)	3.2	1,709	51,140 Note (f)	3.1	1,593	1,368	226	2.2	1,141	68,467 Note (i)	3.1	2,122	77,913	3.0	2,337	83,292	2.9	2,415
Medicaid	269,241 Note (j)	8.1	21,900	271,011 Note (k)	7.1 Note (2)	19,235	18,704	572	6.7	18,132	271,630 Note (l)	6.4	17,384	327,003	6.0	19,620	359,378	5.6	20,125
CHIP	8,993 Note (m)	N/A	N/A	8,629 Note (n)	8.2 Note (3)	704	681	27	7.6	654	10,022 Note (o)	N/A Note (4)	N/A	10,860	N/A	N/A	11,200	N/A	N/A
TANF	17,026	N/A	N/A	16,538	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	17,017 Note (p)	N/A	N/A	17,025	N/A	N/A	16,732	N/A	N/A
Head Start	7,235	0.6	44.1	7,969	0.6	46.2	46.2	-	N/A Note (6)	N/A	8,054 Note (q)	0.6 Note (7)	46.7	8,054	0.6	46.7	8,054	0.6	46.7
Foster Care	1,374	5.3	72.1	1,294	6.2	80.2	71.2	9.1	4.8	62.1	1,276	6.0	76.6	1,244	5.8	72.2	1,255	5.5	69.0
Child Care	5,677	11.2	638	5,170	9.4	488	449	39	7.9	410	5,078	9.0	457	5,196	8.5	442	5,195	8.0	416

Note: In the CY columns the IP percentage, when multiplied by the outlays, may not produce the exact total in the IP$ cell. This is a result of using rounded numbers in the table for presentation purposes. Other calculations may not add perfectly, also due to rounding.

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 period for each program may 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) Prior Year (PY) benefit outlays for Medicare FFS are from the November 2011 Improper Medicare FFS Payments Report (based on claims from January 2010 – December 2010).

(b) CY benefit outlays for Medicare FFS are from the November 2012 Improper Medicare FFS Payments Report (based on claims from July 2010 – June 2011)

(c) Medicare FFS CY+1, CY+2, CY+3 benefit outlays are based on the FY 2013 Midsession Review (Medicare Benefit Outlays current law (CL)).

(d) Medicare Advantage PY benefit outlays reflect 2009 Part C payments, as reported in the FY 2011 Medicare Part C Payment Error Final Report.

(e) Medicare Advantage CY benefit outlays reflect 2010 Part C payments, as reported in the FY 2012 Medicare Part C Payment Error Final Report.

(f) Medicare Advantage CY+1, CY+2, CY+3 benefit outlays are based on the FY 2013 Midsession Review (Medicare Benefit Outlays (CL)).

(g) Medicare Prescription Drug Benefit PY outlays reflect 2009 Part D payments as reported in the FY 2011 Medicare Part D Payment Error Final Report

(h) Medicare Prescription Drug Benefit CY outlays reflect 2010 Part D payments, as reported in the FY 2012 Medicare Part D Payment Error Final Report.

(i) Medicare Prescription Drug Benefit CY+1, CY+2, CY+3 benefit outlays are based on the FY 2013 Midsession Review (Medicare Benefit Outlays (CL)).

(j) Medicaid PY benefit outlays are from the FY 2011 Medicaid Annual Error Rate Report (based on FY 2010 claims).

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

(l) Medicaid CY+1, CY+2, CY+3 benefit outlays are based on the FY 2013 Midsession Review (Medicaid Net Benefit Outlays (CL), excluding CDC Program Vaccine for Children obligations).

(m) CHIP PY benefit outlays are based on the FY 2012 Midsession Review (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL)).

(n) CHIP CY benefit outlays are from the FY 2012 CHIP Annual Error Rate Report (based on FY 2011 claims)

(o) CHIP CY+1, CY+2, CY+3 benefit outlays are based on the FY 2013 Midsession Review (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL)).

(p) TANF CY+1, CY+2, CY+3 outlays reflect the FY 2013 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).

(q) Foster Care CY+1, CY+2, CY+3 outlays reflect the federal share of maintenance payments and are based on the FY 2013 Midsession Review.

1. In FY 2011, HHS refined the Medicare FFS improper payment measurement methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur

after the cut-off date for AFR publication. This refinement applied an adjustment factor that was an estimate, based on the actual historical data from prior years, of the impact of the additional documentation and appeals decisions. As a result, the FY 2011 improper payment rate was adjusted downward from 9.9 percent to 8.6 percent. Because FY 2011 was the first year we applied such an adjustment for the improper payment methodology, we committed to continuously monitor these factors to ensure the ongoing validity of the adjustment and the accuracy of the improper payment rate calculation.

Since the publication of the FY 2011 AFR, HHS made two significant observations. First, HHS observed that fewer denials were overturned on appeal than in previous years. This was because HHS strengthened its appeals approach in FYs 2011 and 2012 by encouraging the medical review entities to participate at the hearings, providing education to appeals entities on Medicare policies, improving the coordination of hearings and working to strengthen the quality of case file documentation and preparation for appeal hearings. Thus, the historical trends that were experienced in the past were significantly changed. Second, HHS observed that by shifting the report period back six months, we are able to capture approximately 91 percent of the actual impact that late documentation and appeals has on the improper payment estimates. It is important to capture the impact of these events in order to report the most accurate improper payment rate possible.

HHS concluded that it is preferable to use a method that enables HHS to report the actual impact of appeals and late documentation, rather than a prospective adjustment factor to estimate this impact. Accordingly, beginning with the FY 2012 AFR, HHS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. Using this methodology, the FY 2011 error rate would have been 9.6 percent or $32.4 billion instead of 8.6 percent or $28.8 billion as previously reported and the FY 2012 error rate is 9.3 percent (rounded) or $32.4 billion. The new report period will result in a more accurate reflection of improper payment estimates in the Medicare FFS program.

In addition, under current Medicare policy, hospitals that submit a claim for Part A inpatient services that should have been provided on an outpatient basis under Part B are not permitted to re-submit a claim for such payment. These hospitals can only bill for a limited set of ancillary services that were provided to the patient, such as diagnostic laboratory and X-ray tests. Because of this policy, any claim that was inappropriately submitted as inpatient was counted as an error for the total amount billed under Part A. In the past year, the Administrative Law Judges (ALJs) and the Departmental Appeal Board (DAB), which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that, contrary to HHS's longstanding policy and interpretation of certain Medicare manuals, policy statements in the manuals support Part B rebilling in these circumstances. As a result, the ALJs and the DAB have directed Medicare to pay hospitals under Part B for all of the services provided (not just the ancillary services) after a Part A inpatient claim is denied. HHS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services. This decision does not reflect a change in HHS policy with respect to rebilling in these circumstances but rather was undertaken to properly reflect the practical impact of the Medicare claim appeals.

HHS calculated an adjustment factor of 0.8 percentage points based on a statistical subset of inpatient claims that were in error because the services should have provided as an outpatient. Consistent with ALJ and DAB rebilling decisions, the adjustment factor reflects the difference between the inpatient Part A payment and the appropriate outpatient Part B payment. Using this methodology, the FY 2012 improper payment rate is

8.5 percent, or $29.6 billion. If this adjustment had been applied in FY 2011, the improper payment rate would have decreased 0.7 percentage points.

These two modifications include (1) allowing an additional six months for the receipt of late documentation and the effectuation of all appeals and (2) accounting for the impact of rebilling denied Part A claims under Part B. These modifications comply with the requirements of OMB Circular A-123, Appendix C, and produce a more accurate portrayal of the actual incidence of improper payments in the Medicare FFS program. These changes will also be incorporated into future improper payment reporting for the Medicare FFS program.

2. HHS calculated and is reporting the three-year weighted average national Medicaid error rate that includes data reported in the AFR for FYs 2010, 2011 and 2012. The three-year weighted national Medicaid error component rates are as follows: Medicaid FFS: 3.0 percent, Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent. Note, as required under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009, HHS published a final rule on August 11, 2010, which required the eligibility reviews to be consistent with the State's eligibility verification policy rather than reviewing eligibility against a uniform methodology, which was done in the past. Based on current regulations, certain cases from FY 2010 would no longer be considered as errors. After publication of the final rule States were allowed to review cases under the new methodology.

3. HHS calculated and is reporting a single-year national FY 2012 CHIP error rate. The national FY 2012 CHIP error component rates are as follows: CHIP FFS: 6.9 percent; CHIP managed care: 0.1 percent; and CHIP eligibility: 5.8 percent.

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

5. The TANF program is not reporting an error rate for FY 2012. Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

6. The Head Start program did not calculate a net error rate.

7. HHS is engaged in a number of efforts to reduce erroneous determinations in the Head Start eligibility process and to improve detection and measurement of errors. Similar to FY 2011, the FY 2012 results show that many programs are maintaining copies of source documentation used to determine eligibility status. As a result, the error rate continues a downward trend for FY 2012 at 0.58 percent, as compared to 0.61 percent in FY 2011. Due to this continued downward trend, HHS will maintain its FY 2012 rate as the out-year targets.

10.0 Medicare Fee-for-Service Program

10.10 Medicare Fee-for-Service Program - A Federal health insurance program for people age 65 or older, people under age 65 with certain disabilities and people of all ages with End-Stage Renal Disease.

10.11 Medicare FFS Statistical Sampling Process

The Medicare FFS improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program.

The Medicare FFS error rate for FY 2012 is 8.5 percent, or $29.6 billion. The FY 2012 net error rate is 7.8 percent, or $27.4 billion. The net improper payment rate is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program.

In FY 2011, HHS refined the Medicare FFS improper payment measurement methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the cut-off date for AFR publication. This refinement applied an adjustment factor that was an estimate, based on the actual historical data from prior years, of the impact of the additional documentation and appeals decisions. As a result, the FY 2011 improper payment rate was adjusted downward from 9.9 percent to 8.6 percent. Because FY 2011 was the first year we applied such an adjustment for the improper payment methodology, we committed to continuously monitor these factors to ensure the ongoing validity of the adjustment and the accuracy of the improper payment rate calculation.

Since the publication of the FY 2011 *Agency Financial Report* (AFR), HHS made two significant observations. First, HHS observed that fewer denials were overturned on appeal than in previous years. This was because HHS strengthened its appeals approach in FYs 2011 and 2012 by encouraging the medical review entities to participate at the hearings, providing education to appeals entities on Medicare policies, improving the coordination of hearings and working to strengthen the quality of case file documentation and preparation for appeal hearings. Thus, the historical trends that were experienced in the past were significantly changed. Second, HHS observed that by shifting the report period back six months, we are able to capture approximately 91.0 percent of the actual impact that late documentation and appeals has on the improper payment estimates. It is important to capture the impact of these events in order to report the most accurate improper payment rate possible.

HHS concluded that it is preferable to use a method that enables HHS to report the actual impact of appeals and late documentation, rather than a prospective adjustment factor to estimate this impact. Accordingly, beginning with the FY 2012 AFR, HHS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. Using this methodology, the FY 2011 error rate would have been 9.6 percent or $32.4 billion instead of 8.6 percent or $28.8 billion as previously reported and the FY 2012 error rate is 9.3 percent (rounded) or $32.4 billion. The new report period will result in a more accurate reflection of improper payment estimates in the Medicare FFS program.

In addition, under current Medicare policy, hospitals that submit a claim for Part A inpatient services that should have been provided on an outpatient basis under Part B are not permitted to re-submit a claim for such payment. These hospitals can only bill for a limited set of ancillary services that were provided to the patient, such as diagnostic laboratory and X-ray tests. Because of this policy, any claim that was inappropriately submitted as

inpatient was counted as an error for the total amount billed under Part A. In the past year, the Administrative Law Judges (ALJs) and the Departmental Appeal Board (DAB), which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that, contrary to HHS's longstanding policy and interpretation of certain Medicare manuals, policy statements in the manuals support Part B rebilling in these circumstances. As a result, the ALJs and the DAB have directed Medicare to pay hospitals under Part B for all of the services provided (not just the ancillary services) after a Part A inpatient claim is denied. HHS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services. This decision does not reflect a change in HHS policy with respect to rebilling in these circumstances but rather was undertaken to properly reflect the practical impact of the Medicare claim appeals.

HHS calculated an adjustment factor of 0.8 percentage points based on a statistical subset of inpatient claims that were in error because the services should have provided as an outpatient. Consistent with ALJ and DAB rebilling decisions, the adjustment factor reflects the difference between the inpatient Part A payment and the appropriate outpatient Part B payment. Using this methodology, the FY 2012 improper payment rate is 8.5 percent, or $29.6 billion. If this adjustment had been applied in FY 2011, the improper payment rate would have decreased .7 percentage points.

These two modifications include (1) allowing an additional six months for the receipt of late documentation and the effectuation of all appeals and (2) accounting for the impact of rebilling denied Part A claims under Part B. These modifications comply with the requirements of OMB Circular A-123, Appendix C, and produce a more accurate portrayal of the actual incidence of improper payments in the Medicare FFS program. These changes will also be incorporated into future improper payment reporting for the Medicare FFS program.

The Medicare FFS improper payment methodology begins with a random sample of claims. This year approximately 43,000 claims were sampled. For each sampled claim, HHS obtains medical records from providers and additional claims detail from its shared systems. This information is reviewed for compliance with Medicare coverage, coding and billing rules. When a provider does not provide the requested medical record documentation or the information submitted does not meet the Medicare requirements, the claim is counted as an error.

10.12 Medicare FFS Corrective Action Plans

The primary cause of improper payments was Administrative and Documentation errors (53 percent), which were mainly due to insufficient documentation. Other notable causes include Authentication and Medical Necessity errors (47 percent), caused by medically unnecessary services and to a lesser extent, incorrect coding, accounted for the remaining errors. Data shows that many improper payments occur as a result of claims paid for services that would have been clinically appropriate if provided in less intensive settings.

Physicians and DME suppliers contribute substantially to the amount of insufficient documentation errors. Hospitals contribute substantially to medical necessity errors. Coding errors are most prevalent in physician services.

HHS developed an Error Rate Reduction Plan (ERRP) that outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. Of particular importance are three demonstrations that HHS launched in FY 2012 to prevent and reduce improper payments:

- First, HHS is expanding the use of Recovery Audit Contractors in the Medicare program. Over the past several years, Recovery Audit Contractors have recovered billions of taxpayer dollars by finding improper payments that have already been paid by the Medicare FFS program. HHS is now allowing the Recovery Audit Contractors to review claims before they are paid, which will prevent improper payments from occurring.

- Second, HHS is testing a change in hospital billing policies that allows some hospitals to rebill for inpatient claims that should have been billed as outpatient. These errors account for over 20 percent of all Medicare improper payments.
- Third, HHS is testing a change in payment policies requiring prior authorization for power mobility devices which have historically seen an extremely high improper payment rate. HHS instituted a demonstration program in seven states with the expectation of reducing improper payments for power mobility devices.

Administrative and Documentation Errors - Corrective Actions:

HHS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments:

- HHS partnered with the Department of Justice (DOJ) to host a Health Care Fraud Prevention Summit in Chicago, IL during FY 2012, building upon the success of four summits held in FY 2011. These summits bring together a wide array of federal, State and local partners, beneficiaries and providers to discuss innovative ways to eliminate fraud across the U.S. health care system.
- HHS has awarded six of the seven contracts required to complete the realignment of the Zone Program Integrity Contractors (ZPICs) with the Medicare Administrative Contractors (MACs). The seven zones were created to target fraud "hot spots" in the United States. HHS is still determining the potential course of action for awarding the remaining ZPIC zone contract.
- HHS awarded a contract on September 30, 2011 for an automated screening solution that will support the revalidation of 1.5 million providers, as required by the ACA, by checking multiple databases. In FY 2012, the enrollment screening solution has found over 32,000 providers with potential licensure issues. As a result, all of these providers are being prioritized for revalidation and to date, HHS has revoked approximately 6,600 providers for non-licensure.
- HHS and its contractors conduct ongoing education to inform providers about the importance of submitting thorough and complete documentation. This involves national training sessions, individual meetings with providers with high improper payment rates, presentations at industry association meetings and the dissemination of educational materials.

Authentication and Medical Necessity Errors - Corrective Actions:

- HHS updates its review manuals, as needed, to clarify requirements for reviewing documentation. These clarifications promote uniform interpretation of the policies across all medical review entities involved in the Medicare FFS program.
- HHS shares information about those areas of the Medicare FFS program that are particularly susceptible to improper payments in the Medicare Quarterly Provider Compliance Newsletter. The information published includes the nature of the errors, the Medicare coverage requirements and how providers can prevent errors in the future.
- HHS implemented the ability to accept medical records electronically through the Electronic Submission of Medical Documentation (ESMD) program. This program creates greater program efficiencies and allows for quicker response times to documentation requests.
- HHS developed Comparative Billing Reports (CBRs) to help non-hospital providers analyze their administrative claims data. CBRs compare a provider's billing pattern for a specific procedure, or service, to

their peers on a state and national level. HHS also developed the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows inpatient hospital providers to analyze their billing patterns through a comparison to other inpatient hospitals in their State and in the nation.

- HHS developed a Program Vulnerability Tracking Systems (PVTS) that tracks vulnerabilities identified by internal and external sources, including the National Fraud Prevention program and the Recovery Auditors. In the future, PVTS will be used by the Medicare Administrative Contractors to report corrective actions to respond to certain vulnerabilities.

- HHS is conducting probe samples on providers to identify potential problem areas. Based on the probe results, HHS takes corrective actions to prevent the continuation of improper payments, such as increased or more targeted pre-payment or post-payment reviews.

- HHS is increasing and improving medical review through the detection of and focus on services, supplies, providers and suppliers that are at high risk for improper payments.

- HHS continues to allow Recovery Auditors to review more provider types than in previous years while closely monitoring the decisions made by the Recovery Auditors.

- HHS requires its contractors to develop ERRPs that identify the specific causes of improper payments in their jurisdictions and outline corrective actions. HHS provides its contractors with rolling improper payment rate data reports for their jurisdictions which allows the contractors, in a timely manner, to focus on those areas that are responsible for the most improper payments.

- HHS requires its contractors to review and validate the improper payment data for their jurisdictions to determine the education outreach and review strategies needed to reduce improper payments.

- HHS develops medically unlikely auto-deny edits to catch those services where the level billed exceeds a number that would be clinically reasonable. HHS updates these edits quarterly.

- HHS implemented a National FPS on June 30, 2011, as required by the *Small Business Jobs Act of 2010*. Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare FFS claims prior to payment. HHS uses the FPS to target investigative resources to focus on suspect claims and providers and to swiftly impose administrative action when warranted. The FPS helps HHS target fraudulent providers, reduce the administrative and compliance burdens on legitimate ones and prevent improper payments.

10.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified in the FY 2012 Medicare FFS Improper Payments Report were $19,961,109. The identified overpayments are to be recovered by the Medicare contractors via standard payment recovery methods. As of the report publication date, Medicare contractors reported collecting $16,269,115, or 81.5 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 levels targeted. HHS' systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the HHS level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. No other systems or infrastructure are needed at this time.

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

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

10.16 Medicare FFS Best Practices

The following best practices have been incorporated into the overall CERT process to ensure the highest degree of efficiency for the program:

- CERT offers many educational forums for providers and suppliers to gain additional knowledge about the CERT program. Such educational resources include several CERT-related websites, a toll-free CERT contractor customer service line, CERT provider outreach calls and on-line reference materials.
- HHS holds weekly calls with all CERT contractors to facilitate communication, solve problems and to improve the CERT process.
- HHS holds quarterly calls with the Medicare Administrative Contractors (MAC) to communicate timely information about the CERT program and to receive feedback about problem areas and best practices.
- CERT collaborates with other review contractor entities, such as the MACs and Recovery Audit Contractors, to clarify unclear policies, in an effort to ensure review consistency.
- 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 continued DME, Part A and Part B Medicare Administrative Contractor (MAC) provider outreach and education task forces during FY 2012. These task forces consist of contractor medical review professionals that meet regularly to develop strategies for provider education in error prone areas. The groups have written informational articles that are distributed on an as-needed basis to promote education among providers. These articles are maintained on the publically available Medical Learning Network (MLN).
    - When a supplier is contacted for documentation, HHS notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation.
    - HHS conducts calls with contractors and sends notices to providers and suppliers advising them of special studies being conducted in areas at high risk for improper payments. Information is provided regarding the documentation requests the provider or supplier may receive and what information and records are required to be provided.
    - HHS revises the medical record request letters, as needed, to clarify the components of the medical record that are required for a CERT review.
    - HHS contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a physician who orders a power wheelchair from a supplier that submits the claim.
    - HHS regularly calls providers in an attempt to collect medical documentation that supports the submitted claim.

