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ASH

Congress of the United States
House of Representatives

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RANKING MEMBER

REPUBLICAN STUDY COMMITTEE
CHAIRMAN

DEPUTY WHIP

April 8, 2010

VIA FACSIMILE

Ms. Andrea Palm
Acting Assistant Secretary for Legislation
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 416 G
200 Independence Avenue, SW
Http://www.hhs.gov/
Washington, DC 20201-0001

Dear Ms. Palm:

My constituent, CAPT (b)(6) has contacted me regarding a problem he is having. Please find enclosed a copy of his correspondence.

Please verify the status of this situation and provide me with any information that I may use to properly assist my constituent. Please forward all correspondence to Tina McIntosh in my Marietta District Office at 3730 Roswell Rd., Suite 50, Marietta, GA 30062. She may also be reached by email at tina.mcintosh2@mail.house.gov or by phone at 770-565-4990.

Thank you in advance for your time and assistance in this matter. I look forward to hearing from you soon.

Yours truly,

Tom Price, M.D.
Member of Congress

TP/tm

There are 2 page(s) to this fax. ***Confidential Notice: This facsimile, including any attachments, is for the sole use of the intended recipient (s) and may contain confidential and privileged information. Any unauthorized review; use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender immediately and destroy all copies of the original message.***

(b)(6)

Congressman Tom Price
3730 Roswell Road, Suite 50
Marietta, GA 30062

Dear Representative Price:

I am hoping you can help me get a response from the United States Public Health Service (PHS), as I have been unsuccessful despite repeated inquires. I was commissioned in the PHS as a Medical Officer in the late 1970s and mandatorily retired in August 2007 after 30 years of active duty. At the time of my retirement, I had 35 years of *creditable service* because the PHS gives physicians credit for 4 years of medical school and 1 year of internship. Annual retirement pay for PHS officers who entered the service when I did is calculated as a percentage of annual base pay. Previously, under Title 42 of the US Code, this percentage was capped at 75%.

In an effort to retain senior officers in the unformed services, Section 642 of John Warner National Defense Authorization Act for Fiscal Year 2007 removed the 75% cap on retirement pay for officers retiring on or after 1 January 2007. Under this law, the retirement percentage is calculated as 2.5% multiplied by the number of years of *creditable service*. For me, this would equate to 87.5% (35 years x 2.5%) of annual retirement pay rather than 75% (the previous cap removed by Congress) under which I am now paid.

I sent a memo to the PHS in May 2009 requesting a recalculation of my retired pay under the new law, but have never gotten a formal response to my memo. I have e-mailed several people in the PHS, called PHS staff in Atlanta and Washington, and visited the CDC's Commissioned Corps Office. Nonetheless, I am still waiting 11 months later to know what the status of my request is. I cannot even find out who is responsible for providing a response to me. A number of my fellow medical officers with more than 30 years of creditable service have retired since 1 January 2007 and also submitted memos to PHS requesting that their retirement pay be recalculated in view of the new law; PHS has not responded to them either.

After nearly a year of runaround, I am frustrated by my government's lack of response to what I believe is a legitimate question. I would greatly appreciate your help in determining the status of our requests for consideration under the new law, what review or other processes are underway to evaluate the issues we raised, and the PHS timeline for addressing this matter.

Thank you for your assistance.

(b)(6)

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REPUBLICAN STUDY COMMITTEE
CHAIRMAN

DEPUTY WHIP

November 16, 2010

Mr. James R. Esquea
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 416 G
200 Independence Avenue, Sw
Washington, DC 20201-0001

Dear Mr. Esquea:

My constituent, Ms. (b)(6) has contacted me regarding a problem she is having. Please find enclosed a copy of her correspondence.

Please verify the status of this situation and provide me with any information that I may use to properly assist my constituent. Please forward all correspondence to the attention of Tina McIntosh in my Marietta District Office at 3730 Roswell Rd., Suite 50, Marietta, GA 30062. You may also contact her by phone at 770-565-4839, by facsimile at 770-565-7570, or by email to tina.mcintosh2@mail.house.gov.

Thank you in advance for your time and assistance in this matter. I look forward to hearing from you soon.

Yours truly,

Tom Price, M.D.
Member of Congress

TP/tm

Congressman Price, my name is (b)(6) and you are my elected representative.

I have written you in the past, as recently as last month and I appreciate your reply and the assistance you provided me. Today I am writing to express to you my concerns regarding the U.S Department of Health and Services' National Health Service Corp program and the type of health care professionsals that are eligible. While this program is a great resource and an amazing way to get more people involved in the health care profession by allowing loan repayment and scholarships for those who dedicate to a minimum service commitment to expand access of health care services and improve the health of people who live in urban and rural areas where health care is scarce, it does not allow for those of use who are dedicating our lives to Nutrition as it relates to overall wellness in these same communities and are also willing to dedicate ourselves to the same kind of minimum service commitment. Nutrition or lack of nutritional education resources happens to be one of the major reasons why our society is in need of extensive health care; it is a trickle down effect that is directly related. We, as a country, are willing to create and educate more people to become doctors, nurses, psychiatrists, dentists, etc but we are not willing to invest in and educate more individuals to focus on our human nutrition and its ability to help conquer diabetes, high cholesterol that leads to heart disease and obesity to name a few.

I would like to know exactly what it would take to include Dietitians and Clinical Nutritionists as a part of this wonderful NHSC program. Besides this correspondence to you, where do I start and to whom else do I reach out to? I am currently enrolling in higher education for a Master in Human Nutrition to become Clinical Nutritionist, something that I am deeply passionate about. My goal is to work in the community to educate our children from the ground up about the importance of eating and being mindful of where our food comes from. My hope is to help eradicate and rehabilitate childhood obesity so that our future does not fall victim to the effects of what the lack of this knowledge will ultimately do to our society in an effort to leave our country in the hands of healthy individuals for generations to come that at minimum have the ability to make better nutritional decisions for themselves. It is imperative that the NHSC program allows for people like me so that others are also influenced to want to be in the Nutrition industry.

Thank you in advance for your time and your help. I look forward to hearing from you.

(b)(6)

From: Ammen, Faith [mailto:Faith.Ammen@mail.house.gov]
Sent: Tuesday, March 04, 2014 1:40 PM
To: Street, Amanda
Cc: Super, Nora (HHS/ONCIT)
Subject: RE: Mtg w/ Doc Caucus

Hi,

The Congressman is available for 30 min in any of the following times:

March 24: 3-5pm
March 26: 4-5pm
April 1: 3-4pm
April 2: 4-5pm
April 7: 3-5pm

I do not schedule for the Doc Caucus but 8am time slots that work on our end are:

March 27
April 3
May 8
May 22

Thanks!

Faith Ammen
Executive Assistant
Congressman Tom Price, M.D.
100 Cannon House Office Building
www.tomprice.house.gov

From: Zebley, Kyle [mailto:Kyle.Zebley@mail.house.gov]
Sent: Wednesday, December 04, 2013 1:18 PM
To: Salsberg, Edward (HRSA); Atkinson, Leslie (HRSA)
Cc: Street, Amanda; Spitzgo, Rebecca (HRSA)
Subject: RE: GME Reform

Mr. Salsberg,

Thank you very much for following up. Leslie, any help you may be able to provide in pointing us to the right person would be most appreciated.

Kyle Zebley
Senior Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Tel: 202-225-4501
Fax: 202-225-4656

From: Salsberg, Edward (HRSA) [mailto:esalsberg@hrsa.gov]
Sent: Wednesday, December 04, 2013 12:14 PM
To: Zebley, Kyle; Atkinson, Leslie (HRSA)
Cc: Street, Amanda; Spitzgo, Rebecca (HRSA)
Subject: RE: GME Reform

Kyle, glad to hear of the interest in federal GME policies. While the National Center for Health Workforce Analysis collects and analyzes physician workforce data, we are not involved in GME policies. Leslie Atkinson in our Office of Legislation, who I have copied on this email, is in the best position to direct you to the appropriate staff to discuss this issue.

Best of luck in your efforts.

Regards

Ed

Edward Salsberg
Director
National Center for Health Workforce Analysis
Bureau of Health Professions
Health Services and Resources Administration
U.S. Department of Health and Human Services
5600 Fishers Lane,
Rockville, MD 20857

esalsberg@hrsa.gov
301 443-9355

From: Zebley, Kyle [mailto:Kyle.Zebley@mail.house.gov]
Sent: Tuesday, December 03, 2013 10:07 AM
To: Salsberg, Edward (HRSA)
Cc: Street, Amanda
Subject: GME Reform

Mr. Salsberg,

I hope you are having a wonderful morning. Amanda Street and I work for Congressman Tom Price of Georgia. Amanda handles healthcare while I handle education. At the direction of the Congressman, both of us are collaborating on some kind of fix/reform of federal GME policy. In a recent discussion with Dr. Erin Fraher from UNC regarding GME, your name came up as a leading expert on the topic.

Amanda and I were wondering if there was a time in the coming weeks to talk on the phone with you regarding GME. Perhaps a week Congress is out of session, like Dec. 16-20? Let me know if this would work for you. Thanks in advance for your consideration.

Kyle Zebley
Senior Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Tel: 202-225-4501
Fax: 202-225-4656

From:	DiBlasio, Carla
To:	Sealy, Camille (HRSA)
Cc:	Hacking, Rose (HHS/ASL); Atkinson, Leslie (HRSA)
Subject:	RE: 340B Concerns
Date:	Wednesday, August 24, 2016 6:41:10 PM

Thanks, Camille.

We appreciate your consideration.

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From: Sealy, Camille (HRSA) [mailto:CSealy@hrsa.gov]
Sent: Wednesday, August 24, 2016 12:45 PM
To: DiBlasio, Carla
Cc: Hacking, Rose (HHS/ASL); Atkinson, Leslie (HRSA)
Subject: RE: 340B Concerns

Hi Carla,
I hope this message finds you well.

Thanks for your inquiry regarding HRSA's 340B Drug Pricing Program (340B Program) and the status of the proposed 340B Omnibus Guidance. As you know, the proposed guidance was open for review and public comment in the *Federal Register* (80 FR 52300 (August 28,2015)) with a 60-day comment period, which closed on October 27, 2015. HRSA is currently analyzing the comments received to develop the final 340B Omnibus Guidance. We are targeting December 2016 for publication of the final guidance. We understand the importance of the 340B Program to you and your constituents and appreciate you reaching out on this matter.

If you should have additional questions, please do not hesitate to reach out.

Sincerely,
Camille

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]
Sent: Wednesday, August 24, 2016 11:56 AM
To: Sealy, Camille (HRSA)
Subject: 340B Concerns

Camille,

I hope this email finds you well. I handle healthcare for Congressman Tom Price. Emory University

recently presented us with a list of concerns regarding 340B. We greatly appreciate your attention to their concerns as described in their comments below. Any feedback you can provide us on any of these concerns would also be greatly appreciated.

Emory University Hospital Midtown (EUHM), a 511-bed academic community hospital in the heart of midtown Atlanta, is a strong supporter of the 340B program and its impact on our patients. As a DSH facility in a large urban area, it is our role to ensure access to world-class care to our community's most vulnerable patients. Access to 340B pricing allows us to fulfill this mission and improve the overall health of our city.

EUHM takes compliance with HRSA guidance extremely seriously. We are committed to running a highly compliant program and we are excited to see additional clarifying statements provided in the omnibus proposal. In reviewing the proposed language, we found some content to be of concern and we thank you for the opportunity to provide feedback. Please find a summary of our comments below.

1. Hospital Relationships with Their Providers
    a. We do not understand what HRSA intends with the requirement that we have employment or independent contractor relationships with our providers such that we may bill for their services. Currently EUHM has a mix of employed physicians, community / private practice physicians who are active medical staff at EUHM, and GME residents and fellows. We review our list of eligible providers daily to ensure that all providers are active medical staff at EUHM.
        a. We request that HRSA remove this requirement, as the remaining requirements in this area already limit 340B use to services and prescriptions that are written in the hospital or one of its registered locations, thereby ensuring hospital responsibility for the services
        b. If HRSA intends to maintain this requirement, then we request that HRSA revise and republish it for comment. As written, we do not believe we have a meaningful opportunity to comment because the language used is too vague
        c. If HRSA intends for this provision to impose new standards for the health industry regarding provider contracting (e.g., outside of what is currently required by health programs and the Joint Commission), HRSA needs to more clearly articulate what would be required
    b. Issues related to who is an "independent contractor" of the hospital:
    i. The guidance would require that for a provider to be able to write a prescription or order for a 340B drug, the provider must be an employee or "independent contractor" of the hospital.
        1. While many of our providers are employed through Emory University, our community / private practice physicians are neither employees nor do they have a contract with the facility
        2. All EUHM providers undergo a rigorous credentialing process prior to becoming "active medical staff"
    ii. Using an "independent contractor" standard is not appropriate for guidelines, as the legal rules in this area are not subject to a national standard and vary significantly by state and even within states.
    c. Issues related to what HRSA means by "may bill for services on behalf of the provider":
    i. The language stating that hospitals must have arrangements such that they "may bill for services on behalf of the provider" is even more unclear. Does this refer to services that hospitals bill in connection to services furnished by a provider (e.g., the facility fee)? Or does it refer to billing for the professional services furnished by our providers?

2. Orders for Infusion
    a. EUHM, as the infusion provider for the nationally recognized Winship Cancer Institute, will reach in excess of 100,000 infusion visits in calendar year 2015. Access to 340B pricing for our infusion center allows EUHM to provide millions of dollars in charity care directly associated with the treatment of hematologic and oncologic conditions, funds direct access to these sites through transportation subsidies, improves overall patient experience through the funding of dieticians, clinical pharmacy specialists, nursing navigators, midlevel clinical providers and clinical nurse educators, and funds a robust patient assistance program for oral therapies and a co-pay assistance program for infusion related therapy. These programs simply could not exist without access to 340B pricing.
    b. The proposed guidance would only allow 340B for infusion orders if they were written as a result of services provided in the hospital or a registered child site.
    c. EUHM owns many of the hematology / oncology clinics that refer patients to our infusion centers but we also accept patients who have been seen at non-EUHM clinics for their medical care.
    d. Individuals receiving infusion at the hospital are unquestionably hospital patients, even if the order is written in a location outside the hospital. The individuals are registered as hospital patients and the hospital is responsible for administering the infusion and is required to provide health care services in conjunction with the drug's administration.
    e. No other government program or other health care payer requires infusion orders to be written at the hospital as a condition of payment. HRSA is proposing a 340B-specific requirement for infusion orders that does not exist anywhere in health care policy.
    f. Administration of infusion drugs are highly complex services, requiring skill and direct attention, and may only be performed by trained health care professionals. Failure to administer infusion drugs appropriately can result in severe consequences for the patient, for which the hospital is responsible.
    g. The concerns about this proposal exist even if GPO pricing were permitted for these drugs.
    h. Imposing this unique 340B standard would require hospitals to develop new tracking systems to distinguish their outpatients for whom an order was written on the premises of the hospital and those for whom the order was written outside the hospital. Since the individuals receive the same hospital outpatient services in both cases, this tracking is not currently necessary and would impose a new burden on safety-net hospitals and is one that may not even be feasible.

3. Discharge Prescriptions
    a. The proposed guidance would prohibit hospitals from using 340B pricing for drugs that are billed as outpatient drugs if the script/order was written in connection to a discharge from an inpatient stay.
    b. Using 340B for discharge prescriptions is a longstanding practice that allows 340B hospitals to reduce readmissions for their patients, is easy to administer and audit, and is consistent with the purpose of the 340B program.
    c. As a 340B hospital, we discount the cost of medications provided upon discharge for our low income patients to help ensure that patients can get the drugs they need. Over the last 3 fiscal years, EUHM has provided approximately $300,000 annually in uncompensated discharge medication to uninsured and low income patients to transition the patient to the next level of care. Without access to 340B pricing for discharge prescriptions, we will not be able to support the same level of support.
    d. Eligibility for 340B pricing should be applied to all drugs furnished in connection to services received at the hospital, for registered hospital patients, and that are billed on an outpatient

basis. This is an easy bright line rule for hospitals to follow and for HRSA to audit. EUHM currently audits 100% of all discharge prescriptions using 340B drugs to ensure that they meet the requirements as outlined in the current guidance.

1. Tracking discharge prescriptions that tie to an inpatient service so they could be excluded from 340B would be operationally challenging and burdensome because hospitals generally do not track in their retail pharmacies whether a prescription resulted from an outpatient encounter. Compliance with the proposed change would require significant modifications to hospital systems.

e. 340B pricing is available under the 340B statute for "covered outpatient drugs." There is no requirement under the 340B statute that covered outpatient drugs that are billed as outpatient drugs must also pertain directly to an outpatient service. Indeed, many hospitals are able to participate in the 340B program only by demonstrating that they provide *inpatient* services to a disproportionate number of low income patients. It would be inconsistent with the statute to deny 340B pricing for outpatient prescriptions needed by those low income patients upon discharge.

4. Outpatient Services That Are Not Billed As Outpatient
   a. The proposed guidance would prohibit use of 340B for drugs given to hospital outpatients if the patient's insurer requires that the outpatient service resulting in the script/order being written be included in a bill for inpatient services.
   b. This new proposed policy would change HRSA's longstanding rules in this area and is inconsistent with the purpose of the 340B program. The purpose of the 340B program, in contrast, is to allow providers that treat a significant share of low income individuals to stretch their resources and provide more services to more patients. The purpose of insurer billing rules that include outpatient services with inpatient is to save money for insurers.
   c. Insurance company billing rules do not change the underlying nature of the service or drug provided. A drug given to a registered hospital outpatient is still an outpatient drug regardless of how the insurer requires that it be billed or paid.
   d. Hospitals should be able to use 340B for drugs administered in outpatient settings, regardless of whether the drug is billed as part of an inpatient stay, if the patient was an outpatient at the time the drug was administered or if the drug itself was billed on an outpatient basis.
   e. This proposed policy would impose significant operational challenges:
   i. EUHM currently utilizes a commercially available accumulation software that tracks inpatient and outpatient dispenses at the time of dispensation (consistent with the current guidance for both 340b eligibility and GPO exclusion). Determination of inpatient or outpatient status is made at the point of dispensation, based on the providers order for level of care. Our commercially available accumulation software would not longer function as designed.
   ii. Rules about inpatient and outpatient status may differ depending on the payer.
   iii. Subsequent payer determinations make tracking more challenging and we are frequently finding that we do not finality to patient status for weeks after the initial bill has been submitted to the payor.
   iv. Unfortunately, payer determinations are more and more frequently not aligning with the provider's determination about the appropriate patient status or level of care.

5. Bundled Medicaid Drugs
   a. 340B covered entities should be able to use 340B for all Medicaid drugs regardless of whether the drug is bundled into payment made for other services.
   b. The 340B program allows certain hospitals to participate only if the hospitals can demonstrate that they provide a disproportionate amount of care to Medicaid and low-income Medicare patients. It would be inconsistent with the purpose of the program to disallow 340B pricing

for drugs dispensed to that population.

6. **GPO Prohibition - EUHM supports the three exceptions to the GPO prohibition included in the proposed guidance and requests that HRSA clarify the exceptions to allow for additional flexibility.**
   a. **Proposed New Exceptions:**
   i. **340B not available:** HRSA should not require hospitals subject to the GPO prohibition to use WAC pricing when 340B pricing is not available, such as when a:
      1. Drug is in shortage
      2. Manufacturer is refusing to offer the 340B price
      3. Manufacturer is not participating in 340B
   ii. **340B not permitted:** HRSA should not require hospitals subject to the GPO prohibition to use WAC pricing when 340B use is not permitted, such as when a hospital:
      1. Is treating an outpatient who is not eligible to receive a 340B drug (e.g., walk-in patient, ineligible employee)
      2. Carves-out and must provide non-340B drugs to Medicaid patients
      3. Is unable to track a drug appropriately to justify 340B use, such as for intravenous saline solutions, contrast agents, anesthesia gases, and other similar products.
   iii. HRSA has stated that a purpose behind its GPO prohibition policy is to prevent hospitals from buying covered outpatient drugs through 340B and GPO (i.e., to prevent "cherry picking."). In these situations, when the 340B price cannot be used, there is no danger of cherry picking. HRSA should therefore allow hospitals to use a GPO in these instances.
   b. **HRSA should allow hospitals subject to the GPO prohibition to use inventory replenishment systems based on initial GPO purchase and should not require initial purchases to be made through non-340B, non-GPO accounts (i.e. WAC).**
   i. HRSA should clarify whether HRSA's February 7, 2013 Policy Release on the Statutory Prohibition on Group Purchasing Organization Participation still applies. In particular, does HRSA still intend to impose the requirement that hospitals subject to the GPO prohibition using virtual replenishment systems "should purchase using a non-GPO account and only replenish with 340B drugs once 340B patient eligibility is confirmed and can be documented through auditable records"? This policy release made clear that hospitals using replenishment models may not first purchase through a GPO and then replenish accordingly.
   ii. HRSA should allow inventory replenishment systems that make initial purchases at GPO pricing, rather than using non-340B, non-GPO pricing (i.e., WAC).
   iii. Inventory replenishment is based on the theory that the repurchased drug takes the place of the drug administered or dispensed to the patient. If a GPO drug purchase is "cured" through a subsequent 340B purchase, there is no harm to manufacturers.
   iv. There are some cases when a hospital is not able to cure a GPO purchase through a 340B replenishment, such as when a drug is in shortage and the drug is not available at 340B for repurchasing or when the package size necessary to make a replacement order is never reached. In these situations, the hospital can cure the GPO use by replenishing at WAC, or some other non-340B, non-GPO price.
   v. Hospitals should be able to use GPO-based replenishment systems because requiring WAC-based inventory management systems increases hospital costs, inconsistent with the purpose of the 340B program.

7. **Self-Disclosure - Notification to HRSA should only be required for material changes in eligibility and material breaches of program requirements**
   a. Current HRSA policy requires that covered entities report material noncompliance to HRSA.

The proposed guidance suggests that all such instances must be reported, even if they are not material.

a. At current, EUHM has a robust and active 340B Governance Committee that reviews monthly audits of compliance. The committee is charged with identifying any corrective actions and determining materiality.

i. The annual recertification process would require notification of "any 340B Program requirement, subject to HHS audit," while other sections would require the reporting of "all corrective actions" relating to diversion and discount discounts.

b. HRSA should limit all disclosures to those that rise to level of being "material." Notifying HRSA of all program violations, no matter how minor, would be too burdensome for both HRSA and providers, and not provide significant program integrity value.

8. Child Site Eligibility

a. HRSA should permit hospitals to certify that all clinics in an offsite building are 340B-eligible instead of requiring individual registration of each office.

b. For hospitals that operate in multiple buildings, HRSA should allow a hospital to register one of its hospital buildings as the parent site and register the other buildings as child sites, so long as the hospital could attest that every outpatient clinic/department in the offsite buildings was reimbursable on the hospital's cost report. Although these offsite hospital buildings may also include inpatient areas that are not 340B-eligible, that should not preclude a hospital from registering the offsite buildings as child sites. HRSA does not require parent hospitals to register 340B-eligible outpatient areas inside the four walls of the parent site, even though parent sites generally include ineligible inpatient areas. The same policy should apply to offsite hospital buildings.

c. Allowing these certifications would continue to ensure transparency in the registration process and provide manufacturers and other stakeholders with the information necessary to confirm covered entity compliance while making the process simpler for hospitals

d. HRSA should allow hospitals to register outpatient facilities without waiting for the facility to file its cost report

i. The proposed guidance includes HRSA's current policy on outpatient facilities, which requires a hospital registering an outpatient facility as a child site to show that the facility's costs appear on a reimbursable line of the hospital's most-recently filed Medicare Cost Report.

ii. Relying only on the most-recently filed cost report can cause significant delays to registering child sites. If a hospital opens a new clinic just after the hospital filed its cost report, the hospital must wait another 17 months before filing a new cost report that includes the costs of the new clinic on a reimbursable line and then may potentially have to wait another 6 months before the hospital can register the clinic and have the clinic appear on the OPA database. Meanwhile, Medicare will not require the hospital to wait until it files a new cost report for the clinic to bill for services as part of the hospital.

iii. HRSA should accept alternative documentation to show that the clinic is an integral part of the hospital while the hospital waits to file a new cost report. This could include:

1. Medicare 855A enrollment form
2. A certification submitted to HRSA that: (1) the clinic will be listed on a reimbursable line of the cost report when the cost report is filed, (2) the hospital is currently billing for outpatient services at the clinic, and (3) the hospital agrees to repay manufacturers for 340B purchases made for the clinic if the clinic ends up not being billed on a reimbursable line of the cost report once it is filed.