10.20 Medicare Advantage or Part C - A Medicare health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan

10.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2012 Medicare Part C Composite Payment Error Rate is based on CY 2010 payments and combines two component payment error measures: the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) estimate and the Risk Adjustment Error (RAE) estimate.

The Medicare Part C error rate for FY 2012 is 11.4 percent, or $13.1 billion. The net error rate for FY 2012 is 5.7 percent, or $6.5 billion. The net error rate is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program.

The Part C MPE estimate captures errors in prospective Part C payments caused by errors in the transfer of data, interpretation of data and payment calculations in the MARx system. For FY 2012 reporting, HHS is computing the MPE based on the CY 2009 dollars in error, rather than the CY 2010 dollars in error, due to data issues that would affect an accurate calculation of this component estimate. The MPE error rate reflects CY 2009 dollars in error divided by total CY 2010 payments. The FY 2012 methodology consists of:

- Selection of a random sample of beneficiaries for whom HHS made payments to plans for each month of CY 2009;
- Computation of the prospective payment error amount for sampled beneficiaries; and
- Extrapolation of the sample payment error to the population, resulting in a Part C gross payment error amount.

For FY 2012, the MPE rate is 0.2 percent. The MPE rate has declined significantly and steadily since it was first reported as 2.3 percent in FY 2008, demonstrating the improved accuracy of the MARx payment system. As a result, FY 2012 is the last year for which the MPE will be reported and included in the Part C composite estimate.

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

The FY 2012 RAE methodology consists of:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in CY 2010, 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.

For FY 2012, the RAE rate is 11.4 percent. Note that the denominator for the RAE rate is total payments for risk adjusted plans, which does not include MA plans that are paid on a cost basis. Therefore, the MPE and RAE component rates do not sum to the composite rate.

10.22 Medicare Advantage Corrective Action Plans

The root cause of improper payments in the Medicare Part C program reported in FY 2012 is entirely due to administrative and documentation errors. The majority of the payment error estimate was insufficient documentation to support the diagnoses submitted by the plans, as measured by the RAE. The remainder of the payment error in the program is related to transfer of data, interpretation of data and payment calculations within the MARx payment system, as reflected in the MPE estimate. HHS is taking steps to address the error measured by both the MPE and RAE. The error rate estimate for the RAE increased slightly for FY 2012 due to a decrease in the submission of physician attestations for records that lack proper signatures or credentials.

For the MPE error estimate, HHS will continue to routinely implement payment controls in the MARx payment system to ensure accurate and timely payments, including monthly payment validation and authorization processes. MARx payment errors are corrected and payment adjustments are made on a flow basis, including payment adjustments applied as part of the final Part C risk score reconciliation.

For the RAE error estimate, HHS has implemented three key initiatives as part of its corrective action plan: Contract-level audits, physician outreach and Medicare Advantage (MA) organization guidance and training. The three initiatives are described in the bullets below.

- Contract-Level Audits: HHS is proceeding with the Risk Adjustment Data Validation (RADV) contract-level audits for the purposes of recovering overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. RADV audits are HHS' primary corrective action to recoup improper payments. HHS also expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted for payment as MA organizations recognize the potential financial impact.

  On February 24, 2012, HHS released the *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits.* The notice clarifies the final audit methodology that will be implemented for audited contracts going forward. Payment year 2011 is the first year that HHS will conduct payment recovery based on extrapolated estimates. HHS expects to audit approximately 30 MA contracts each year.

- Physician Outreach: HHS enhances physician understanding of the way HHS pays MA organizations and the payment methodology impact on physicians through physician outreach. The focus of this effort is to improve medical record documentation prepared by physicians to support risk adjustment diagnoses.

- Medicare Advantage Organization Guidance and Training: HHS conducts national training sessions for MA organizations that provide comprehensive information on submitting accurate risk adjustment data. Additionally, HHS has developed a method for identifying risk adjustment diagnoses that are more likely to be associated with payment error. This study has been and will continue to examine the reasons these diagnoses are problematic. HHS has used and will continue to use these findings to conduct outreach, education and provide guidance to MA organizations.

10.23 Medicare Advantage Program Improper Payment Recovery

The MARx payment system error rate is based on an analysis of prospective payments. MARx payment system errors are fixed continuously throughout the payment year. The resulting payment adjustments are regularly corrected in the MARx system, including payment adjustments as a result of the final Part C risk score reconciliation. Therefore, recovery of MPE errors occurs as part of the routine operation of the MARx payment system.

Regarding the RAE reported in FY 2012, the Medical Record Review was based on a national sample of beneficiaries across all MA contracts. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery has been initiated. To recover overpayments due to RAE, HHS is proceeding with the RADV audits. In FY 2012 HHS conducted payment recovery for the first five contracts involved in the CY 2007 RADV (the pilot plans) and recovered approximately $3.4 million.

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 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 Medicare Advantage program. HHS performs a monthly evaluation of the MARx payment system, as represented in the MPE estimate, which has led to system refinement and more accurate prospective payments to plans.

10.30 Medicare Prescription Drug Benefit or Part D - A Federal prescription drug benefit program for Medicare beneficiaries

10.31 Part D Statistical Sampling Process

The FY 2012 Part D Composite Payment Error Rate combines five component payment error measures: the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) estimate, the Payment Error relating to Low Income Subsidy Status (PELS), the Payment Error Related to Medicaid Status (PEMS), the Payment Error Related to Prescription Drug Event Data Validation (PEPV) and the Payment Error related to Direct and Indirect Remuneration (PEDIR). Combining these five different units of analysis poses complex technical and statistical challenges in calculating a confidence interval for the composite rate. Each component independently meets the OMB precision requirements. The four PDE/beneficiary level measures (MPE, PELS, PEMS and PEPV) combined into a four-component composite measure also meets the precision requirement (without PEDIR).

The Medicare Part D error rate for FY 2012 is 3.1 percent, or $1.6 billion. The net error rate for FY 2012 is 2.2 percent, or $1.1 billion. The net error rate is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program.

The FY 2012 Part D composite payment error amount is the sum of the payment error amounts for the five component measures divided by the CY 2010 total Part D payments. The five component measures are described in the paragraphs below.

The Part D MPE estimate captures errors in prospective Part D payments caused by errors in the transfer of data, interpretation of data and payment calculations in the MARx system. For FY 2012 reporting, HHS is computing the MPE based on the CY 2009 dollars in error, rather than the CY 2010 dollars in error, due to data issues that would affect an accurate calculation of this component estimate. The FY 2012 methodology consists of:

- Selection of a random sample of beneficiaries for whom HHS made payments to plans, for each month of CY 2009.
- Computation of the prospective payment error amount for sampled beneficiaries.
- Extrapolation of the sample payment error to the population, resulting in a Part D gross payment error amount.

For FY 2012, the MPE rate is 0.08 percent. The MPE rate has declined significantly and steadily since it was first reported as 0.59 percent in FY 2008, demonstrating the improved accuracy of the MARx payment system. As a result, FY 2012 is the last year for which the MPE will be reported and included in the Part D composite estimate.

The Part D PELS estimate captures payment errors due to inconsistent HHS data on beneficiary Low-Income Subsidy (LIS) status and the related Low Income Cost Sharing Subsidy (LICS) payments. The payment error may occur when a State Medicaid agency or the Social Security Administration (SSA) submit to HHS' systems an update on a beneficiary's level of LIS after a Prescription Drug Event (PDE) record has been accepted. The FY 2012 PELS methodology consists of:

- Identification of the population subject to PELS in CY 2010.
- For this population, computation of beneficiary-level differences between LICS payments based on LIS status in the accepted PDE record generated on the date of service and the corrected LICS payments based on LIS status in HHS' systems at the time of reconciliation.
- Program-level computation of: (1) the gross payment amount in error (the absolute difference between actual and corrected LICS payments for accepted PDE records) and (2) the PELS rate.

For FY 2012, the PELS rate is 0.12 percent.

The Part D PEMS estimate captures payment errors due to incorrect assignment of Medicaid status, which results in incorrect LIS-related payments. Full benefit dually-eligible beneficiaries (those eligible for Medicare and Medicaid benefits --comprehensive health benefits and/or the Medicare Savings Program) are also eligible for the Part D full LIS. If a beneficiary were incorrectly assigned Medicaid eligibility, all or part of HHS' LIS-related payment to the Part D plan would be in error. The FY 2012 PEMS estimate is based on the FY 2010 national Medicaid active eligibility case error rate determined by the Medicaid Payment Error Rate Measurement (PERM) program. For the PEMS estimate, the PERM eligibility error rate, which represents incorrect status for the entire Medicaid population, is assumed to be a proxy for the eligibility error rate for a subset of Medicaid beneficiaries, those also eligible for Medicare. The PEMS rate reflects overpayments only. The FY 2012 PEMS methodology consists of:

- Application of the PERM eligibility active case error rate to 100 percent of dual-eligible beneficiaries, by dividing them into three groups: (1) those beneficiaries who would remain eligible for the Part D full LIS even without dual eligible status; (2) those beneficiaries who would become eligible for the Part D partial LIS; and (3) those beneficiaries who would no longer be LIS-eligible.
- Beneficiaries with a PELS error were excluded from receiving a PEMS-related error to avoid the over-estimation of payment error.
- Computation of: (1) the PEMS gross payment error amount as the sum of the LIS payment amounts in error for the three groups and (2) the PEMS rate.

For FY 2012, the PEMS rate is 0.31 percent.

The Part D PEPV estimate captures errors in payment due to invalid and/or inaccurate PDE records that result in adjustments to the benefit phase assignment of beneficiaries' PDE records, thus changing Part D LICS and reinsurance payments. The FY 2012 PEPV methodology consists of:

- Validation of a statistically valid sample of PDE records using hard copy prescriptions and claim detail documentation submitted by plan sponsors and the creation of a corrected PDE record for all sampled records with discrepancies.
- Imputation of PDE sample validation findings onto the PDE records for a random five percent sample of the Part D population.
- Calculation of a payment error estimate for the sample of beneficiaries. A simulation process measures the change in LICS and reinsurance payments as they relate to the changes in gross drug costs.
- Extrapolation of the sample payment error to the entire Part D population resulting in a PEPV gross payment error amount and PEPV rate.

For FY 2012, the PEPV rate is 2.49 percent.

The Part D PEDIR estimate captures error in the final Part D program payment due to incorrect total Direct and Indirect Remuneration (DIR) amounts reported by Part D plans to HHS. DIR refers to all rebates, subsidies or other price concessions from any source (e.g., manufacturers) that serve to decrease the costs incurred by the Part D plan (directly or indirectly) for the Part D drug. The FY 2012 PEDIR methodology consists of:

- Determination of DIR error amounts for a CY 2009 sample of plans by identifying discrepancies between the total DIR amount reported for a plan for a year and the total DIR amount validated for that plan through HHS' financial audits of the plans.
- Extrapolation of DIR error from the sample to the CY 2010 population of plans.
- Conversion of DIR error amounts into payment error by recalculating reinsurance, risk sharing and final reconciliation payments for each plan in the population.
- The payment reconciliation amount in error, which represents the difference between the original and corrected Part D payment reconciliation amount, is summed for all plans, resulting in a program-wide PEDIR gross payment error amount and rate.

For FY 2012, the PEDIR rate is 0.11 percent.

10.32 Corrective Action Plan

The root cause of all improper payments in the Part D program reported in FY 2012 is administrative and documentation errors.

For the MPE component, HHS will continue to routinely implement payment controls in the MARx payment system to ensure accurate and timely payments, including monthly payment validation and authorization processes.

MARx payment errors are corrected and payment adjustments are made on a flow basis, including the payment adjustments applied to the final Part D risk score reconciliation.

For the PEMS component, the corrective action steps identified in Medicaid Section 10.42 will assist in reducing the PEMS error estimate because this component is driven by the PERM findings.

HHS will conduct more in-depth analyses on the PELS error estimate to further describe the PELS population and assist in identifying subsequent steps that could be taken to address improper payment issues. Further, HHS will provide additional guidance to Part D sponsors to update beneficiary LIS status prior to reconciliation.

Going forward, HHS plans to continue the national training sessions for Medicare Prescription Drug Benefit Plans that provide comprehensive information on all aspects of Part D payment and data submission requirements, including sessions focusing on improvements in PDE record submission, which is reflected in the PEPV error rate estimate.

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

10.33 Medicare Prescription Drug Benefit Improper Payment Recovery

The MARx payment system error rate is based on an analysis of prospective payments. MARx payment system errors are fixed continuously throughout the payment year. The resulting payment adjustments are regularly corrected in the MARx system, including payment adjustments as a result of the final Part D risk score reconciliation. Therefore, recovery of MPE errors occurs as part of the routine operation of the MARx payment system.

Regarding the PELS estimate, further investigation must be done to better understand the inconsistencies identified by this analysis in order to determine how to conduct payment recovery.

Regarding the PEMS estimate, 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 any beneficiary-level payments for which HHS could pursue payment recovery.

Regarding the PEPV error, the PDE validation reported in FY 2012 was 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.

Regarding the PEDIR error, the original data used to develop the FY 2012 error rate was based on CY 2009 audits. Plans submit updates to their reported DIR amounts on a flow basis. As a result, HHS expects to update the CY 2009 Part D reconciliation in CY 2012 and payment recoveries will be addressed at that time.

Regarding the Part D Recovery Audit Contractor (RAC) program, the Part D RAC became fully operational in FY 2012 and the first audits identified overpayments made as a result of prescriptions written by excluded providers or filled at excluded pharmacies. Future audits will include additional areas of review such as duplicate payments and Direct and Indirect Remuneration. Data for the Medicare Part D RAC program will not be reported in this fiscal year's Agency Financial Report, as the Part D RAC program is still in the initial stages for collecting improper payments. HHS is expected to begin recoupment in the second quarter of FY 2013.

10.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Prescription Drug Benefit 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

HHS has taken several steps to ensure payment accuracy in the Medicare Prescription Drug program.

- Monthly validation of the MARx generated prospective payments, as represented in the MPE estimate, has led to system refinement and more accurate prospective payments to plans.
- Outreach to plans before and during the PEPV data collection and validation process provides an open forum for improving instructions for data submission. In addition, extending the collection period has allowed for increased response rates and decreased improper payment estimates over time.

10.40 Medicaid - A joint Federal/State program, administered by the States that provides health insurance to certain low income individuals.

10.41 Medicaid Statistical Sampling Process

The Payment Error Rate Measurement (PERM) program uses a 17 State three-year rotation for measuring Medicaid improper payments. To select the 17 states for the three-year cycle, states were ranked by size based on their past federal FFS expenditures and grouped into three major strata with 17 states in each stratum. The expenditure data showed that nine states represent the major portion (approximately 50 percent) of total Federal FFS expenditures. To get a precise estimate for the national rate, it was important to make these nine high-expenditure States their own stratum. Therefore, the 17 states in Strata - 1 were further divided into two substrata – Strata - 1A (consisting of the nine states with the highest Federal FFS expenditures) and Strata - 1B (consisting of the eight remaining high-expenditure states). The States were sampled such that three states were selected from Strata - 1A each year. Given the criterion that each state be sampled exactly once over a three-year cycle, each stratum will have one year in which only five states are sampled. That is, the pattern will resemble the sample distribution shown in Table 2.

Table 2: Number of States to be Selected from Each Stratum in Each Year

Strata	Year 1	Year 2	Year 3
1A	3	3	3
1B	3	3	2
2	6	5	6
3	5	6	6

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.

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. For states reporting in FY 2012, the FFS sample size was between 260 and 880 claims per state and the managed care sample size was 240 payments per state. The sample sizes are based on each state's historical FFS and managed care improper payment rate data. All states qualified for the minimum managed care sample size. When a FFS component or

managed care component for a state 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 happened for FFS and managed care claims in two States in FY 2012.

Eligibility Component

For FY 2012, States conducted an eligibility review on a randomly selected sample of between 144 and 972 active cases and between 156 and 420 negative cases. The difference in sample sizes is based on the State's historical eligibility improper payment rate data.

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

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

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

Calculations and Findings

All improper payment rate calculations for the Medicaid program (the FFS component, managed care component, eligibility component and national Medicaid error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual State improper payment rate components are combined to calculate the national component improper payment rates. The national Medicaid program improper payment rate is calculated by combining the individual State improper payment rates. 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. The national program improper payment rate represents the combination of Medicaid FFS, Medicaid managed care and Medicaid eligibility improper payment rates. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted."

HHS calculated and is reporting the 3-year weighted average national improper payment rate that includes data from FYs 2010, 2011 and 2012. The 3-year rolling error rate is 7.1 percent or $19.2 billion. The net improper payment rate for FY 2012 is 6.7 percent, or $18.1 billion. The net improper payment rate is calculated by subtracting underpayments from overpayments, thus reflecting the overall estimated monetary loss to the program.

The 3-year weighted average national component improper payment rates are as follows: Medicaid FFS – 3.0 percent; Medicaid managed care – 0.3 percent; and Medicaid eligibility – 4.9 percent. Within the Medicaid eligibility improper payment rate, the 3-year weighted average active case improper payment rate is 4.8 percent and the negative case improper payment rate is 4.4 percent[19].

Medicaid Corrective Action Plans

States reviewed for the FY 2012 AFR measurement were the same states reviewed for the FY 2009 AFR. The re-measurement of this group reflects the impact of effective corrective action plans implemented after the last measurement. The improper payment rate for this group of states dropped from 8.7 percent in FY 2009 to 5.8 percent in FY 2012, causing the three-year rolling error rate to decrease. The greatest improvement was made in the eligibility component, which dropped from 6.7 percent to 3.3 percent.

Overall, the majority of the FY 2012 improper payments were a result of Verification errors (48 percent), which were mostly caused by cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined and system pricing errors. A large portion of improper payments was also caused by Administrative and Documentation errors (33 percent), which were mostly due to insufficient documentation. Authentication and Medical Necessity errors accounted for 19 percent of the improper payments, which were mostly due to diagnosis coding errors.

For FY 2012, the most common causes of improper payments were:

- Verification errors:
  - Eligibility errors
  - Pricing error
  - Non-covered service
- Administrative and Documentation errors:
  - Insufficient documentation
  - No documentation
- Authentication and Medical Necessity errors:
  - Number of units error
  - Policy violation
  - Diagnosis coding error
  - Procedure coding error

[19] As required under Section 601 of the *Children's Health Insurance Program Reauthorization Act of 2009*, HHS published a final rule on August 11, 2010, effective September 30, 2010, which requires the eligibility reviews to be consistent with the State's eligibility verification policy rather than reviewing eligibility against a uniform methodology, which was done in the past. After publication of the final rule States were allowed to review cases under the new methodology. Based on current regulations, certain cases from FY 2010 would no longer be considered errors.

HHS works closely with states to develop state-specific Corrective Action Plans (CAPs). States are responsible for implementing, monitoring and evaluating the effectiveness of their CAPs. HHS received CAPs from all states whose Medicaid programs were measured and reported in FYs 2007-2011 and States that were measured and reported in FY 2012 will also be required to submit CAPs. States continue to take steps to reduce errors identified during the measurement.

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

States focus their efforts on major causes of improper payments where HHS and the State can identify clear patterns. For example, States have implemented corrective actions to address documentation issues, particularly among provider types that have difficult complying with documentation requirements.

For eligibility errors, specific corrective action strategies implemented by the States to reduce improper payments have included leveraging technology and available databases to obtain eligibility verification information without client contact, providing additional caseworker training, particularly in areas determined by the PERM review to be error-prone and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution and evaluation of the State-specific CAPs, HHS has also made significant efforts to lower improper payments rates:

- A significant portion of medical review errors result from providers failing to submit necessary documentation. It is possible that some of these claims are accurate, but HHS could not verify their validity in the absence of sufficient documentation. The claims are therefore considered to be fully in error. HHS increased its efforts to reach out to providers and to obtain medical records to help resolve this problem. HHS also gives States more information on the potential impact of these documentation errors and more time for the States to work with providers to resolve them.
- For the third year, HHS sponsored a series of provider open forum calls for all states in the PERM review cycle. HHS also enhanced the PERM website with up-to-date information, included a separate web page for providers and an email account for providers to communicate directly with HHS.
- HHS developed PERM+, a new method for States to submit claims data for the PERM review. PERM+ makes claims data submission easier for states, condenses the PERM audit timeline and improves the accuracy of the PERM universe. HHS incorporated PERM+ beginning with the PERM cycle being reported in the FY 2012 AFR.
- Previously, the PERM sampling and review methodology required individual service-level claims. States struggled to provide documentation for payments not made or stored at the beneficiary level (aggregate payments). HHS developed an aggregate payment methodology that, if appropriate, allows aggregate payments to be submitted and sampled for PERM. HHS incorporated the aggregate payment methodology beginning with the PERM cycle being reported in the FY 2012 AFR.
- HHS conducts national best practice calls to facilitate idea sharing and lessons learned among the States in order to decrease improper payments. The first call was conducted in May 2010 and calls are conducted

quarterly. During the calls, States present their corrective action success stories in decreasing improper payment so other states can implement similar initiatives. All states, as well as PERM staff, Medicaid and CHIP Regional Office (RO) staff and Medicaid Integrity staff attend.

- HHS conducts post-CAP onsite visits or webinars with the States. The first round of onsite visits or webinars began in Spring 2011. HHS continues to conduct these meetings annually. These meetings entail collaboration with the Medicaid Integrity Group (MIG), ROs and the PERM team. The information covered during each meeting includes a recap of the previous PERM cycle, the disclosure of improper payment trends, the strategies for success in the upcoming PERM cycle, a discussion of State specific eligibility issues, a review of previous CAPs submitted, a discussion of upcoming PERM initiatives, an overview of the various HHS workgroups and a summary of applicable OIG audits.
- HHS published a Final rule titled, "Medicaid Program: Recovery Audit Contractors" in the *Federal Register* on September 16, 2011, that implemented Section 6411(a) of the ACA. The Final rule, effective January 1, 2012, requires States to implement RAC programs in an effort to identify and recover overpayments and identify underpayments made for services in their Medicaid programs. The Final rule aligns the Medicaid RAC requirements to existing Medicare FFS Recovery Auditor program requirements, where feasible and provides each state the flexibility to tailor its RAC program where appropriate. As of September 30, 2012, 36 states have implemented Medicaid RAC programs.
- HHS published a proposed rule for public comment on the face-to-face documentation requirements for Medicaid home health services and medical supply benefit on July 12, 2011, as required by Section 6407 of the ACA.
- HHS enhanced the Medicaid and CHIP State Information Sharing System (MCIS) to help states identify those providers whose billing privileges Medicare has revoked or whom other State Medicaid or CHIP programs have terminated. Using this web-based portal, a state is able to download information regarding terminated providers in other states and Medicare and to upload information regarding its own terminations. As of October 2012, 48 states have registered to use the MCIS database.
- HHS formed a state systems workgroup to address individual State system problems that may cause payment errors. The workgroup includes representatives from HHS and State staff.

10.43 Medicaid Program Improper Payment Recovery

HHS identified $784,877; $1,743,563; and $1,779,010 in Medicaid improper payments for FYs 2010, 2011 and 2012, respectively.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed.

The recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at Part 433, Subpart F under which states must return the federal share of overpayments. States reimburse HHS for the federal share on the Medicaid CMS-64 expenditure report.

Section 6506 of the ACA allows 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.

HHS provides guidance to states as they implement their Medicaid RAC programs, monitor the progress of those programs and encourage states to be as transparent as possible. On September 13, 2012, HHS launched an

enhanced tool that encourages transparency and monitoring called the Medicaid RACs At-A-Glance Phase II website. This tool can be found at http://w2.dehpg.net/RACSS/. The enhanced website contains State-reported information on each state's program, the name of each RAC vendor and Medical Director, contact information for the State Program Integrity Director and user-friendly charts and data. The information displayed will be part of HHS' required Report to Congress on the effectiveness of State Medicaid RAC programs. See Section 11.0 for further information on payment recovery.

10.44 Medicaid Information Systems and Other Infrastructure

Since Medicaid payments occur at the State level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems that had paper only and aggregate claims, changes in information systems at the State level during the course of the measurement cycle and a wide variation of system designs and capabilities. HHS has been active in encouraging and supporting states in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS). Such improvements will produce greater efficiencies in the PERM measurement and strengthen program integrity. The state systems workgroup consisting of state and HHS representatives meets regularly to identify and discuss state system vulnerabilities and the impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS is developing a comprehensive plan to modernize the Children's Health Insurance Program (CHIP) and Medicaid 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), which will facilitate state submission of timely claims data submission to HHS, expand the MSIS data set, and allow HHS to review the completeness and quality of state MSIS submittals as they are received. 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.

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 aspect of the PERM measurement. The pre-cycle phase occurs prior to the first submission of data and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. The following additional measures have been incorporated into the overall process:

- States receive further education on the PERM process through HHS-initiated cycle calls and website activity.
- HHS has designated a cycle manager as the lead for a fiscal year measurement and the main point of contact at HHS for that year.
- HHS utilizes dashboards, a compilation of the contractors' and States' work, to monitor the progress of the measurement. The dashboards enable HHS to monitor problems in the measurement early and provide assistance to resolve issues that could delay the measurement progress.

- HHS published the online PERM Manual in January 2011 to offer states day-to-day operating instructions, policies and procedures based on statutes, regulations, guidelines, models and directives.
- The use of monthly all-contractor meetings has been employed to facilitate communication and problem solving between HHS and its contractors to improve the PERM process.
- For states having difficulty providing complete data, HHS has provided onsite technical assistance.
- HHS published the online Medicaid Integrity Manual on September 23, 2011. This is the first time various forms of guidance to State Medicaid programs have been consolidated into one easy-to-use location.
- HHS continues to offer training to State Medicaid program officials through the Medicaid Integrity Institute (MII). The MII provides a unique opportunity for HHS to offer substantive training, technical assistance and support to States in a structured learning environment. Between FYs 2008 and 2012, the MII provided training to 3,098 State employees and officials from 50 states, the District of Columbia and Puerto Rico.
- CHIPRA required HHS to review the requirements of the Medicaid Eligibility Quality Control (MEQC) and PERM programs and coordinate the implementation of the requirements to reduce redundancies between the measurements. Beyond what was proposed in the August 2010 final rule, HHS is exploring options to further coordinate and consolidate the requirements of Section 1903(u) of the Medicaid statute for MEQC with the requirements of PERM, including any necessary legislative or regulatory changes. The eventual goal is to allow one measurement to meet the quality control requirements of MEQC and the improper payment requirements of PERM. Harmonization would benefit states by reducing workload for conducting eligibility reviews, providing meaningful results for corrective actions and allowing HHS to recover identified erroneous payments based on Medicaid eligibility determinations.
- HHS is exploring what changes will be needed for PERM in light of ACA implementation, particularly with regard to the significant changes in Medicaid eligibility determination required by the *Act*.

10.50 Children's Health Insurance Program (CHIP) - A joint Federal/State program administered by the States that provides health insurance for qualifying children

10.51 CHIP Statistical Sampling Process

Medicaid and CHIP employed the same state sampling process. 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 selected states in the same year, each state will be measured for CHIP once every three years. For detailed information on the State sampling process, please refer to Section 10.41, Medicaid Statistical Sampling Process.

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.

On August 11, 2010, as part of enhanced efforts to reduce improper payments in federal programs, HHS issued the final regulations (PERM final rule) that fully implement improvements to the PERM program for Medicaid and CHIP. Section 601 of the CHIPRA prohibited HHS from calculating or publishing any national or state-specific improper payment rates for CHIP until six months after a new PERM final rule was in effect. In addition, Section 205(c) of the *Medicaid Extenders Act of 2010* exempted HHS from reporting a 2011 CHIP improper payment rate. As a result, HHS did not report a national error rate for CHIP in the FYs 2009 through FY 2011 AFRs. HHS is commencing CHIP improper payment rate reporting in the FY 2012 AFR.

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. For states reporting in FY 2012, 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 CHIPRA, states reporting in FY 2012 could elect to accept or reject the CHIP improper payment rate reported for the state in FY 2009. If a state elected to accept their FY 2009 CHIP improper payment rate, the State would utilize a state-specific sample size in FY 2012 based on their FY 2009 improper payment rate. Only one state elected to accept their CHIP improper payment rate from FY 2009. That State had a FY 2012 managed care sample size of 240 based on their FY 2009 managed care error rate data (the state had no CHIP FFS program). For the remaining 16 states, since no historical FFS and managed care improper payment rate data was available, state-specific sample sizes were not 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 happened for FFS and managed care claims in one state.

Eligibility Component

For FY 2012, 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, state-specific sample sizes were not utilized except for one state. The state that elected to accept their FY 2009 CHIP improper payment rate had a state-specific sample size of 360 active cases and 156 negative cases based on their FY 2009 eligibility improper payment rate data.

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

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

- The payment error rate is calculated using the weighted dollar values of payments made for services provided to beneficiaries who were ineligible for the program, or received a service that was not included in the beneficiary's benefit package, divided by the weighted dollar value of claims for the sample of beneficiaries each month (i.e., weighted dollars in error over total weighted dollars in the sample). HHS combines the State reported eligibility component payment error rates to develop a national eligibility error rate for CHIP.
- 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. For the active and negative case error rates, the errors are not dollar weighted, but they are sample weighted by stratum within a month.

Calculations and Findings

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

HHS calculated and is reporting the single-year FY 2012 national improper payment rate. The FY 2012 national CHIP improper payment rate is 8.2 percent or $704 million. The net improper payment rate for FY 2012 is 7.6 percent, or $654 million. The net improper payment rate is calculated by subtracting underpayments from overpayments, thus reflecting the overall estimated monetary loss to the program.

The national component improper payment rates are as follows: CHIP FFS – 6.9 percent; CHIP managed care – 0.1 percent; and CHIP eligibility – 5.8 percent. Within the CHIP eligibility error rate, the active case error rate is 6.4 percent and the negative case error rate is 4.6 percent.

The single-year FY 2012 CHIP error rate does not meet the IPIA required confidence and precision levels of plus or minus 2.5 percentage points at a 90 percent confidence level. The reported 8.2 percent error rate is at plus or minus 4.2 percentage points at a 90 percent confidence level. The large margin of error is due to a large variation in state FFS error rates.

10.52 CHIP Corrective Action Plans

HHS is actively working with states to develop corrective action plans to address errors. However, our experience shows that improper payments are typically higher in the early years of improper payment measurement programs since 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 2012 improper payments were a result of Verification errors (39 percent), which were mostly caused by cases reviewed for eligibility that were not eligible. A large portion of improper payments was also caused by Authentication and Medical Necessity errors (33 percent), which were mostly due to providers billing the wrong number of units and policy violations. In addition, a large portion of improper payments was caused by Administrative and Documentation errors (29 percent), which were mostly due to no documentation.

For FY 2012, the most common causes of improper payments for CHIP were:

- Verification errors:
  - Eligibility errors
  - Managed Care payment error
  - Pricing error
- Authentication and Medical Necessity errors:
  - Policy violation
  - Number of units error

  - Procedure coding error
  - Diagnosis coding error
- Administrative and Documentation errors:
  - No documentation
  - Insufficient documentation

FY 2012 is the first year HHS commenced reporting a national CHIP improper payment rate. States will submit and implement corrective action plans that will include the following:

- Data analysis – States must conduct data analysis such as reviewing clusters of errors, general error causes, characteristics and frequency of errors that are associated with improper payments.
- Program analysis - States must review the findings of the data analysis to determine the specific programmatic causes to which errors are attributed (i.e., provider lack of understanding of the requirement to provide documentation) and to identify root error causes.
- Corrective action planning - States must determine the corrective actions to be implemented that address the root error causes.
- Implementation and monitoring - States must develop an implementation schedule for each corrective action initiative and implement those actions in accordance with the schedule. The implementation schedule must identify major tasks, key personnel responsible for each activity and a timeline for each action including target implementation dates, milestones and monitoring.
- Evaluation – States must evaluate the effectiveness of the corrective action by assessing improvements in operations, efficiencies, number of errors and improper payments. HHS works closely with States to develop State-specific corrective action plans. States are responsible for implementing, monitoring and evaluating the effectiveness of their corrective actions. HHS is also developing corrective actions at the federal level.

10.53 CHIP Program Improper Payment Recovery

For FY 2012, HHS identified $523,577 in CHIP improper payments.

HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed.

The recoveries of CHIP improper payments are governed by Section 2105(e) of the *Social Security Act* (SSA) and related regulations at Part 457, Subpart B under which states must return the federal share of overpayments. States reimburse HHS for the Federal share on the CHIP CMS-21 expenditure report. Section 2105(c)(6)(B) of the SSA incorporated the overpayment requirements of Section 1903(d)(2) for CHIP. Section 6506 of the ACA allows 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. 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 been

active in encouraging and supporting states in their efforts to modernize and improve State MMIS. Such improvements will produce greater efficiencies in the PERM measurement and strengthen program integrity. The State systems workgroup consisting of State and HHS representatives meets regularly to identify and discuss State system vulnerabilities and the impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS is developing a comprehensive plan to modernize the CHIP and Medicaid 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 developing the TMSIS system, which will allow states to submit timely claims-data submissions to HHS. HHS will use this data for the CHIP improper payment measurement and to satisfy other HHS requirements. Through the use of TMSIS, HHS will not only acquire higher quality data, but will also reduce State data requests.

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 Medicaid PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle aspect of the Medicaid and CHIP PERM measurements. The pre-cycle phase occurs prior to the first submission of data and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states. The following additional measures have been incorporated into the overall process:

- States receive further education on the PERM process through HHS-initiated cycle calls and website activity.
- HHS has designated a cycle manager as the lead for a fiscal year measurement and the main point of contact at HHS for that year.
- HHS utilizes dashboards, a compilation of the contractors' and States' work, to monitor the progress of the measurement. The dashboards enable HHS to monitor problems in the measurement early and provide assistance to resolve issues that could delay the measurement progress.
- HHS published the online PERM Manual in January 2011 to offer states day-to-day operating instructions, policies and procedures based on statutes, regulations, guidelines, models and directives.
- The use of monthly all-contractor meetings has been employed to facilitate communication and problem solving between HHS and its contractors to improve the PERM process.
- For states having difficulty providing complete data, HHS has provided onsite technical assistance.
- HHS is exploring what changes will be needed for PERM in light of ACA implementation, particularly with regard to the significant changes in CHIP eligibility determination required by the *Act*.

10.60 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

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 2012. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

10.62 TANF Corrective Action Plans

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

- HHS issued a letter to all States with recommendations to help reduce improper payments based on past reviews done by the OIG. The OIG reviews indicated that the primary causes of error were ineligible recipients, incorrect payment amounts and insufficient documentation.
- HHS is also working with states to analyze Single Audit findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the Federal level and is working to mitigate these programmatic risks.

10.63 TANF Improper Payments Recovery

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 or any results from improper payment recoveries for FY 2012. Despite statutory limitations, HHS continues to explore options that will allow for a future error rate measurement.

10.64 TANF Information Systems and Other Infrastructure

Since TANF payments occur at the state level, information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the State level. States utilize the PARIS, the National Directory of New Hires (NDNH) and the Income and Eligibility Verification System (IEVS) to ensure that improper payments are minimized. 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.
- Consider payment accuracy as proper case documentation measures or elements of staff performance.

- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with child support, IEVS "hits", redeterminations of eligibility or failure to fulfill work requirements.
- Establish a process for the collection of TANF overpayments from the applicable recipients.
- Periodically remind TANF recipients of their responsibility to accurately report income, resources and other family circumstances to the local TANF agency on a timely basis.
- Conduct training on investigative interviewing techniques for intake workers and case managers.
- 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.
- 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.
- Use NDNH information to verify the eligibility of adult TANF recipients residing in the State and use the information to modify benefits or close the case if the individual is not eligible for assistance.

10.70 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.

10.71 Foster Care Statistical Sampling Process

There have been no changes to the statistical sampling process for *Title IV-E* Foster Care during the current year. Under the regulatory review promulgated at *45 CFR 1356.71*, Foster Care Eligibility Reviews are conducted systematically in each state (the 50 states, the District of Columbia and Puerto Rico) every three years. During these reviews, a team comprised of Federal and State staff review 80 cases selected from the State's *Title IV-E* Foster Care population to determine a State's level of compliance in meeting the Federal eligibility requirements for the Foster Care program and to validate the accuracy of a state's claim for Federal reimbursement of Foster Care maintenance payments. 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* 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. An error case is defined as a case in which a *Title IV-E* Foster Care maintenance payment is made on behalf of an ineligible child during the PUR. Payment errors may include payments for error cases, payments made for non-error cases which failed to meet an eligibility criterion outside the PUR and payments for services not covered by *Title IV-E* or its regulatory provisions (e.g. therapy). Payment errors associated with underpayments are also identified during the reviews. If any overpayment errors are identified during a primary review, HHS imposes a disallowance in the total amount of all identified overpayment errors.

HHS employs a 10 percent error threshold to determine the level of state compliance in meeting the federal requirements of the Foster Care program. If during a primary review, in which 80 cases are reviewed, four or fewer cases are found to be in error, HHS can be 91 percent certain that no more than 10 percent of the entire population of *Title IV-E* Foster Care cases will be in error. If, however, during a primary review a State exceeds the error threshold because more than four cases are found to be in error, then (1) HHS takes a disallowance as described above and (2) the State is required to develop and implement a Program Improvement Plan (PIP). Following PIP implementation, which generally is completed within a year, the State is subjected to a secondary review where 150 cases are selected for review. If a State exceeds the error threshold for the case and dollar error

rates in a secondary review, the State is assessed an additional extrapolated disallowance, which is equal to the lower limit of a 90 percent confidence interval for the State Foster Care population's total dollars in error during the six-month PUR. The extrapolation increases geometrically the resulting disallowance. Since FY 2000, HHS has systematically conducted more than 190 regulatory Foster Care reviews, with over 17,000 Foster Care cases reviewed.

The Foster Care error rate and national estimates of improper payments are calculated each year using data collected in the most recent eligibility review for each state, the District of Columbia and Puerto Rico. Since each State is reviewed every three years, each year's "composite sample" of data from 52 state reviews incorporates new review data for about one-third of the States[20]. While each State sample represents a distinct six-month PUR, the national "composite" sample reflects a composite PUR. Consequently, the resulting error rate is referred to as a "rolling" estimate, since about one-third of the review data are replaced with new data each year. Each annual update typically incorporates new data on states reviewed during a 12-month period. In order to facilitate timely annual reporting, HHS received OMB approval to shift the FY 2012 reporting period back one month. Therefore the FY 2012 reporting period encompasses the eleven months between August 2011 and June 2012. Beginning in FY 2013, the rate will again incorporate new data on states reviewed during a 12-month period.

To arrive at the national improper payment estimate, data from each State review sample are used to develop an estimate of State improper payments for the PUR. This estimate considers both under- and overpayments in accordance with the IPIA implementing guidance. State estimates are then aggregated to estimate national improper payments for the composite PUR. The national estimate is divided by the sum of payments received during respective PURs to determine the national payment error rate for the program. The standard error of each State estimate is used to develop a 90 percent confidence interval for the national estimate. Each annual estimate since FY 2008 has reflected a shift from a case-based estimation to a refined dollar-based methodology for estimating State improper payments. Continued application of the OMB-approved methodology to eligibility review data for this year indicates that, for FY 2012, the estimated national payment error rate for the Foster Care program is 6.2 percent, or $80.2 million. The net error rate is 4.8 percent, or $62.1 million. The net improper payment rate is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program.

This year's error rate represents a modest increase compared to the FY 2011 error rate of 5.3 percent; however, current performance still represents a decrease of nearly 40 percent from the baseline rate of 10.3 percent. This year's error rate increase is attributable primarily to a high error rate in one large State reviewed this year. Excluding new data from that state, the overall error rate would have decreased in FY 2012. In addition, the remaining states performed extremely well, eleven of thirteen states reviewed during the current cycle had error rates under four percent.

10.72 Foster Care Corrective Action Plans

All payment errors in the *Title IV-E* Foster Care Program are Administrative and Documentation errors because they all reflect incorrectly classifying or processing payments by State agencies or third parties who are not the beneficiaries. Thus, all corrective action plans are targeted to improving the processing of *Title IV-E* claims by State

[20] The State of Florida is excluded from the current composite sample pending completion of a statewide demonstration project.

and local agencies. Corrective action plans instituted by HHS to address improper payments in the Foster Care program have been designed to help states address those payment errors (e.g., underpayments) that have contributed most to the improper payments made by the *Title IV-E* program.

In FY 2012, the most common payment errors made by states involving *Title IV-E* Foster Care funds included the following:

- Ineligible payment (e.g., therapy or unallowable transportation costs) (19 percent of errors)
- Underpayments (17 percent of errors)
- Provider not licensed or approved (10 percent of errors)
- Not AFDC eligible at time of removal (10 percent of errors)
- Duplicate or excessive maintenance payments to providers (8 percent of errors)
- Criminal records check not completed (7 percent of errors)

Together these six items account for over 70 percent of the payment errors for Foster Care. The overall frequency of all types of payment errors in the composite Foster Care sample (i.e., across all states) increased by just 1 percent from FY 2011 to FY 2012.