9. Contract Pharmacy

a. HRSA should not expect covered entities to conduct an annual independent audit and

quarterly reviews of each contract pharmacy location.

i. A covered entity should be able to conduct a single annual independent audit or quarterly review for each contract it has with a contract pharmacy provider, rather than at each site. Typically all of the sites subject to a single agreement use the same processes and software, which is usually maintained at a central location. Requiring covered entities to audit each and every site is an unnecessary drain on resources that provides no added assurances of compliance.

ii. At current, EUHM conducts monthly audits of contract pharmacy transactions and an annual independent program audit is completed.

b. **HRSA should not require contract pharmacy agreements to list all child sites that plan to use the contract pharmacy.**

i. This requirement would be unnecessarily burdensome.

1. A covered entity would have to amend the contract pharmacy agreement whenever it adds or removes a child site.
2. Nearly all existing contract pharmacy agreements would have to be amended.
3. Very few contract pharmacies serve only a subset of child sites.

ii. The requirement would not provide additional transparency concerning a covered entity's use of its contract pharmacy, as an entity does not submit a copy of its contract pharmacy agreement to HRSA when registering a contract pharmacy.

10. Audits

a. HRSA should make the following clarifications to the HRSA audit process of covered entities.

i. HRSA should publish its 340B audit protocol.

ii. Covered entities should have at least 30 days to respond to a pre-audit data request given the large quantity of data required for submission.

iii. HRSA should reinstitute the process of issuing a preliminary audit report. HRSA should communicate preliminary audit findings to covered entities and facilitate an informal dialogue among the auditor, HRSA, and the covered entity so that the covered entity can ask questions about the finding and obtain more detailed information regarding the nature of any adverse findings.

iv. Covered entities should have at least 90 days to respond to a final audit report.

v. HRSA should commit to creating a mechanism to receive protected health information (PHI) in written disagreements.

vi. When a final audit report would result in program termination, the covered entity should be able to request an in-person hearing.

vii. HRSA should develop an independent administrative review process between the final audit report and possible judicial action, similar to the administrative law judge (ALJ) process for Medicare audits.

viii. If HRSA does not adopt an intermediate review process, HRSA should make clear that the final audit report is final agency action that is ripe for judicial review if the covered entity continues to disagree with HRSA's findings.

ix. HRSA proposes to work with covered entities to specify the time frame for the submission of a corrective action plan (CAP), and we appreciate HRSA's willingness to work with covered entities. HRSA should clarify that covered entities have at least 90 calendar days to submit the CAP for HRSA's approval. Covered entities could have more than 90 days, depending on the scope of the audit findings, but never less than 90 days.

b. **HRSA should make the following clarifications to the manufacturer audit process of covered entities.**

i. We are pleased to see that HRSA proposes that a manufacturer must work in good faith with a covered entity to resolve a matter before the manufacturer may submit an audit work plan

to HRSA. We ask that HRSA clarify that in the event that a manufacturer contacts a covered entity to request data from the entity, but is unwilling to disclose the specific reason for the request, then the manufacturer will be in violation of the good faith negotiation requirement.

ii. HRSA should instruct manufacturers that communications to covered entities reflecting a good faith attempt to resolve differences should include a statement indicating that the communication is not a HRSA-sanctioned manufacturer audit.

iii. HRSA should allow covered entities at least 60 days to respond to manufacturer data requests.

c. **We support HRSA's plans to audit manufacturers.**

i. We are pleased to see that HRSA has included in the proposed guidance procedures for HRSA to audit manufacturers.

ii. We are also pleased that any findings would be made public, as only one audit of a manufacturer has been conducted to date and those results have not yet been made public.

iii. HRSA should begin auditing manufacturers on a regular basis to ensure that manufacturers are complying with 340B program requirements so that covered entities may receive the discounts they are entitled to under the program.

11. Inventory Management

a. HRSA should clarify that improper accumulations that are fixed prior to a replacement order being made do not constitute diversion.

i. The preamble states that "if a covered entity improperly accumulates or tallies 340B drug inventory, *even if it is prior to placing an order*, the covered entity has effectively sold or transferred drugs..." (emphasis added).

ii. HRSA should clarify that diversion could not occur in a replenishment system until an incorrectly accumulated order is actually placed. Until such time, the accumulation is merely an accounting of what the covered entity may order.

12. Manufacturer Provisions

a. We support HSRA's recognition of the manufacturer obligation to offer the 340B price and have the following comments.

i. The proposed guidance states that manufacturers "subject to a PPA must offer all covered outpatient drugs at no more than the [340B] ceiling price to a covered entity listed on the public 340B database."

ii. We appreciate that the proposed guidance reiterates HRSA's view that the "must offer" provision is a requirement for manufacturers who have entered into a PPA, regardless of whether the PPA includes the "must offer" language.

iii. The "must offer" provision should apply to specialty drugs that are distributed through limited distribution networks. Some manufacturers have required covered entities to purchase their 340B-priced drugs through a wholesaler's specialty drug division instead of the hospital's usual wholesaler. HRSA should clarify that a manufacturer must allow covered entities to buy a drug through its 340B wholesale account if it would allow the same entity to purchase the drug through a non-340B wholesale account.

iv. HRSA should clarify that a manufacturer that offers a covered outpatient drug to any entity must also offer the same drug at 340B pricing to other entities in the same class of trade.

v. Some hospitals have faced challenges trying to buy a drug through a contract pharmacy that participates in a limited specialty pharmacy network. The guidance does not clearly address these situations. HRSA should make clear that manufacturers must provide 340B pricing to a covered entity that has a contract pharmacy agreement with a pharmacy in the manufacturer's specialty pharmacy network.

b. **We support HRSA's proposal to continue its policy of asking manufacturers to notify HRSA**

of limited distribution plans.

i. The proposed guidance states that HRSA "may" publish the details of limited distribution plans submitted by manufacturers. HRSA should make all limited distribution plans public. It is important that hospitals have access to limited distribution plans in order to assess the impact on the hospital's operations and to plan accordingly.

c. **We support HRSA's proposed requirement for manufactures to issue refunds or credits for instances of overcharging within 90 days and have the following comments.**

i. The guidance says that HRSA expects manufacturers to issue refunds or credits for instances of overcharging within 90 days of the determination of the manufacturer or HRSA that an overcharge occurred and that covered entities that fail to accept a refund within 90 days waive their right to repayment. The guidance also states that manufacturers must submit to HHS the price recalculation information, an explanation of why the overcharge occurred, how the refund will be calculated, and to whom refunds or credits will be issued.

ii. Covered entities should have 1 year to accept a refund, not 90 days.
    1. There have been instances when a refund offer is sent to someone without the power to accept it and it takes time to get it to the correct person. There should also be time given for entities to contest a repayment amount if they do not believe it was calculated correctly.
    2. We recommend a one-year period to accept a refund to make sure the repayment is properly received by the covered entity.

iii. We support HRSA's expanded scope of what constitutes an overcharge, which includes errors, intentional overcharges and routine pricing adjustments. We appreciate HRSA recognizing that overcharges can occur due to miscalculation, retroactive readjustments, as well as intentional overcharging.

iv. We support HRSA's interest in knowing how an overcharge occurred. HRSA should expect manufacturers to submit details of overcharging within 30 days of discovery.

v. We support HRSA's proposal that manufacturers may only calculate refunds on an NDC-by-NDC basis, not based on aggregated purchases, *de minimis* amounts, or netting purchases. Refunds on an NDC-by-NDC basis are the fairest way of ensuring that entities receive the correct amount of a refund for each overcharge of a single type of drug.

d. **We support HRSA's proposal to conduct an annual recertification process for manufacturers.**

i. The proposed guidance says manufacturers should annually review and update their 340B database information as part of a recertification process.

ii. We support this proposed process because it will improve database accuracy and enhance program compliance. It is difficult for covered entities to communicate with manufacturers, either to report errors and make repayment or request refunds for overcharges, if manufacturer contact information in the database is not correct.

Many thanks!
Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From:	DiBlasio, Carla
To:	Fitzsimons, Maura (HHS/ASL)
Subject:	RE: Secretary Burwell response: PFS global procedures proposal
Date:	Tuesday, October 18, 2016 8:22:36 PM

Thanks so much for the response!

From: Fitzsimons, Maura (HHS/ASL) [mailto:Maura.Fitzsimons@hhs.gov]
Sent: Tuesday, October 18, 2016 9:48 AM
To: DiBlasio, Carla
Subject: Secretary Burwell response: PFS global procedures proposal

Hi Carla,

Thank you for Representative Price's letter to Secretary Burwell regarding the CY 2017 Medicare physician fee schedule proposed rule. Attached please find a letter from the Secretary responding to concerns about the global procedure data reporting proposal.

Thanks,
Maura

Maura Fitzsimons
Office of the Assistant Secretary for Legislation
Department of Health and Human Services
202.260.7199 | Maura.Fitzsimons@hhs.gov

From:	Fitzsimons, Maura (HHS/ASL)
To:	carla.diblasio@mail.house.gov
Subject:	Secretary Burwell response: PFS global procedures proposal
Date:	Tuesday, October 18, 2016 9:47:00 AM
Attachments:	Price-10-14-16.pdf

Hi Carla,

Thank you for Representative Price's letter to Secretary Burwell regarding the CY 2017 Medicare physician fee schedule proposed rule. Attached please find a letter from the Secretary responding to concerns about the global procedure data reporting proposal.

Thanks,
Maura

Maura Fitzsimons
Office of the Assistant Secretary for Legislation
Department of Health and Human Services
202.260.7199 | Maura.Fitzsimons@hhs.gov

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

OCT 14 2016

The Honorable Tom Price, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your letter regarding your concerns with the Centers for Medicare & Medicaid Services' (CMS) proposal in the calendar year 2017 Medicare physician fee schedule (PFS) proposed rule for gathering data to use in valuing global procedures under the PFS from all practitioners furnishing such services. I greatly appreciate your bringing these concerns to my attention.

You urged us not to implement the proposal that would require all practitioners furnishing 10 and 90-day global packages to report data on post-operative services and instead to finalize a policy that would only require reporting by a "representative sample" of practitioners. You expressed appreciation that we did not propose to withhold 5-percent of payment until reporting occurred and encouraged us to maintain this provision in the final rule. As you are aware, we made this proposal to comply with section 1848(c)(8), which was added to the Social Security Act by section 523 of the Medicare and CHIP Reauthorization Act, and requires us to collect the data need to value global surgery services.

The comment period on this proposed rule closed on September 7, 2016. In addition to the opportunity to submit comments on the proposed rule, we held a town hall meeting at CMS headquarters. Stakeholders were given the opportunity to make presentations at this meeting, in person or virtually. We are in the process of considering the comments submitted as specified in the proposed rule and developing final regulations, which we expect to issue on or around November 1, 2016.

I appreciate your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. If you or your staff have questions, please feel free to contact Jim Esquea, Assistant Secretary for Legislation, at (202) 690-7627. I will also provide this response to co-signers of your letter.

Sincerely,

Sylvia M. Burwell

Sylvia M. Burwell

From:	Schlichting, Emily (HHS/ASL)
To:	Jim.Herz@mail.house.gov
Subject:	FY 2015 Agency Financial Report
Date:	Monday, November 16, 2015 5:32:00 PM
Attachments:	HHS_FY2015 AFR.PDF FY 2015 AFR Letter - Tom Price.pdf

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Hi Jim,

Attached please find a letter notifying your boss of the FY15 Agency Financial Report for HHS and the full report.

Thanks,
Emily

Emily Schlichting
Advisor to the Assistant Secretary for Legislation
U.S. Department of Health and Human Services
(202) 690-7414

Department of Health and Human Services

Advancing the health, safety, and well-being of the nation

Fiscal Year 2015
Agency Financial Report

U.S. Department of Health and Human Services

ADMINISTRATION FOR CHILDREN & FAMILIES

ACL

AHRQ

ATSDR
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FDA

HRSA

INDIAN HEALTH SERVICE
PHS · 1955

NIH
National Institutes of Health

Substance Abuse and Mental Health Services Administration
SAMHSA

One Department, One Mission, One HHS!

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An electronic copy of the FY 2015 *Agency Financial Report* is available at: www.hhs.gov/afr

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MESSAGE FROM THE SECRETARY

Sylvia M. Burwell

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing effective services and fostering advances in medicine, public health, and social services. We are committed to ensuring that every American has access to the building blocks for healthy and productive lives.

I am pleased to present HHS's Fiscal Year (FY) 2015 Agency Financial Report (AFR). The report highlights our major accomplishments, illustrates how we manage our resources, and outlines our plans to address the challenges we face. At HHS, we are dedicated to meeting the high standards of government reporting and accountability.

FY 2015 Highlights

HHS administers more than 300 programs that enhance the well-being of others. Four important efforts are highlighted below:

Access to Health Care. The Department celebrated two milestone anniversaries this year: the fifth anniversary of the *Affordable Care Act* and the 50th anniversary of Medicare and Medicaid.

Medicare and Medicaid were signed into law by President Johnson in 1965, providing a foundation for health and financial security for our elderly and most vulnerable citizens. Today, 1 in every 3 Americans is covered by Medicare or Medicaid, and they are a lifeline for families across the nation.

The *Affordable Care Act* is expanding access to health coverage to millions of Americans, including many who gained coverage for the first time. A recent analysis shows that since the law passed five years ago, 17.6 million people have gained coverage. The rate of uninsurance in America has dropped to the lowest levels on record.

And the *Affordable Care Act* isn't just about getting insurance. Thanks to new protections, like certain preventive services at no extra cost, everyone's insurance is better, no matter where they buy it. Families across America can now rest a little easier knowing that they can't be dropped just because they get sick or discriminated against if they have a pre-existing condition.

Thanks to the *Affordable Care Act*, community health centers will continue to be a vital source of quality primary care for uninsured and medically underserved patients. Today, there is a national primary care network of more than 1,300 health centers serving nearly 23 million individuals. The *Affordable Care Act* provides additional funding to help new centers reach a projected 1.4 million more Americans to increase access to services such as medical, oral, behavioral, pharmacy, and vision care.

Behavioral Health. We are confronting a national opioid abuse crisis. Over the last decade, deaths caused by overdoses of prescription opioid pain relievers and heroin use have increased significantly. The Department is working with state and federal leaders on a coordinated and comprehensive approach to address this crisis. Together, we are focusing on preventing opioid overdose and opioid use disorder, including prescribing practices, increasing access to drugs that reverse opioid overdose, and expanding the use of medication-assisted treatment. Medication-assisted treatment is a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders. HHS will also revise regulations related to prescribing products approved by the Food and Drug Administration for treatment of opioid

dependence. This will increase access to evidence-based treatment, helping more people get the treatment necessary for their recovery.

Advancing Science and Research. We recently announced the appointment of nationally recognized experts to the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria. The council will provide advice, information, and recommendations to HHS on initiatives and policies related to combating antibiotic-resistant bacteria. Antibiotic resistance is a growing public health threat across our country and around the world. The Centers for Disease Control and Prevention has estimated that antibiotic-resistant bacteria are responsible for 2 million infections and 23,000 deaths annually in the U.S.

Work is underway to implement a National Plan for Combating Antibiotic-Resistant Bacteria, a research-driven plan to identify and coordinate action across the Administration to prevent and control outbreaks of resistant pathogens. Detecting, preventing, and controlling antibiotic resistance requires a strategic, coordinated, and global effort. We are working closely with our international partners, recognizing that diseases do not recognize national borders. Together these efforts provide a roadmap to preserve the effectiveness of antibiotics, strengthen surveillance, prevent the transmission of antibiotic-resistant bacteria, further new research, and improve international coordination.

Leaving the Department Stronger. Finally, as we look to leave our Department stronger, we are investing in program integrity initiatives that allow us to crack down on waste, fraud and abuse. These initiatives are projected to yield $22 billion in gross savings for Medicare and Medicaid over the next decade. In 2015, a national fraud takedown led by the Medicare Fraud Strike Force in 17 districts, resulted in charges against 243 individuals for about $712 million in false billings. In addition, the Department suspended a number of providers using authority provided in the *Affordable Care Act*. This coordinated takedown is the largest in Strike Force history.

How We Manage Our Resources

As responsible stewards of the public resources that the American taxpayers and Congress entrust to us, one of our most important duties is to practice fiscal responsibility and transparency. To that end, our Department-wide financial statement audit is one of our most important tools. This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" of this report includes more detailed information.

As required by the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Internal Control*, we also evaluated our internal controls and financial management systems. We identified one material weakness, which also constitutes a non-conformance under Section 4 of FMFIA relating to Information System Controls and Security. We also identified one material noncompliance relating to Error Rate Measurement. Management continues efforts to improve our financial reports and systems. The "Management's Discussion and Analysis" section of this report includes further details. Based on our internal assessments and the auditor's report, I believe that our financial and performance data are reliable and complete.

Future Challenges

Despite our successes, HHS still faces challenges and opportunities for improvement. We have worked closely with the Office of Inspector General to gain its perspective about our most significant management and performance challenges, which are presented in the "Other Information" section under *FY 2015 Top Management and Performance Challenges Identified by the Office of Inspector General*. The HHS Inspector General identified 10 performance challenges that present opportunities for improvement. These challenges include overseeing the Health Insurance Marketplace, safeguarding privacy and data security, and protecting HHS grants and contract funds from fraud, waste, and abuse.

Looking Ahead

We look forward to continuing our work to protect the health and well-being of the American people in the coming years. We will build and strengthen relationships with anyone and everyone who shares our passion for impact and progress while helping Americans obtain the building blocks for healthy and productive lives.

/Sylvia M. Burwell/

Sylvia M. Burwell
Secretary
November 13, 2015

ABOUT THE AGENCY FINANCIAL REPORT

The HHS FY 2015 AFR provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2014 through September 30, 2015. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We have prepared this report in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements.* This document consists of three primary sections and appendices:

Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) section provides an overview of the entire report. Specifically, the MD&A presents an overview of performance and financial highlights for FY 2015. It also discusses HHS's compliance with legal and regulatory requirements, a summary of audit and management assurances, and gives a brief look ahead to FY 2016.

Financial Section

The Financial Section includes the Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.

Other Information

The Other Information section contains additional financial information including the Schedule of Spending, the Improper Payments Information Act Report, and the Office of Inspector General's FY 2015 assessment of management challenges facing the Department.

Appendices

The appendices include data that supports the main sections of the AFR. This includes a glossary of acronyms used in the report and resources for connecting with the Department.

The Department has chosen to produce an AFR and *Annual Performance Plan and Report*. In February 2016, additional reports that will be available on HHS/About HHS/Budget & Performance (www.hhs.gov/budget) include:

1. FY 2015 *HHS Summary of Performance and Financial Information*
2. FY 2017 *Annual Performance Plan and Report*
3. FY 2017 *Congressional Budget Justification*

Certificate of Excellence in Accountability Reporting

In May 2015, HHS received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its FY 2014 AFR. The CEAR Program was established by the AGA, in conjunction with the Chief Financial Officers Council, to further performance and accountability reporting. FY 2014 marks the second year the Department received this prestigious award. AGA also presented HHS with a Best in Class Award for its Summary of Performance and Financial Information.

Management's Discussion and Analysis

About the photo

Secretary Burwell reading to children during a visit to the Nia Family Center (Head Start).

In This Section

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ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (HHS or the Department) is the United States (U.S.) government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS represents almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for 1 in 3 Americans.

Mission Statement

Our mission is to enhance the health and well-being of Americans by providing for effective health and human services, and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.

HHS works closely with state and local governments and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. The HHS Office of the Secretary (OS) and its 11 Operating Divisions (OpDivs) administer more than 300 programs, covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data.

Our vision is to provide the building blocks that Americans need to live healthy, successful lives. Each HHS OpDiv contributes to our mission and vision as follows:

The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. For more information, refer to www.acf.hhs.gov.

The Administration for Community Living (ACL) is the single agency charged to work with states, localities, tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities live independently and fully participate in their communities. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. For more information, refer to www.acl.gov.

A teacher reads to children in a West Virginia Head Start program.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. This mission is supported by focusing on (1) improving health care quality, (2) making health care safer, (3) increasing accessibility, and (4) improving health care affordability, efficiency, and cost transparency. For more information, refer to www.ahrq.gov.

The Agency for Toxic Substances and Disease Registry (ATSDR) is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. For more information, refer to www.atsdr.cdc.gov.

The Centers for Disease Control and Prevention (CDC) collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC works to protect America from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. For more information, refer to www.cdc.gov.

The Centers for Medicare & Medicaid Services (CMS) administers public insurance programs that serve as the primary sources of health care coverage for seniors and a large population of medically vulnerable individuals. CMS acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and to promote quality care for beneficiaries. CMS is also responsible for helping to implement many provisions of the *Patient Protection and Affordable Care Act* (*Affordable Care Act*), such as the establishment of the Federally Facilitated Marketplace (FFM). For more information, refer to www.cms.gov.

The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.

Food coloring contains one or more of the certified color additives approved by the FDA.

FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.

Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. For more information, refer to www.fda.gov.

The Health Resources and Services Administration (HRSA) is responsible for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, and economically, or medically vulnerable. For more information, refer to www.hrsa.gov.

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 states. For more information, refer to www.ihs.gov.

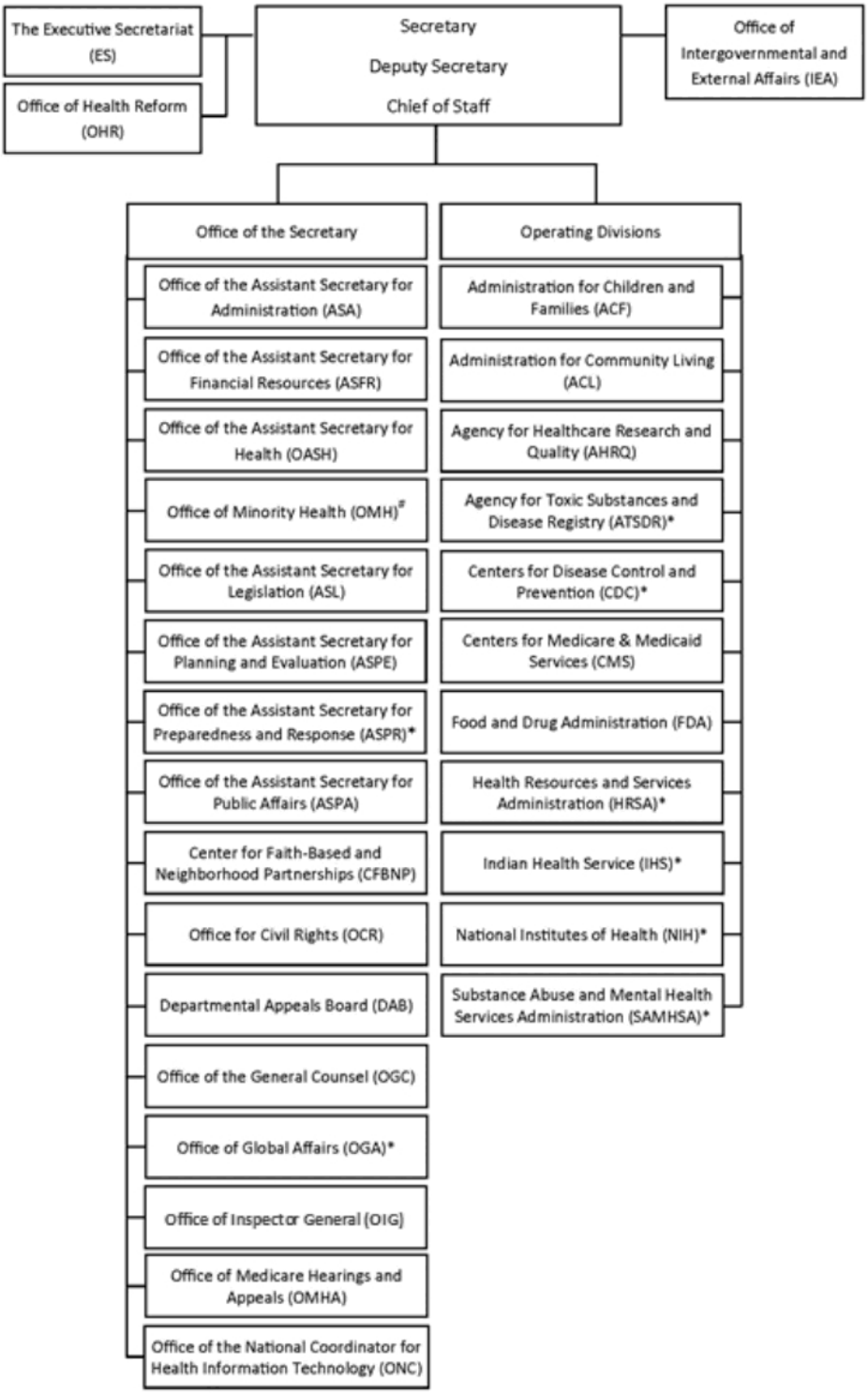
The National Institutes of Health (NIH) seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. For more information, refer to www.nih.gov.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. For more information, refer to www.samhsa.gov.

The Office of the Secretary (OS), with the Secretary, leads HHS and its 11 OpDivs to provide a wide range of services and benefits to the American people. In addition, the following Staff Divisions (StaffDivs) report directly to the Secretary, managing programs and supporting the OpDivs in carrying out our mission. The StaffDivs are:

- Immediate Office of the Secretary (IOS) www.hhs.gov/about/agencies/staff-divisions/immediate-office-secretary/index.html
    - The Executive Secretariat (ES)
    - Office of Health Reform (OHR)
    - Office of Intergovernmental and External Affairs (IEA) www.hhs.gov/intergovernmental
- Office of the Assistant Secretary for Administration (ASA) www.hhs.gov/asa
    - Program Support Center (PSC) www.hhs.gov/asa/psc
- Office of the Assistant Secretary for Financial Resources (ASFR) www.hhs.gov/asfr
- Office of the Assistant Secretary for Health (OASH) www.hhs.gov/ash
- Office of Minority Health (OMH) www.minorityhealth.hhs.gov
- Office of the Assistant Secretary for Legislation (ASL) www.hhs.gov/asl
- Office of the Assistant Secretary for Planning and Evaluation (ASPE) www.aspe.hhs.gov
- Office of the Assistant Secretary for Preparedness and Response (ASPR) www.phe.gov/preparedness
- Office of the Assistant Secretary for Public Affairs (ASPA) www.hhs.gov/aspa
- Center for Faith-Based and Neighborhood Partnerships (CFBNP) www.hhs.gov/partnerships
- Office for Civil Rights (OCR) www.hhs.gov/ocr
- Departmental Appeals Board (DAB) www.hhs.gov/dab
- Office of the General Counsel (OGC) www.hhs.gov/ogc
- Office of Global Affairs (OGA) www.globalhealth.gov
- Office of Inspector General (OIG) www.oig.hhs.gov
- Office of Medicare Hearings and Appeals (OMHA) www.hhs.gov/omha
- Office of the National Coordinator for Health Information Technology (ONC) www.healthit.gov/newsroom/about-onc

Below, we present the HHS organizational chart, which consists of the OS (www.hhs.gov/secretary), and the noted StaffDivs and OpDivs. For further information regarding our organization, components, and programs, visit our website at www.hhs.gov/about/foa.



*Components of the Public Health Service
#Administratively-supported by OASH

PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

Overview of Strategic and Agency Priority Goals

Every four years HHS updates its strategic plan, which describes its work to address complex, multifaceted, and evolving health and human services issues. An agency strategic plan is 1 of 3 main elements required by the *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010*. The Department's Strategic Plan (Plan) defines its mission, goals, and the means by which it will measure its progress in addressing specific national problems over a four-year period. In addition, each of the Department's OpDivs and StaffDivs contribute to the development of the strategic plan, as reflected in the Plan's strategic goals, objectives, strategies, and performance goals.

The HHS Strategic Plan FY 2014 – 2018 describes the Department's efforts within the context of broad strategic goals. This Plan identifies four strategic goals and 21 related objectives. The four strategic goals are:

Goal 1: Strengthen Health Care

Goal 2: Advance Scientific Knowledge and Innovation

Goal 3: Advance the Health, Safety, and Well-being of the American People

Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

The strategic goals and associated objectives focus on the major functions of HHS. Although the strategic goals and objectives in the Plan are presented as separate sections, they are interrelated, and successful achievement of one strategic goal or objective can influence the success of others. For example, the application of a promising new scientific discovery (Strategic Goal 2) can affect the quality of health care patients receive (Strategic Goal 1) and/or the success of human service programs (Strategic Goal 3). Improving economic well-being and other social determinants of health (Strategic Goal 3) can improve health outcomes (Strategic Goal 1). Responsible management and stewardship of federal resources (Strategic Goal 4) can create efficiencies the Department can leverage to advance its health, public health, research, and human services goals. For the second consecutive year, HHS conducted an annual Strategic Review, which consisted of various senior Department leaders reviewing performance data, evidence, and other factors for the 21 objectives. The annual review allows HHS leadership to undertake a high-level look at results, challenges, and future initiatives across the Department.


CDC participants in one of 585 emergency response training events.

Following is a summary of the strategic goals and objectives established in the FY 2014 – 2018 Plan.

Strategic Goal 1
Strengthen Health Care

Objectives

- Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured
- Improve health care quality and patient safety
- Emphasize primary and preventive care, linked with community prevention services
- Reduce the growth of health care costs while promoting high-value, effective care
- Ensure access to quality, culturally competent care, including long-term services and support for vulnerable populations
- Improve health care and population health through meaningful use of health information technology

Strategic Goal 2
Advance Scientific Knowledge and Innovation

Objectives

- Accelerate the process of scientific discovery to improve health
- Foster and apply innovative solutions to health, public health, and human services challenges
- Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation
- Increase our understanding of what works in public health and human services practice
- Improve laboratory, surveillance, and epidemiology capacity

Strategic Goal 3
Advance the Health, Safety, and Well-being of the American People

Objectives

- Promote the safety, well-being, resilience, and healthy development of children and youth
- Promote economic and social well-being for individuals, families, and communities
- Improve the accessibility and quality of supportive services for people with disabilities and older adults
- Promote prevention and wellness across the life span
- Reduce the occurrence of infectious diseases
- Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies

Strategic Goal 4
Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Objectives

- Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management
- Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American people
- Invest in the HHS workforce to help meet America's health and human services needs
- Improve HHS environmental, energy, and economic performance to promote sustainability

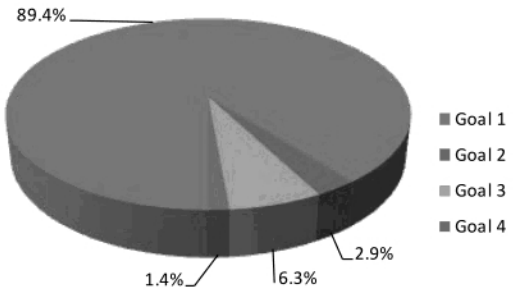
Looking Back at FY 2014 Performance and Budget

It is helpful to look at how HHS invests resources toward fulfilling the Department's mission through its strategic goals. Below are two charts that show the proportion of financial resources that are primarily dedicated to achieving each strategic goal.

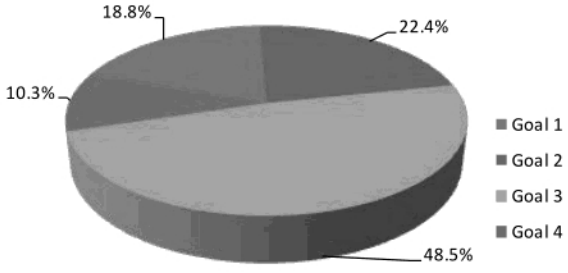
Although HHS funding here is broken down into strategic goals, many of the programs in HHS are crosscutting in nature and support a number of strategic goals. The chart on the left provides the breakdown of the HHS budget by strategic goal. The majority of the Department's funding was primarily associated with Goal 1 because of the large amount of money invested in delivering quality care and services through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). For FY 2014, of the four strategic goals, 89.4 percent was spent on Goal 1, 2.9 percent on Goal 2, 6.3 percent on Goal 3, and 1.4 percent on Goal 4.

The chart on the right illustrates the HHS budget excluding the costs of Medicare, Medicaid, and CHIP. Of the four strategic goals excluding Medicare, Medicaid, and CHIP, 18.8 percent was spent on Goal 1, 22.4 percent on Goal 2, 48.5 percent on Goal 3, and 10.3 percent on Goal 4.

Total FY 2014 HHS Budget



FY 2014 HHS Budget Excluding Medicare, Medicaid, and CHIP



Similar information on resource allocation for FY 2015 strategic goals will be published in the FY 2015 *HHS Summary of Performance and Financial Information,* available in February 2016 on HHS/About HHS/Budget & Performance (www.hhs.gov/budget). A detailed breakdown of FY 2015 spending by HHS activity and budget function is available in the "Other Information" section of this report.

Performance Management

HHS uses Agency Priority Goals (APGs), also referred to as HHS Priority Goals, to improve performance and accountability. HHS developed APGs by collaborating across the Department to identify activities that would reflect HHS priorities. We utilized the knowledge we gained through collaboration and during data-driven reviews to develop our APGs. These goals are a set of ambitious, but realistic performance objectives that the Department will strive to achieve within a 24-month period. APGs are a limited number of specific performance targets that advance progress toward longer-term outcomes. HHS is currently engaged in five APGs for FY 2014 – FY 2015 that will support the achievement of our strategic goals:

- Improve Patient Safety
- Improve Health Care Through Meaningful Use of Health Information Technology
- Improve the Quality of Early Childhood Education
- Reduce Combustible Tobacco Use
- Reduce Foodborne Illness in the Population

HHS performance initiatives, including APGs, continue to influence plans and policies as demonstrated in the Department's Plan, which guides our efforts into the future.

Secretary Burwell attends G7 Health Ministers Meeting in Germany to discuss strategies and best practices in disease prevention and treatment.

HHS continues to engage with individuals across the federal performance management community to implement best practices and refine our processes. These refinements and lessons learned have also influenced future plans and priorities. Refer to the "Looking Ahead to 2016" section for further details. HHS will actively monitor progress and work towards achieving our goals through quarterly data-driven reviews and other mechanisms. The most recent data, accomplishments, and future actions on HHS APGs, as well as information on previous APG cycles, can be found on www.performance.gov. The website provides information on the measures and milestones used by HHS to monitor progress toward these goals.

In addition to the APGs and strategic reviews, HHS reported data on 137 key performance measures in its FY 2015 *HHS Annual Performance Plan and Report*. These measures represent important issue areas being addressed by the health care and human services communities. The performance measures present a powerful tool to improve HHS operations and help to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions. While HHS does not yet have FY 2015 data available for all measures due to the lag associated with data collection and reporting, HHS's OpDivs and StaffDivs constantly strive to find lower-cost ways to achieve positive impacts in addition to sustaining and fostering the replication of effective and efficient government programs. For more information on results from FY 2015 and earlier, consult the *HHS Annual Performance Plan and Report,* released annually in February along with the President's Budget.

Performance Results

The performance results in this section represent key measures and performance highlights demonstrating progress toward each HHS strategic goal.

The accomplishments and performance trends, including progress on HHS Priority Goals, underscore HHS's dedication to sustained performance improvement, and emphasis on working to meet the Department's four strategic goals. Targets presented within the graphs represent performance expectations based on a number of factors and may not exceed the previous years' results, although they may represent an improvement over previous years' targets. The results marked with an asterisk (*) within each strategic goal indicate targets that were met or exceeded for the applicable period. Some results were not available at the time of this report due to the lag associated with data collection requirements. The target is displayed to show planned progress. In February 2016, additional performance measures and trends will be available in related reports on HHS/About HHS/Budget & Performance (www.hhs.gov/budget).

Strategic Goal One: Strengthen Health Care

On March 23, 2010, President Obama signed the *Affordable Care Act* into law, transforming and modernizing the American health care system. HHS continues to drive the effort to strengthen and modernize health care to improve patient outcomes. Through its programs, HHS also promotes efficiency and accountability, ensures patient safety, encourages shared responsibility, and works toward high-value health care. In addition to addressing these responsibilities, HHS is improving access to culturally competent, quality health care for uninsured, underserved, and vulnerable populations.

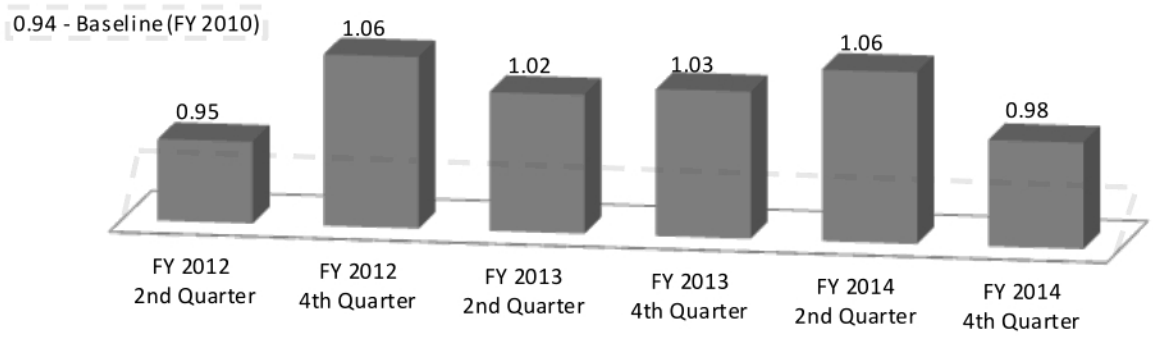
Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections. HHS's efforts to reduce Healthcare-Associated Infections (HAIs), which would improve patient safety and health care quality, are reflected in the "Improve Patient Safety" APG (www.performance.gov/content/improve-patient-safety). These infections can lead to significant morbidity and mortality, with tens of thousands of lives lost each year. During the FY 2014 – FY 2015 APG period, HHS efforts focused on catheter-associated urinary tract infections (CAUTI).

Leveraging the combined programmatic efforts within HHS, including AHRQ, CDC, CMS, and OASH, the "Improve Patient Safety" APG is working to reduce CAUTI by 10 percent in hospitals nationwide by the end of FY 2015. This is measured over the FY 2013 Standardized Infection Ratio (SIR) of 1.03. The most current National Healthcare Safety Network (NHSN) data for the time period through September 30, 2014 shows a CAUTI SIR of 0.98. This is a reduction from the previous cycle's CAUTI SIR of 1.06. Knowledge gained during this period has led to better data tracking and monitoring as well as new approaches in the Intensive Care Units (ICUs) based on identified potential barriers. Analysis of the CAUTI data continues to reveal marked difference in reductions between ICUs and non-ICUs. ICUs have significantly higher SIRs, higher number of catheter-days, and show less reductions in these indicators of progress than in the non-ICU setting. Lessons learned were also used to focus HHS efforts, including targeting the hospitals with the highest excess number of CAUTIs. HHS program efforts that help health care partners achieve this goal include AHRQ's Comprehensive Unit-based Safety Program (CUSP), CDC's development and maintenance of the NHSN, CMS's Quality Improvement Organizations and Partnership for Patients initiative, and strategic direction and support from OASH, including the National Action Plan to Prevent HAIs.

APG - Improve Patient Safety

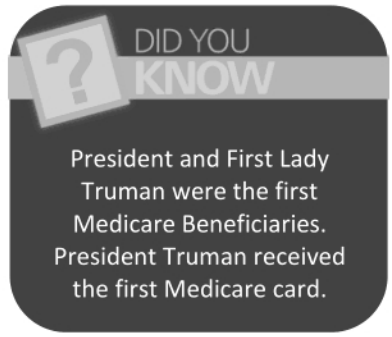
Standardized Infection Ratio of Catheter-Associated Urinary Tract Infections

(result met or exceeded target)*[1]



[1] The reporting frequency for this measure is semi-annually. A new CAUTI definition went into effect in January 2015; therefore, this chart only presents results and baseline data prior to January 2015. Outstanding data and a new baseline are expected in March 2016.

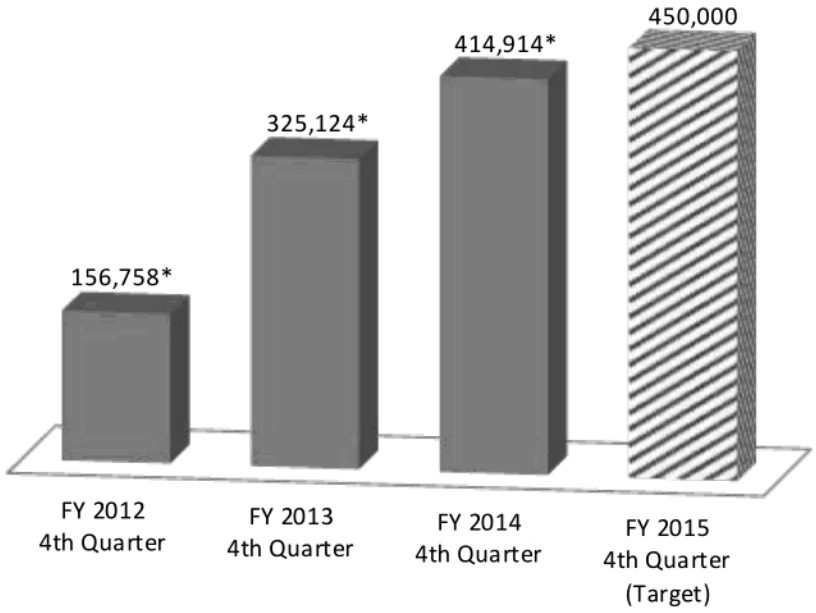
Incentive Payments from CMS Medicare and Medicaid Electronic Health Records Incentive Programs. At the heart of HHS's strategy to strengthen and modernize health care is the use of data to improve health care quality, reduce unnecessary health care costs, decrease paperwork, expand access to affordable care, improve population health, and support reformed payment structures. The nation's health information technology infrastructure enables the flow of information to power these critical efforts that can help facilitate the types of fundamental changes in access and health care delivery set forth in the *American Recovery and Reinvestment Act of 2009*. A key step in this strategy is to provide incentive payments to eligible providers serving Medicare and Medicaid beneficiaries who adopt and meaningfully use certified electronic health records (EHR) technology. The "Improvement of Health Care through Meaningful Use of Health Information Technology" (www.performance.gov/content/improve-health-care-through-meaningful-use-health-information-technology) continued as an APG for the FY 2014 – FY 2015 period, with a goal of 450,000 incentive payments by the end of 2015. As of the third quarter of 2015, this goal has already been surpassed, with 471,516 incentive payments made. Note that while information is collected quarterly, targets are generally set annually.



APG – Improve Health Care through Meaningful Use of Health Information Technology

Number of Eligible Providers who Receive an Incentive Payment from CMS Medicare and Medicaid Electronic Health Records Incentive Programs

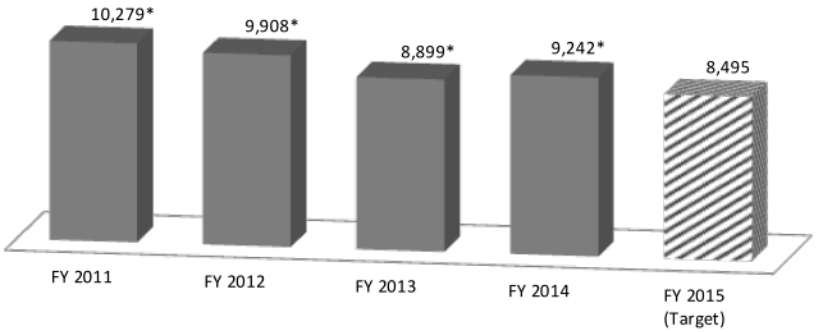
(result met or exceeded target)*[2]



[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

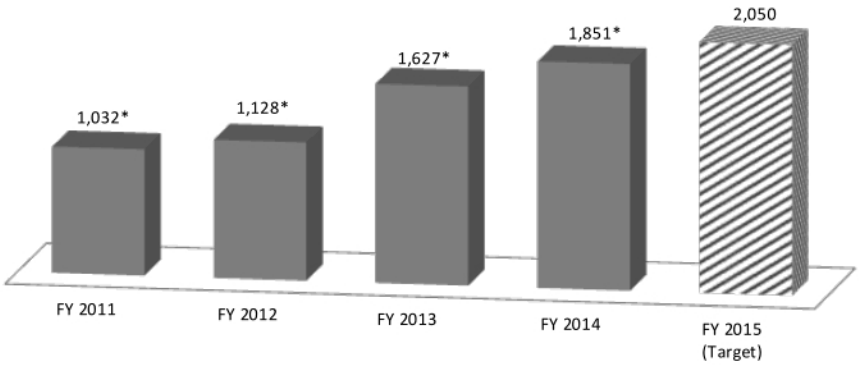
Field Strength of the National Health Service Corps. The National Health Service Corps (NHSC) addresses the nationwide shortage of health care providers by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. More than 45,000 primary care medical, dental, mental, and behavioral health professionals have served in the NHSC since its inception. The field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas in exchange for scholarship or loan repayment support. In FY 2014, the NHSC field strength was 9,242, exceeding the target of 7,522. The annual field strength is dependent upon funding levels and programmatic policy decisions that allocate funding between the scholarship and loan repayment programs. NHSC loan repayors are immediately counted in the annual field strength, while NHSC scholars are not counted until completion of training. Future designated mandatory funding will further bolster the NHSC field strength to expand access to primary care services in underserved communities and vulnerable populations in high need urban and rural communities across the country.

Field Strength of the NHSC, as Measured by the Number of Providers Fulfilling Active Service Obligations in Exchange for Scholarship and Loan Repayment Agreements
(result met or exceeded target)*[2]



Users of AHRQ-Supported Research Tools. As an indicator of the number of health care organizations using AHRQ-supported tools to improve patient safety, AHRQ relies in part on the Hospital Survey of Patient Safety (HSOPS). Some organizations that use the survey voluntarily submit their data to a comparative database for aggregation. In FY 2014, 1,851 hospitals indicated in this survey that they use AHRQ-supported tools to improve patient safety, exceeding the target as the program has consistently for years. Interest in other AHRQ tools and resources has also remained strong, as evidenced by on-going participation in informational webinars, electronic downloads, and orders placed for various products.

Number of Users of Research Using AHRQ-Supported Research Tools to Improve Patient Safety Culture
(result met or exceeded target)*[2]



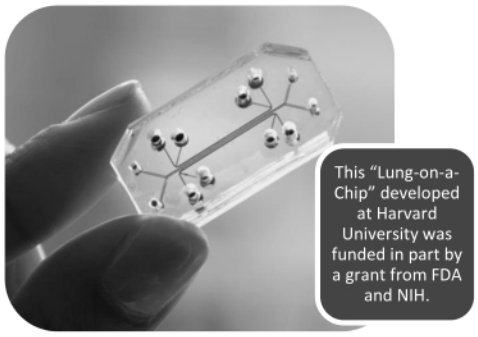
[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to Medicare patients. This coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. Leveraging the innovative model of ACOs is a key part of promoting health care cost savings through the *Affordable Care Act*. As part of the delivery system reform process, we aim to increase the number of Medicare beneficiaries who aligned with the ACOs and the number of physicians participating in the ACOs. While data collection on a number of ACO-related measures began only in 2013, early results are encouraging. In calendar year 2013, the baseline year, over 4 million Medicare beneficiaries aligned to ACOs, with the expectation of increasing alignment to more than 7 million beneficiaries during the 2015 calendar year. The number of physicians participating in an ACO in FY 2013 was 102,717. For the 2015 calendar year, we expect physician participation to increase by almost 80 percent to 178,000 physicians. Data results for 2014 were not available at the time of publication. Results should be available in the FY 2017 *HHS Annual Performance Plan and Report* published in February 2016.

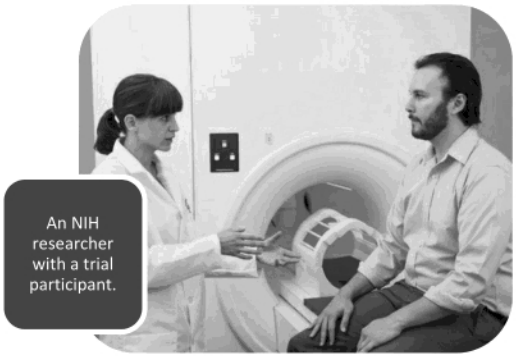
Strategic Goal Two: Advance Scientific Knowledge and Innovation

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, and biomedical research and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services. These efforts encourage efficiency, effectiveness, sustainability, and sharing or translating that knowledge into better products and services.