In HHS' efforts to reduce improper payments, the overall number of payment errors has dropped substantially and the composition of error types identified has changed as well. When reporting commenced in FY 2004, the most prevalent errors were associated with the requirement for a judicial determination in finalizing the permanency plan. These errors have been reduced from a frequency of 286 in FY 2004 to 29 in FY 2012.

The slight increase in payment errors in FY 2012 highlights the importance of maintaining diligence in corrective action efforts. Key features of HHS' corrective action strategies include the following:

- HHS conducts onsite and post-site review activities to effectively validate the accuracy of a State's claim for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the State agency to directly impact the proper and efficient administration and implementation of the State's *Title IV-E* Foster Care program. Further, a comprehensive report is issued to the State agency to confirm the final findings of the onsite review. The final report serves as the basis for the development of a PIP for States that exceed the error threshold.
- States are required to develop and execute State-specific PIPs that target corrective actions to the root cause of payment errors in the state. The PIP is developed by State staff in consultation with Federal staff and is required to include:
    1. Specific goals or outcomes for program improvement
    2. Measurable action steps required to correct each identified weakness or deficiency
    3. A target date for completing each action step
    4. A description of how progress will be evaluated by the State and reported to HHS, including the frequency and format of the evaluation procedures
    5. A description of how the State will report to HHS when an action step has been achieved
- The PIP is designed to lead to measurable changes in State program operations and is required to identify the specific action steps to attain the desired outcomes and correct program deficiencies. Each action strategy

has a projected completion date that will not extend more than one year from the date the PIP is approved by HHS. This assures that proper attention is given to correcting deficiencies in a timely manner. HHS believes that the development and implementation of the PIP is the key to identifying the reasons why cases are in error and motivating States to correct the identified problems. Requiring states to implement PIPs has proven to be an effective solution in addressing eligibility errors, as reflected in the decrease in the national error rate since FY 2004.

- HHS provides onsite training and technical assistance to states to develop and implement program improvement strategies.
- HHS works toward heightening judicial awareness and monitoring of reviews. In past years, three of the six most frequently occurring errors have involved the judiciary. In FY 2012, none of the six most frequent payment errors involved the judiciary. HHS continues to share the results of the Foster Care reviews with judicial organizations and offers training and technical assistance to educate and inform the judiciary in areas pertaining to their role directly impacting the State agency's performance on the eligibility factors.
- HHS works closely with the Court Improvement Program in states to reduce improper payments related to the judiciary.
- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings. HHS' expectation is that these disallowances, in conjunction with the development and implementation of the PIP, will serve as strong encouragement to the States to improve their programs to the extent that when a secondary review is conducted they will be determined to be in substantial compliance.
- HHS provides technical guidance to ensure reliable identification of underpayments by:
    1. Discussing any underpayments identified during a *Title IV-E* eligibility review at the exit conference with State agency senior management;
    2. Identifying underpayments in final reports issued to states following *Title IV-E* eligibility reviews; and
    3. Including language in the *Title IV-E Foster Care Eligibility Review Guide* clarifying what constitutes an "underpayment" to ensure that Federal and State agency staff accurately identify underpayments.
- HHS provides training and technical assistance tailored to assist States in improving their child welfare systems and to conform to outcomes and systemic factors identified in the results of the regulatory Foster Care monitoring reviews. The aim is to refine their management and operations, expand organizational capacity and foster effective and consistent practices while improving outcomes for children, youth and families.

Through implementation of its comprehensive corrective action plan, HHS is working to reduce the national Foster Care error rate. Examination of the FY 2012 error rate indicates that the gross error rate of 6.2 percent is comprised of a 5.5 percent overpayment rate and a 0.7 percent underpayment rate, representing a net error rate of 4.8 percent.

Applying the error rate to program maintenance payments for FY 2012 yields an estimate of gross annual improper payments (i.e., overpayments *plus* underpayments) of $80.2 million. Examination of the overpayment and underpayment error rates indicates that the $80.2 million in improper payments consists of $71.2 million in overpayments and $9.1 million in underpayments. Thus, the estimated net annual improper payments (i.e., overpayments *less* underpayments) are $62.1 million for the *Title IV-E* Foster Care program. Net improper payments represent the overall loss to the program.

10.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 13 States during the 11-month period between August 2011 and June 2012, HHS recovered over $2.3 million in *Title IV-E* improper payments. The funds recovered are comprised of $1,503,146 in disallowed maintenance payments and $845,943 in disallowed administrative payments.

The recovery of improper payments through eligibility reviews is most aptly classified as occurring through *post-payment reviews*. The Foster Care program does not systematically track cost recovery through OIG reviews and Single Audit Reports; however, such information has been obtained from HHS reports generated as part of the audit clearance process. Specifically, audit findings where the audit has been closed and a recommended cost recovery has been sustained for the *Title IV-E* Foster Care program were identified and tabulated. These amounts are in addition to amounts identified through the eligibility reviews and are presumed as recovered in the fiscal year, when the audit is closed. Recoveries of improper payments through audits can include *Title IV-E* Foster Care maintenance assistance payments, administration and 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. Utilizing this existing source of data 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 that could limit Corrective Actions

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 on improper payments, HHS is working with State child welfare agencies to improve administrative procedures for tracking and documenting eligibility. HHS is also working 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 resulting improper payments since baseline reporting. The payment error rate has been reduced from a baseline rate of 10.3 percent of payments in FY 2004 to a rate of 6.2 percent in FY 2012. Furthermore, in the years since baseline reporting commenced, the *Title IV-E* Foster Care program has recovered a total of $16.8 million in improper payments.

In addition to the ongoing efforts to address improper payments outlined above, in FY 2012 the Foster Care program has continued to lay the groundwork for and move towards future implementation of a new methodology to review administrative payments for *Title IV-E* Foster Care (i.e., Administrative Cost Review, or ACR). In FY 2012, HHS issued final reports for two FY 2011 pilot tests of the ACR methodology and transmitted the results to State agency leadership for their consideration. Recommendations focused on improving allocation and

assignment of administrative costs to *Title IV-E* Foster Care. Two additional pilot tests were conducted during FY 2012. HHS is currently working to complete reports on the FY 2012 pilot tests and will compile all pilot results to inform next steps in this effort.

10.80 Head Start - A Federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families.

10.81 Head Start Statistical Sampling Process

HHS is legislatively required to perform reviews of each Head Start program every three years and at the end of the program's first year of service. The Erroneous Payments (EP) study occurs simultaneously with a program's scheduled triennial monitoring or first year review and includes a review of eligibility documentation. As required by *45 CFR 1305.4(c)*, *(d)* and *(e)*, programs must verify family income, state the child's eligibility to participate in the program and include within the child's file a signed statement identifying which documents were used to establish income eligibility. In addition, in May 2010 HHS issued a program instruction that emphasized the requirements of *1305.4(c)*, *(d)* and *(e)* and recommended programs use the signed statement designed by HHS and retain copies of eligibility documentation.

The objective of the Head Start EP study is to produce a national level error rate of enrolled children who are ineligible for Head Start or Early Head Start services according to Head Start's income eligibility guidelines. Improper payments in the Head Start program are defined as more than the allowed percentage of children enrolled whose family income exceeds the income eligibility guidelines.

The Head Start EP's study sample design is a three-stage sample selection process:

- The first stage is to identify programs scheduled for review.
- The second stage is to select the programs to be reviewed through a stratified random sample, where programs were divided into five stratums by size of enrollment. The number of programs sampled within each stratum is roughly proportional to the number of children represented in each stratum.
- The third stage occurs when the onsite EP Reviewer selects the records to be reviewed using a systematic sampling scheme.

In FY 2012, 50 programs were sampled and a total of 11,411 child files were examined. The FY 2012 error rate is 0.6 percent, or $46.2 million.

10.82 Head Start Corrective Action Plans

HHS is maintaining the corrective action activities identified in the FY 2011 AFR: (a) enforcing Program Instruction ACF-PI-HS-10-02; (b) encouraging use of the signed statement template; (c) maintaining the enhanced targeted questions in the protocol; and (d) focusing on training and technical assistance. These corrective actions will help address Administrative and Documentation errors, which are the root cause of all errors in the Head Start program. Details of each corrective action are explained below.

- HHS issued a Program Instruction (ACF-PI-HS-10-02) indicating that programs are required to verify family income before determining a child is eligible to participate in the program. The Program Instruction also encouraged programs to maintain copies of the eligibility documents with the eligibility verification form in the child's official record and to provide annual training to employees responsible for determining and verifying income eligibility.
- HHS also developed a standard signed statement template form for Head Start. This form helps guide grantees on the type of information they need to collect from prospective families during the enrollment

process and provides them with a structure for recording this information. Although OMB clearance (OMB 0907-0374) was obtained in FY 2010, the use of the form is optional, but grantees are strongly encouraged to use it. HHS published a Notice of Proposed Rule Making (NPRM) proposing that grantees be required to maintain copies of all documents that are reviewed to determine eligibility and the final rule is pending.

- In FY 2011, the onsite monitoring protocol was enhanced to include targeted questions that require reviewers to review source documentation, when available, in addition to assessing the information contained in the signed statement. These questions were sustained in the FY 2012 Onsite Monitoring Protocol.
- In addition, EP Reviewers were instructed on communicating with the Onsite Monitoring team. Under these instructions, EP Reviewers are required to alert the Review Team Leader (RTL) of any concerns identified during the EP study and the RTL is required to follow up on the concerns and include any findings in the preliminary monitoring report.
- HHS continues to utilize Regional Risk Management meetings as a forum to identify grantees that are at-risk for not implementing eligibility requirements and to connect them with the appropriate training and technical assistance services.
- Lastly, in FY 2012 HHS performed a detailed risk assessment of the Head Start program. As part of this process, HHS identified potential programmatic risks and is implementing corrective actions to mitigate these programmatic risks.

10.83 Head Start Improper Payments Recovery

HHS determined that no program reviewed as part of the FY 2012 EP study will be subject to a disallowance. However, HHS will continue to concentrate on improper payment recovery where necessary.

10.84 Head Start Information Systems and Other Infrastructure

HHS has the information systems and infrastructure needed to reduce improper Head Start payments to the levels that HHS has targeted. HHS has two systems in place that identify grantees that are not complying with Head Start's income eligibility requirements. First, all review reports are processed centrally by HHS as part of the Head Start monitoring process. Secondly, Head Start is using the Risk Management System, implemented in each region, to help identify and manage grantee compliance with eligibility requirements. Both systems allow HHS to identify grantees that fail to comply with income eligibility requirements. No other systems or infrastructure are needed at this time.

10.85 Head Start Statutory or Regulatory Barriers

Currently, HHS cannot require programs to maintain source documentation that supports the determination of income eligibility. HHS published an NPRM that will potentially require grantees to maintain source documentation. The final rule is pending.

10.86 Head Start Program Best Practices

HHS continues to explore ways to improve the Head Start error rate process and address the Administrative and Documentation errors. The topic of eligibility is foremost in HHS' planning discussions. HHS facilitates ongoing discussions with Regional Offices' training and technical assistance staff to identify challenges and best practices related to eligibility.

HHS also receives data analysis of onsite monitoring review findings to help inform policy decisions. The results of these analyses are used to inform the training and technical assistance system for both national centers and state-based providers.

10.90 Child Care - A Joint Federal/State program, administered by the States that provides child care financial assistance to low-income working families

10.91 Child Care Statistical Sampling Process

There were no changes to the statistical sampling process in FY 2012. For the Child Care improper payments statistical sampling methodology please see: http://www.acf.hhs.gov/sites/default/files/occ/data_final_0.pdf.

The FY 2012 Child Care error rate is 9.4 percent, or $488 million. The net error rate for FY 2012 is 7.9 percent, or $410 million. The net error rate is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program.

10.92 Child Care Corrective Action Plans

Administrative and Documentation errors accounted for an estimated 56 percent of the improper authorization for payment errors found in the Child Care Improper Authorizations review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited reasons for errors due to missing or insufficient documentation included: (1) insufficient documentation of earned income, unearned income and income deductions, (2) insufficient documentation of the hours of care needed, (3) missing or incomplete documentation about the work, or educational or training activity of the head of household, and (4) while less common, States also cited lack of documentation for the child's immigration status; correct household size/composition; and qualifying provider documentation.

Verification errors represented 44 percent of errors found in the reviews. For purposes of this report, verification errors were identified as those with a lack of information to verify portions of the case record. These consisted of the failure to apply policy correctly including: (1) income calculation errors (inability to determine income calculation method, use of an incorrect monthly conversion factor), (2) incorrect computation of the hours of care needed, (3) inclusion or exclusion of income, (4) co-pay calculations, including incorrect use of the fee schedule (5) failure to process reported changes, and (6) data errors.

Corrective actions targeting both error types include efforts by both the States administering the program as well as HHS.

States' efforts include:

- Conducting ongoing case record reviews. Several states focused their attention on conducting reviews or re-reviews of policy areas identified during the review as error prone. Other actions included reviewing supporting documentation to ensure that all case action was taken properly and sub-recipient monitoring was conducted on all entities through validation reviews.
- Increasing program monitoring to incorporate performance improvement plans, increasing awareness through review of results and targeted corrective actions to managers.
- Evaluating and revising program policies and procedures. For example, one state reported successfully identifying and implementing efficiencies for workload management.
- Additional training, policy clarification, calculation tools and checklists for workers to ensure accuracy in the application process.
- Aligning eligibility policies with that of other income assistance programs (TANF, SNAP and Medicaid) where possible.

- Several states added performance results and corrective action plans as performance requirements.
- Many grantees updated system edits to support tracking attendance, caseworker alerts for action items and monitoring reports.
- Developing an aggressive training plan to assist eligibility workers in all facets of the eligibility determination process in order to reduce specific errors, such as, income calculation, co-payment and fee schedules, etc.

HHS corrective actions include:

- Providing technical assistance, specifically designed to help states focus on staff training, eligibility determination procedures, documentation requirements, routine case reviews and overall program administration.
- Assigning contracted technical assistance specialists to work with individual states on implementing the Error Rate Review process. This added support was in addition to the technical assistance provided through the HHS and its Regional Offices.
- Conducting onsite visits to assist States in the implementation of the Error Rate Review methodology. For example, in FY 2012 two States that received technical assistance showed a marked reduction in the error rate as a result of Federal technical assistance.
- Providing guidance to all grantees through the issuance of a Program Instruction which highlights Program Integrity, Financial Accountability and Access to Child Care. The Program Instruction can be found on the Office of Child Care's website at: http://www.acf.hhs.gov/sites/default/files/occ/pi2010-06%5B1%5D.pdf.
- Facilitating the National Program Integrity Conference Call Series that highlights various topics including: monitoring sub-recipients, enhancing program integrity processes and identifying fraud before it occurs.
- Convening a State Error Definition Workgroup to share ideas in developing a more consistent approach to a meaningful improper payment definition.
- Revising the CCDF improper payments methodology to increase accuracy by measuring improper payments rather than improper authorizations. OMB approved revising the methodology and the collection of this information in September 2012. The first data from the revised methodology will be reported in FY 2014.
- Providing States with an opportunity for peer-to-peer sharing of both error causes and program improvements, in an effort to reduce and/or eliminate errors and improper payments.
- Planning technical assistance and training opportunities to encourage States to begin their next review early, through examining current policies and procedures and automating their case review tool.
- Determining additional means to ascertain data on the scope of improper payments.
- Implementing the technical assistance tool *Grantee Internal Control Self-Assessment Instrument* with high error rate States to help them assess their internal control system, identify areas of risk, develop mitigation strategies and receive technical assistance as they implement corrections.
- Performing a detailed risk assessment of the Child Care program. As part of this process, HHS identified potential programmatic risks and is implementing corrective actions to mitigate the programmatic risks.

10.93 Child Care Program Improper Payment Recovery

The cumulative CCDF improper over authorizations for payments identified as part of the FY 2012 error rate is $690,674. Since the overall error rate is comprised of three review cycles, the improper over authorizations for

payment amounts are as follows for each cycle: Year One States $159,012 (reported in FY 2011), Year Two States $146,914 (reported in FY 2012) and Year Three States $384,748 (reported in FY 2010).

The FY 2012 review cycle represents the second time that Year Two States have conducted the error rate measurement. Compared to FY 2009, the last time these States were measured, the improper over authorizations for payment amount declined by $67,561 (from $214,475 to $146,914).

Overall, Year Two States expect to recover an estimated 18 percent, or $26,825, of the $146,914 in over authorizations for payment identified during the review. This estimate breaks down as follows: six Year Two States expect to recover more than 50 percent of over authorizations for payment; two States expect to recover between 0 and 50 percent; and nine Year Two States expect to recover none of the errors they identified in the sample cases. The current review methodology only requests that States provide an estimate for potential recovery of funds identified from the sampled cases. Requesting information regarding actual collections would be in violation of the *Paperwork Reduction Act.* The proposed revision effective in FY 2014, to measure payments instead of authorizations for payment, requires grantees to provide information on both the estimate they expect to recover in the future and any funds recovered from prior reviews.

The CCDF methodology distinguishes between authorizations for payment and actual payments made to providers. Therefore, the amount of improper authorizations for payment identified during the review process does not represent actual improper payments. In general, the amount of payments is lower, computed to be on average about 17 percent lower. States are required to recover child care payments that are the result of fraud. States have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Improperly spent funds are subject to disallowance by HHS regardless of whether the State pursues recovery.

10.94 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. All Year Two States have statewide automated systems with multiple features designed for reducing improper authorizations. All of these systems have automated eligibility, case-management, payment and provider linkage features. The Year Two States implemented information system enhancements, including document scanning, time and attendance monitoring and data mining or red-flag reports to identify and prevent improper payments.

States have reported implementing a range of improvements to information systems including:

- Incorporating alerts into the child care application system to remind eligibility workers to check completeness and accuracy of case files.
- Enhancing child care information systems to include capacity for the automated calculation of authorization amounts, given family income, hours of care needed, provider payment rate and co-pay requirements.
- Linking the child care eligibility system with the provider licensing system to ensure that only eligible providers are paid.
- Developing portals for clients and providers to submit applications, redeterminations, interim changes, invoices and other electronic documents.
- Implementing document imaging systems that increase accuracy, efficiency and productivity. Imaging systems help States eliminate manual processing and create a paperless office where documentation is received, scanned, connected with a case file and then immediately made available to a caseworker.

10.95 Child Care Program Statutory or Regulatory Barriers

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

10.96 Child Care Program Best Practices

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

- *Centralized Case-Record Reading* - Centralizing case-record reading supported the re-review process through the consistency of policy interpretation and error definition and allowed for copying record materials, regular meetings of the reviewers to discuss issues and the increasingly important management of operational costs.
- *Review Team Composition* - Several States utilized a smaller review team as a lesson learned from the prior review process. This facilitated more uniform interpretation of case-file information, but at times resulted in a larger burden on the review team. For some States, using the same review staff who were involved in the first review cycle and their quality control staff was a major benefit. In one case, a technical assistance site visit was requested to work with Quality Control and State program staff.
- *Starting the Planning Process Early* - All phases of the process (customizing the *Record Review Worksheet*, the record-review process and resolving sampling problems) took longer than States expected. Starting the process earlier allowed time to react to the unexpected, such as sampling problems or delays, review-team issues or record-reading problems. One change noted was that nine Year Two States began the process 12 to 19 months prior to the submission of the final report which eased the burden of the reviews.
- *Re-evaluation of the Existing Monitoring Process* – Due to the Child Care improper payment review process, in some States, the guidance for the review process will be rewritten to comply both with State audit procedures and the requirements outlined in the *State Improper Payments Data Collection Instructions*.
- *Automating the Record Review Worksheet* - During the first review cycle, three Year Two States automated the *Record Review Worksheet*. The number of states automating the worksheet increased to twelve for the second cycle.
- *Involving Local Partners* – Year Two States involved local partners *(*for example, Child Care Resource and Referral agencies and department of social services county offices), which simplified the record-request process, afforded the opportunity to produce missing information or explain actions by sharing preliminary review findings on error cases and created buy-in and accountability for reductions in improper authorizations for payment.

States that availed themselves of the technical assistance regarding sampling, error definition and scope of review experienced fewer challenges.

11.0 Recovery Auditing Reporting

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

More recently, HHS created a risk-based strategy to implement the recovery auditing provisions of the Improper *Payments Elimination and Recovery Act of 2010*. Specifically, HHS is focusing initially on implementing recovery

audit programs in Medicare and Medicaid, which accounted for 84 percent of HHS' outlays in FY 2012. In addition, HHS is also exploring implementing recovery audit programs in a cost-effective manner for programs beyond CMS, which account for the remaining 16 percent of HHS' outlays in FY 2012. In the meantime, we are making great progress in recovering improper payments in Medicare and Medicaid, which make up the vast majority of HHS' outlays.