In FY 2014, electronic media reach of the *CDC Vital Signs* monthly report was over 3.5 million potential viewings, exceeding its year-end target goal of 2.9 million potential viewings. During FY 2014, CDC published over 240 Morbidity and Mortality Weekly Report (MMWR) publications, and increased total electronic media reach by 23 percent since FY 2012 from 18.1 million to 22.2 million during FY 2014. In FY 2015, CDC expects an increase in electronic media reach of *CDC Vital Signs* and MMWR weekly and serial publications.


This "Lung-on-a-Chip" developed at Harvard University was funded in part by a grant from FDA and NIH.

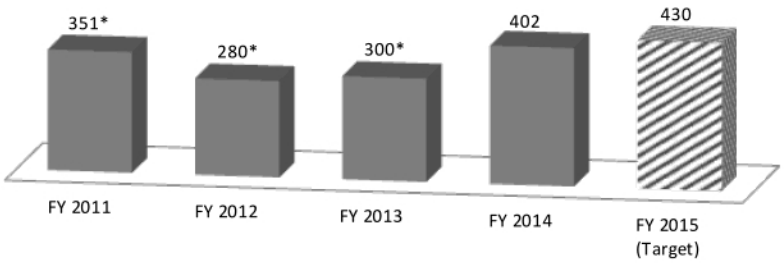
Since 2013, SAMHSA has leveraged mobile technology to increase the reach of its resources by launching multiple mobile applications (apps). Each new app has had a greater reach than the ones that preceded it. First, to further support behavioral health first responders, SAMHSA developed and launched the behavioral health disaster mobile app that allows behavioral health first responders to zero in on the exact location to respond to a disaster and easily access and share behavioral health resources, updated in real-time, for those most in need at a disaster site. In August of 2014, SAMHSA released "KnowBullying." "KnowBullying" empowers parents, caregivers, and educators with the tools they need to start a conversation about bullying with their children. "KnowBullying," a 2014 recipient of the Bronze Award in the Mobile category from the Web Health Awards, describes strategies to prevent bullying and explains how to recognize warning signs that a child is bullying, witnessing bullying, or being bullied. Then, in February of 2015, SAMHSA launched the "Suicide Safe" app for primary care and behavioral health providers. This app is designed to help providers address suicide risk and integrate suicide prevention strategies in patient care. "Suicide Safe" has been downloaded over 23,500 times since its launch, and received the 2015 Silver Digital Health Information Award. In the future, SAMHSA will continue to innovate in these new platforms by launching additional mobile apps to address other important behavioral health topics.


An NIH researcher with a trial participant.

Individuals who have experienced a traumatic brain injury (TBI) are more likely to experience ongoing neurological and psychological symptoms. Currently, there is no way to identify those who are at greatest risk for developing these chronic symptoms. However, recent NIH research suggests that a protein known as tau may be responsible for the long-term complications from TBI. Using a new, ultra-sensitive technology, a team of researchers led by the NIH was able to measure levels of tau in the blood months and years after military personnel had experienced TBI. Elevated levels of tau are associated with chronic neurological symptoms, including post-concussive disorder, during which an individual has symptoms such as headache and dizziness in the weeks and months after injury. These chronic neurological symptoms have been linked to progressive brain degeneration that leads to dementia following repetitive TBIs, independent of other factors such as depression and post-traumatic stress disorder. With further study, these findings may provide a framework for identifying patients who are most at risk for experiencing chronic symptoms related to TBI. Knowledge of the relationship of tau accumulation to chronic complications related to TBI may also someday provide a therapeutic target for treating the causes of neurodegenerative and psychological conditions that can result from these types of injury.

International Field Epidemiology Training Programs. Since 1980, CDC has developed International Field Epidemiology Training Programs (FETP) serving 60 countries that have graduated over 3,600 epidemiologists. Through FETPs, CDC helps establish a network of disease detectives around the globe that are the first line of defense in detecting and responding to outbreaks in their respective countries as well as neighboring countries. From the most current data available in FY 2014, FETP graduates and residents led 424 outbreak investigations, and CDC's Global Disease Detection Centers responded to 319 disease outbreaks. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. Although short of its target of 430 new residents, CDC brought on more new FETP residents in FY 2014 than in any previous year, strengthening global health ministries' ability to detect and respond to outbreaks.

Capacity of Epidemiology and Laboratory within Global Health Ministries through FETP as measured by the Number of New Residents
(result met or exceeded target)*[2]



Strategic Goal Three: Advance the Health, Safety, and Well-Being of the American People

HHS strives to promote the health, economic, and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies

[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

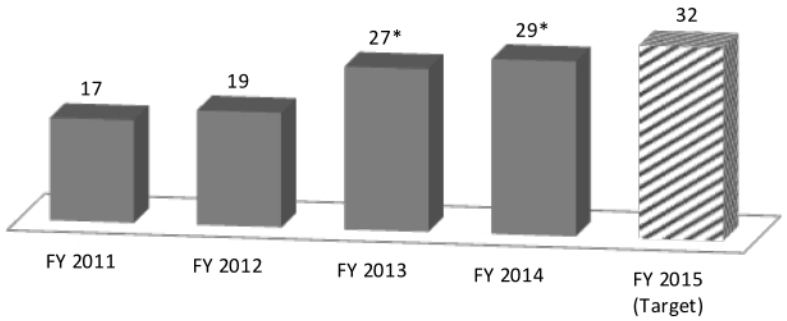
to strengthen families and to improve outcomes for children, adults, and communities. A focus on prevention underlies each objective and strategy associated with this goal.

Quality Rating and Improvement Systems with High-Quality Benchmarks. The "Improve the Quality of Early Childhood Education" APG (www.performance.gov/content/improve-quality-early-childhood-education) calls for actions to improve the quality of programs for children of low-income families, namely Head Start and Child Care. For the Child Care program, the aim is to increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet the seven high-quality benchmarks for child care and other early childhood programs developed by HHS. QRIS is a mechanism used to improve the quality of child care available in communities and to increase parents' knowledge and understanding of available child care options. Through FY 2014, 29 states had a QRIS that met high-quality benchmarks, meeting the APG target. States made several changes to their QRIS, such as opening eligibility to family child care providers, expanding from a pilot program to statewide program, and implementing new consumer education efforts.

APG – Improve the Quality of Early Childhood Education

Number of States Implementing QRIS that Meet the High-Quality Benchmarks

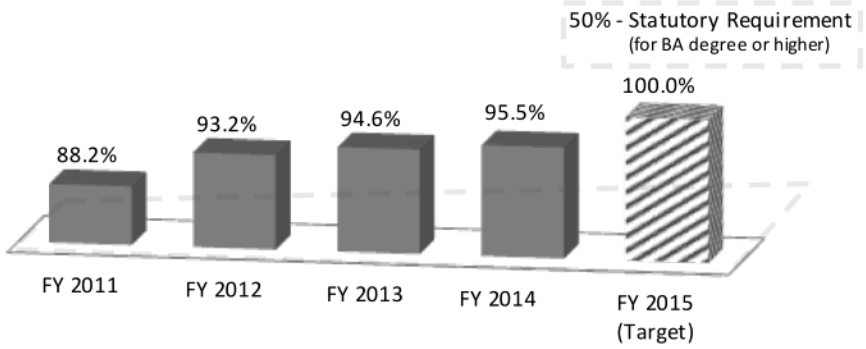
(result met or exceeded target)*[2]



Head Start Teachers with Degrees in Early Childhood Education. Head Start has shown a steady increase in the number of Head Start teachers with an Associate of Arts (AA), Bachelor of Arts (BA), or other advanced degree in early childhood education, supported by plans to improve the qualifications of staff. Based on the most recent data available from FY 2014, 95.5 percent of Head Start teachers (41,977 out of 43,946) had an AA degree or higher, missing the target of 100 percent but improving significantly since 2008. Additionally, 66 percent of Head Start teachers have a BA degree or higher, far exceeding the statutory requirement of 50 percent.

Percentage of Head Start Teachers with AA, BA, Advanced Degree, or Other Degree in a Field Related to Early Childhood Education

(result met or exceeded target)*[2]

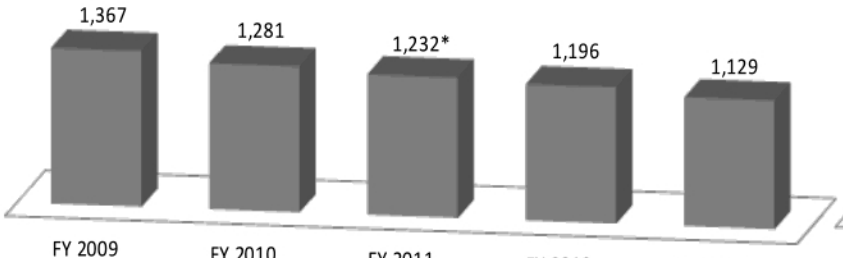


[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

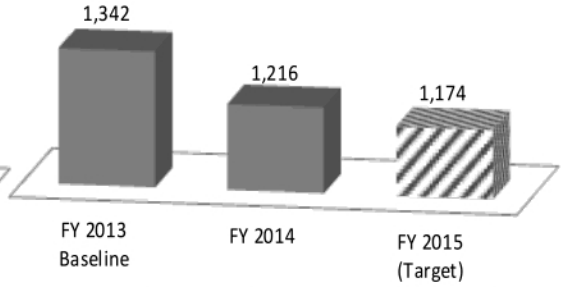
Combustible Tobacco Consumption (Cigarette Equivalents). Smoking and secondhand smoke kill an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. $133 billion in medical costs and $156 billion in lost productivity each year. While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. In addition, the coordinated efforts of the APG to reduce combustible tobacco use (www.performance.gov/content/reduce-combustible-tobacco-use) have resulted in reductions in adult cigarette consumption, based on FY 2013 results (reported in June 2014). In the FY 2014 – FY 2015 iteration of this APG, HHS focused on a new measure of smoking – annual per capita adult combustible tobacco consumption in the U.S. This new measure focuses on all combustibles, not just cigarettes, as a way to ascertain broader trends in tobacco use among adults. For FY 2014, the annual per capita adult combustible tobacco consumption fell to 1,216, missing the FY 2014 target of 1,212 by only four cigarette equivalents. This represents an approximate 9 percent decrease from the FY 2012 baseline of 1,342. The data represented on the left captures the results from the measure used during the previous FY 2012 – FY 2013 APG period. The data on the right represents the current measure.

The U.S. Surgeon General Vice Admiral Vivek H. Murthy demonstrating his commitment to reducing combustible tobacco use.

FY 2012 - 2013 APG - Reduce Cigarette Smoking
Annual Per Capita Cigarette Consumption by Adults in the U.S.
*(*result met or exceeded target)*



FY 2014 - 2015 APG - Reduce Combustible Tobacco Use
Annual Per Capita Adult Combustible Tobacco Consumption in the U.S.
*(*result met or exceeded target)*[2]



Rate of Salmonella Enteritidis Illness. Salmonella is the leading known cause of bacterial foodborne illness and death in the U.S. Each year in the U.S., Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of Salmonella in the U.S. and accounts for approximately 20 percent of all salmonella cases in humans; reducing its prevalence supports the HHS Priority Goal to reduce foodborne illness in the population (www.performance.gov/content/reduce-foodborne-illness-population).

The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (U.S. Department of Agriculture-regulated). Therefore, reducing SE illness from shell eggs is the most appropriate FDA strategy for reducing illness from SE. Preventing Salmonella infections depends on actions taken by regulatory agencies, the food industry, and consumers to reduce contamination of food, as well as actions taken for detecting and responding to outbreaks.

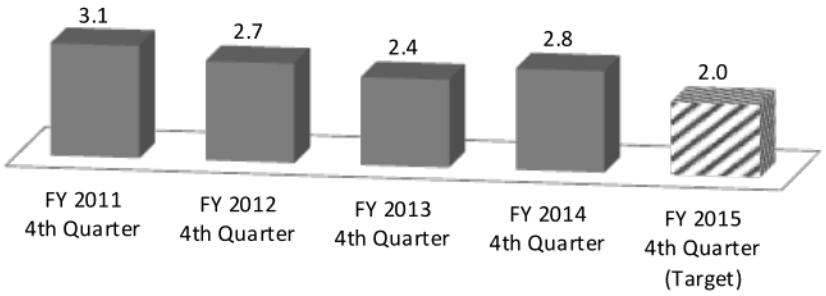
[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

As part of the shared vision to reduce foodborne illness, FDA has developed a priority goal to reduce Salmonella contamination in shell eggs, and CDC is working with FDA to gather more data to better estimate sources of illness. CDC estimated that, for FY 2007 – FY 2009, 40 percent of domestically acquired, foodborne SE illnesses were from eating shell eggs and 28 percent of total SE illnesses (foodborne, non-foodborne, and international travel-associated) were from shell eggs. CDC completed an evaluation of a "food product" model to estimate annual change in percentage of SE illnesses from shell eggs, but determined that necessary data about contamination of shell eggs were not available. CDC concluded that this model could not be used unless new sources of egg data were obtained. Therefore, as of January 2014, CDC began collecting exposure data from persons with SE infection in FoodNet sites, a network that conducts surveillance for infections diagnosed by laboratory testing of samples from patients. CDC will conduct a preliminary evaluation of this data to assess its quality and determine its usefulness in updating CDC's exposure model for estimating the proportion of total SE illnesses attributable to shell eggs during 2014 – 2015. While information is collected quarterly, targets are generally set annually. FDA and CDC will continue to discuss sampling strategies for collection, to assure progress on data sharing, and to identify and remove any obstacles in achieving targets.

APG – Reduce Foodborne Illness in the Population

Rate of Salmonella Enteritidis Illness in the Population

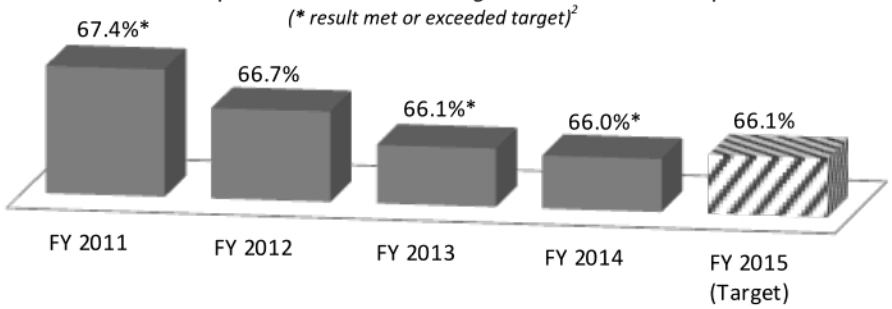
(result met or exceeded target)*[2]



Adults Receiving Homeless Support Services with Positive Follow-Up. One of SAMHSA's goals in its Strategic Initiative on Recovery Support is to ensure that permanent housing and supportive services are available for individuals with mental and substance use disorders. A way to meet this goal is to ensure the most vulnerable individuals who experience chronic homelessness receive access to sustainable permanent housing, treatment, and recovery support through grant funds and mainstream funding sources. Target populations include veterans and individuals with serious mental illness and/or substance use disorders who experience chronic homelessness. A measure of the effectiveness of this effort is to determine overall physical and emotional health status, from the consumer's perception of his or her recent functioning. Following the initial 13-percentage-point increase from FY 2008 to FY 2009, the percentage has consistently remained over 60 percent. FY 2014 progress indicated continued sustained performance.

Percentage of Adults Receiving Homeless Support Services who Report Positive Functioning at 6 Month Follow-up

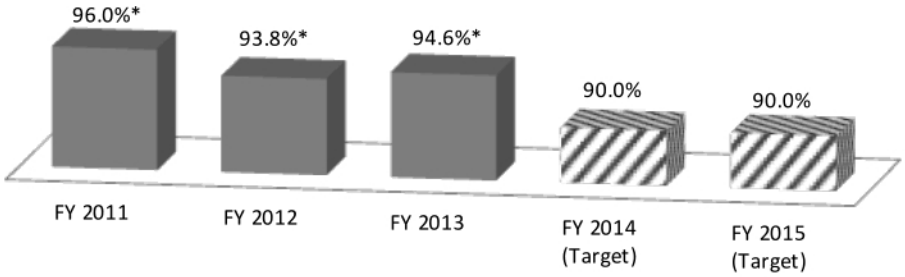
(result met or exceeded target)*[2]



[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

National Family Caregiver Support Program. ACL's Administration on Aging (AoA) Family Caregiver Support Services enables family members who have a loved one with disabilities or conditions that require assistance to use an array of supportive services, including respite care, information and assistance, support groups, and training. Caregivers are frequently under substantial strain with the responsibilities of caring for their ill relatives while also caring for children or other family members while employed. Since 2008, Family Caregiver Support Services clients have rated services good to excellent consistently above the target level of 90 percent. Nearly 90 percent of respondents reported that the services helped them to be a better caregiver, and nearly three quarters report feeling less stressed due to the services.

Percentage of National Family Caregiver Support Program clients who rate services good to excellent
(result met or exceeded target)*[2]

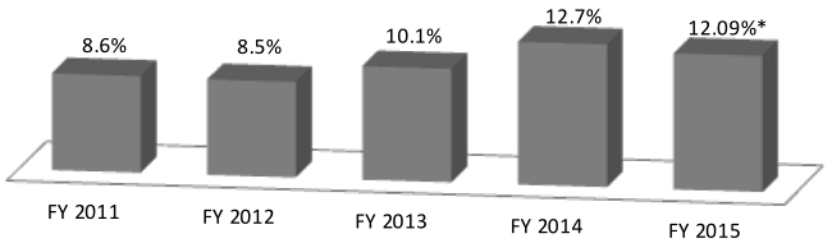


Strategic Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

As the largest grant-awarding agency in the federal government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services, which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

Medicare and Medicaid Improper Payment Rates. One of CMS's key goals is to pay Medicare claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable dollars. The Medicare fee-for-service improper payment rate in FY 2015 was 12.09%. The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or Insufficient Documentation to Determine errors. The other causes of improper payments are classified as Medical Necessity errors and Administrative or Process Errors Made by Other Party, due to incorrect coding errors. CMS continues to implement corrective actions to address the agency vulnerabilities.

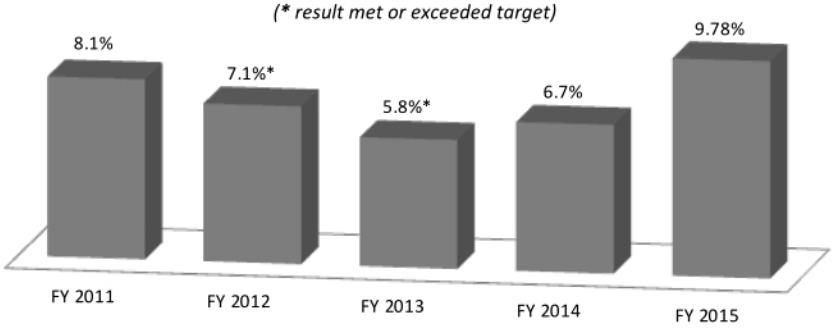
Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program
(result met or exceeded target)*



[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

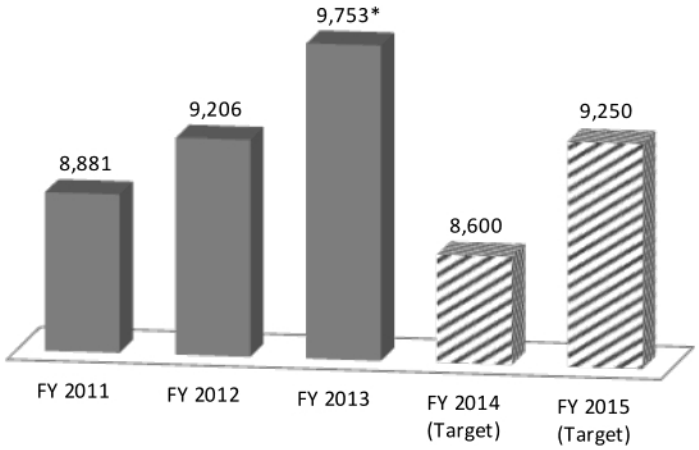
Since roughly one third of the states are measured each year to calculate the Medicaid improper payment rates, these measures are calculated as a rolling rate that includes the reporting year and the previous two years. The Medicaid improper payment rate in FY 2015 was 9.78 percent. The increase was due to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes and, therefore, many states had not fully implemented these new requirements. CMS works closely with states to develop state-specific corrective action plans that address improper payments and describe systems updates to bring states into compliance. In an attempt to reduce the national Medicaid error rates, states are required to develop and submit state-specific corrective action plans.

Estimate of the Payment Error Rate in the Medicaid Program
(result met or exceeded target)*



Clients Served by Home and Community-Based Services. A key factor contributing to ACL's program success is access to Home and Community-based Services. Between FY 2008 and FY 2013, performance has improved by 17.5 percent, without benefit of adjustment for inflation. In FY 2013, the Aging Services Network served 9,753 clients per million dollars of *Older Americans Act* funding, exceeding the target of 8,700 clients per million dollars. Performance trended upward and performance targets were consistently attained. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers, along with increased commitments and partnerships at the state and local levels, have all had positive impacts on program efficiency. Between FY 2014 and FY 2017, however, the targeted number of clients served is expected to vary as delayed effects of sequestration may occur.

Number of Clients Served by Home and Community-Based Services, including Nutrition and Caregiver Services, per Million Dollars of Title III Older Americans Act Funding
(result met or exceeded target)*[2]



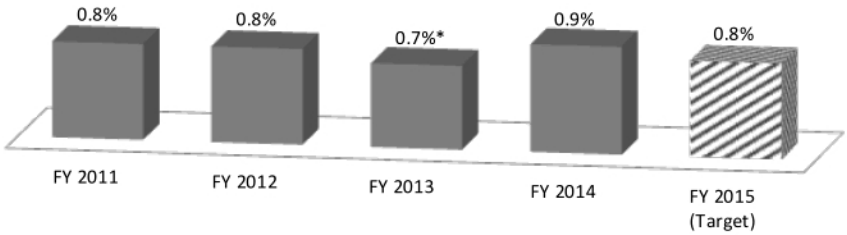
[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

ACF's Head Start program works to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently by measuring under-enrollment across programs. Since Head Start grantees range in size from super-grantees with multiple delegate agencies serving up to 20,000 children to individual centers that serve as few as 15 children, a national under-enrollment rate better captures the under-enrollment than the proportion of grantees that meet under-enrollment targets. An un-enrolled space or vacancy in Head Start is defined as a funded space that is vacant for over 30 days.

2015 marks the 50th anniversary of the Head Start program.

Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as state pre-kindergarten programs grow, parents may choose to send their children to those programs. The most recent data available indicate that, during the 2013-2014 program year, Head Start grantees had, on average, not enrolled 0.9 percent (0.88 percent) of the children they were funded to serve, missing the FY 2014 target of 0.6 percent. This represents approximately 8,200 children who could have been served using the Head Start funds appropriated and awarded to grantees.

Decrease in the Under-Enrollment Rate of Head Start Programs; Increased Number of Children Served Per Dollar
(result met or exceeded target)*[2]



Cross-Agency Priority Goals

Cross-Agency Priority goals address the longstanding challenge of tackling horizontal problems across vertical organizational silos. In the 2015 President's Budget, 15 Cross-Agency Priority Goals were announced – seven mission-oriented and eight management-focused goals with a four year time horizon. Established by the *GPRA Modernization Act of 2010*, these Cross-Agency Priority Goals are a tool used by federal leadership to accelerate progress on a limited number of Presidential priority areas where implementation requires active collaboration between multiple agencies. HHS contributes to Cross-Agency Priority Goals with other federal agencies in the mission-oriented goals of Science, Technology, Engineering and Mathematics (STEM) Education; and Service Members and Veterans Mental Health. We are also maximizing federal spending through participation in the management-focused goals of Shared Services; Benchmark and Improve Mission-Support Operations; and Customer Service. For more information on HHS's contributions to Cross-Agency Priority Goals and progress, refer to www.performance.gov.

[2] Data results were not available at the time of publication. Results should be available in the FY 2017 *Annual Performance Plan and Report* published in February 2016.

SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROLS

Systems

Financial Systems Environment

HHS's CFO Community strives to provide effective stewardship of taxpayer funds through transparency and accountability in support of the Department's mission and programs. The HHS financial systems environment forms the financial and accounting foundation for managing the $1.5 trillion in budgetary resources entrusted to the Department in FY 2015. These resources represent about a quarter of all federal outlays and encompass more grant dollars than all other federal agencies combined.