- In FY 2012, the Medicare FFS Recovery Audit program demanded approximately $2.634 billion and recovered $2.291 billion in overpayments nationwide. FY 2012 recoveries continued to grow and were 187 percent higher than recoveries in FY 2011. The Recovery Auditors continued to focus their reviews on short hospital stays and claims for durable medical equipment.
- The Medicare Part D RAC program, became fully operational in FY 2012 and the first audits identified overpayments made as a result of prescriptions written by excluded providers or filled at excluded pharmacies. Future audits will include additional areas of review such as duplicate payments and Direct and Indirect Remuneration. Data for the Medicare Part D RAC program will not be reported in this fiscal year's Agency Financial Report, as the Part D RAC program is still in the initial stages for collecting improper payments. HHS is expected to begin recoupment in the second quarter of FY 2013.
- Regarding the Part C RAC program, HHS is still exploring the most effective way to structure a Part C Medicare RAC program. The Part C payment model provides payments to health plans based on beneficiary health status. Health plans receive the payments for each beneficiary on a monthly basis whether or not services are provided. This payment structure presents more design challenges for a recovery audit program than a simpler transaction based payment structure, as is found in Medicare FFS. HHS is still exploring options for implementing a Medicare Part C recovery audit program.
- Section 6411(a) of the ACA also required states to establish Medicaid RAC programs by submitting State plan amendments, which attest that their programs meet the statutory requirements, by December 31, 2010. HHS published a Final rule titled, "Medicaid Program: Recovery Audit Contractors" in the Federal Register on September 16, 2011, that requires States to implement RAC programs in an effort to identify and recover improper payments in their Medicaid programs.

  States were required to implement recovery audit programs in the second quarter of FY 2012. A few States implemented similar programs prior to the required effective date of January 1, 2012. As States began to implement their Medicaid RAC programs, Medicaid RAC Federal-share recoveries increased from $9.37 million in the second quarter of FY 2012, to $28.53 million in the last quarter of FY 2012. For FY 2012, the States have recovered a total federal and State share combined amount of $95.64 million and returned a total of $57.57 million to HHS, through the State Medicaid RAC programs.

Finally, some of our programs have results to report in this area and those results are included below 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 3
Payment Recapture Audit Reporting
FY 2012
(in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY)	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$2,634.1	$2,291.4 Note 1	87%	$342.7	13%	N/A	N/A	$1,097.0 Note 2	$872.8 Note 2	$3,731.1	$3,164.2	$566.9	N/A
Medicare Part C Recovery Auditors	N/A Note 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Part D Recovery Auditors	N/A Note 4	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
Medicaid Recovery Auditors	N/A Note 5	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
HHS-Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.5	$0.074	$1.5	$0.074	N/A	N/A

Notes:

1. The Medicare FFS recovery auditors Amount Recovered (CY) column is the amount recovered in FY 2012, regardless of the year the overpayment was identified
2. The Medicare FFS Prior Year (PYs) columns reflect recovery audit information reported in the FY 2010 and FY 2011 AFRs.
3. HHS is still exploring options for implementing a Medicare Part C recovery audit program. Accordingly, HHS is not reporting Medicare Part C RAC results in the FY 2012 AFR.
4. HHS awarded a contract for the Medicare Part D recovery auditor in FY 2011 and the program became fully operational in FY 2012. Initial findings identified by the Part D recovery auditor are currently going through the HHS review and appeals process; therefore results are not yet available. HHS will report the results of the Medicare Part D recovery audit program in the FY 2013 AFR.
5. States were required to implement State Medicaid RAC programs beginning in the second quarter of FY 2012, and as of September 30, 2012, 36 States launched a Medicaid RAC program. Since HHS does not have a full year of results to report for FY 2012, HHS has reported the initial results of the State Medicaid RAC programs to date in Section 11.0.

Table 4
Payment Recapture Audit Targets
FY 2012
(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	$2,634.1	$2,291.4	87%	85%	85%	85%

Table 5
Aging of Outstanding Overpayments
FY 2012
(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	$541.5	$138.8	N/A

Notes: The amount of outstanding overpayments identified in this table ($680.3 million) does not match the amount outstanding identified in Table 3 because this table includes information from FY 2012 only whereas Table 3 includes information on recoveries from multiple years.

It is important to note that under the Medicare FFS RAC program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (O-6 months) includes identified overpayments that HHS cannot begin collecting.

Table 6
Disposition of Recaptured Funds
FY 2012
(in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$85.8	$142.3	N/A	$1,953.9	N/A	N/A

Note: For the Medicare FFS Recovery Auditors program, funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and RAC contingency fees (amounts are listed above) and underpayments to providers ($109.4 million).

Table 7
Overpayments Recaptured Outside of Payment Recapture Audits
FY 2012
(in Millions)

Agency Source	Amount Identified (CY)	Amount Recovered (CY)	Amount Identified (PYs)	Amount Recovered (PYs)	Cumulative Amount Identified (CY+PYs)	Cumulative Amount Recovered (CY+PYs)
Medicare FFS Error Rate Measurement	$20.0	$18.0	$10.9	$9.2	$30.9	$27.2
Medicare Contractors	$11,991.2 Note 1	$10,129.4 Note 1	$12,922.7 Note 2	$9,383.6 Note 2	$24,913.9	$19,513.0
Medicare Part C Note 3	$0.1	$0	$1.6 Note 4	$0	$1.7	$0
Medicare Part D Note 3	$0.1	$0	$0.1 Note 4	$0	$0.2	$0
Medicare Part C RADV Audits	$3.5	$3.5	N/A Note 5	N/A	$3.5	$3.5
Medicaid Error Rate Measurement	$1.8	$0.6	$2.5	$0.7	$4.3	$1.3
CHIP Error Rate Measurement	$0.5	$0.01	N/A	N/A	$0.5	$0.01
Medicaid Integrity Contractors-Federal Share-FMAP rates	$8.0 Note 6	$1.8	N/A	N/A	$8.0	$1.8
Foster Care Eligibility Reviews = Post-Payment Reviews	$2.3	$2.3	$14.5	$14.5	$16.8	$16.8
Foster Care OIG Reviews	$0	$0	$217.8 Note 7	$102.7	$217.8 Note 7	$102.7
Foster Care Single Audits	$6.9	$6.9	$27.5	$26.3	$34.4	$33.2
Child Care-Single Audit	$4.1	$3.3	$0.8	N/A	$4.9	$3.3
Child Care-Error Rate Measurement	$0.1	N/A	$0.5 Note 8	$0	$0.7 Note 9	N/A
Head Start- OIG Reviews	$0	$0	$0.3	$0.3	$0.3	$0.3
Head Start- Single Audits	$0.7	$2.8	$1.4	$0.7	$2.1	$3.5

Notes:

1. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS RAC program, which are reported in Table 3.
2. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS RAC program, which are reported in Table 3. In addition, the prior year amount that was reported in the FY 2011 AFR was amended to exclude results from the Medicare FFS RAC program reported in Table 3.
3. These amounts represent money owed to HHS by health plans that terminated their Part C or Part D contracts.

4. HHS did not report this amount in the FY 2011 AFR; therefore, PY amounts identified represent FY 2011.
5. This amount represents overpayments identified and recovered as a result of the CY 2007 risk adjustment data validation (RADV) pilot audits. FY 2012 is the first year these pilot audits results have been reported.
6. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the federal and State shares. For the current year (CY) amount identified, 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.
7. The Foster Care OIG review information that was published in the FY 2011 AFR was amended to reflect updated totals for the amounts identified (PYs) and the cumulative amounts identified (CY + PYs).
8. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported in the FY 2011 AFR reflected over- and underpayments. The current table was amended to reflect only the overpayment information, which represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recovered 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.
9. The Child Care cumulative amount total does not add due to rounding.

MANAGEMENT REPORT ON FINAL ACTION

October 1, 2011 – September 20, 2012

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 the OIG audit recommendations. This annual management report provides the status of OIG A-133 audit 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 Agencies 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 Agencies' 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 Agencies and the OIG.

Status of Audits in the Department

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

Departmental Conflict Resolution

In the event that HHS agencies and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2012, there were no disagreements requiring the convening of the Conflict Resolution Council.

Final Action Tables and Departmental Findings

Table I on the next page, the Management Action on Costs Disallowed in OIG Report, presents costs that HHS challenged because a grantee has violated a law, regulation, grant term or condition.

- In FY 2012, HHS initiated Recovery Action, through collection, offset or other means, on 366 cases for a total of $916,911,935.

- In FY 2012, HHS completed Recovery Action, through collection, offset or other means, on 338 cases for a total of $527,270,511.
- As of September 30, 2012, HHS reports 176 outstanding balances over one year old totaling $1,808,667,738. Forty-eight percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by State and local governments (101), hospital and medical related organizations (40), non-profit organizations (18), Indian tribes (14) and educational institutions (3). A detailed list of reports over one year old with outstanding balances to be collected can be found at: http://www.hhs.gov/asfr/of/finpollibrary/financialpolicies.html - Audit Guidance.

TABLE 1

Management Action on Costs Disallowed in OIG Reports

as of September 30, 2012

(in Thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	289	$2,134,867
B. Reports on which management decisions were made during the reporting period. See Note 2.	366	916,912
Subtotal (A + B)	**655**	**3,051,779**
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.	338	527,271
ii. The dollar value of disallowed costs that were written off by management.	7	2,397
Subtotal (i + ii)	**345**	**529,668**
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	310	$2,522,111

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents the three organizations having different cut-off dates.
3. In addition to current unresolved cases, this figure includes audits over one year old with outstanding balances totaling $1,808,667,738 (e.g., audits under current collection schedule or audits under administrative or judicial appeal).

Table II, 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.

- In FY 2012, HHS initiated action on $3,218,247,848 in OIG recommendations to put funds to better use.
- In FY 2012, HHS completed action on $2,885,746,788 in OIG recommendations to put funds to better use.

TABLE 2

Management Action on OIG Reports
with Recommendations that Funds Be Put to Better Use
as of September 30, 2012
(in Thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	8	$109,154
B. Reports on which management decisions were made during the reporting period.	12	3,218,248
Subtotal (A + B)	**20**	**3,327,402**
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.	12	2,885,747
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	0
Subtotal (i + ii)	**12**	**2,885,747**
D. Reports for which no final action has been taken by the end of the reporting period.	8	$441,655

Notes:

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

FY 2012 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY OFFICE OF THE INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary
Through: DS _____
COS _____
ES _____

NOV – 9 2012

FROM: Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2012

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 2012 are:

1) Implementing the Affordable Care Act
2) Identifying and Reducing Improper Payments
3) Preventing and Detecting Medicare and Medicaid Fraud
4) Ensuring Patient Safety and Quality of Care
5) Avoiding Waste and Promoting Value in Health Care
6) Ensuring Efficiency and Effectiveness of Medicare and Medicaid Program Integrity Contractors
7) Grants Management and Administration of Contract Funds
8) Protecting Consumers of Food, Drugs, and Medical Devices
9) Integrity and Security of Health Information Systems and Data
10) Fostering an Ethical and Transparent Environment

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

/Daniel R. Levinson/

Attachment

Management Issue 1: Implementing the Affordable Care Act

Why This Is a Challenge

The work of the Department of Health and Human Services (HHS or the Department) implementing the *Affordable Care Act* (ACA) continues. Although much has been accomplished, significant provisions remain to be implemented, most notably the Affordable Insurance Exchanges (the Exchanges), which add a new dimension to the Department's program landscape. While implementing the Exchanges, the Department must concurrently focus on sound administration of a wide range of new and modified program responsibilities covering reforms to private insurance, Medicare, Medicaid, the Children's Health Insurance Program, public health service programs and others. Notable reforms include those that seek to transform Medicare and Medicaid by changing from volume-driven to value-driven payment mechanisms and by focusing on achieving better health and lower costs through promoting coordinated rather than fragmented care.

As with any new initiative, the Department faces substantial challenges in ensuring efficient and effective implementation and administration of the ACA so that the programs achieve their objectives and operate free from fraud waste and abuse. Developing effective oversight strategies to prevent, detect and correct any problems that occur is critical. The large number of new and complex program responsibilities under the ACA makes achieving these twin goals challenging.

Responsibility for implementing ACA provisions, administering new and changed programs and overseeing ACA funding rests with Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) across the Department. Many programs, including the Exchanges, also require close coordination and sharing of sensitive data between the Department and other Federal and State agencies necessitating effective management of intergovernmental relationships and infrastructure. In addition, the Department will be forging new relationships with private insurers, providers, employers and consumers, all of whom will need clear information about benefits and responsibilities under ACA programs.

Progress in Addressing the Challenge

The Department and its Government partners have issued and will continue to issue regulations and other guidance for ACA programs. Numerous informational resources are available to inform the public about ACA programs. The Department has taken steps to foster the integrity of new programs, as illustrated by the regulations for the Medicare Shared Savings Program (MSSP), which incorporate a number of specific safeguards intended to mitigate potential vulnerabilities. Although it is too early to assess the outcome of these particular regulations, the Centers for Medicare & Medicaid Services' (CMS) efforts to integrate program integrity into the initial design of the MSSP is a promising approach that should be replicated in other programs.
The Office of Inspector General (OIG) has provided technical assistance on identifying risks and preventing fraud, waste and abuse.

OIG has ongoing and planned work assessing a range of ACA programs, including the Exchanges, the Early Retiree Reinsurance Program and the Prevention and Public Health Fund.

What Needs To Be Done

The Department and its partners should be vigilant in identifying and addressing existing and emerging fraud, waste and abuse risk areas across all ACA-related programs. This will require a comprehensive approach to program integrity that integrates effective front-end program gatekeeping, sound payment design, the promotion of provider compliance, vigilant monitoring of program operations and outcomes and rapid remediation of

detected problems. The Department should continue to apply lessons learned about accountability, transparency, compliance and risk management from its experience with the *American Recovery and Reinvestment Act of 2009* (*Recovery Act*) and other programs. Staff overseeing ACA grants and contracts should be trained on effective internal controls and best practices for preventing and detecting fraud, waste and abuse. Data systems supporting ACA programs must be scrutinized for accuracy and completeness, as well as compliance with security and privacy rules. The Department should continue its efforts to provide stakeholders with clear guidance about ACA programs.

A number of specific ACA-related challenges are addressed elsewhere in these *Top Management Challenges*.

Key OIG Resources

- Office of Inspector General Work Plan Fiscal Year 2012 available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP08-ACA.pdf.

Management Issue 2: Identifying and Reducing Improper Payments

Why This Is a Challenge

Improper payments cost Federal programs billions of dollars annually. An improper payment is any payment that should not have been made or that was made in an incorrect amount and includes overpayments and underpayments. For FY 2011, the Department reported improper payments totaling more than $64 billion in the Medicare and Medicaid programs and $754 million in Administration for Children and Families (ACF) programs.

The Office of Management and Budget (OMB) identified nine HHS programs as susceptible to significant improper payments: Medicare fee-for-service (FFS or Parts A and B), Medicare Advantage (Part C), the Medicare Prescription Drug Benefit (Part D), Medicaid, the Children's Health Insurance Program (CHIP), Foster Care, Head Start, Temporary Assistance for Needy Families (TANF) and the Child Care and Development Fund.

Despite departmental efforts to reduce improper payments, OIG has found vulnerabilities in the Department's ability to identify and eliminate improper payments. CMS relies largely on contractors to prevent and identify improper payments in Medicare and Medicaid. Challenge 6, Ensuring Efficiency and Effectiveness of Medicare and Medicaid Program Integrity Contractors, addresses specific issues associated with contractor oversight and effectiveness. OIG's analyses of Medicare and Medicaid claims data have revealed improper billing patterns and payments for many services. For instance, OIG found that improper payments to skilled nursing facilities cost Medicare $1.5 billion in 2009. Skilled nursing facilities frequently billed for more intensive services than were provided or needed by beneficiaries. In another example, OIG identified hundreds of millions of dollars in improper Medicaid payments for personal care services across several States.

In addition, the Department did not fully comply with Executive Order 13520 in its fiscal year 2010 quarterly reports on high-dollar improper payments. The Department's quarterly reports were incomplete and therefore cannot be used to adequately assess the level of risk of each of the Department's programs or to determine the extent of existing oversight activities.

Progress in Addressing the Challenge

Because of statutory prohibitions that may hinder reporting for TANF and CHIP, the Department did not report improper payment estimates for 2011 as required and the Department also had two programs with improper

payment rates exceeding 10 percent. OIG found that, as a result, the Department was not in substantial compliance with the *Improper Payments Elimination and Recovery Act of 2010* (IPERA). However, OIG also found that the Department was in compliance with elements of OMB's guidance for IPERA reporting for five of the nine programs deemed to be susceptible to significant improper payments: Medicare FFS, Medicare Part D, Medicaid, Foster Care and Head Start. The Medicare Prescription Drug Benefit program reported an error rate for the first time in FY 2011. The Department reported reductions in improper payment rates for five of the six programs for which it previously reported improper payment rates (i.e., Medicare FFS, Medicare Advantage, Medicaid, Head Start and the Child Care and Development Fund). Although the Department reduced the improper payment rate for Medicare Advantage from 14.1 percent to 11 percent and for the Child Care and Development Fund from 13.3 percent to 11.2 percent, rates for both programs remain above 10 percent.

The Department has taken actions to address some improper payment vulnerabilities. CMS uses the Comprehensive Error Rate Testing (CERT) program as a way to measure the Medicare FFS error rate and as a guide in developing corrective actions to reduce improper payments. CMS analyzes the CERT improper payment data and uses the results to provide feedback to Medicare contractors to enhance their medical reviews, focus on high-risk areas and reduce improper payments. Additionally, Medicare's automated systems have edits in place to detect and reject payment for medical services that are physically impossible, such as a hysterectomy for a male beneficiary and medically unlikely, such as services claimed for which the quantity billed exceeds acceptable clinical limits. OIG is examining the extent to which Medicare contractors meet error rate reduction plan requirements and the extent to which implementation of these plans affects overall contractor evaluation. Error rate reduction plans describe the corrective actions that contractors plan to take to lower the CERT paid-claims error rate and provider-compliance error rate in their jurisdictions.

To prevent recurrence of improper payments, CMS has made policy and manual changes and has implemented local system edits and CMS Medicare Administrative Contractors have conducted local provider education. Moreover, the ACA expanded the Recovery Audit Contractors (RAC) program from Medicare FFS to identify improper payments in Medicaid and Medicare Parts C and D for recovery and corrective action. OIG work underway is evaluating the results of the RAC program in Medicare.

The Department is also examining techniques used by private sector entities to identify improper payments. In 2011, CMS implemented the Fraud Prevention System (FPS), which is an advanced predictive analytic technology used to conduct data analysis and predictive modeling, to identify improper payment claims as they enter the payment system and to detect and generate alerts for suspicious billing behavior across provider types. (See Challenge 3, Preventing and Detecting Medicare and Medicaid Fraud, for more discussion of FPS and predictive analytics.) Additionally, CMS recently started a demonstration to require prior authorizations for certain power mobility devices in seven States with high populations of fraud and error-prone providers. CMS is also exploring ways to leverage existing compliance programs within the provider community to educate providers about payment vulnerabilities.

CMS developed the Payment Error Rate Measurement (PERM) program to review improper payments for Medicaid and CHIP FFS claims, managed care claims and beneficiary eligibility. Though causes of improper Medicaid payments vary from State to State, PERM helps CMS identify trends and common errors across States. On the basis of PERM results, States are required to submit Corrective Action Plans (CAP) 90 days after they are notified by CMS of their error rates. Many States' CAPs focus on provider education to reduce improper payment rates.

In addition, the Department is strengthening its program integrity efforts by working with its OPDIVs and STAFFDIVs to identify and prioritize programmatic risks. (See Challenge 7, Grants Management and Administration of Contract Funds, for additional information regarding improper payments.)

What Needs To Be Done

The Department is slated to publish a projected error rate for CHIP in the 2012 reporting period. The Department should continue to develop error rates for additional programs, including TANF, to comply with IPERA requirements.

HHS has developed CAPs for the programs for which it reports improper payment rates that, if implemented as designed, could be effective in further reducing improper payments. OIG has recommended that HHS consider changes to its quarterly reporting on high-dollar overpayments that include developing a comprehensive list of overpayments using all potential sources of information and reporting any high-dollar overpayments made by the five State-administered programs (i.e., Medicaid, CHIP, TANF, Foster Care and the Child Care and Development Fund.) Further, the Department should use historical improper payment data to identify the root causes of improper payments. In addition, for Medicare FFS claims, CMS should continue to monitor its payment systems to identify additional edits and prepayment reviews that could identify suspicious claims and prevent improper payments.