The robust financial systems environment supports a diverse portfolio of programs and business operations. Its purpose is to: provide complete and accurate financial information for decision-making; improve data integrity; strengthen internal controls; and mitigate risk.

The HHS financial systems environment consists of a core financial system (with three instances) and two Department-wide reporting systems used for financial and managerial reporting that – taken together – satisfy the Department's financial accounting and reporting needs.

Core Financial System

The core financial system operates on a commercial off-the-shelf (COTS) platform to support data standardization and facilitate Department-wide reporting. Each of the instances operates the same COTS solution.

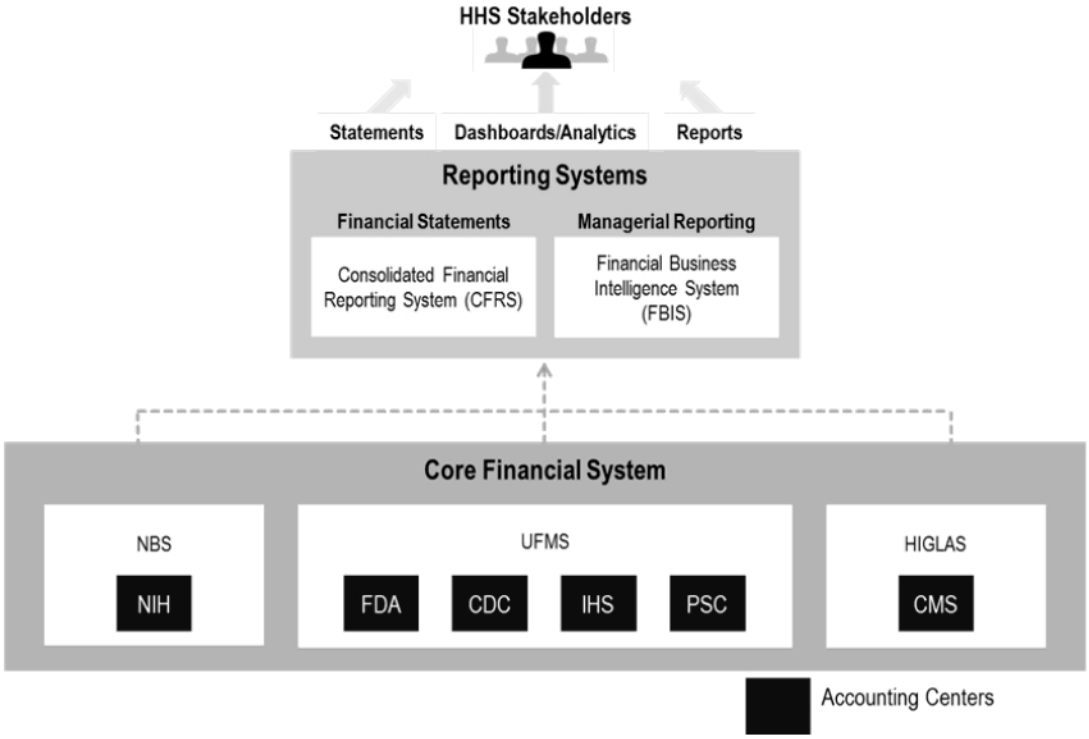
- The NIH Business System (NBS) serves NIH's 27 research institutes and accounts for nearly $27.5 billion in annual grants payments.
- The Unified Financial Management System (UFMS) serves 10 OpDivs (including the OS) and 18 StaffDivs across the Department. The following accounting centers utilize UFMS: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for the rest of the Department.
- The Healthcare Integrated General Ledger Accounting System (HIGLAS) supports CMS. HIGLAS serves 15 Medicare Administrative Contractor organizations, Administrative Program Accounting, and the Center for Consumer Information and Insurance Oversight. It processes an average of five million transactions daily.

Reporting Systems

Reporting components within the HHS financial systems environment consist of two Department-wide applications: Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS). These reporting systems facilitate data reconciliation, financial and managerial reporting, and data analysis.

- CFRS systematically consolidates information from all three instances of the core financial system. It generates Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.
- FBIS is a financial business intelligence application for managerial reporting. It consolidates information from the core financial system to support strategic and operational reporting requirements. FBIS utilizes a variety of business intelligence techniques to present data for decision-making, including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting.

The illustration below depicts the current financial systems environment.



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

- *Federal Managers' Financial Integrity Act of 1982*
- *Chief Financial Officers Act of 1990*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002*
- *Digital Accountability and Transparency Act (DATA Act) of 2014*
- *Federal Information Technology Acquisition Reform Act of 2014*
- Office of Management and Budget (OMB) directives related to these laws

Financial Systems Environment Improvement Strategy

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The goal of the strategy is to improve the effectiveness and efficiency of the Department's financial management capabilities and to mature the overall financial systems environment. This is a multi-year initiative, and the Department is making significant progress in each of the following key strategic areas.

Governance

- *Strategy*: In November 2013, the Department established the Financial Management Governance Board (FGB) to address enterprise-wide issues, including those related to financial policies and procedures, financial data, and technology. The FGB's goals include establishing HHS financial management governance; providing people, processes, and technology to support governance; engaging stakeholders through effective communication and management strategies; and supporting project alignment with federal mandates and priorities.

- *Progress*: Since its inception, the FGB has met monthly and facilitated executive-level oversight of financial management-related areas. It promotes collaboration among stakeholders from the different disciplines within the financial management community by engaging senior leadership from HHS OpDivs and StaffDivs and across functions such as finance, budget, grants, and information technology (IT). Further, it has become a key forum to address pervasive audit findings related to governance through regular decision-making meetings and clear documentation to support actions taken.

Program Management

- *Strategy*: To support FSIP, HHS has established a Department-wide program management framework to facilitate effective implementation of FSIP projects and to enhance collaboration across project teams. This includes the Financial Systems Consortium: a body of contractors, federal project managers, and federal contracting officers representing NBS, UFMS, and HIGLAS, that foster communication and implement best practices.

- *Progress*: Department-wide program management and the Consortium have been critical in coordinating the overall upgrade of the HHS core financial system through communication with HHS leadership and key external stakeholders. Through this framework, project teams have been able to share industry best practices, lessons learned, and risks identified during the upgrade while minimizing overall costs. This has included sharing solutions across system upgrade teams to streamline implementation, as well as coordinating vendor support to resolve software issues. Effective program management has also reduced duplication of effort and costs by identifying potential sharing opportunities and improvements.

Accounting Treatment Manual and Data Standardization

- *Strategy*: HHS is incrementally developing and implementing a standardized Department-wide Accounting Treatment Manual (ATM) that will improve fiscal transparency and accountability, while enhancing the accuracy of financial reporting.

- *Progress*: HHS completed its initial development of a Department-wide ATM in April 2014, and recommendations are being implemented concurrently with the system upgrade. The FGB has chartered the Data Standardization Working Group (DSWG), which meets on a quarterly basis, leads ATM changes, and coordinates with the HHS DATA Act Program Management Office (PMO) on *DATA Act* implementation.

Financial System Upgrade

- *Strategy*: A critical component of the multi-year FSIP initiative is upgrading the core financial system to the most current version of the COTS software to maintain a secure and reliable financial systems environment. In 2014, HHS began the upgrade in phases, while continuing to support current operations.

In addition, a post-upgrade roadmap was developed for implementing future projects and enhancements to further mature the HHS financial systems environment.

- *Progress*: The NBS and HIGLAS upgrades were completed and put into production during FY 2015. The UFMS upgrade is on-track for completion in FY 2016, as planned. Project teams leveraged the upgrade to identify opportunities for reducing or consolidating many customizations.

Sharing

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

- *Progress*: Examples of sharing opportunities pursued to date include transitioning the financial system to a cloud shared service provider; the use of shared acquisition contracts and consolidation of system operations and maintenance contracts; the development of a Department-wide ATM; and sharing solutions across the HHS financial community. The FGB will assess future opportunities to ensure alignment with financial management and system policies, business processes and operations, and the overall financial system vision and architecture.

Business Intelligence

- *Strategy*: Leveraging the FBIS platform, HHS is expanding the use of business intelligence with the goals of further enhancing financial management information and reporting, as well as facilitating effective decision-making.

- *Progress*: Since first deployed in FY 2012, FBIS has been providing operational and business intelligence to users across the HHS finance, budget, grants, and acquisition communities. FBIS provides accurate, consistent, near real-time data from UFMS, and summary data from HIGLAS and NBS, supporting over 1,500 users across the Department, with plans to have over 2,000 users by the end of 2015.

Systems Policy and Compliance

- *Strategy*: HHS has placed a high-priority on maturing and enhancing its financial systems control environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress towards remediating the Department's IT Material Weakness. HHS is implementing a policy management program to standardize development, implementation, and monitoring of financial systems policies.

- *Progress*: HHS addresses the Department's IT material weakness by analyzing audit findings, identifying root causes, and implementing solutions collaboratively. The FGB chartered an IT Material Weakness Working Group (MWWG), with members from OpDiv Chief Information Officer (CIO), Chief Financial Officer (CFO), and Chief Information Security Officer (CISO) communities. The IT MWWG developed a roadmap to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. HHS has also initiated projects to develop role-based security controls and identify areas to enhance and automate additional internal controls.

Legal Compliance

Anti-Deficiency Act

The *Anti-Deficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found at www.gao.gov/legal/anti-deficiency-act/about.

HHS management is taking necessary steps to prevent future violations. With respect to three possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

Digital Accountability and Transparency Act of 2014

The *DATA Act* expands the *Federal Funding Accountability and Transparency Act of 2006* to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on www.USAspending.gov. Among other goals, the *DATA Act* aims to improve the quality of the information on www.USAspending.gov, as verified through regular audits of the posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the *DATA Act* accelerated the referral of delinquent debt owed to the federal government to the Treasury's Offset Program (TOP) after 120 days of delinquency.

HHS is actively implementing requirements of the *DATA Act*. One of the Department's initial moves was to establish the *DATA Act* PMO to facilitate a collaborative Department-wide approach to implementation. We have updated applicable Department financial management policy, reduced our delinquent debt referral window from 180 days to 120 days, and we are auditing the information on www.USAspending.gov. HHS also revamped our ATM to facilitate data standards throughout the Department.

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

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment. The *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA), and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), requires federal agencies to review their programs and activities, identify programs that may be susceptible to significant improper payments, perform testing of programs considered high risk, and develop and implement corrective action plans for high risk programs. HHS is striving to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Improper Payments Information Act Report."

Patient Protection and Affordable Care Act

The *Affordable Care Act* implements comprehensive health care reform to make quality health care more affordable and accessible. The *Affordable Care Act* includes provisions for a patient's bill of rights, a Health Insurance Marketplace, tax credits for low-income Americans, incentives for high-quality care from physicians, and expansion of the Medicaid program, helping to provide access to affordable health insurance options for all Americans.

The *Affordable Care Act* also aims to reduce health care fraud, waste and abuse by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, improving the monitoring of providers, and using predictive modeling technology to target suspect behaviors. These efforts have enabled the government to recover billions of dollars related to improper payments over the last five years. For detailed information on improper payment recovery efforts, see the "Program-Specific Reporting Information" section of the "Improper Payments Information Act Report."

A key aspect of the *Affordable Care Act* allows eligible Americans to receive a premium tax credit when purchasing their health insurance coverage through the Health Insurance Marketplace. The amount of the credit can be paid in advance directly to the consumer's health insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service (IRS) on this process.

HHS has implemented many provisions of the *Affordable Care Act*. For more information about implementation of the many *Affordable Care Act* provisions, visit the "Key Features" page at www.hhs.gov/healthcare/facts/timeline/timeline-text.html.

Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA) passed Congress in December 2014 and OMB followed with final implementation guidance in June 2015. FITARA established an enterprise-wide approach to federal IT investments and provides the CIO of *CFO Act* agencies with greater authority over IT investments, including authoritative oversight of IT budgets and budget execution, as well as IT-related personnel practices and decisions. FITARA also promotes cross-functional partnerships between CIOs and senior agency officials to facilitate the enterprise-wide approach to IT management. HHS's senior officials, including the CIO, CFO, Chief Human Capital Officer, and Chief Acquisition Officer, have collaborated on a FITARA Implementation Plan, which the Department is coordinating with OMB for approval.

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

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

In September 2014, the U.S. Government Accountability Office (GAO) released an updated edition of its *Standards of Internal Control in the Federal Government*, effective FY 2016. The document includes several new principles and priorities, including a focus on a framework for Enterprise Risk Management (ERM). OMB is also expected to release in FY 2016 an updated version of Circular A-123, titled *Management's Responsibility for Risk Management and Internal Control*. The new Circular will complement GAO's *Standards*, and will implement requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of ERM. The Department and its OpDiv and StaffDiv stakeholders will coordinate and collaborate to implement the new requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially

comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to risk management. Based on thorough ongoing internal assessments and FY 2015 audit findings, HHS provides reasonable assurance that controls are operating effectively. For further information, see the "Management Assurances" section. We are actively engaged with our OpDivs to correct the identified weakness, supported by a renewed emphasis on a stringent corrective action process focused on addressing the true root cause of deficiencies along with active management oversight. More information on Department's internal control efforts and the HHS Statement of Assurance follows.

Nearly half of U.S. adults do not have the resources and plans in place in the event of an emergency. Emergency kits should include a three-day supply of food and water, flashights, chargers, and a first aid kit.

Internal Control

FMFIA requires agency heads to annually evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. Since FY 2006, HHS has performed rigorous evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Internal Control*.

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

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2015 OMB Circular A-123 assessment and the financial statement audit reported one material weakness in Information System Controls and Security, which also constitutes a non-conformance under Section 4 of FMFIA. Additionally, HHS recognizes one material noncompliance with IPIA regarding Error Rate Measurement. These material findings were also reported in FY 2014.

DID YOU KNOW

Flu season usually peaks in January or February, but it can occur as late as May. Early immunization is most effective, but it is not too late to get the vaccine in December, January, or February. Everyone over 6 months of age is recommended to get the vaccine every year.

Visit flu.gov to use the flu vaccine finder.

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

Secretary Burwell receives her flu shot.

MANAGEMENT ASSURANCES

Statement of Assurance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the *Federal Managers' Financial Integrity Act* (FMFIA) and Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*. These objectives are to ensure (1) effective and efficient operations; (2) compliance with applicable laws and regulations; and (3) reliable financial reporting. The safeguarding of assets is a subset of these objectives.

As required by OMB Circular A-123, HHS has evaluated its internal control and financial management systems to determine if these objectives are being met. The Department provides reasonable assurance that internal controls were operating effectively as of September 30, 2015, with the exception of one material weakness related to Information System Controls and Security (which also constitutes a system non-conformance) and one material noncompliance with the *Improper Payments Information Act* (IPIA) related to Error Rate Measurement.

Remediation for the material weakness is underway, as described in the "Corrective Action Plans for Material Deficiencies" section. Remediation for the material noncompliance relies on a modification to legislation to require states to participate in an improper payment rate measurement.

Internal Control over Financial Reporting (ICOFR)

HHS conducted its assessment of the effectiveness of ICOFR, which includes safeguarding assets and compliance with applicable laws and regulations, in accordance with the requirements of OMB Circular A-123, Appendix A. Other than the one material weakness mentioned above, the Department provides reasonable assurance that internal controls over financial reporting were operating effectively as of June 30, 2015.

Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular A-123. Other than the one material weakness and the one material noncompliance mentioned above, the Department provides reasonable assurance that internal control over operations and compliance with applicable laws and regulations was operating effectively as of September 30, 2015.

Federal Financial Management Improvement Act of 1996 (FFMIA)

FFMIA requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. As mentioned above, HHS identified one material weakness, which also constitutes a system non-conformance under FMFIA, Section 4, and as a result determined that its financial management systems neither fully comply with the FFMIA, nor fully conform to the objectives of FMFIA, Section 4. The Department is nearing completion of a phased, enterprise-wide financial system upgrade that will address many factors contributing to the material weakness, with stabilization expected in Fiscal Year (FY) 2016.

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

/Sylvia M. Burwell/

Sylvia M. Burwell
Secretary
November 13, 2015

Summary of Material Weaknesses

Control Areas	FMFIA Section 2			FMFIA Section 4
	Financial Reporting (As of 6/30/2015)	Operations (As of 9/30/2015)	Compliance (As of 9/30/2015)	System Non-Conformance (As of 9/30/2015)
1. Information System Controls and Security	**1**	**1**	0	**1**
2. Error Rate Measurement	0	0	**1**	0

1. Information System Controls and Security

HHS acknowledges a material weakness related to Information System Controls and Security. This material weakness includes general and application controls specifically related to segregation of duties, access controls, and configuration management, as well as other information system security weaknesses that were identified through the annual *Federal Information Systems Control Audit Manual*, *Federal Information Security Management Act* (FISMA), and other internal management reviews. While no single financial management system had a material weakness, the pervasive nature of the deficiencies throughout the Department leads management to conclude that these aggregate deficiencies warrant classification as a material weakness under Section 2 of FMFIA and a non-conformance under Section 4 of FMFIA. While the Department has made progress in the remediation of this material weakness, our financial management systems are not yet in substantial compliance with FFMIA and its associated regulatory guidelines.

2. Error Rate Measurement

HHS did not identify any material weaknesses in our internal control over compliance with applicable laws and regulations; however, HHS reports a statutory limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in one material noncompliance with IPIA. The TANF program is not reporting an error rate for FY 2015, as required by IPIA, because statutory limitations currently prohibit HHS from requiring states to provide information needed for determining a TANF improper payment measurement.

Corrective Action Plans for Material Deficiencies

1. Information System Controls and Security

HHS has placed a high priority on remediating the Information System Controls and Security material weakness and maturing its financial systems control environment through strengthening policy, proactively monitoring emerging issues, and ensuring progress toward correcting deficiencies contributing to the material weakness. A Department-wide IT Material Weakness Working Group (MWWG) was established in FY 2015 with members from the Chief Financial Officer, Chief Information Officer, and Chief Information Security Officer communities to collaboratively identify challenges, conduct root cause analyses, and jointly implement comprehensive solutions. In FY 2015, the IT MWWG developed a roadmap for improving the financial systems safeguards related to segregation of duties, access controls, configuration management, and FISMA weaknesses that contribute to the Information System Controls and Security material weakness.

Additional efforts are required beyond FY 2015 to address the range of challenges stemming from HHS's Information System Controls and Security material weakness and system non-conformance. In FY 2016, HHS will continue its collaborative efforts to identify high risk areas within the HHS financial systems environment, develop remediation plans, and monitor corrective action implementation to meet the Department's objectives. HHS will continue to report remediation progress to the Risk Management and Financial Oversight Board and maintain accountability and commitment to strengthen the HHS financial systems environment.

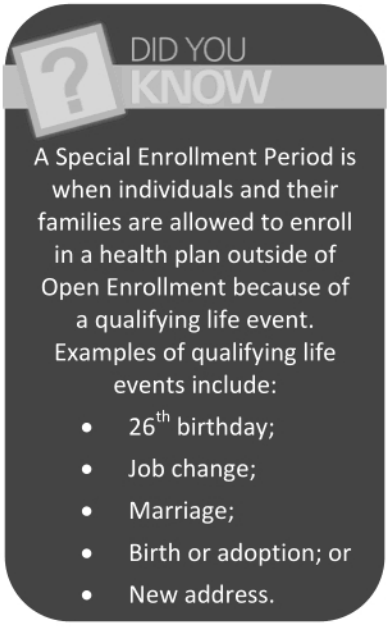
2. Error Rate Measurement

Current statutory limitations restrict corrective actions HHS can take to develop an error rate for TANF. HHS plans to encourage Congress to consider statutory modifications that would allow for reliable error rate measurement when legislation is considered to reauthorize TANF.

LOOKING AHEAD TO 2016

HHS is the U.S. government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. Guided by the HHS Strategic Plan, 2016 will be crucial in supporting continuing Health Insurance Marketplace operations as well as many other efforts in a number of exciting and challenging areas.

Strengthen Health Care



HHS is responsible for implementing many of the provisions included in the *Affordable Care Act,* which makes health insurance coverage more secure and reliable for Americans, makes coverage more affordable and accessible for families and small business owners, and helps bring down health care costs. The *Affordable Care Act* also expands consumer choice, supports informed decision making, and increases health insurance coverage for low-income populations, partly through the expansion of Medicaid eligibility and the advent of the Health Insurance Marketplace, which launched on October 1, 2013. Medicaid enrollment has grown from 57.8 million enrollees in September 2013 to 70.0 million enrollees in January 2015, which represents a 21 percent growth in enrollment.

As of June 30, 2015, about 9.9 million Americans had effectuated Health Insurance Marketplace coverage through the Health Insurance Marketplaces established by the *Affordable Care Act*. The Department is also working to strengthen the ties between Medicare payments and value as opposed to volume, a shift made possible by the *Affordable Care Act* and the *Medicare Access and CHIP Reauthorization Act* (MACRA).

In an effort to improve access to health care, the Department continues to make significant investments in new access points and expanded services, including funding for substance abuse treatment and care, which is critical to combatting the opioid epidemic affecting our country, especially in rural communities.

Advance Scientific Knowledge and Innovation

HHS is working to advance scientific knowledge and innovation to prevent, diagnose, and treat diseases and disorders as well as address emerging health threats, and sustain a vital and cutting edge workforce and scientific infrastructure. Future HHS plans include accelerating the development of opportunities for the prevention and treatment of substance use and abuse, researching Alzheimer's disease and related dementias, as well as human immunodeficiency virus (HIV) and reversing the national epidemic of obesity and diabetes. Research will also address health disparities, multiple chronic conditions, and cardiovascular disease, all critical health priorities facing America. In order to build on past successes, the Department will encourage initiatives focused on the President's priority areas of Precision Medicine as well as the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The Department will also encourage advancements associated with the Cures Acceleration Network, the National Library of Medicine, and expanding the number of competing research project grants.

Advance the Health, Safety, and Well-Being of the American People

HHS's focus will continue aligning with the Surgeon General's National Prevention Strategy, which seeks to create environments that promote healthy behaviors such as preventing and reducing tobacco use, and implementing a 21st century food safety system to reduce foodborne illness in the population. HHS will also help Americans achieve and maintain healthy weight through school-based, workplace-based, and community-based strategies.

Nurse Nina Pham is discharged from NIH after being successfully treated for Ebola.

HHS plays a crucial role in global health security. Through the Biomedical Advanced Research and Development Authority (BARDA), the Department provides an integrated, systematic approach to the advanced development and purchase of necessary vaccines, drugs, therapies, and diagnostic tools. BARDA, along with HHS and industry partners, is developing, manufacturing, and storing medical countermeasures for chemical, radiological, biological, and nuclear threats; pandemic influenza; and emerging infectious threats, and is also working to provide new options to treat antibiotic-resistant infections. The Department will also continue its effort to promote global well-being and health diplomacy, as well as create a nimble system better able to respond to unanticipated demands.

DID YOU KNOW

Measles is still common in many parts of the world. Unvaccinated travelers continue to get measles in other countries and bring the disease into the U.S.

HHS plans to continue investing in efforts to prevent and manage chronic diseases and conditions, enhancing clinical efforts including childhood and adult immunizations, threat detection and response, and supporting behavioral and primary health integration. These efforts will support overall public health as well as protect Americans' health and safety during emergencies, and foster resilience in response to emergencies. Health at all ages is a priority for the Department. Continued partnering between HHS and state, local, tribal, urban Indian, and other service providers will sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity, and ensure their healthy development from birth through transition to adulthood. Health and early intervention services ensure children get off to a good start from infancy. To support this, HHS will maintain efforts to improve the quality of early childhood education for all children, and other efforts that will put children and youth on the path to successful futures, such as improving access to care, treatment, and services for children and youth exposed to traumatic events. Furthermore, by implementing evidence-based strategies in home visiting, foster care, and teen pregnancy prevention, HHS will ensure that this population is given the chance to succeed in adulthood and can contribute to America's success. Community living for older adults and people with disabilities will continue to be a focus area as the U.S. population over the age of 65 is projected to increase by 29 percent between 2012 and 2020.

Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

DID YOU KNOW

An average of 22 minutes of brisk walking a day can significantly reduce the risk for chronic disease.

As we near the end of this Administration, HHS leadership is committed to leaving the Department in a strong position to continue its vital work. To do this, HHS will stay committed to developing effective systems, workforce, and infrastructure that can address complicated and emerging challenges. These efforts will allow HHS to continue toward its goal of improved health and well-being among Americans. Specifically, HHS will continue its evaluation efforts, including program integrity reviews that ensure compliance with federal program integrity regulations and identify areas to improve efficiency and effectiveness. Additionally, HHS is entrusted with a wealth of sensitive data, including personally identifiable information, financial and patient data, and biodefense research; ensuring its security is a high priority. As cybersecurity threats are constantly evolving and becoming more sophisticated, the Department will need to continually hone the skills necessary to monitor threats and quickly respond to a changing environment.

While continuing the spirit of collaboration from stakeholders throughout the Department, HHS will pursue seven APGs for FY 2016 – FY 2017. These efforts support significant improvements in near-term outcomes and advanced progress toward longer-term, outcome-focused strategic objectives. These APGs include efforts around the following areas:

- Early Childhood Education
- Combustible Tobacco Use
- Foodborne Illness
- Health Care Payment Reform
- Combating Antibiotic-Resistant Bacteria
- Opioid Abuse
- Serious Mental Illness

More information on the FY 2016 – 2017 APGs is available on www.performance.gov.

FDA field inspectors check shipments of imported seafood.

ANALYSIS OF FINANCIAL STATEMENTS AND STEWARDSHIP INFORMATION

The financial statements, which include the Consolidated Balance Sheets, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as the Notes discussed in this section, are prepared in conformity with U.S. generally accepted accounting principles (GAAP) established by the Federal Accounting Standards Advisory Board (FASAB). These financial statements and Notes are audited by the independent accounting firm of Ernst & Young LLP, under the direction of the Office of Inspector General. The *CFO Act* requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management.

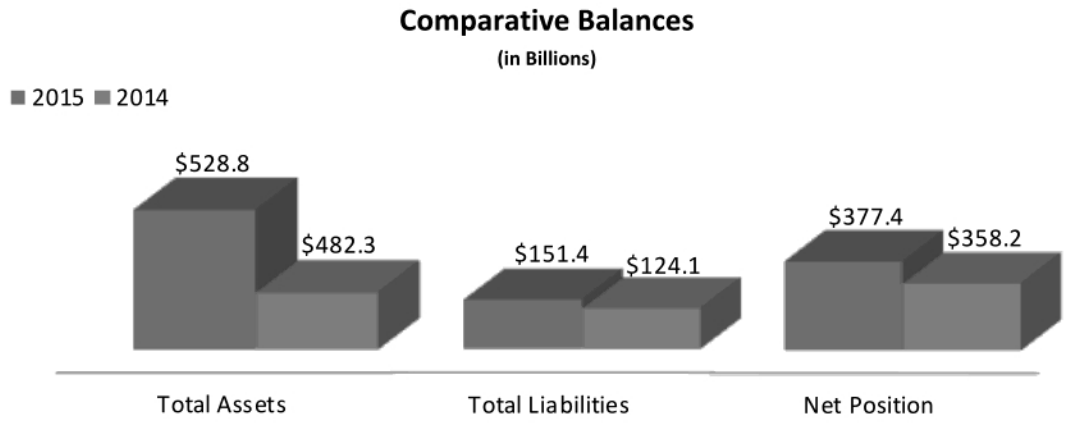
Accurate, timely, and reliable financial information is necessary for making sound decisions, assessing performance, and allocating resources. The "Financial Section" of this report presents our audited financial statements and Notes. The analysis within this section is a summary of those audited statements and highlights certain significant balances and variances; supplemented by graphic presentations and explanations which help clarify their relevance to HHS.

Through OS and its 11 OpDivs, HHS administers over 300 programs for the benefit of the American people. CMS is the largest OpDiv, which oversees a significant share of the Department's financial activity. Fluctuations in the financial statements for FY 2015 over FY 2014 are primarily the result of program growth and changes at CMS. Year-over-year summary changes for each HHS financial statement are discussed in the following sections. Greater detail can be found in the "Notes to the Principal Financial Statements" in the "Financial Section" of this report.

Balance Sheets

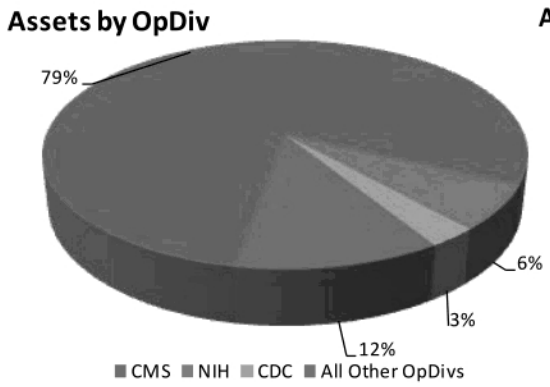
The table below summarizes current and prior year information concerning components of our financial condition as of September 30 each year. The components of the Consolidated Balance Sheets are the assets under HHS authority, the responsibilities owed by the Department, and the difference between them, or net position.

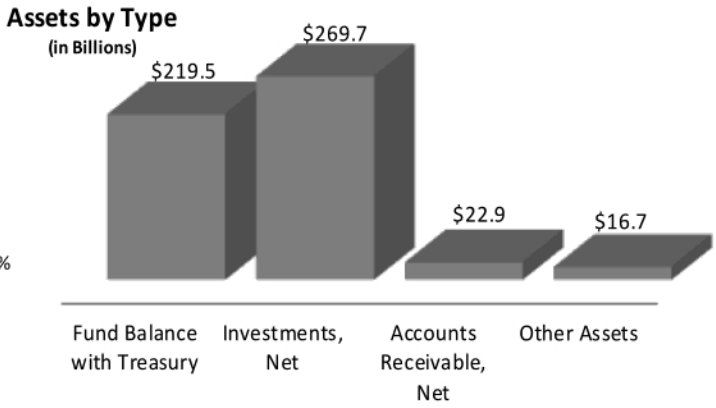
Financial Condition Summary			Change (2014-15)	
(in Billions)	2015	2014	$	%
Fund Balance with Treasury	$219.5	$177.0	$42.5	24%
Investments, Net	269.7	278.9	(9.2)	(3)%
Accounts Receivable	22.9	11.1	11.8	106%
Other Assets	16.7	15.3	1.4	9%
Total Assets	**$528.8**	**$482.3**	**$46.5**	**10%**
Accounts Payable	$0.9	$1.0	($0.1)	(10)%
Entitlement Benefits Due and Payable	108.1	91.0	17.1	19%
Accrued Liabilities	14.3	3.3	11.0	333%
Federal Employee and Veterans' Benefits	12.1	12.0	0.1	1%
Other Liabilities	16.0	16.8	(0.8)	(5)%
Total Liabilities	**$151.4**	**$124.1**	**$27.3**	**22%**
Net Position	**$377.4**	**$358.2**	**$19.2**	**5%**
Total Liabilities & Net Position	**$528.8**	**$482.3**	**$46.5**	**10%**



Assets

Assets represent the value of what we own and manage. Our total assets were $528.8 billion on September 30, 2015. This amount represents an increase of $46.5 billion or approximately 10 percent greater than last year's assets. We have experienced a slight change in the overall composition of our assets in FY 2015 compared to FY 2014. The Fund Balance with Treasury (FBwT) and Net Investments together currently comprise 93 percent of our total assets, versus 95 percent in FY 2014.





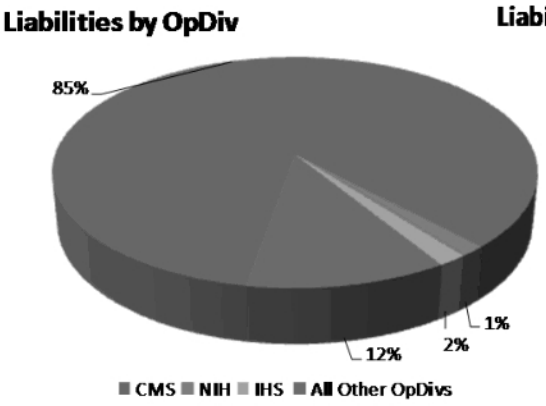
The majority of the increase in FBwT is attributable to a $36.2 billion increase in CMS's FBwT related primarily to Supplementary Medical Insurance (SMI), CHIP, and Medicaid increases of $25.0, $5.6, and $5.1 billion; respectively. Other notable changes in the FBwT include a $1.8 billion direct appropriation increase for CDC to support the Emergency Ebola Response and Preparedness.

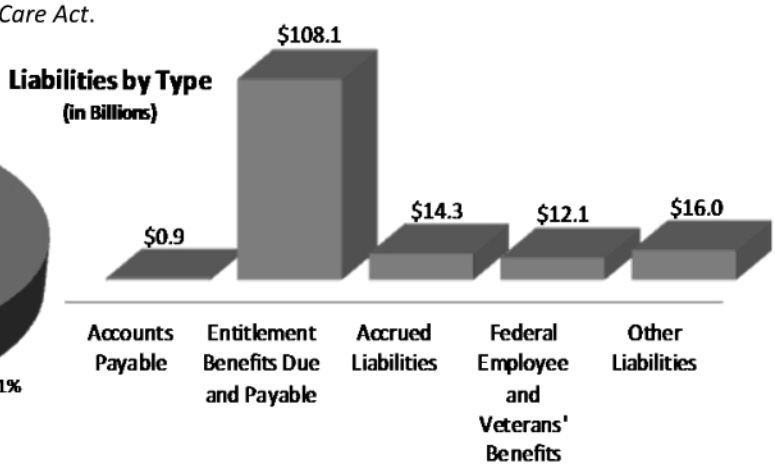
Out of the $11.8 billion Accounts Receivable increase, $11.0 billion is attributable to CMS. This is largely attributable to the $10.0 billion Accounts Receivable increase related to the *Affordable Care Act*. FY 2015 Other Assets, totaling $16.7 billion, consist of: Inventory and Related Property ($9.5 billion); General Property, Plant and Equipment (PP&E) ($5.9 billion); and Other Assets such as Travel Advances and Direct Loans (totaling $1.3 billion).

HHS reports PP&E exclusive of Stewardship Land, which comprises land held by IHS for providing health services to American Indians and Alaska Natives. HHS invests in other stewardship assets such as, Investments in Human Capital and in Research and Development. A discussion of stewardship assets is presented in Note 20 and in the "Required Supplementary Stewardship Information" within the "Financial Section."

Liabilities

Our liabilities, or amounts that we owe from past transactions or events, were $151.4 billion on September 30, 2015. This represents an increase of $27.3 billion, or 22 percent more than the FY 2014 liabilities, primarily due to the Entitlement Benefits Due and Payable at CMS ($17.1 billion) for SMI, Medicaid, and Hospital Insurance (HI) claims Incurred But Not Reported (IBNR), and for the Risk Corridor, Reinsurance, and Risk Adjustment programs within the *Affordable Care Act*.





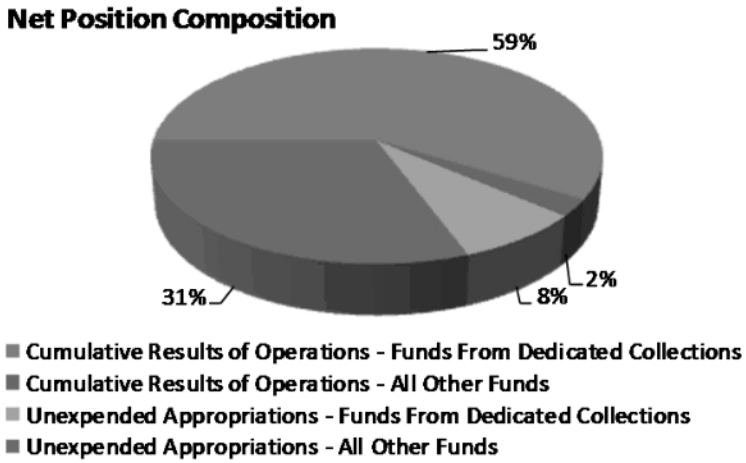
Accrued Liabilities increased by $11.0 billion, largely as a result of the addition of the FY 2015 liabilities related to the Reinsurance and Risk Adjustment programs associated with the *Affordable Care Act* ($10.4 billion).

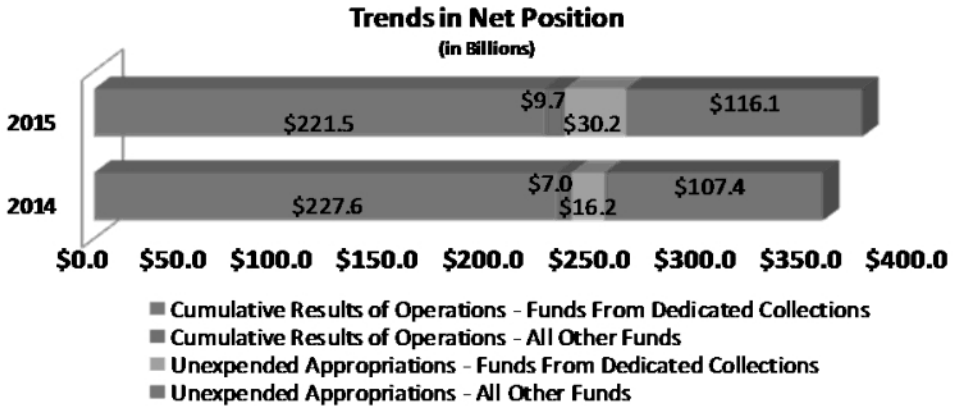
Consistent with federal accounting standards, we recognize the responsibility for future program participants of Medicare as a social insurance program, rather than a pension program. Accordingly, we have not recognized a liability for future payments to current and future program participants. The estimated long-term cost for Medicare is included in the Statement of Social Insurance and discussed later in this analysis. A more extensive discussion is provided in the "Notes to the Principal Financial Statements" located in the "Financial Section" of this report.

Statement of Changes in Net Position

Our net position represents the difference between assets and liabilities. Changes in our net position result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Our net position increased by $19.2 billion (5 percent), from $358.2 billion in FY 2014 to $377.4 billion in FY 2015.

The net position increase of $19.2 billion is comprised of an increase in Funds From Dedicated Collections ($251.7 billion in FY 2015 compared to $243.8 billion in FY 2014) and an increase in All Other Funds ($125.8 billion in FY 2015 compared to $114.4 billion in FY 2014).





The significant changes within Unexpended Appropriations are primarily related to increases in Appropriations Received ($93.9 billion) and Appropriations Used ($80.4 billion) at CMS. These changes included an increase in Appropriations Received for Medicaid ($78.4 billion) and Medicare ($14.9 billion). Additionally, the OS received higher appropriations for the Community Health Center Fund and Public Health and Social Services Emergency Fund (mainly for Ebola response) for a $2.2 billion combined increase. The increase in Appropriations Used primarily relates to an increase of $46.1 million for Medicaid as a result of expansion associated with the *Affordable Care Act*.

Statement of Net Cost

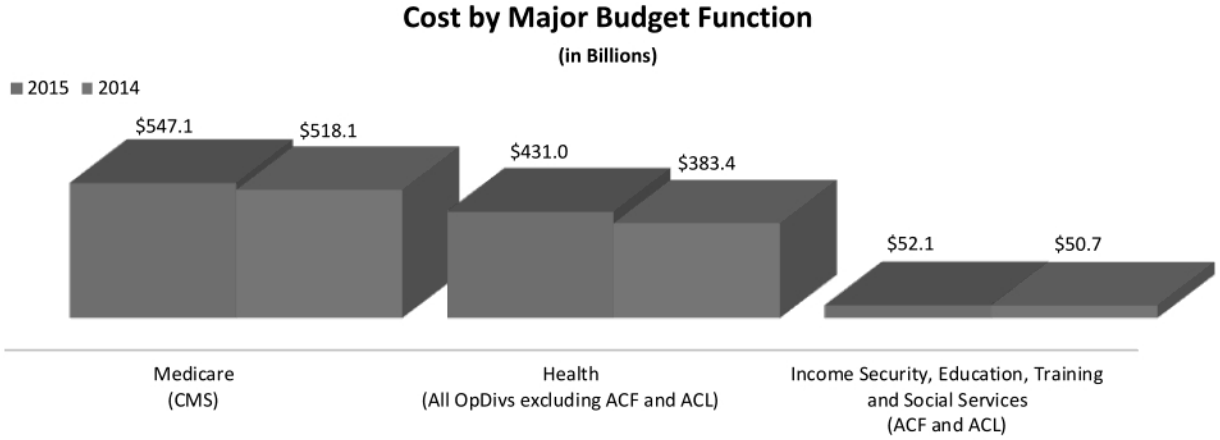
Our Net Cost of Operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Net Cost of Operations for the year ended September 30, 2015, totaled $1.0 trillion.

Net Cost of Operations (in Billions)	2015	2014	Change (2014-15) $	Change (2014-15) %
Responsibility Segments:				
CMS Gross Cost	$1,011.3	$910.5	$100.8	11%
CMS Exchange Revenue	(98.0)	(73.3)	(24.7)	34%
CMS Net Cost of Operations	**$913.3**	**$837.2**	**$76.1**	**9%**
Other Segments:				
Other Segments Gross Cost	$120.7	$120.5	$0.2	0% *
Other Segments Exchange Revenue	(4.0)	(5.7)	1.7	(30)%
Other Segments Net Cost of Operations	**$116.7**	**$114.8**	**$1.9**	**2%**
Net Cost of Operations	$1,030.0	$952.0	$78.0	8%

* Change less than 1 percent

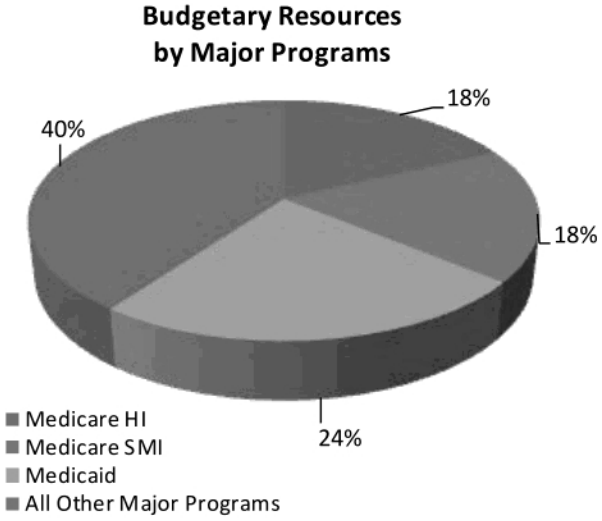
The table above presents our FY 2015 Consolidated Net Cost of Operations by responsibility segments (OpDivs). Gross costs less exchange revenue for CMS increased by $76.1 billion between FY 2015 and FY 2014. There was a nominal increase in total net cost of operations for the remaining HHS segments (excluding CMS) at approximately $1.9 billion. The majority of FY 2015 net costs relate to benefit expenses for CMS's programs.

HHS classifies costs by major budget functions such as Medicare, Health, Education, and Income Security. The table below depicts consolidating costs by major budget function, comparatively between FY 2015 and FY 2014. Total costs for Medicare ($547.1 billion) and Health ($431.0 billion) programs account for almost 95 percent of our annual net costs. The Health budget function increased 12 percent ($47.6 billion), primarily due to increases in Medicaid. During FY 2015, the Medicare budget function increased 6 percent ($29.0 billion), primarily due to increases in the SMI benefit expenses and Medicare Part D administrative expenses. For more information on the budget functions, see the "Consolidating Statement of Net Cost by Budget Function" in the "Other Information" section of this report.



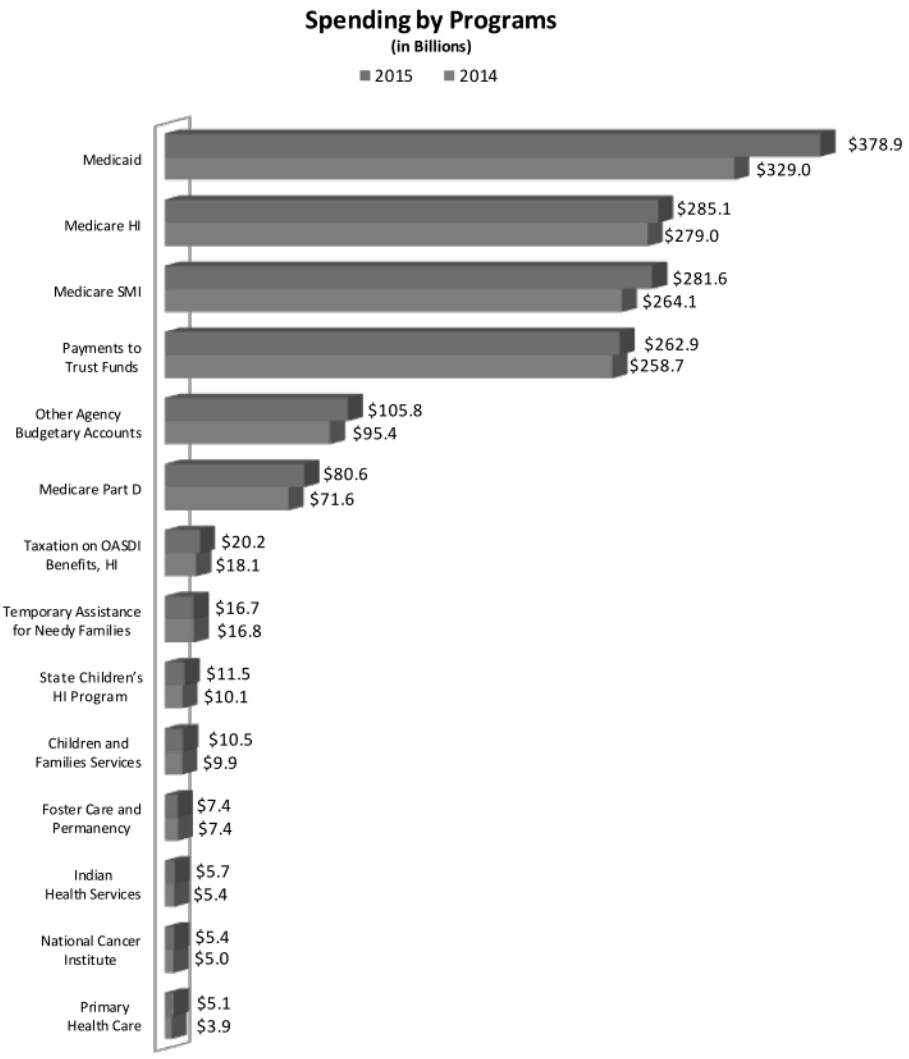
Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information on availability of budgetary and non-budgetary resources at the end of the year. FY 2015 total resources were $1.5 trillion, representing an increase of $130.8 billion, or 9 percent, over FY 2014. Total obligations in FY 2015 were $1.5 trillion, an increase of $103.1 billion, or 8 percent as compared to FY 2014. These significant changes in resources are related primarily to the increase in funding for Medicare and Medicaid programs within CMS and the appropriations for Emergency Ebola Response and Preparedness and Public Health Service Evaluation funds at CDC. The chart below shows the percentage of budgetary resources by major programs. For further details, see the "Combining Statement of Budgetary Resources" in the "Financial Section" of this report.



Schedule of Spending

The Schedule of Spending (Note 23) presents an overview of how and where HHS has spent (obligated) money for the reporting period. The Chart to the right illustrates a summary of spending by select programs as of September 30, 2015 and 2014. Total obligations for this year were $1.5 trillion. This is an 8 percent increase over the $1.4 trillion in obligations for FY 2014.



Four major programs at CMS accounted for 82 percent of all HHS spending: Medicaid at 26 percent ($378.9 billion), Medicare HI at 19 percent ($285.1 billion), SMI at 19 percent ($281.6 billion), and Payments to Trust Funds[3] at 18 percent ($262.9 billion). The majority (91 percent) of all HHS spending was for Grants, Subsidies, and Contributions (47 percent) at $699.1 billion and Federal Assistance Direct Payments (44 percent) at $652.3 billion. For more information on services and items purchased, see the Combined Schedule of Spending by Object Class in the "Other Information" section of this report.

Statement of Social Insurance

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

Actuarial present values are computed under the intermediate set of assumptions specified in the Annual Report of the Medicare Board of Trustees. The basis for the projections in the Trustees Report has changed since last year

[3] Payments to Trust Funds include appropriations resulting from the *Social Security Act*, *Health Insurance Portability and Accountability Act of 1996* (HIPAA), and *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA) legislation to provide payments to HI and SMI trust funds.

due to the enactment of the *Medicare Access and CHIP Reauthorization Act (MACRA) of 2015*. This law repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments, which were usually modified, and replaced it with specified payment updates for physicians. The projections shown in last year's Trustees report reflected a projected baseline scenario, which assumed an override of the SGR payment provisions. With the enactment of MACRA, the projections in this year's report are based on current law (for more information, see Notes 24 and 25 of the "Financial Section").