The Department should continue to identify best practices in the private sector that it can use to further prevent improper payments. It should also expand its provider education efforts around program requirements and improper payment vulnerabilities. Implementation of planned program integrity initiatives, such as evaluating and monitoring risks, identifying and addressing cross-cutting issues, resolving reported grantee audit findings and sharing best practices across HHS, will help the Department achieve its goal of integrating program integrity into all aspects of its operations and culture. (See Challenge 7, Grants Management and Administration of Contract Funds, for additional information regarding improper payments.)

Key OIG Resources

- U.S. Department of Health and Human Services Did Not Fully Comply With Federal Requirements for Reporting Improper Payments (A-17-12-52000) available at http://oig.hhs.gov/oas/reports/other/171252000.asp and U.S. Department of Health and Human Services Did Not Fully Comply With Executive Order 13520 When Reporting Fiscal Year 2010 High-Dollar Improper Payments (A-02-11-01007) available at http://oig.hhs.gov/oas/reports/region2/21101007.asp.
- Inspector General Levinson's testimonies on improper payments delivered before Congress on July 28, 2011 available at http://oig.hhs.gov/testimony/docs/2011/levinson_testimony_07282011.pdf and on March 17, 2011 available at https://oig.hhs.gov/testimony/docs/2011/levinson_testimony_03172011.pdf
- Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009 (OEI-02-09-00200) available at https://oig.hhs.gov/oei/reports/OEI-02-09-00200.asp.

Management Issue 3: Preventing and Detecting Medicare and Medicaid Fraud

Why This Is a Challenge

Perpetrators of schemes to defraud Medicare and Medicaid range from criminals who masquerade as bona fide health care providers and suppliers but who do not provide legitimate services or products to Fortune 500 companies that pay kickbacks to physicians in return for referrals. Fraud is a crime of deception and perpetrators design their schemes to avoid detection. The Department faces multiple challenges in preventing and detecting these frauds, including:

- Effectively using CMS's provider enrollment and payment suspension authorities against those providers and suppliers that have exploited weaknesses to commit fraud rather than provide legitimate patient care;
- Managing the Department's expanding use of data analysis;
- Collecting and maintaining complete and accurate data, particularly Medicaid data from diverse State programs and systems, to support CMS and OIG oversight and enforcement activities;
- Monitoring Medicare and Medicaid benefits delivered by private plans for fraud; and
- Excluding individuals and entities from Federal health care programs to protect the programs and beneficiaries.

Many of CMS's essential program integrity activities are carried out by contractors. (See also Challenge 6, Ensuring Efficiency and Effectiveness of Medicare and Medicaid Program Integrity Contractors, for information on issues specific to CMS contractor oversight and effectiveness.)

Progress in Addressing the Challenge

Enrollment and Payment. In February 2011, CMS published a final rule implementing the ACA provisions concerning screening of providers and suppliers on the basis of fraud risk. CMS's enhanced payment suspension regulations took effect in March 2011. In this rule and subsequent regulations, CMS established three levels of screening for providers (limited, moderate and high) and designated categories of providers and suppliers to each level. In December 2011, CMS launched its Automated Provider Screening (APS) system, which is designed to identify ineligible providers or suppliers prior to their enrollment or revalidation. CMS completed the procurement of a national contractor to increase efficiency and standardization of provider site visits and this contractor began performing these visits in January 2012. In addition, CMS plans to increase the frequency of unannounced, out-of-cycle site visits.

Data Analysis and Data Quality. Enhanced data analysis made possible the impressive enforcement results of the nine Medicare Fraud Strike Forces, which are part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The strike forces are interagency teams of prosecutors and special agents that focus enforcement resources on geographic areas at high risk for fraud. CMS has made claims data available more quickly and efficiently by providing law enforcement increased access to data, including real-time data. Through HEAT, these data are analyzed and inform the deployment of Strike Force teams.

CMS uses FPS to risk-score Medicare FFS claims prepayment and has awarded a contract to develop and test new predictive models for inclusion in the FPS. Additionally, CMS opened its Command Center which provides a collaborative, multidisciplinary environment for investigators, data analysts, clinicians and subject-matter experts to work on cases, drive innovation and improvement in predictive modeling and monitor progress. CMS established the Medicaid and Children's Health Insurance Program Business Information and Solutions (MACBIS) Council, which provides leadership for the development and deployment of enterprisewide improvements in the

accuracy and availability of data for Medicaid program integrity and oversight. To improve the quality of data collected from States in the Medicaid Statistical Information System (MSIS), CMS has undertaken a pilot test of 10 States (2 States have subsequently joined the pilot test however they have not yet contributed data) to expand the MSIS data set (called Transformed-MSIS, or T-MSIS) and allow CMS to review the completeness and quality of State MSIS submittals as they are received. CMS states that it plans to launch national implementation of T-MSIS in 2014.

Monitoring Medicare and Medicaid Benefits Delivered by Private Plans. CMS has strengthened its oversight of Parts C and D program integrity by auditing Part D sponsors' compliance plans: issuing guidance regarding Parts C and D sponsors' program integrity training responsibilities including identifying invalid prescriber identifiers; and hosting its first annual program integrity conference for Parts C and D sponsors. In 2010, CMS began implementing a broad set of Medicaid initiatives focused on assessing and improving States' performance in meeting regulatory requirements and ensuring that managed care systems deliver accessible, available and appropriate services to Medicaid beneficiaries.

Accountability. CMS's imposition of payment suspensions is one example of the Department's increased focus on using its administrative tools to ensure accountability. Each year, OIG excludes thousands of individuals and entities from participating in Federal health care programs for a variety of reasons set forth in law, ranging from health care fraud convictions to loss of medical license for professional incompetence. OIG issued guidance on its authority to pursue exclusion of responsible corporate officers of sanctioned providers and suppliers that may otherwise view civil penalties and fines as the cost of doing business. OIG and its law enforcement partners, including the Medicaid Fraud Control Units, also investigate suspected fraud and refer cases to the Department of Justice for criminal and civil adjudication.

What Needs To Be Done

CMS has additional opportunities to strengthen the enrollment system, including adopting a more flexible screening approach, tailoring screening measures to fraud risks and classifying reenrolling durable medical equipment (DME) and home health providers as "high risk" when appropriate. CMS should also focus enrollment scrutiny on providers such as independent diagnostic testing facilities (IDTF) and comprehensive outpatient rehabilitation facilities (CORF), as OIG found that IDTFs and CORFs did not comply with basic Medicare requirements to maintain open and accessible physical locations as reported to and on file with CMS. In addition, CMS should consider instituting temporary enrollment moratoria for certain types of providers in geographic areas at significant risk for fraud, such as home health providers in Florida and Texas.

The Department should continue to collect and maintain more robust data sets, particularly for State Medicaid programs, as well as further facilitate law enforcement's access to data. OIG and the Department must also ensure that OIG has the capacity to handle the volume of new fraud referrals that can be expected from CMS's expansion into predictive modeling and that CMS and OIG coordinate closely on such referrals. CMS should also strengthen fraud and abuse prevention efforts by issuing regulations for mandatory provider compliance plans under sections 6102 and 6401 of the ACA.

CMS must also continue to monitor Medicare Advantage and Part D plans' implementation of integrity safeguards, provision of covered services to all eligible beneficiaries and compliance with marketing rules. CMS will also need to oversee plans' compliance with medical loss ratios and ensure that plans are not inflating their direct health care costs. As States increasingly use managed care to deliver Medicaid services, CMS should require that State contracts with managed care entities (MCEs) include a method to verify with beneficiaries whether services billed

by providers were received and CMS should update guidelines to reflect current concerns expressed by MCEs and States.

The Department should continue to focus on accountability for fraud. In addition, OIG will continue to use its exclusion authority to protect the Department's programs and beneficiaries, including considering cases in which excluding responsible corporate officers of sanctioned providers and suppliers is appropriate and monitoring the effect of such an exclusion on recidivism.

Key OIG Resources

- Inspector General Levinson's testimony, Anatomy of a Fraud Bust: From Investigation to Conviction, April 24, 2012, available at http://oig.hhs.gov/testimony/docs/2012/levinson_testimony_04242012.pdf.
- Exclusion Program information available at http://oig.hhs.gov/exclusions/ and guidance available at https://oig.hhs.gov/exclusions/ .
- OIG reports on questionable Medicare billing for independent diagnostic testing facility services (OEI-09-09-00380) available at http://oig.hhs.gov/oei/reports/oei-09-09-00380.asp and comprehensive outpatient rehabilitation facility services (OEI-05-10-00090) available at http://oig.hhs.gov/oei/reports/oei-05-10-00090.pdf.
- Program Integrity Problems With Newly Enrolled Medicare Equipment Suppliers (OEI-06-09-00230) available at http://oig.hhs.gov/oei/reports/oei-06-09-00230.asp.
- Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards (OEI-01-09-00550) available at http://oig.hhs.gov/oei/reports/oei-01-09-00550.asp.

Management Issue 4: Ensuring Patient Safety and Quality of Care

Why This Is a Challenge

As a purchaser of health care for over 100 million Americans, the Department faces challenges in ensuring the quality of care rendered to Federal health care program beneficiaries. Despite increased attention to patient safety, quality problems persist. According to the Joint Commission, 40 wrong-site surgeries are performed in U.S. hospitals and surgicenters every week. In a 2010 report, OIG found that 13.5 percent of hospitalized Medicare beneficiaries suffered harm from adverse events (i.e. patient harm resulting from medical care) during their hospital stays. Forty-four percent of these adverse events were preventable and were caused by care failures, such as medical error, substandard care or inadequate monitoring. OIG continues to conduct followup work on studying adverse events, including determining the extent to which adverse events occur in other care settings, such as nursing homes.

Other OIG work has raised concerns about overmedication with atypical antipsychotic drugs in nursing homes; more than 20 percent of atypical antipsychotic drugs claimed for Medicare patients in nursing homes violated Federal standards to protect nursing home residents from unnecessary drug use. OIG also found that nursing homes generally were not meeting all requirements for care plans and resident assessments when administering antipsychotics. OIG has also identified concerns with the licensure and qualifications of health care providers across various health care settings.

Quality of nursing home care remains a critical challenge. OIG investigations have uncovered various problems, including inadequate staffing, failure to provide adequate nutrition and hydration, patients' development of preventable or untreated pressure wounds (bedsores), inappropriate medication practices and other serious

deficiencies. Other enforcement actions target nursing homes that maximize reimbursement by rendering excessive therapy services that are medically unnecessary or even harmful to beneficiaries.

Progress in Addressing the Challenge

The Department has taken steps to improve quality of care and promote patient safety, both targeting specific populations, such as improving care coordination for Medicare beneficiaries with multiple chronic conditions and improving care for all patients. The Department has committed up to $1 billion in ACA funding to the Partnership for Patients Initiative, a public-private partnership to keep patients from becoming injured or sicker while undergoing treatment and to help patients heal without added complication. Two specific partnership goals are to reduce hospital readmissions by 20 percent and reduce preventable harm to hospital patients by 40 percent by the end of 2013.

CMS awarded $218 million to State, regional, national, or hospital system organizations to establish Hospital Engagement Networks (HEN) to make health care safer and less costly by targeting and reducing preventable injuries. Pursuant to the ACA, CMS specifically committed $500 million towards a Community Based Care Transition Program to improve patient outcomes following hospital discharge.

The Department is also testing and implementing new care delivery models in the Medicare and Medicaid programs designed to improve the quality of care by enhancing provider accountability for quality and improving coordination of care and care transitions. The Department continues to provide incentives for improved quality of care through its value-based payment policies, including policies that link payment to quality measures and that address hospital-acquired conditions. The Department also continues to promote the adoption of electronic health records and electronic prescribing, which promise to improve quality of care, reduce medication errors and otherwise promote patient safety. The Department established tools to help beneficiaries compare facility-specific quality indicators to better inform their decisions regarding where to seek treatment. (See also Challenge 5, Avoiding Waste and Promoting Value in Health Care, for more discussion of promoting value and coordination in health care and Challenge 9, Integrity and Security of Health Information Systems and Data, for more discussion of electronic health records.)

The Five Star Quality Rating System and Nursing Home Compare report on many important quality measures for nursing homes. Recent regulation has also targeted therapy utilization in nursing facilities. In March 2012, CMS launched a new initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. A primary goal is to reduce antipsychotic drug use in nursing homes 15 percent by the end of 2012. Additionally, CMS' Nursing Home Value-Based Purchasing demonstration is currently testing ways to improve care for this population.

OIG continues to pursue enforcement actions against health care providers that render substandard care. OIG maintains corporate integrity agreements with several nursing homes, hospitals, assisted-living facilities and dental clinics that include quality-monitoring provisions. CMS and OIG continue to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to promote better care for elderly persons and to prosecute providers that subject them to abuse or neglect.

What Needs To Be Done

The Department should continue to prioritize quality of care and patient safety and build upon its past efforts, including continuing to implement the quality improvement provisions of the ACA and achieving the goals set by

the Partnership for Patients and the National Quality Strategy. OIG has offered recommendations that can assist the Department in this mission. For example, OIG suggested enhancements to nursing home oversight to ensure that Medicare does not pay nursing homes to overmedicate or otherwise inappropriately medicate beneficiaries. OIG also suggested enhancements to outpatient prescription drug claims that could help the Department ensure that Medicare and Medicaid beneficiaries receive only the drugs that are appropriate for their medical indications. The Department should also continue denying payments for services of such low quality that they are virtually worthless and work with OIG to exclude providers that have rendered grossly substandard care, thereby preventing additional harm to vulnerable beneficiaries.

The Department must also ensure that health care professionals working in all sites of service, such as hospitals, nursing homes, school-based facilities and beneficiaries' homes, meet qualification and licensure requirements before they treat Federal health care program beneficiaries.

Key OIG Resources

- Summary and index of OIG reports related to adverse events among hospitalized Medicare beneficiaries available at http://oig.hhs.gov/newsroom/spotlight/2012/adverse.asp.
- Testimony of Inspector General Levinson on Medicare claims for atypical antipsychotic drugs for nursing home residents, November 30, 2011 available at http://oig.hhs.gov/testimony/docs/2011/levinson_testimony_11302011.pdf.

Management Issue 5: Avoiding Waste and Promoting Value in Health Care

Why This Is a Challenge

In an era of fiscal belt-tightening and expanding enrollment of "baby boomers" into the Medicare system, the Department must be vigilant in reducing waste and increasing value in its health care programs. The Institute of Medicine (IOM) estimated that about 30 percent of U.S. health spending in 2009—roughly $750 billion—was wasted. Waste in health care programs is a multidimensional problem. The IOM report identified six major areas of waste: unnecessary services, inefficient delivery of care, excess administrative costs, inflated prices, prevention failures and fraud.

As described in Challenge 3, Preventing and Detecting Medicare and Medicaid Fraud, curbing fraud is vital to conserving scarce health care resources and the Department must continue to direct all necessary resources toward fraud prevention, detection and remediation. However, while all fraud is waste, not all waste is fraud. Challenge 2, Identifying and Reducing Improper Payments and Challenge 4, Ensuring Patient Safety and Quality of Care, describe opportunities to address waste and increase value by reducing improper payments and ensuring patient safety and quality of care. Maximizing efficiencies and value derived in health care requires the Department to continue to focus on other areas prone to waste as well.

One area is payment inefficiency. OIG has found, for example, payment inefficiencies in Medicare's bundled payment for global surgery fees, which has not been adjusted to reflect evolving physician practices that result in fewer services' typically being provided than assumed in the payment model. Similarly, OIG work on evaluating Medicare payment for two medications used to treat wet age-related macular degeneration revealed substantial opportunities for Medicare to save money by paying on the basis of the cost of the less expensive drug, which is equally effective according to preliminary results of a clinical study. OIG work evaluating drug pricing showed shifts in utilization patterns for drugs coinciding with changes in Medicare payment and coding policies. Utilization of a

more expensive respiratory drug increased when Medicare's reimbursement for that drug was more favorable to suppliers compared to reimbursement for a less expensive alternative drug and decreased when Medicare changed its pricing policy.

The Department is implementing a variety of policy changes designed to shift from volume-driven payment to value-driven payment. These include, for example, the Hospital Value-Based Purchasing Program, the Readmissions Reduction Program, the Hospital Acquired Conditions Program and the End Stage Renal Disease (ESRD) Prospective Payment System. They also include broader delivery reforms that pair payment incentives with changes aimed at producing better coordinated, higher quality and more efficient and effective care. Examples include the MSSP, as well as models being tested under the auspices of the Center for Medicare and Medicaid Innovation (CMMI), such as the Pioneer ACO Program, the Independence at Home Program and the Bundled Payment for Care Initiative.

These reforms rely significantly on complex data, advanced health information technology and sophisticated quality and performance measurement. To ensure reliable results, data must be accurate, complete and timely. Measures must be appropriate and meaningful. Outcomes must be correctly assessed to ensure correct payment. The growing linkage of payment with quality presents new challenges for administering Medicare and Medicaid payment systems.

The Hospital Acquired Conditions Program provides an example of the challenges in designing and implementing initiatives in ways that achieve their goals. OIG reviewed the incidence of adverse events among hospitalized Medicare beneficiaries and found that very few of the events that beneficiaries experienced were covered by the Hospital Acquired Conditions policy. Further, for the few incidents that were covered by the policy, none of the events in OIG's review were documented in the claims data in a way that would enable CMS to identify them as hospital-acquired conditions and apply appropriate payment denial for increased costs associated with those events.

Opportunities afforded by innovations in science and information technology and advances in evidence-based medicine and quality measurement are fueling transformations in health care aimed at improving care and lowering costs. To meet this challenge, the Department must design and oversee payment systems that produce the greatest health benefits to patients at the lowest cost.

Progress in Addressing the Challenge

The Department is implementing policy changes, including a number of ACA-related changes, designed to reduce waste and increase value in the health care programs through enhanced payments for positive patient outcomes and/or financial penalties for negative patient outcomes. For example, the Hospital Value-Based Program provides financial incentives to hospitals for achievements and improvements in measures related to patient outcomes, patient experiences and processes of care. CMS issued a final rule to implement its Hospital Readmissions Reduction Program, effective October 1, 2012, under which Medicare payments may be reduced to applicable hospitals with high patient readmission rates. In that same final rule, CMS also continued its list of existing hospital-acquired conditions with some updated billing codes and added two new conditions to this list. The Department continues to administer the MSSP and to foster a variety of payment and delivery models in the Medicare and Medicaid programs. CMS intends to learn from the Nursing Home Value-Based Purchasing demonstration to inform improved payment in this postacute care setting.

In addition, the Department continues to implement the Competitive Bidding Program for DME, which holds promise for addressing prior OIG findings that Medicare paid significantly more than market prices for many types of DME.

What Needs To Be Done

The Department should continue to seek opportunities to harness the promise of value-driven payment. The Department should continuously evaluate the effectiveness of payment policies and scrutinize payment systems to ensure that quality, efficiency and payment accuracy goals are met. For example, the Department could strengthen its Hospital-Acquired Conditions policy by improving compliance with present-on-admission coding rules and, if supported by evidence of effectiveness, further expanding the list of hospital-acquired conditions. Timely implementation of the new payment adjustment under ACA section 3008 for conditions acquired in hospitals, slated to go into effect in 2015, will further strengthen the Department's efforts to improve patient care and reduce wasteful expenditures on hospital-acquired conditions. The Department should also consider revising its payment policy for the drugs used to treat wet age-related macular degeneration and apply the lessons learned from the utilization changes in the respiratory drugs to design payments and monitor billing to avoid unintended consequences.

For newly implemented programs, such as the MSSP and CMMI demonstration programs, the Department must vigilantly monitor implementation, ensure efficient and effective operations, evaluate program outcomes and assess the effectiveness of oversight strategies. The Department should implement a comprehensive and flexible oversight strategy, with robust tools to prevent, detect and remedy instances of fraud, waste and abuse.

Key OIG Resources

- Medicare Payments for Drugs Used To Treat Wet Age-Related Macular Degeneration (OEI-03-10-00360) available at http://oig.hhs.gov/oei/reports/oei-03-10-00360.asp.
- Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries (OEI-06-09-00090) available at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
- Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided (A-05-09-00053) available at http://oig.hhs.gov/oas/reports/region5/50900053.asp.
- Index of resources related to Accountable Care Organizations available at http://oig.hhs.gov/compliance/accountable-care-organizations/index.asp.

Management Issue 6: Ensuring Efficiency and Effectiveness of Medicare and Medicaid Program Integrity Contractors

Why This Is a Challenge

CMS relies on a number of program integrity contractors to identify and respond to fraud, abuse and improper payments in the Medicare and Medicaid programs. These contractors include Medicare Drug Integrity Contractors (MEDIC), Program Safeguard Contractors (PSC), Zone Program Integrity Contractors (ZPIC), RACs, Review Medicaid Integrity Contractors (MIC) and Audit MICs. OIG work has raised concerns about contractors' performance in protecting Medicare and Medicaid from fraud, waste and abuse and has identified barriers that may limit their ability to perform successfully.

Questionable Contractor Performance. Recent OIG reports examining early MIC efforts revealed limited success and negative return on investment. Review MICs initially identified over 113,000 providers with potential

overpayments of $282 million, but after performing audits, the Audit MICs found actual overpayments to only 25 of these providers, totaling less than $300,000. In FY 2010, CMS paid MICs more than $32 million, but MIC efforts in 2010 yielded less than $14 million in identified overpayments. Similarly, in 2007 and 2008, CMS spent $60 million on the Medicare-Medicaid Data Match program (Medi-Medi Program), administered by the PSCs, but the program recovered or avoided expenditures totaling just under $58 million.

OIG work has also raised concerns about the variability in performance results among integrity contractors, which was not necessarily linked to relative budget size or oversight responsibilities. In addition, OIG found that RACs made few fraud referrals to CMS under a demonstration project, despite having identified more than $1 billion in improper payments.

Inadequate Program Data. The integrity contractors rely heavily on data to conduct program integrity tasks, yet OIG work has found significant limitations in the Medicare and Medicaid data available to contractors. For example, the MSIS is the only national database of Medicaid claims and beneficiary eligibility information. However, OIG has found that MSIS data are not complete, accurate or timely and do not capture all data elements that can assist in the detection of fraud, waste and abuse. These factors contributed to MICs' misidentification of potential overpayments and the Medi-Medi Program's limited identification of Medicaid overpayments and potential fraud. Furthermore, ZPICs' and MEDICs' lack of access to Medicare claims data and, in the case of MEDICs, to medical records and prescriptions has hindered or delayed their ability to identify possible fraud and abuse.

CMS Oversight Challenges. OIG has also identified weaknesses in CMS's management and oversight of its integrity contractors. For example, CMS uses contractor-reported workload statistics to oversee performance. However, the data contractors report is not always accurate or uniform, hindering the ability to make meaningful comparisons. In addition, CMS has not always held contractors accountable for the tasks outlined in their contracts.

Progress in Addressing the Challenge

CMS has made some progress toward addressing the above challenges as it works with its contractors to implement the new anti-fraud authorities provided in the ACA and the *Small Business Jobs Act of 2010*. Additionally, several information technology initiatives aim to improve the quality, availability and meaningful use of data, including the FPS and the recently launched pilot project to improve Medicaid data, the Transformed MSIS initiative. CMS has also reported actions to improve the Medi-Medi and MIC programs consistent with OIG recommendations, such as assigning more Medicaid audits through the collaborative process, which showed greater success than the traditional process. Further, CMS told OIG that it is realigning Review MICs enabling it to discontinue three of five Review MIC task orders for options years that were scheduled to be renewed at the end of FY 2012.

In addition, MEDICs now have access to Part D data to conduct analyses and to identify and investigate potential fraud. CMS has also increased the quantitative data it collects on contractors; however, inaccuracies and inconsistencies in reporting persist.

What Needs To Be Done

As its programs continue to expand, CMS must do more to ensure that integrity contractors are fully equipped and are performing at levels that do not waste taxpayer dollars. OIG has offered a number of recommendations to CMS about improving the quality, accuracy and availability of data, particularly for the Medicaid program. CMS's

initiatives offer promise and will require sustained focus and resources at the Federal and State levels to deliver improved results.

CMS should continue to build on its progress in addressing contractor performance and oversight challenges. For example, OIG continues to recommend that CMS pursue authority to allow MEDICS to collect information directly from pharmacies, pharmacy benefit managers and physicians. CMS should also continue to improve contractor performance data so that they are accurate and consistent and then use the data to more effectively evaluate contractor performance.

Key OIG Resources

- Office of Inspector General testimony on Medicare contractors, delivered before Congress on June 8, 2012, available at http://oig.hhs.gov/testimony/docs/2012/Vito_testimony_06082012.pdf and on Medicaid contractors delivered before Congress on June 14, 2012 available at http://oig.hhs.gov/testimony/docs/2012/Maxwell_testimony_06142012.pdf.
- The Medicare-Medicaid (Medi-Medi) Data Match Program (OEI-09-08-00370), available at http://oig.hhs.gov/oei/reports/oei-09-08-00370.asp.

Management Issue 7: Grants Management and Administration of Contract Funds

Why This Is a Challenge

HHS is the largest grant-making organization in the Federal Government and its funding of health and human services programs touches the lives of almost all Americans. In FY 2011, the Department awarded over 82,000 grants totaling approximately $382 billion. Of these, approximately 80,000 grants and $91 billion were for programs other than Medicare or Medicaid. These grants include those added to the HHS grant portfolio by the ACA and the *Recovery Act*, thus expanding the oversight necessary by grant managers and project officers.

HHS is also the third largest contracting agency in the Federal Government; in 2011, HHS awarded over $19 billion in contracts across all program areas. Additionally, four HHS OPDIVs fund SBIR (Small Business Innovation Research) and STTR (Small Business Technology Transfer) grants and contracts. In 2010, HHS spent $690 million on these programs. HHS is the second largest funder of grants and contracts under these programs (the Department of Defense is the first).

Oversight and management of both new and continuing grant programs is crucial to the Department's mission and to the health and well-being of the public. However, OIG has found internal control deficiencies, problems with financial stability, inadequate organizational structures, inadequate procurement and property management policies and inadequate personnel policies and procedures among grantees. For example, recent audits of *Recovery Act* grantees determined that grantees did not (1) maintain financial management systems that accounted for grants separately, (2) appropriately allocate direct and indirect costs, or (3) maintain documentation to support property records and actual personnel costs charged to the grant awards.

The Department also faces challenges with monitoring its HIV/AIDS relief grant funds awarded to foreign and domestic recipients. Through the President's Emergency Plan for AIDS Relief (PEPFAR) program, the Department received over $10 billion in grant funding to prevent, treat and combat HIV/AIDS, tuberculosis and malaria—with the majority allocated to the Centers for Disease Control and Prevention (CDC). OIG's review of CDC's oversight

found that while some monitoring had been performed, it was not consistent. OIG found that grant-related files and documentation were not maintained in accordance with departmental and other Federal requirements.

With respect to contracts, OIG focused on the National Institutes of Health's (NIH) use of appropriations to fund 21 longer term contracts. We have reported instances of improper funding on 11 of the 18 completed audits. Audits of the remaining three contracts are ongoing. In FY 2011, HHS reported a department-wide violation of the *Anti-Deficiency Act* that involved 47 HHS contracts from NIH and other OPDIVs that were awarded between 2004 and 2009. As OIG continues to review grants and contracts oversight vulnerabilities across the Department, we plan to assess the effectiveness of the remedial actions taken by the Department to properly fund its contracts and prevent future violations of the *Anti-Deficiency Act*.

Progress in Addressing the Challenge

To conduct grant oversight, the Department continues to work with OIG to address audit findings, implement recommendations and provide updated information on recoveries of unallowable costs related to grant programs. In addition, the Department is strengthening its program integrity efforts by working with its OPDIVs and STAFFDIVs to identify programmatic risk utilizing a uniform risk management approach. This approach will enable the Department to look across programs for commonalities and solutions, as well as to consistently evaluate the results. For example, in 2010, the Health Resources and Services Administration (HRSA) launched its Program Integrity Initiative (PII) to identify and reduce risks through new or enhanced oversight activities while sharing new and best practices across programs. In 2011 OIG provided training to 200 HRSA grants management and program officials. In 2012, two PII Webinars were held: one focused on risk and fraud generally and the other addressed risk and fraud within the 340B Discount Drug Program. In total, more than 500 grantee participants and 200 HRSA staff attended the first Webinar and 400 participants including HRSA staff, grantees and A-133 auditors attended the second Webinar.

With respect to systemic contract funding problems, the Department, as required by law, reported multiple violations of the *Anti-Deficiency Act;* issued detailed policy guidance; developed and mandated a department-wide appropriations law training course for all budget, finance, program and contracting officials; developed an online reference tool for contract funding, formation and appropriations law compliance; and is conducting appropriations law compliance reviews of all contract actions exceeding $5 million or $10 million, depending on the type of requirement reviewed and the awarding OPDIV or STAFFDIV. CMS ensures that all employees involved in the acquisition process receive the necessary training to ensure that grants and contracts management policies and procedures are followed. Additionally, in May, 2012, the Department issued Suspension and Debarment Procedures. In June 2012, the HHS Suspension and Debarment Official and her staff began holding monthly coordination meetings with representatives from OIG, the Office of Research Integrity and the Office of the General Counsel (OGC). These meetings provide an opportunity for discussion of pending referrals as well as other operational and implementation activities either being considered or underway.

The Department has also taken steps to improve monitoring of its HIV/AIDS relief programs. For example, CDC is developing additional standard operating procedures for monitoring recipients. CDC also established a multi-disciplinary team from CDC headquarters to conduct reviews at its offices in various countries.

What Needs To Be Done

Sustained focus by the Department is needed to address vulnerabilities in its grant programs and contract administration. With respect to grant oversight, OPDIVs need to continue to be vigilant in monitoring grant

resources stemming from the *Recovery Act*, the ACA, PEPFAR and other grant programs. Implementation of planned program integrity initiatives, such as evaluating and monitoring risks, identifying and addressing cross-cutting issues, resolving reported grantee audit findings and sharing best practices across the Department, will better position HHS to integrate program integrity into all aspects of its operations and culture. Additionally, OIG has found that OPDIVs vary in their grant oversight processes. The Department should work toward making the grants management function more consistent across OPDIVs.

With respect to contract funding, the Department has advised that it is heavily focused on preventing new violations and that it is taking legally appropriate actions to ensure that there are no further violations of the *Anti-Deficiency Act* among ongoing contracts. OIG continues to recommend that the Department correct the improper funding of contracts that resulted in appropriations violations and continue to ensure that appropriate officials attend mandated training, that future contracts are funded properly and that policy guidance is consistently followed. The Department also needs to fully implement its Suspension and Debarment Procedures, including operationalizing the referral and decision process and setting up a department-wide tracking system.

Key OIG Resources

- Review of 83 Early Head Start Applicants Under the *American Recovery and Reinvestment Act* (A-01-10-02501), available at http://oig.hhs.gov/oas/reports/region1/11002501.pdf.
- Review of Centers for Disease Control and Prevention's (CDC) Oversight of PEPFAR Funds for Fiscal Years 2007 Through 2009 (A-04-10-04006), available at http://oig.hhs.gov/oas/reports/region4/41004006.pdf.
- See summary of recent NIH contract audits on pages IV-16-17 of OIG's *Spring 2012 Semiannual Report to Congress*, available at http://oig.hhs.gov/reports-and-publications/archives/semiannual/2012/spring/sar-S12-04-phhs+.pdf.

Management Issue 8: Protecting Consumers of Food, Drugs and Medical Devices

Why This Is a Challenge

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

Inadequate Food Facility Inspections and Recordkeeping. OIG found that FDA was conducting food facility inspections infrequently—many food facilities went 5 years or longer without an FDA inspection. FDA took action against less than half of food facilities after the agency found conditions that warranted its most severe inspection classification. FDA relies upon States to conduct food facility inspections under contract; however, FDA has failed to ensure that States completed all required inspections, that the completed inspections were properly classified, or that all violations were remedied.

Similarly, food facilities' failure to comply with FDA's recordkeeping requirements impedes the Department's ability to ensure the safety of the Nation's food supply. We found that 59 percent of selected food facilities did not comply with FDA's recordkeeping requirements. Additionally, in reviews of food safety recalls, we found that FDA

often did not follow its own procedures for ensuring that the recall process operated efficiently and effectively. Further, FDA's procedures for monitoring recalls were not always adequate.

Ensuring Compliance With 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 these items are approved for sale, qualified medical providers may prescribe them for any uses on the basis of their medical judgment. However, manufacturers are prohibited from promoting products for uses for which FDA has not specifically approved them (known as off-label uses). OIG works with its law enforcement partners, including FDA's Office of Criminal Investigations and has investigated many instances in which manufacturers have 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. FDA faces ongoing challenges in adequately monitoring and preventing illegal off-label promotional activities. Additionally, this illegal off-label promotion may increase fraudulent claims for payment submitted to Federal health care programs, including Medicare and Medicaid.

Inadequate Procedures and Monitoring. OIG has found vulnerabilities in FDA's oversight of regulatory decisions and monitoring of drugs and medical devices. For example, OIG found weaknesses in FDA's management of internal scientific disagreements related to regulatory decisions for medical devices under agency review. Other concerns include weaknesses in ensuring the adequate monitoring of adverse-event reporting for medical devices and the accuracy of FDA's National Drug Code Directory.

OIG is reviewing FDA's progress in reclassifying high-risk devices cleared under the 510(k) process. OIG is also reviewing FDA's monitoring of the Risk Evaluation and Mitigation Strategies (REMS) that sponsors are required to submit for drugs associated with known or potential risks that may outweigh a drug's benefits.

Progress in Addressing the Challenge

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

OIG will continue to oversee the Department's management of food safety issues and FSMA implementation. In ongoing work, OIG is examining whether the structure/function claims made by manufacturers of dietary supplements may be misleading to consumers and whether dietary supplement companies have registered as required with the Food Facility Registry so that FDA may contact companies in an emergency.

OIG is working with law enforcement partners to investigate and prosecute drug and device manufacturers that engage in illegal activity. For example, GlaxoSmithKline recently agreed to plead guilty to misbranding charges, pay more than $3 billion in criminal fines, enter into a civil settlement and enter into a corporate integrity agreement with OIG to resolve criminal, civil and administrative liability resulting from various types of conduct, such as unlawful promotion of certain drugs and failure to report safety data on a particular drug to FDA. In November 2011, Medtronic, Inc., agreed to pay $23.9 million to resolve allegations under the *Civil False Claims Act* that it caused false claims to be submitted to Medicare and Medicaid by inducing doctors to implant the company's pacemakers and defibrillators in patients in exchange for payments to those doctors.

What Needs To Be Done

The Department and FDA will need to focus on implementing the new Food and Drug Administration Safety and Innovation Act, which was signed into law in July 2012. In addition, FDA will need to continue its efforts to fully implement FSMA to better protect the Nation's food supply. FSMA addresses many of OIG's recommendations; however, we continue to recommend that FDA vigorously use its new authorities to remedy identified weaknesses in its inspections and recall procedures. FDA should also ensure that States properly conduct contracted food facility inspections.

The Department also needs to focus on eliminating off-label promotion to protect patients and HHS health care programs.

Key OIG Resources

- OIG reports on imported food recalls (A-01-09-01500), available at http://oig.hhs.gov/oas/reports/region10/10901500.pdf, food facility safety inspections (OEI-02-09-00430), available at http://oig.hhs.gov/oei/reports/oei-02-09-00430.asp and traceability in the food supply chain (OEI-02-06-00210), available at http://oig.hhs.gov/oei/reports/oei-02-06-00210.pdf.
- Scientific Disagreements Regarding Medical Device Regulatory Decisions (OEI-01-10-00470), available at http://oig.hhs.gov/oei/reports/oei-01-10-00470.asp.
- Adverse Event Reporting for Medical Devices (OEI-01-08-00110), available at http://oig.hhs.gov/oei/reports/oei-01-08-00110.pdf.
- FDA's Approval Status of Drugs Paid for by Medicaid (OEI-03-08-00500), available at http://oig.hhs.gov/oei/reports/oei-03-08-00500.pdf.
- Department of Justice press release on the resolution with GlaxoSmithKline, July 2, 2012, available at http://www.justice.gov/opa/pr/2012/July/12-civ-842.html.

Management Issue 9: Integrity and Security of Health Information Systems and Data

Why This Is a Challenge

As health care providers modernize their medical recordkeeping and billing systems, the adoption of electronic health records (EHR) and other innovations offer opportunities for improved patient care and more efficient practice management. However, as growing quantities of personal medical information are stored in electronic format, protecting the privacy and security of these data and ensuring the integrity of EHRs is critical. In addition, ensuring the integrity, privacy and security of sensitive data will be critical to the successful administration of the ACA Exchanges and related programs, including the premium tax credit program.

Data Security. A series of OIG audits revealed that some hospitals lack sufficient security features, potentially exposing patients' electronic protected health information to unauthorized access. Vulnerabilities included unsecured wireless access, inadequate encryption, authentication failures and other access control vulnerabilities. OIG also found security breaches in data stored by CMS's contractors.

Over 5,000 Medicare physician identifiers and almost 300,000 Medicare beneficiary numbers are known to be compromised. Protecting beneficiaries' and providers' identifiers is critical because fraud perpetrators often use stolen beneficiary and/or physician identities to submit false claims. For example, OIG investigated fraudulent medical clinics in California that used stolen physician identifiers to falsely bill Medicare for equipment the

physicians did not order and services the physicians did not render. The perpetrators pleaded guilty to Medicare fraud and the operation was shut down.

Integrity of EHRs and EHR Investments. Between 2009 and 2021, the Federal Government will spend over $20 billion on the Medicare and Medicaid EHR incentive programs. The Department must ensure that recipients of Medicare and Medicaid EHR incentive payments truly qualify for payment and that policies effectively promote desirable technological practices and outcomes. OIG found shortcomings in Medicaid agencies' ability to ensure the integrity of their EHR incentive programs and eligibility of providers receiving incentive payments. More than half of Medicare physicians currently use electronic health record systems. Beginning in 2015, the Department must implement Medicare payment reductions for physicians who cannot demonstrate meaningful use of certified EHR systems.

Finally, EHRs should facilitate more accurate billing and support better quality of care but, when misused, may promote fraudulent billing or inappropriate care. For example, cut-and-paste features and auto-fill templates can reduce paperwork burdens, but can also be misused to fabricate information, generating improper payments and corrupting patients' records with inaccurate and potentially dangerous information. Similarly, well-designed decision support tools can help physicians select the best care for their patients, but inappropriately designed decision support tools can promote waste and inappropriate care.

Progress in Addressing the Challenge

The Department has promulgated various rules that address privacy and security of patient information, encourage health care providers to use EHRs and ensure that record systems are interoperable and facilitate accurate and secure exchange of information between authorized users. The Department has provided guidance to help covered entities comply with privacy and security rules mandated by the *Health Insurance Portability and Accountability Act of 1996* and pursued enforcement actions against entities that have failed to do so.

The Department has also addressed, in limited ways, privacy and security matters in its regulations governing Medicare and Medicaid EHR incentive payments. The Department has developed and shared with the States a pre- and post-payment audit toolkit to help States verify eligibility for incentive payments under the Medicaid EHR program.

The Department has implemented numerous recommendations to make its own electronic data more secure. The Department has educated physicians on protecting their provider identifiers and preventing unauthorized individuals from using the physicians' credentials to order or bill for services. The Department established databases to track compromised beneficiary and provider identifiers and implemented a new remediation process to assist physicians whose identities were stolen and used to submit false bills to Medicare and Medicaid.

In addition, OIG has undertaken educational initiatives, including direct outreach by special agents and dissemination of an identity theft brochure, to help beneficiaries and providers protect themselves from medical identity theft.

What Needs To Be Done

The Department needs to heighten its focus on oversight and enforcement of privacy and security protections to ensure that health care providers and the Department's own systems and contractors effectively safeguard individuals' protected health and other sensitive personal information. This should entail continued compliance

reviews to ensure adoption of adequate privacy and security standards. The Department should also increase protections for provider and beneficiary identifiers to prevent medical identity theft and better assist beneficiaries whose identifiers have been compromised.

The Department should also provide additional guidance on information technology security standards and best practices that the health care industry should adopt for EHRs. As providers increasingly claim financial incentives for adoption of electronic record and prescribing technologies, strict oversight, including prepayment verification and postpayment auditing, will be essential.

Key OIG Resources

- Security Gaps May Threaten Electronic Health Records (A-04-08-05069 and A-18-09-30160), available at http://oig.hhs.gov/newsroom/news-releases/2011/security.asp.
- Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight (OEI-05-10-00080), available at http://oig.hhs.gov/oei/reports/oei-05-10-00080.pdf.
- Use of Electronic Health Record Systems in 2011 Among Medicare Physicians Providing Evaluation and Management Services (OEI-04-10-00184), http://oig.hhs.gov/oei/reports/oei-04-10-00184.asp.
- Protect Yourself Against Medical Identity Theft, available at http://oig.hhs.gov/fraud/medical-id-theft/.
- CMS Response to Breaches and Medical Identity Theft, (OEI-02-10-00040), available at https://oig.hhs.gov/oei/reports/oei-02-10-00040.pdf.