The Statement of Social Insurance presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(3.8) trillion, determined as of January 1, 2014, to $(3.2) trillion, determined as of January 1, 2015.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2015, of future cash flow for all current and future participants to $(2.9) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(8.6) trillion.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The table below shows the HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the FY to the expenditures for the year. This ratio has steadily dropped from 107 percent at the beginning of FY 2011 to 74 percent at the beginning of FY 2015.

Trust Fund Ratio Beginning of Fiscal Year					
	2011	**2012**	**2013**	**2014**	**2015**
HI	107%	95%	86%	77%	74%

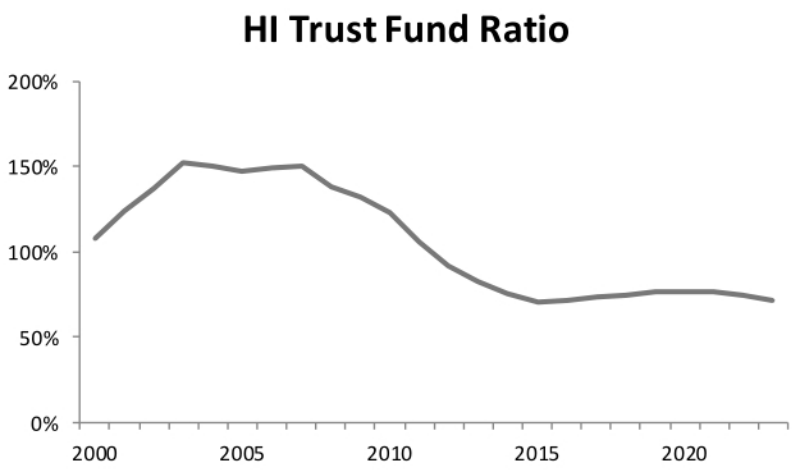
Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short-term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2015 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2015 Trustees Report, the HI Trust Fund ratio is estimated to continue decreasing through the beginning of 2017 and remain at approximately 70 percent through 2022. From the end of 2014 to the end of 2024, assets are expected to increase, from $197.3 billion to $290.0 billion.

Long-Term Financing

The short-range outlook for the HI Trust Fund is about the same as projected last year. After 2022, the trust fund ratio starts to decline quickly until the fund is depleted in 2030, the same date projected last year. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost exceeded total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2024 and later. When the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 86 percent in 2030 to 79 percent in 2039 and then to increase to about 84 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3 percent in 2014 to about 2 percent by 2089. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.0 trillion, which is less than 1 percent of taxable payroll and Gross Domestic Product (GDP) over the same period.



Significant uncertainty surrounds the estimates for the Statement of Social Insurance. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for all categories of Part A providers by the growth in economy-wide private nonfarm business multifactor productivity—will occur as the *Affordable Care Act* requires. The Trustees believe that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. However, if the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, and if the provider reimbursement rates paid by commercial insurers continue to follow the same negotiated process used to date, then the availability and quality of health care received by Medicare beneficiaries would, under current law, fall over time relative to that received by those with private health insurance.

SMI Trust Fund Solvency

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

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D appropriation has generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, General Fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(24.8) trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid growth in SMI expenditures as a percent of GDP. In 2014, SMI expenditures were 2 percent of GDP. By 2089, SMI expenditures are projected to grow to 4 percent of the GDP. The table below presents key amounts from CMS's basic financial statements for FY 2013 through 2015.

Table of Key Measures[4]

Financial Condition Summary (in Billions)	2015	2014	2013
Net Position (end of fiscal year)			
Assets	$418.6	$380.0	$370.2
Less Total Liabilities	129.1	104.7	88.3
Net Position (assets net of liabilities)	$289.5	$275.3	$281.9
Change in Net Position (end of fiscal year)			
Net Costs	$913.8	$837.8	$779.8
Total Financing Sources	910.3	820.4	756.1
Change in Net Position	($3.5)	($17.4)	($23.7)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	($3,187.0)	($3,822.9)	($4,771.8)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	($3,822.9)	($4,771.8)	($5,581.2)
Change in present value	$635.9	$948.9	$809.4

[4] The Table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.

Statement of Changes in Social Insurance Amounts

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

The present value as of January 1, 2015, would have decreased by $202.2 billion due to advancing the valuation date by one year and including the additional year 2089, by $82.1 billion due to changes in the projection base, and by $35.2 billion due to the changes in demographic assumptions. However, changes in economic and health care assumptions and legislation changes increased the present value of future cash flows by $754.6 billion and $200.8 billion, respectively.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, *Accounting for Social Insurance* (as amended by SFFAS Number 37, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the Medicare trust funds – HI and SMI. The "Required Supplementary Information" section presents required long-range cash flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the "Required Supplementary Information" section. The "Required Supplementary Information" section assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

Limitation of the Principal Financial Statements

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

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

Financial Section

About the photo

Secretary Burwell takes the stage at the 2015 White House Conference on Aging.

In This Section

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MESSAGE FROM THE CHIEF FINANCIAL OFFICER

The Department of Health and Human Services (HHS or the Department) oversees one of the largest budgets in the world, managing one of every four dollars spent by the federal government. This Agency Financial Report (AFR) represents our accountability in reporting for Fiscal Year (FY) 2015. To complement the AFR, we will publish the FY 2015 *HHS Summary of Performance and Financial Information*, along with the FY 2017 *Congressional Budget Justification* and *Annual Performance Plan and Report* in February 2016.

The Department was recently recognized for demonstrating excellence in all aspects of accountability and transparency by the Association of Government Accountants (AGA). HHS was awarded AGA's *Certificate of Excellence in Accountability Reporting* for our FY 2014 AFR. Our Chief Financial Officer (CFO) community collaboratively manages financial accountability, transparency, compliance, and risk across the Department by prioritizing resources to drive mission results. We are dedicated to working together as a CFO community to improve Department-wide operations, financial reporting and systems, with the overall goal to consistently strengthen internal control, maintain data integrity, increase data transparency, and report reliable information on a timely basis. During FY 2015, we took on new initiatives, achieved many key milestones, and worked to address audit deficiencies. We discuss our plans for continuing to correct audit weaknesses and non-compliances in the "Management's Discussion and Analysis" section of the AFR. Examples of our drive for excellence include:

- Implementing Enterprise Risk Management (ERM) across the Department, and making great strides in developing our standard risk language and vision for the HHS ERM program. These ERM initiatives will help us better understand and mitigate risks in our operational environment.
- Upgraded 2 of 3 instances of our commercial off-the-shelf software supporting the Department's core financial system during FY 2015, with the third instance on-schedule to be upgraded in FY 2016. The upgrades are key components of the Department-wide strategy to mature our overall financial systems environment and ensure the continued reliability, availability, and security of our core financial system. We also expanded the use of business intelligence to further enhance the availability and analysis of financial management information to facilitate effective decision making.
- Established a Program Management Office (PMO) to oversee implementation of the *Digital Accountability and Transparency Act* (*DATA Act*). The *DATA Act* PMO operates in partnership with Operating Divisions, Staff Divisions, and system business owners to ensure government-wide data standards, data exchange, and data reporting requirements are met and implemented. Additionally, the DATA Act PMO serves as the Federal Government's executing agent of the Section 5 Grants Pilot. Launched the Common Data Element Repository (CDER) Library. The CDER Library is a government-wide online, searchable repository for data standards, definitions, and context. Currently, the CDER Library can identify data elements within the universe of grant forms, as defined by the Section 5 Grants Pilot.
- Initiated the review, update, and development of HHS policies in financial management, grants, and acquisitions to ensure compliance with applicable federal regulations and guidance.
- Began the transition from Government-wide Accounting to the Central Accounting and Reporting System. This change will standardize Treasury Account Symbol formatting and allows agencies to report transactions in real-time to the U.S. Department of the Treasury.

This year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. Please refer to the "Report of the Independent Auditors," "Principal Financial Statements," and "Notes to the Principal Financial Statements," in this section for further information.

I want to thank our employees and our full range of partners for their efforts and collaboration throughout the FY. The achievements depicted in this report are a reflection of their tireless dedication to our mission and the American people. We are striving together to strengthen the Department's financial management capabilities and our stewardship of the resources entrusted to us.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 13, 2015

REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV 13 2015

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

FROM: Inspector General Daniel R. Levinson

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2015 (A-17-15-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2015 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP (Ernst & Young), to audit the HHS (1) consolidated balance sheet as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 15-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2015 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. As presented beginning in notes to the financial statements, with respect to the estimates for the statement of social insurance as of January 1, 2015 and 2014, and the related Statement of Social Insurance Amounts, HHS management noted in the financial statement footnotes the Medicare Board of Trustees'

alternative scenario to illustrate, when possible, the potential understatement of Medicare cost and projection results. This scenario assumes that the various cost-reduction measures—the most important of which are the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. No. 114-10)—will occur as current law requires. Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

> The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the ACA's cost-reduction provisions would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014. Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in that program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, Ernst & Young identified a material weakness in HHS's financial information management systems and significant deficiencies in its financial reporting systems, analyses, and oversight and financial management close and review processes:

- *Financial Information Management Systems*—Ernst & Young noted that HHS had continued to make strides to improve controls that support the information technology infrastructure and financial application system. HHS Senior Leadership established a Material Weakness Working Group to provide an enterprise-wide focus on corrective actions. This additional focus has led to remediation of a number of deficiencies related to HHS financial information systems identified in past audits. For example, Ernst & Young noted that HHS had reviewed and updated critical entity-wide governance documentation, such as authorities that allow systems to operate, plans to account for and improve system security, and plans to improve configuration management. HHS also updated application-level contingency plans and backup policies and procedures and performed testing to improve redundancy and availability of the supporting Information Technology infrastructure and financial application systems. As in previous FYs, Ernst

& Young indicated a focused effort is still needed to completely remediate long-outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, configuration management, and access to HHS financial systems. The deficiencies identified represent a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2015 audit, Ernst & Young continued to note progress in certain areas to improve HHS's and its Operating Divisions' financial management processes. While progress has continued, the FY 2015 audit, as in prior years, identified internal control deficiencies in financial systems and processes for producing financial statements, including a lack of integrated financial management systems and insufficient analysis of certain accounts. Ernst & Young continued to note that HHS did not consistently perform controls to ensure that differences were properly identified, researched, and resolved in a timely manner and account balances were complete and accurate. Ernst & Young concluded that additional improvements in the financial reporting systems and processes are required. These deficiencies collectively constitute a significant deficiency in internal control.

- *Financial Management Close and Review Processes*—In FY 2015, Ernst & Young noted that the National Institutes of Health (NIH) upgraded its financial system, which required additional analysis to ensure that account balances recorded in the new system matched those shown at the U.S. Treasury. NIH also had a significant change in financial management personnel. These events caused NIH to identify account balances that did not correspond to those reported by Treasury. To correct these differences, NIH prepared and recorded a series of large manual journal entries. Ernst & Young found that NIH did not adequately research the differences or did not have sufficient support for the manual journal entries. Ernst & Young also found that for many of these manual journal entries, NIH did not follow the approval processes established by HHS. The deficiencies related to insufficient research, lack of adequate support, and not properly following HHS approval processes for manual journal entries collectively constitute a separate significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2015, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. One program, Medicare fee-for-service, reported an error rate of over 10 percent, a violation of IPIA. Five other high-priority programs reported error rates that did not meet their FY 2015 target error rates, another violation of IPIA. We will communicate further details on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2016. In addition, HHS's management determined that it may have potential violations of certain provisions of the Anti-Deficiency Act (P.L. No. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending and a potential violation related to the appointment of a presidentially

nominated official without the required confirmation. On the basis of the material weakness reported over Financial Information Management Systems and the significant deficiencies reported over Financial Reporting Systems, Analysis, and Oversight and the Financial Management Close and Review processes, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L No.104-208).

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 15-02, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2015 Agency Financial Report*.

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

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-15-00001.

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer

Sheila Conley
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Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to these financial statements.

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

As discussed in Note 24 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance and Supplementary Medical Insurance trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Chip Reauthorization Act (MACRA).

As further described in Note 25 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2015, 2014, 2013, 2012, and 2011, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 25, the ability of health care providers to sustain these price reductions will be challenging, as the best available

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evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to the passage of MACRA and may be necessary in the future if cost rates prove inadequate, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014.

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

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related changes in the social insurance program for the periods ended January 1, 2015 and 2014.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2015 and 2014, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Required Supplementary Information

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

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obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information and Other Information

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

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

The Other Information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 13, 2015, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 13, 2015

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 13, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 15-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented,

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or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Management Systems, described below, which we concluded to be a material weakness. We also identified certain deficiencies related to Financial Reporting Systems, Analyses, and Oversight, and Financial Management Close and Review Processes described below, which we concluded to be significant deficiencies.

Material Weakness

Financial Information Management Systems

The Department continued to make strides during fiscal year (FY) 2015 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. Senior leadership has established a Material Weakness Working Group (MWWG) tasked with monitoring remediation activities across all IT systems in scope of the Financial Statement Audit and Federal Information Security Management Act (FISMA). The MWWG has established an enterprise-wide focus on corrective actions that has led to the remediation of a number of deficiencies identified during past audits. The following summarizes some of the improvements achieved that resulted from this increased attention.

- Review and update of critical entity-wide governance documentation, such as System Security Plans, Configuration Management Plans and security documentation in support of system-level authority to operate

- Update of application-level contingency plans, backup policies, and procedures and the performance of testing to improve redundancy and availability of the supporting IT infrastructure and financial application systems.

While the MWWG has implemented specific action plans to decrease the number and severity of the deficiencies remaining in the significant financial systems, remediating the root cause of the deficiencies is an iterative process. A focused effort is still necessary to more completely remediate the long outstanding deficiencies in access controls, configuration management, and segregation of duties. The remaining deficiencies continue to constitute a material weakness in internal control. We grouped the deficiencies into topics and categories.

- Access controls
  - Inconsistently performing user access reviews, to monitor for access anomalies and suspicious activities

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  - Use of generic IDs, some with administrative access, that are not proactively monitored
  - Users maintaining multiple user IDs to the application and/or users with excessive access to applications that are not commensurate with their job roles and responsibilities
- Configuration management
  - Verification that no changes were made that did not go through the change approval and management process to include proactive monitoring of changes in support of those reviews
  - Lack of automated mechanisms to support change management activities
  - Inconsistent maintenance of the application-level or database-level baseline configuration
- Segregation of duties:
  - Lack of role-based security and established policies and procedures supporting role-based security
  - Inconsistent implementation of least privileged access considerations for all users and lack of documentation for business justifications for necessary conflicts

The following is a summary of the deficiencies that we considered most critical. When assessed in aggregate, we continue to conclude they could have a material effect on the financial statements and as a result this forms the basis for our conclusion of an IT material weakness:

- Access controls – Access controls exceptions were identified across the Unified Financial Management System (UFMS); HHS Consolidated Acquisition Solution (HCAS); Grants Administration Tracking and Evaluation System (GATES); GrantSolutions; Enterprise Human Resources & Payroll (EHRP); Information for Management, Planning, Analysis, and Coordination (IMPACII); National Institutes of Health Business System (NBS); and Consolidated Financial Reporting System (CFRS) systems. Specifically, UFMS and HCAS use Oracle Grid Control audit logs to monitor user access and activity; however, the audit logs are not reviewed/monitored on a consistent basis. Additionally, UFMS has a user that has multiple user IDs within the application that is not required to accomplish organizational missions / business functions, providing them access that is not commensurate with their job roles and responsibilities. EHRP and NBS user activity is not consistently reviewed for suspicious or malicious activity. Also, we noted that UFMS, HCAS, and GATES leverage the use of shared user IDs, some with privileged access, without monitoring user activity performed when using shared IDs. Additionally, we noted UFMS has a large number of generic IDs that are active, without a business need for the generic ID. EHRP had users with excessive access within the application that did not map back to the access provision on their user access request form on file, while GATES does not have detailed user access procedures in place for program administrators governing the new user access provisioning process. Similarly, CMS did not have sufficient evidence of regular management reviews of user access at both the Medicare contractors and the Central Office for appropriateness. In addition, procedures for adding or removing users were not consistently followed.

- Configuration management – Configuration management exceptions were identified across the GATES, EHRP, HCAS, and UFMS systems. For EHRP, we noted that the configuration management process is currently being revamped and that configuration management plans, change control charters, and release management standard operating procedures were not developed or implemented across the span of the audit. Additionally, for EHRP and GATES, we noted that there is no automated and consistent process in place to monitor configuration changes made to the production environment. Furthermore, the EHRP and GATES applications do not maintain updated baseline configurations for all aspects of the application, to include back-end databases. Lastly, for EHRP, we found that users have access to the production environment as well as development access giving them the capability to develop and subsequently migrate code. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security policies at both the Medicare fee-for-service contractors and the Central Office. One significant CMS application did not have adequate segregation of duties as it relates to implementing new program code. Secure access configuration settings were not consistently implemented or reviewed. Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems. Evidence supporting testing of claims processing software changes was not always retained.

- Segregation of duties – Segregation of duties (SOD) exceptions were identified across the UFMS, EHRP, and IMPACII systems. For EHRP, there is no entity-wide governance in place to establish segregation of duties for user access. Additionally, for EHRP, segregation of duties is not adequately enforced among the EHRP environments and the SOD matrix does not document the conflicting roles between the developer and system administrator roles, which would provide individuals the ability to develop code and migrate it into production. For UFMS, a listing of all users with SOD conflicts and their respective business justifications is not proactively maintained. For IMPACII, a listing of system-generated individuals and their corresponding roles in the IMPACII development, test, and production environments could not be provided by management, which could lead to excessive access for users across the different environments. CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. We found several deficiencies that may result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and across the enterprise.

- FISMA compliance – The security management program, as required by FISMA of 2002, and amended by the Federal Information Security Modernization Act of 2014, provides a framework to help identify security threats, assess risks continuously, determine that control objectives are appropriately designed and formulated, support the development and implementation of relevant control techniques, and apply consistent managerial oversight to support the overall effectiveness of security measures. Without a fully integrated security management program, the design and implementation of security

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controls may be inadequate; user roles and responsibilities may be unclear; and management, operational, and technical controls may be inconsistently implemented. Such conditions will lead to insufficient protection of sensitive or critical resources. As part of our FY 2015 FISMA assessment, we performed our procedures at the following OpDivs: (1) Indian Health Service (IHS), (2) Administration for Children and Families, (3) National Institutes of Health (NIH), (4) Centers for Medicare & Medicaid Services (CMS), and the (5) HHS Office of the Secretary. We noted progress since the prior year procedures at some of the OpDivs; however, our procedures identified the following deficiencies across the OpDivs reviewed:

- Incident response and reporting – The Department's HHS Computer Security Incident Response Center is either not documenting or reporting to US-CERT within the one-hour time frame required by OMB.

- Continuous monitoring – The Department does not have an effective process for managing and identifying unauthorized software on devices in the HHS environment.

- Patch management – The Department does not have an effective process for timely implementation of critical system patches.

- Contingency planning – The Department does not have an effective process for managing contingency plan documentation and performing a timely review. Additionally, the Department does not have sufficient oversight over testing of contingency plans.

- Plan of action and milestones (POA&M) – The Department's security management has not fully implemented an effective POA&M process to ensure that all fields for each POA&M record are entered and updated on a timely basis and that all POA&M records are resolved and closed in a timely manner. Additionally, POA&M records extracted from the HHS Data Warehouse are not reconciled to OpDiv-level data.

Recommendations

HHS should continue the focus achieved in FY 2015 to remediate the remaining deficiencies. The following are some specific considerations:

- Continue to identify, assess, modify, and monitor access controls, configuration management, and segregation of duties to further enhance the security posture of all applications. Specific recommendations for the non-CMS OpDiv applications include the following:

  - For UFMS/HCAS/EHRP/NBS, monitor user activity, leveraging automated tools or mechanisms, on a consistent basis for suspicious activity

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- For UFMS/HCAS/GATES, remove all generic IDs that do not have a business need or are no longer needed to be active within the system. For generic IDs that are needed to run the application, proactively monitor user activity performed when using shared generic IDs

- For UFMS, management should leverage their analysis to identify users with multiple UFMS user IDs and remove any instances of multiple user IDs that exist without documented and valid business justification

- For GATES, develop and implement detailed user access provisioning procedures so that leadership can leverage documented procedures when approving new user access, while attempting to prevent unauthorized or excessive access

- For EHRP, develop and finalize all entity-wide configuration management plans and charters to efficiently manage the application's configuration management process

- For EHRP/GATES, develop and implement processes to monitor the production environment to detect configuration changes made to the system and verify if these changes were implemented in accordance with the established configuration management policies and procedures

- For EHRP/GATES, define and document baseline security configurations and ensure the system configuration settings are finalized and mirror the current operational environment

- For EHRP, remove excessive access allowing users with the ability to develop code and subsequently migrate that code into the production environment

- For EHRP, system ownership should collaborate with the individual HR Centers and security and administration resources to further refine the SOD Matrix (i.e., document functional roles, system roles, and conflicting access and functions) based on all applicable roles within the system

- For UFMS, implement standardized and centralized segregation of duties policies across all the OpDivs, perform and monitor mitigation testing, and monitor the SOD reviews for each of the OpDivs to ensure that they are being performed and all SOD conflicts are resolved or justified

- For EHRP, management should develop and document procedures to implement controls for identifying, documenting, and monitoring segregation of duties conflicts within the change management process

• Throughout the course of this year's audit, we noted that GATES is going to be retired in the near future and replaced by other internal systems or other Governmental centers of

excellence. However, a focused effort should still be made to remediate weaknesses identified across all systems currently in operation, including systems that will be retired in the coming years, so as to mitigate risk and exposure to exploitation.

- We have performed a separate financial statement audit of CMS for FY 2015 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

Significant Deficiencies

Financial Reporting Systems, Analysis, and Oversight

Although progress in certain areas has been identified, HHS and its OpDivs' internal reviews and the results of our testing of internal control continued to identify internal control deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts. In many cases, processes continued to be developed throughout FY 2015 and will require additional refinements in FY 2016 and beyond. Within the context of the approximately $1 trillion in departmental net outlays, the ultimate resolution of our specific 2015 findings was not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that should continue to be resolved.

Lack of Integrated Financial Management System

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems and compliance with the United States Standard General Ledger at the transaction level and applicable federal accounting standards. Over the past 18 years, HHS has continued its efforts to overcome certain issues that have affected its ability to become compliant with the FFMIA, including the following long-standing issues, for which HHS and the audit continue to identify:

- The recording of billions of dollars in manual journal entries to ensure balances within financial systems are correct

- Departures from requirements specified in OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*, and OMB A-130, *Management of Federal Information Resources*, related to access and change management controls within financial systems, as discussed above

- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective-type controls, including

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CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' Healthcare Integrated General Ledger Accounting System and the NIH Business System which continues to have certain transactions which are captured inconsistently to the Treasury United States Standard General Ledger at the transaction level and requires adjustments to the accounting records

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized.

Resource limitations and other priorities have consistently been identified as the causes for delays in upgrading certain system and financial internal control processes limiting HHS's ability to comply with requirements under FFMIA.

With the passage of new laws, including the Digital Accountability and Transparency Act (the DATA Act), the continued implementation of Treasury requirements, and upgrades to its financial management systems, HHS has made progress in addressing its compliance with the FFMIA. During FY 2015, the Department has moved forward in its planning and implementation of upgrades to its financial systems, expected to be completed by FY 2016; prioritized and centralized additional resources in addressing certain issues related to controls within its financial information management systems; updated various sections of departmental financial management policies; and continued to automate the manual journal entry processes required to ensure financial data is accurate.

As it continues its pursuit in resolving these long-standing issues, HHS needs to be vigilant in developing, maintaining, and implementing consistent policies and procedures, monitoring the implementation of its upgrades, providing extensive training throughout the Department to ensure consistent application, and enhancing its monitoring program to ensure continued compliance.