Management Issue 10: Fostering an Ethical and Transparent Environment

Why This Is a Challenge

Conflicts of interest in the health care system and in Government have been the subject of scrutiny by Congress, the medical community and the media. With a heightened focus on transparency in the Federal Government and the imperative to use resources efficiently and appropriately, the Department must ensure that employees, grantees and contractors are free of conflicts of interest or other ethics concerns. However, our work indicates that the Department can do more to ensure that ethics vulnerabilities and transparency issues related to potential conflicts of interest in the health care arena are identified and addressed.

OIG has found that the Department provides limited oversight of conflicts of interest of FDA clinical investigators, NIH grantees and Federal employees. For example, in a 2011 report, OIG found that 56 percent of the HHS employees' conflict-of-interest waivers in our review were not documented as recommended in Governmentwide Federal ethics regulations, guidance and the Secretary's instructions. In another review, we found that only 70 of 156 responding NIH grantee institutions had written policies and procedures for addressing institutional conflicts of interest (these policies are not required by law).

CMS continues to rely on an extensive network of contractors to perform essential program functions and relationships among those contractors and their relationships with CMS raise potential concerns. For instance, OIG found that entities that applied to be CMS's ZPICs, referred to as "offerors," often had business and contractual relationships with CMS and with CMS contractors performing other functions, such as Medicare claims processors. Offerors, subcontractors and CMS identified 1,919 business and contractual relationships as involving possible conflicts and 16 as involving actual conflicts. CMS does not have a written policy for reviewing conflict and financial interest information submitted by offerors and such information provided by offerors was not always consistent or

complete. For example, some offerors and subcontractors failed to provide requisite information regarding financial interests in other entities, making a fully informed decision difficult, if not impossible.

Under the ACA, HHS has new responsibilities with respect to promoting transparency in the health care industry. For example, under section 6002, HHS will operate a "sunshine" database of information disclosed by applicable manufacturers and group purchasing organizations identifying financial relationships with physicians and teaching hospitals. The ACA also includes provisions that heighten transparency of hospital ownership, nursing facility ownership and management, drug sampling and drug rebates, as well as provisions that foster more robust consumer information.

Progress in Addressing the Challenge

OGC has issued guidance concerning waivers to HHS component ethics officials as well as partially implemented a planned increase in both the number of waivers issued to Special Government Employees under 18 U.S.C. §208(b)(3) subject to preclearance by OGC and the scope of the review of such waivers.

To better address identified vulnerabilities related to FDA's clinical investigators FDA now requires companies applying to market drugs, devices and biologics to submit a complete list of clinical investigators and either certify the absence of a financial conflict of interest or disclose the nature of the financial arrangement to FDA for each clinical investigator. Additionally, FDA updated the *Compliance Program Guidance Manual* chapter on clinical investigator inspections to help ensure that clinical investigators submit required financial information to sponsors.

Similarly, NIH has taken actions to address conflict-of-interest vulnerabilities identified among NIH grantees. For instance, NIH published a final rule on August 25, 2011, revising 1995 regulations covering financial conflicts of interest for investigators. It addresses a number of issues related to promoting objectivity in research and addresses an OIG recommendation to require grantee institutions to provide details regarding the nature of financial conflicts of interest and the ways in which they are managed, reduced or eliminated. Additionally, CMS is drafting a standardized, formal written policy to evaluate potential organizational conflicts of interest.

What Needs To Be Done

To encourage an environment of transparency and accountability among contractors, OIG has recommended that CMS: (1) provide clearer guidance in the Request for Proposal to offerors and subcontractors regarding which business and contractual relationships should be identified as actual conflicts and which should be identified as possible conflicts; (2) require offerors and subcontractors to distinguish those business and contractual relationships that they deem to be actual conflicts from those that they deem to be possible conflicts; (3) state whether offerors and subcontractors need to report income amounts, periods of performance and types of work performed for their contracts with CMS and income amounts generated from key personnel's other employment; (4) create a standardized format for reporting information in the Organizational Conflict of Interest Certificate and require its use by offerors and subcontractors; and (5) develop a formal written policy outlining how conflict-of-interest information provided by offerors should be reviewed by CMS staff.

OIG also recommended that NIH develop regulations governing institutional conflicts of interest, but the final rule did not address our concerns. Instead, in the final rule, NIH states that "[w]e continue to believe that further careful consideration is necessary before PHS (Public Health Service) regulations could be formulated that would address the subject of institutional conflict of interest...." OIG continues to recommend that NIH issue regulations

requiring institutions to have a written policy on institutional conflicts. This would provide consistency and clarity to institutions.

The Department should ensure compliance with the Secretary's guidance on conflict-of-interest waivers and their documentation. The Department must issue final regulations and develop effective and efficient operational and technology structures to implement and administer the ACA transparency provisions, including the database required by ACA section 6002. In regard to implementation of section 6002 of the ACA, CMS continues to assess the requirements for this program. CMS should use the additional time it has built into the process by changing the start date for required data collection by applicable manufacturers and group purchasing organizations to January 1, 2013 enabling it to address operational and implementation issues.

Key OIG Resources

- Conflicts and Financial Relationships Among Potential Zone Program Integrity Contractors (OEI-03-10-00300), available at http://oig.hhs.gov/oei/reports/oei-03-10-00300.asp.
- Institutional Conflicts of Interest at NIH Grantees (OEI-03-09-00480), available at http://oig.hhs.gov/oei/reports/oei-03-09-00480.pdf.
- FDA's Oversight of Clinical Investigators' Financial Information (OEI-05-07-00730), available at http://oig.hhs.gov/oei/reports/oei-05-07-00730.pdf.

DEPARTMENT'S RESPONSE TO OIG TOP MANAGEMENT CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

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

Subject: FY 2012 Top Management and Performance Challenges Identified by the Office of Inspector General

On November 9, 2012, the Department received the OIG's report, Fiscal Year *2012 Top Management and Performance Challenges Identified by Office of the Inspector General*. The Report, which is published each November in the annual Agency Financial Report (AFR), provides an OIG assessment of major Agency management and performance challenges during the prior fiscal year that pose significant risks, including those that are particularly vulnerable to waste, fraud, error, or mismanagement. This memorandum is in response to the Report.

We concur with OIG's findings concerning HHS top management and performance challenges, which include Implementing the Affordable Care Act; Identifying and Reducing Improper Payments; Preventing and Detecting Medicare and Medicaid Fraud; Ensuring Patient Safety and Quality of Care; Avoiding Waste and Promoting Value in Health Care; Ensuring Efficiency and Effectiveness of Medicare and Medicaid Program Integrity Contractors; Grants Management and Administration of Contract Funds; Protecting Consumers of Food, Drugs and Medical Devices; Integrity and Security of Health Information Systems and Data; and Fostering an Ethical and Transparent Environment. Our management is committed to working toward resolving these challenges and looks forward to continued collaboration with OIG to improve the health and well-being of the American people through our efforts.

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

/Ellen G. Murray/
Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 14, 2012

GLOSSARY

ACRONYM	DESCRIPTION
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADD	Administration of Development Disabilities
AFR	Agency Financial Report
AHRQ	Agency for Healthcare Research and Quality
AIDD	Administration for Intellectual and Development Disabilities
AIDS	Acquired Immune Deficiency Syndrome
AOA	Administration on Aging
APS	Automated Provider Screening
ATSDR	Agency for Toxic Substances and Disease Registry
BHPr	Bureau of Health Professions
CAP	Corrective Action Plan
CCDF	Child Care Development Fund
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	*Children's Health Insurance Program Reauthorization Act of 2009*
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
COLA	Cost of Living Adjustment
CORF	Comprehensive Outpatient Rehabilitation Facilities
CPI	Consumer Price Index
CPIM	Consumer Price Index-Medical
CRADA	Cooperative Research and Development Agreement
CSRS	Civil Service Retirement System
CY	Current Year
DHS	Department of Homeland Security
DME	Durable Medical Equipment
DOJ	Department of Justice
DOL	Department of Labor
EHR	Electronic Health Records
ESRD	End Stage Renal Disease
FASAB	Federal Accounting Standards Advisory Board

ACRONYM	DESCRIPTION
FBIS	Financial Business Intelligence System
FBWT	Fund Balance with Treasury
FCA	False Claims Act
FCRA	Federal Credit Reform Act
FDA	Food and Drug Administration
FECA	Federal Employees' Compensation Act
FERS	Federal Employees' Retirement System
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFS	Fee-for-Service
FICA	Federal Insurance Contributions Act
FIFO	First-in/first-out
FISMA	*Federal Information Security Management Act of 2002*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FPS	Fraud Prevention System
FSMA	Food Safety Modernization Act
FMAP	Federal Medical Assistance Percentage
FMSP	Financial Management System Program
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GDP	Gross Domestic Product
GMRA	*Government Management Reform Act of 1994*
GPRA	*Government Performance and Results Act of 1993*
GSA	General Services Administration
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HEN	Hospital Engagement Networks
HEW	Department of Health, Education and Welfare (now HHS)
HHAs	Home Health Agencies
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
ICUs	Intensive-Care Units
IDTF	Independent Diagnostic Testing Facilities
IEVS	Income Eligibility Verification System
IHS	Indian Health Service
IOM	Institute of Medicine

ACRONYM	DESCRIPTION
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPIA	*Improper Payments Information Act of 2002*
IT	Information Technology
LICS	Low Income Cost Sharing Subsidy
LIS	Low-Income Subsidy
LLP	Limited Liability Partnership
MA	Medicare Advantage
MACs	Medicare Administrative Contractors
MARx	Medicare Advantage Prescription Drug
MCEs	Managed Care Entities
MD&A	Management's Discussion and Analysis
MEDIC	Medicare Drug Integrity Contractors
MLP	Molecular Libraries Program
MIC	Medical Integrity Contractors
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MPD	Medicare Prescription Drug
MMIS	Medicaid Management Information Systems
MPE	MARx Payment Error
MSIS	Medicaid Statistical Information Systems
MSSP	Medical Shared Saving Program
N/A	Not Applicable
NBS	NIH Business Systems
NCI	National Cancer Institute
NDMS	National Disaster Medical System
NDNH	National Directory of New Hires
NHSC	National Health Service Corps
NIH	National Institutes of Health
NPI	National Provider Identification
NPRM	Notice of Proposed Rulemaking
OASDI	Old-Age Survivors and Disability Insurance
OCIIO	Office of Consumer Information and Insurance Oversight
OCR	Office for Civil Rights
OER	Office of Extramural Research
OGC	Office of the General Counsel
OHR	Office of Health Reform
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Development
OPDIV	Operating Division
OS	Office of the Secretary
PARIS	Public Assistance Reporting Information System
PCIP	Pre-Existing Condition Insurance Plan
PCMH	Patient Centered Medical Home
PDE	Prescription Drug Event

ACRONYM	DESCRIPTION
PELS	Payment Error related to Low-Income Subsidy
PEMS	Payment Error related to Medicaid Status
PEPFAR	President's Emergency Plan for AIDS Relief
PEPV	Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PII	Program Integrity Initiative
PIP	Program Improvement Plan
P.L.	Public Law
PNS	Projects of National Significance
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center or Program Safeguard Contractor
PVTS	Program Vulnerability Tracking Systems
PUR	Period Under Review
PY	Prior Year
QIO	Quality Improvement Organization
QIRS	Quality Improvement Rating Systems
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
RAE	Risk Adjustment Error
RSI	Required Supplementary Information
RSSI	Required Supplementary Stewardship Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	*Self-Employment Contribution Act of 1954*
SFFAS	Statement of Federal Financial Accounting Standards
SMI	Supplementary Medical Insurance
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
STAFFDIV	Staff Division
STTR	Small Business Technology Transfer
TANF	Temporary Assistance for Needy Families
T-MSIS	Transformed Medical Shared Saving Program
Treasury	Department of the Treasury
UFMS	Unified Financial Management System
U.S.	United States
VFC	Vaccines for Children
VICP	Vaccine Injury Compensation Program
ZPIC	Zone Program Integrity Contractor

LAWS, REGULATIONS AND GUIDANCE

SHORT TITLE	**LONG TITLE** *(each title is linked to an official government source)*
P.L.	Public Law
OMB	Office of Management and Budget
U.S.C.	United States Code
P.L. 59-384	*Food, Drug, Cosmetic Act* available at http://library.clerk.house.gov/reference-files/PPL_Title21_FoodDrugCosmeticAct.pdf
P.L. 74-271	*Social Security Act of 1935,* as amended, available at http://library.clerk.house.gov/reference-files/PPL_SocialSecurity.pdf
P.L. 78-410 or 42 U.S.C. Ch 6A	*Public Health Service Act* available at http://uscode.house.gov/download/pls/42C6A.txt
P.L. 93-502 or 5 U.S.C. Ch 5 §552	*Freedom of Information Act of 1974* available at http://uscode.house.gov/download/pls/05C5.txt
P.L. 93-579	*Privacy Act of 1974* available at http://www.llsdc.org/attachments/wysiwyg/544/PL093-579.pdf
P.L. 96-88	*Department of Education Organization Act of 1979* available at http://history.nih.gov/research/downloads/PL96-88.pdf
P.L. 97-255	*Federal Managers' Financial Integrity Act of 1982* available at http://www.whitehouse.gov/omb/financial_fmfia1982
P.L. 97-414	*Orphan Drug Act*, as amended, available at http://history.nih.gov/research/downloads/PL97-414.pdf
P.L. 100-235	*Computer Security Act of 1987* available at http://www.nist.gov/cfo/legislation/Public%20Law%20100-235.pdf
P.L. 100-496 or 31 U.S.C. Ch 39	*Prompt Payment Act as Amended of 1996* available at http://uscode.house.gov/download/pls/31C39.txt
P.L. 100-504 or 44 U.S.C. Ch 39	*Inspector General Act Amendments of 1988* available at http://uscode.house.gov/download/pls/44C39.txt
P.L. 101-508 § 500	*Federal Credit Reform Act of 1990* (FCRA) available at http://www.fms.treas.gov/ussgl/creditreform/fcratoc.html
P.L. 101-576	*Chief Financial Officesr* (CFO) *Act of 1990* available at http://govinfo.library.unt.edu/npr/library/misc/cfo.html
P.L. 102-589	*Cash Management Improvement Act of 1990,* as amended, available at http://www.fms.treas.gov/cmia/statute.html
P.L. 103-62	*Government Performance and Results Act of 1993* available at http://www.whitehouse.gov/omb/mgmt-gpra/gplaw2m
P.L. 103-66	*Omnibus Reconciliation Act of 1993* available at http://www.gpo.gov/fdsys/pkg/BILLS-103hr2264enr/pdf/BILLS-103hr2264enr.pdf

P.L. 103-356	*Government Management Reform Act of 1994* available at http://www.gpo.gov/fdsys/pkg/BILLS-103s2170enr/pdf/BILLS-103s2170enr.pdf
P.L. 104-13	*Paperwork Reduction Reauthorization Act of 1995* available at http://www.gpo.gov/fdsys/pkg/PLAW-104publ13/pdf/PLAW-104publ13.pdf
P.L. 104-106	*Clinger-Cohen Act of 1996* available at http://www.gpo.gov/fdsys/pkg/PLAW-104publ106/pdf/PLAW-104publ106.pdf
P.L. 104–134	*Debt Collection Improvement Act of 1996* available at http://www.dol.gov/ocfo/media/regs/DCIA.pdf
P.L. 104-191	*Health Insurance Portability and Accountability Act of 1996* (HIPAA) available at http://library.clerk.house.gov/reference-files/PPL_HIPAA_HealthInsurancePortabilityAccountabilityAct_1996.pdf
P.L. 104-208	*Federal Financial Management Improvement Act of 1996* (FFMIA) available at http://www.gpo.gov/fdsys/pkg/PLAW-104publ208/pdf/PLAW-104publ208.pdf
P.L. 105-206	*Internal Revenue Service Restructuring and Reform Act of 1998* available at http://www.gpo.gov/fdsys/pkg/PLAW-105publ206/html/PLAW-105publ206.htm
P.L. 105-277 § 1701	*Government Paperwork Elimination Act of 1998* available at http://www.gpo.gov/fdsys/pkg/PLAW-105publ277/pdf/PLAW-105publ277.pdf
P.L. 106-107	*Federal Financial Assistance Management Improvement Act of 1999* available at http://www.gpo.gov/fdsys/pkg/PLAW-106publ107/pdf/PLAW-106publ107.pdf
P.L. 106-246 §2403	*Rehabilitation Act Amendments of 1998 (Workforce Investment Act)* available at http://www.gpo.gov/fdsys/pkg/PLAW-106publ246/pdf/PLAW-106publ246.pdf
P.L. 106-531	*Reports Consolidation Act of 2000* available at http://www.dol.gov/ocfo/media/regs/RCA.pdf
P.L. 107-204	*Sarbanes Oxley Act of 2002* available at http://www.gpo.gov/fdsys/pkg/PLAW-107publ204/pdf/PLAW-107publ204.pdf
P.L. 107-289	*Accountability of Tax Dollars Act of 2002* available at http://www.gpo.gov/fdsys/pkg/PLAW-107publ289/pdf/PLAW-107publ289.pdf
P.L. 107-300	*Improper Payments Information Act of 2002* available at http://www.gpo.gov/fdsys/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf
P.L. 107-347	*Federal Information Security Management Act of 2002 (*FISMA - *Title III of the E-Government Act of 2002)* available at http://www.gpo.gov/fdsys/pkg/PLAW-107publ347/pdf/PLAW-107publ347.pdf
P.L. 108-173	*Medicare Prescription Drug, Improvement and Modernization Act of 2003* (a.k.a. *Medicare Modernization Act*, or MMA) available at http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf
P.L. 109-222	*Tax Increase Prevention and Reconciliation Act of 2005* available at http://www.gpo.gov/fdsys/pkg/BILLS-109hr4297enr/pdf/BILLS-109hr4297enr.pdf
P.L. 111-3	*Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) available at https://www.cms.gov/HealthInsReformforConsume/Downloads/CHIPRA.pdf

P.L. 111-5	*American Recovery and Reinvestment Act of 2009 (*ARRA *or Recovery Act)* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf
P.L. 111-240	*Small Business Jobs Act of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ240/pdf/PLAW-111publ240.pdf
P.L. 111-148	*Patient Protection and Affordable Care Act of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
P.L. 111-148, § 8001	*Community Living Assistance Services and Support* (CLASS) *Act* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
P.L. 111-152	*Health Care and Education Reconciliation Act of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf
P.L. 111-148 and 111-152	*Affordable Care Act of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf
P.L. 111-204	*Improper Payments Elimination and Recovery Act* (IPERA) *of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf
P.L. 111-296	*Healthy, Hunger-Free Kids Act* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ296/pdf/PLAW-111publ296.pdf
P.L. 111-352	*Government Performance and Results Modernization Act of 2010* available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ352/pdf/PLAW-111publ352.pdf
P.L. 112-10	*Department of Defense and Full-Year Continuing Appropriations Act of 2011* available at http://www.govtrack.us/congress/bills/112/hr1473/
P.L. 112-25	*Budget Control Act of 2011* available at http://www.gpo.gov/fdsys/pkg/PLAW-112publ25/pdf/PLAW-112publ25.pdf
P.L. 112-78	*Temporary Payroll Tax Cut* available at http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf
P.L. 112-96	*Middle Class Tax Relief and Job Creation Act of 2012* available at http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf
OMB Circular A-11	*Preparation, Submission and Execution of the Budget* available at http://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/a_11_2011.pdf
OMB Circular A-50	*Audit Follow-Up* available at http://www.whitehouse.gov/omb/circulars_a050/
OMB Circular A-123	*Management's Responsibility for Internal Control* available at http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a123/a123_rev.pdf
OMB Circular A-127	*Financial Management Systems* available at http://www.whitehouse.gov/omb/circulars_a127/
OMB Circular A-130	*Management of Federal Information Resources* available at http://www.whitehouse.gov/omb/circulars_a130

OMB Circular A-136	*Financial Reporting Requirements* available at http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a136/a136_revised_2012.pdf
5 U.S.C. 751	*Federal Employees' Compensation Act of 1916* (FECA) available at http://uscode.house.gov/download/pls/05C81.txt
26 U.S.C. Ch 21	*Federal Insurance Contributions Act* (FICA) available at http://uscode.house.gov/download/pls/26C21.txt
26 U.S.C. Ch 2	*Self Employment Contributions Act* (SECA) *of 1954 (§1401 through §1403)* available at http://uscode.house.gov/download/pls/26C2.txt
31 U.S.C. Ch 15 § 1535	*Economy Act* available at http://www.casu.gov/authority/usc1535.html
31 U.S.C. Ch 13	*Anti-Deficiency Act (§ 1341, 1342, 1349-1351 and 1511-1519)* available at http://uscode.house.gov/download/pls/31C13.txt
44 U.S.C. Ch 31 § 3101	*Federal Records Act of 1950* available at http://uscode.house.gov/download/pls/44C31.txt

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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