Financial Analysis and Oversight

Because deficiencies continue to exist in the financial management systems, management must compensate for the deficiencies by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of deficiencies that impact HHS's ability to report accurate financial information on a timely basis. Consistent with prior years, we found that certain controls were not consistently performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:

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Department/Operating Division Periodic Analysis and Reconciliation

As deficiencies exist in financial systems, management compensates by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls may include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, aging of accounts, and manual and supervisory reviews. During our audit, we found that certain controls still required further improvements. The following represent specific areas that need enhanced periodic reconciliation and analysis:

- *Departmental Review of OpDivs Financial Statements and Other Financial Activity* – The Department performs periodic reviews of OpDivs' financial activity as part of the financial reporting process and for external inquiry purposes. However, we noted that further improvements are necessary at the OpDiv level in performing analysis of its financial data and amounts and communication of newly adopted, unique and/or complex financial management activities to the Department. We observed significant improvements from prior years with the identification by the Department's Office of Finance of significant discrepancies through its implementation of new analysis tools. However, NIH and CMS failed to communicate certain significant or complex activities that were material to the Department in a timely fashion.

- *Fund Balance with Treasury* – Every month, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2015, the general ledger and Treasury's records differed by more than an approximate absolute value of $1.4 billion. This primarily relates to differences that were either timing differences or differences that were not adequately researched and cleared from the suspense accounts. Additionally, differences in HHS suspense account reconciliations were not properly cleared within the 60 days required time frame. For example, based on the support provided, the Out of Balance report for NIH which supports its Fund Balance with Treasury reconciliation had outstanding items from FY 2008 to FY 2015, which indicated that differences are not being resolved in a timely manner (i.e., within the required 60 days). Many of the stale differences presented on the Out of Balance report were carried over from the previous financial systems upgrade. As of June 2015, there was a net difference of $0.9 billion with an absolute variance of $1.8 billion. Finally, we identified several Fund Balance with Treasury reconciliations prepared in the Indian Health Service area offices, which were either not reviewed or were improperly prepared.

- *Property, Plant, and Equipment* – We found that sufficient documentation was not readily available to support certain amounts and disclosures related to property, plant, and equipment. For example, the following:

  – Certain assets at the Indian Health Service were purchased in prior years and put into service, but were not recorded to accounting records until FY 2015.

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  - For two of six NIH selected samples, we were not able to agree invoices to the amounts identified in NIH's property subsidiary ledger. We were informed that adjustments to amounts had recently been requested.

- *Commissioned Corp* – During January 2014, HHS transferred the Commissioned Corp retiree, annuitant and surviving payroll processes from a commercial financial shared service center to the US Coast Guard. During FY 2015, we determined that reviews of the respective Coast Guard internal control systems had not sufficiently taken place during the fiscal year nor had sufficient communications taken place to ensure timely access of Commission Corp data or documentation for audit purposes. We have been informed that the active processes will also be transferred from the commercial financial shared service center to Coast Guard in January 2016. In preparation for the move, improvements in the agreements between the two agencies are necessary to ensure a system's assessment would be available in FY 2016 and that documentation to support Commissioned Corp payroll – at the individual level – would be available more timely.

Policies and Procedures

During FYs 2014 and 2015, the Department initiated a plan to upgrade its policies and procedures, including hiring of new personnel to oversee the process, setting up formal prioritized processes from initiation to implementation, defining required levels of approvers, and holding meetings and review periods with OpDivs to ensure input and collaboration into the finalization and implementation of the policy. Many proposed policies were implemented during FY 2015. With certain policies requiring updating, laws being passed and requiring implementation, and as internal control processes change, the Department has not completed its updating of procedural manuals to ensure that sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. For example, HHS management indicated that, while certain policies within its procedural manuals have been drafted awaiting final approval, including sections within its accounting treatment manual, others continue to be on a listing waiting to be updated or approved.

Further, as part of the accounting centers' monthly processes, the Department has instituted a policy whereby the accounting centers certify the status of completing required periodic reconciliations. For each required reconciliation, the preparers and approvers are required to sign off and provide a date of completion. On a monthly basis, the document is forwarded to the Department. Other than the detailed data submitted through CFRS, no supporting documentation is required to be provided as part of the submission. We observed in FY 2015 that follow-up requests from the Department to the OpDivs took place when discrepancies were identified; however, our review of the OpDivs' submissions and the supporting documentation maintained at the OpDivs identified inconsistencies in the procedures performed, the reports utilized, and the results provided among the various OpDivs. Additionally, we noted that although the financial statements are submitted to OMB on the 21st day after the end of the quarter, the Department's policy did not require reconciliations to be completed and certified until the end of the month.

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Financial Management Controls at CMS

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls dated November 9, 2015. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to business partner risk management, noted elsewhere in this report, to be a significant deficiency for the CMS internal control over financial reporting.

Our observations related to financial management controls included a recommendation that as CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating, and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis.

Business Partner Risk Management at CMS

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We identified areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the MACs to develop and follow objectives established by CMS. Through the established procedures, CMS monitors the MACs' compliance with its policies and procedures, established internal controls and the completeness and accuracy of financial reporting. While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process historically has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs.

As noted in the prior year, we identified deficiencies where actions are required but have not been taken or resolved in the following circumstances: (1) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (2) the claims outstanding greater than one year – periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (3) the provider records – reconcile, review or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely, accurately, and completely processed.

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Recommendations

We recommend that HHS continue to develop, refine and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that HHS perform the following:

- Continue to move forward in its planning and implementation to upgrade its financial systems; prioritize and centralize additional resources in addressing certain issues related to controls within its financial information management systems; and continue to automate the manual journal entry processes required to ensure financial data is accurate.

- Continue to focus on reducing the number of manual journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of certain high-volume routine transactions.

- Continue to update and implement the Department-wide policies and procedures and other guidance to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers and headquarters. As policies and procedures are developed, training should be developed and delivered across all OpDivs to determine consistent application of the new policies. Additionally, ongoing monitoring processes should be enhanced to ensure appropriateness and consistency over the long-term and continued compliance.

- Develop increased communication protocols with all OpDivs, especially CMS and NIH, to enhance notification and awareness of newly adopted, unique and/or complex financial management activity for purposes that may impact the Department's required financial reporting.

- Strengthen policy and controls surrounding the property, plant, and equipment and related processes to ensure that documentation is maintained and that balances are accurate and supportable.

- Strengthen the agreement between HHS and the Coast Guard to provide for a system's assessment in FY 2016 and that documentation to support Commissioned Corp payroll – at the individual level – would be available more timely.

- Strengthen controls surrounding Fund Balance with Treasury reconciliations to ensure differences are remediated properly and timely. HHS should develop and monitor processes to ensure suspense account transactions are cleared properly on a timely basis.

- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine, or significant transactions; enhance the financial reporting process; and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document, and validate the new critical accounting matters that are identified or implemented during the year and

improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

Additionally, we recommend that CMS continue to develop and refine its financial management controls and business partner risk management as a means to improve its accounting, analysis, and oversight of financial management activity. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Financial Management Close and Review Processes

In FY 2015, the NIH upgraded its General Ledger system to Oracle R12; partially implemented of the HHS Accounting Treatment Manual, performed additional analysis of its balances and transactions in order to report budgetary activity through the Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS); and underwent a significant change in financial accounting personnel. The convergence of these events caused NIH to find a series of general ledger balances related to Treasury and budgetary activity from current and prior years that did not agree with the corresponding GTAS balances. The process to correct these balances included a series of large dollar balance journal entries. Our analysis of those entries did not cause us to change our opinion on the FY 2015 financial statements of HHS taken as a whole. However, we did find that the research of the differences was inadequate, the supporting documentation underlying the journal entries was insufficient, and the HHS journal entry approval processes were not followed.

Recommendation

The analyses prepared for the audit should be formalized and made a part of the accounting records of NIH. In addition, the analysis and adjustment processes related to balances at NIH should be revised to assure differences are thoroughly researched and adjustments are properly documented and approved. Finally, HHS should continue to perform intensified analyses of balances at all other OpDivs while undergoing the Oracle R12 upgrades.

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Status of Prior Year Findings

In the reports on the results of the FY 2014 audit of the HHS financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Material Weakness		
Issue Area	**Summary Control Issue**	**FY 2015 Status**
Financial Management Information Systems	• Segregation of Duties • Change Management • Access Controls • FISMA Compliance	Certain progress noted; certain issues need continued focus Modified Repeat Condition
Significant Deficiency		
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight	Progress noted; however, certain issues identified require continued focus. Modified Repeat Condition

HHS's Response to Findings

HHS's response to the findings identified in our audit is included in its letter dated November 13, 2015, which has been included at the end of this report. HHS's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

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

Ernst & Young LLP

November 13, 2015

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Department of Health and Human Services (HHS), which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statement of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 13, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 15-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA) (P.L.104-208). However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of non-compliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 15-02, and which are described below.

During fiscal year (FY) 2015, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending and a potential violation related to the appointment of a Presidentially nominated official without the required confirmation.

The Improper Payments Information Act of 2002 (P.L. 107-300) as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (P.L. 111-204) and the Improper Payments Elimination and Recovery Improvement Act of 2014 (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While it continues to make progress, HHS is currently not in full compliance with the requirements of the Acts. For example, HHS has reported error rates for each of its high-risk programs except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the Social Security Act, which specifies the data elements that HHS may require states to report, and Section 417 of the same Social Security Act, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS's position is that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the Social Security Act. Additionally, we noted certain high risk programs that did not meet their identified targets or exceeded the maximum 10% threshold stipulated by the Acts. Also, HHS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, HHS posted a Request for Quote in June 2014; however, no responses were received but HHS anticipates executing a contract in FY 2016.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS's financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of non-compliance related to FFMIA:

- During FY 2015, thousands of manual journal vouchers were required to be recorded in the Unified Financial Management System (UFMS)/National Institutes of Health Business System (NBS) to post certain types of transactions not currently configured

correctly within UFMS/NBS and for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB A-130, *Management of Federal Information Resources,* and OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.

- The lack of sufficient integration within the various financial systems are not complemented with sufficient manual preventative and detective type controls, including Centers for Medicare & Medicaid Services' (CMS') durable medical equipment Medicare Administrative Contractors who have not fully implemented CMS' Healthcare Integrated General Ledger Accounting System and the NBS which continues to have certain transactions which are recorded incorrectly at the entry point as compared to the Treasury Standard General Ledger at the transaction level and require adjustments to the accounting records.

- Inconsistencies were identified across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized.

* * * * *

HHS's Response to Findings

Our Report on Internal Control dated November 13, 2015, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the non-compliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS's management responsible for addressing the non-compliance are provided in its letter dated November 13, 2015. We did not audit management's comments, and accordingly, we express no opinion on them. Additionally, HHS is updating its Department-wide corrective action plan to address FFMIA and other financial management issues.

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Purpose of This Report

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

Ernst & Young LLP

November 13, 2015

DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS

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 2015 Financial Statement Audit

We appreciate the opportunity to comment on the Independent Auditor's Report concerning the audit of our FY 2015 financial statements. We generally concur with the findings identified in the Report on Internal Control. The final reports are included in our FY 2015 Agency Financial Report. In response to your reports, we will prepare and update corrective action plans to address the identified audit findings. HHS leadership is dedicated to effectively resolving our challenges.

The size and complexity of our information technology (IT) environment continues to pose substantial challenges as we address weaknesses across multiple systems, organizations, and business processes. A more strategic and focused approach to strengthening controls and security over our financial systems environment was initiated in FY 2015. The Chief Financial Officer and Chief Information Officer communities formed an IT Material Weakness Working Group to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions to address the material weakness. Also we are nearing completion of the migration of our financial reporting systems to the latest software. This migration is expected to provide improved security, as well as faster access to data, and simplified report queries for systems users.

The prioritization of specific internal control activities will advance our progress toward resolution of the financial reporting significant deficiency identified in the auditor's report. With the strategic direction of the HHS Risk Management and Financial Oversight Board, our stakeholders have committed to strengthening financial management controls.

HHS remains committed to ensuring sound financial management that delivers reliable and actionable information for both internal and external decision makers and stakeholders.

We would like to thank the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the continued collaboration of the OIG to improve our stewardship and transparency of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 13, 2015

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services
Consolidated Balance Sheets
As of September 30, 2015 and 2014
(in Millions)

	2015	2014
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 219,459	$ 176,958
Investments, Net (Note 4)	269,651	278,900
Accounts Receivable, Net (Note 5)	1,005	919
Other Assets (Note 8)	178	95
Total Intragovernmental Assets	**490,293**	**456,872**
Accounts Receivable, Net (Note 5)	21,915	10,159
Inventory and Related Property, Net (Note 6)	9,516	8,606
General Property, Plant and Equipment, Net (Note 7)	5,917	5,868
Other Assets (Note 8)	1,154	810
Total Assets	**$ 528,795**	**$ 482,315**
Stewardship Land (Notes 1 and 20)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 309	$ 401
Other Liabilities (Note 13)	3,609	3,022
Total Intragovernmental Liabilities	**3,918**	**3,423**
Accounts Payable	574	555
Entitlement Benefits Due and Payable (Note 10)	108,149	91,037
Accrued Liabilities (Note 12)	14,250	3,314
Federal Employee and Veterans' Benefits (Note 11)	12,072	11,979
Contingencies and Commitments (Note 14)	9,105	11,332
Other Liabilities (Note 13)	3,320	2,501
Total Liabilities	**151,388**	**124,141**
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	30,184	16,215
Unexpended Appropriations - All Other Funds	116,089	107,427
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	221,480	227,551
Cumulative Results of Operations - All Other Funds	9,654	6,981
Total Funds from Dedicated Collections	**251,664**	**243,766**
Total All Other Funds	**125,743**	**114,408**
Total Net Position	**377,407**	**358,174**
Total Liabilities and Net Position	**$ 528,795**	**$ 482,315**

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

U.S. Department of Health and Human Services
Consolidated Statement of Net Cost
For the Years Ended September 30, 2015 and 2014
(in Millions)

	2015	2014
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 1,011,350	$ 910,511
Exchange Revenue	(98,030)	(73,276)
CMS Net Cost of Operations	913,320	837,235
Other Segments:		
Administration for Children and Families (ACF)	50,300	49,283
Administration for Community Living (ACL)	1,755	1,485
Agency for Healthcare Research and Quality (AHRQ)	359	386
Centers for Disease Control and Prevention (CDC)	10,517	10,336
Food and Drug Administration (FDA)	4,225	3,833
Health Resources and Services Administration (HRSA)	9,158	8,817
Indian Health Service (IHS)	6,158	6,339
National Institutes of Health (NIH)	29,985	30,676
Office of the Secretary (OS)	3,174	4,209
Program Support Center (PSC)	1,942	1,784
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,391	3,275
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 120,964	$ 120,423
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	(249)	82
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 120,715	$ 120,505
Exchange Revenue	(4,006)	(5,758)
Other Segments Net Cost of Operations	116,709	114,747
Net Cost of Operations (Note 15)	**$ 1,030,029**	**$ 951,982**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2015
(in Millions)

	2015			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 227,551	$ 6,981	$ -	$ 234,532
Budgetary Financing Sources:				
Other Adjustments (Rescissions, etc.) (+/-)	-	(746)	-	(746)
Appropriations Used	295,986	478,803	-	774,789
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	237,972	-	-	237,972
Non-exchange Revenue - Investment Revenue	10,854	5	-	10,859
Non-exchange Revenue - Other	3,557	-	-	3,557
Donations and Forfeitures of Cash and Cash Equivalents	75	-	-	75
Transfers-in/out without Reimbursement	(4,673)	3,467	-	(1,206)
Other (+/-)	-	(1)	-	(1)
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	10	-	10
Transfers-in/out Without Reimbursement (+/-)	(6)	(8)	-	(14)
Imputed Financing	30	668	(204)	494
Other (+/-)	1	841	-	842
Total Financing Sources	543,796	483,039	(204)	1,026,631
Net Cost of Operations (+/-)	549,867	480,366	(204)	1,030,029
Net Change	(6,071)	2,673	-	(3,398)
Cumulative Results of Operations:	**$ 221,480**	**$ 9,654**	**$ -**	**$ 231,134**
Unexpended Appropriations:				
Beginning Balances	$ 16,215	$ 107,427	$ -	$ 123,642
Budgetary Financing Sources:				
Appropriations Received	288,636	542,401	-	831,037
Appropriations Transferred in/out	-	387	-	387
Other Adjustments	21,319	(55,323)	-	(34,004)
Appropriations Used	(295,986)	(478,803)	-	(774,789)
Total Budgetary Financing Sources	13,969	8,662	-	22,631
Total Unexpended Appropriations	30,184	116,089	-	146,273
Net Position	**$ 251,664**	**$ 125,743**	**$ -**	**$ 377,407**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2014
(in Millions)

	2014			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 243,996	$ 8,553	$ -	$ 252,549
Budgetary Financing Sources:				
Other Adjustments (Rescissions, etc.) (+/-)	-	(573)	-	(573)
Appropriations Used	260,360	432,855	-	693,215
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	227,822	-	-	227,822
Non-exchange Revenue - Investment Revenue	11,360	3	-	11,363
Non-exchange Revenue - Other	3,826	-	-	3,826
Donations and Forfeitures of Cash and Cash Equivalents	63	-	-	63
Transfers-in/out without Reimbursement	(3,389)	2,083	-	(1,306)
Other (+/-)	-	-	-	-
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	53	-	53
Transfers-in/out Without Reimbursement (+/-)	(4)	(1)	-	(5)
Imputed Financing	37	711	(194)	554
Other (+/-)	-	(1,047)	-	(1,047)
Total Financing Sources	500,075	434,084	(194)	933,965
Net Cost of Operations (+/-)	516,520	435,656	(194)	951,982
Net Change	(16,445)	(1,572)	-	(18,017)
Cumulative Results of Operations:	**$ 227,551**	**$ 6,981**	**$ -**	**$ 234,532**
Unexpended Appropriations:				
Beginning Balances	$ 4,469	$ 105,728	$ -	$ 110,197
Budgetary Financing Sources:				
Appropriations Received	273,772	458,633	-	732,405
Appropriations Transferred in/out	-	(4)	-	(4)
Other Adjustments	(1,666)	(24,075)	-	(25,741)
Appropriations Used	(260,360)	(432,855)	-	(693,215)
Total Budgetary Financing Sources	11,746	1,699	-	13,445
Total Unexpended Appropriations	16,215	107,427	-	123,642
Net Position	**$ 243,766**	**$ 114,408**	**$ -**	**$ 358,174**

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

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2015 and 2014
(in Millions)

	2015		2014	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 37,878	$ 3	$ 41,577	$ 111
Recoveries of Prior Year Unpaid Obligations	26,380	-	26,083	-
Other Changes in Unobligated Balance	20,176	-	(719)	(62)
Unobligated Balance from Prior Year Budget Authority, Net	84,434	3	66,941	49
Appropriations (Discretionary and Mandatory)	1,425,607	-	1,320,180	(4)
Borrowing Authority (Discretionary and Mandatory)	-	50	-	237
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	32,931	80	24,658	198
Total Budgetary Resources (Note 23)	**$ 1,542,972**	**$ 133**	**$ 1,411,779**	**$ 480**
Status of Budgetary Resources:				
Obligations Incurred (Notes 18 and 23)	$ 1,477,350	$ 131	$ 1,373,901	$ 477
Unobligated Balance, End of Year:				
Apportioned	26,449	-	29,384	-
Exempt from Apportionment (Note 16)	(2,621)	-	39	-
Unapportioned	41,794	2	8,455	3
Total Unobligated Balance, End of Year	65,622	2	37,878	3
Total Budgetary Resources (Note 23)	**$ 1,542,972**	**$ 133**	**$ 1,411,779**	**$ 480**
Change in Obligated Balance:				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 216,166	$ 998	$ 188,654	$ 1,248
Obligations Incurred (Notes 18 and 23)	1,477,350	131	1,373,901	477
Outlays (Gross)	(1,430,984)	(754)	(1,320,306)	(727)
Actual Transfers, unpaid obligations	196	-	-	-
Recoveries of Prior Year Unpaid Obligations	(26,380)	-	(26,083)	-
Unpaid Obligations, End of Year	**$ 236,348**	**$ 375**	**$ 216,166**	**$ 998**
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (11,838)	$ (430)	$ (11,018)	$ (536)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	(10,286)	270	(820)	106
Uncollected Payments from Federal Sources, End of Year	**$ (22,124)**	**$ (160)**	**$ (11,838)**	**$ (430)**
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 204,328	$ 568	$ 177,636	$ 712
Obligated Balance, End of Year	$ 214,224	$ 215	$ 204,328	$ 568
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,458,538	$ 130	$ 1,344,838	$ 431
Actual Offsetting Collections (Discretionary and Mandatory)	(23,260)	(350)	(23,687)	(315)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(10,286)	270	(820)	106
Budget Authority, Net (Discretionary and Mandatory)	**$ 1,424,992**	**$ 50**	**$ 1,320,331**	**$ 222**
Outlays, Gross (Discretionary and Mandatory)	$ 1,430,984	$ 754	$ 1,320,306	$ 727
Actual Offsetting Collections (Discretionary and Mandatory)	(23,260)	(350)	(23,687)	(315)
Outlays, Net (Discretionary and Mandatory)	1,407,724	404	1,296,619	412
Distributed Offsetting Receipts	(380,187)	-	(359,650)	-
Agency Outlays, Net (Discretionary and Mandatory)	**$ 1,027,537**	**$ 404**	**$ 936,969**	**$ 412**

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

U.S. Department of Health and Human Services

Statement of Social Insurance (unaudited)

75-Year Projection as of January 1, 2015 and Prior Base Years

(in Billions)

		Estimates from Prior Years			
	2015	2014	2013	2012	2011
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 9,134	$ 8,398	$ 8,147	$ 7,929	$ 7,581
SMI Part B	17,027	17,127	15,227	14,431	13,595
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 or over)					
HI	382	332	301	302	262
SMI Part B	3,300	2,873	2,620	2,395	2,122
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	8,386	7,812	7,744	7,367	7,260
SMI Part B	3,668	4,311	3,530	3,333	3,223
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants					
HI	17,902	16,542	16,192	15,598	15,104
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,494	$ 14,117	$ 14,629	$ 14,919	$ 12,887
SMI Part B	16,818	17,003	15,075	14,303	13,489
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 and over)					
HI	3,803	3,484	3,422	3,369	2,923
SMI Part B	3,637	3,171	2,887	2,646	2,343
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	2,791	2,764	2,913	2,891	2,546
SMI Part B	3,540	4,137	3,415	3,211	3,108
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants:					
HI	21,089	20,365	20,963	21,179	18,356
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (3,187)	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (3,187)	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	197	205	220	244	272
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 24 and 25)					
HI	$ (2,990)	$ (3,618)	$ (4,551)	$ (5,337)	$ (2,980)
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1

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

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

75-Year Projection as of January 1, 2015 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2015	2014	2013	2012	2011
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 4,569	$ 3,980	$ 3,643	$ 3,391	$ 3,079
Expenditures	8,328	7,430	7,031	6,709	5,961
Income less expenditures	(3,759)	(3,450)	(3,388)	(3,319)	(2,882)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	32,585	31,453	29,244	28,227	27,615
Expenditures	37,736	37,048	35,574	35,088	32,814
Income less expenditures	(5,151)	(5,595)	(6,330)	(6,861)	(5,199)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(8,909)	(9,045)	(9,718)	(10,180)	(8,081)
Combined Medicare Trust Fund assets at start of period	266	280	288	325	344
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(8,643)	(8,764)	(9,430)	(9,855)	(7,737)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	14,898	14,732	13,891	13,268	13,300
Expenditures	9,176	9,510	8,945	8,669	8,471
Income less expenditures	5,722	5,222	4,946	4,599	4,829
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,187)	(3,823)	(4,772)	(5,581)	(3,252)
Combined Medicare Trust Fund assets at start of period	266	280	288	325	344
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (2,921)	$ (3,542)	$ (4,484)	$ (5,256)	$ (2,908)

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

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

January 1, 2014 to January 1, 2015

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2014	$ 50,166	$ 53,988	$ (3,823)	$ 280	$ (3,542)
Reasons for change					
Change in the valuation period	2,106	2,308	(202)	(17)	(219)
Change in projection base	1,174	1,256	(82)	3	(79)
Changes in the demographic assumptions	149	184	(35)	-	(35)
Changes in economic and health care assumptions	(1,884)	(2,638)	755	-	755
Changes in law	342	142	201	-	201
Net changes	1,887	1,251	636	(14)	622
As of January 1, 2015	$ 52,053	$ 55,240	$ (3,187)	$ 266	$ (2,921)
HI - Part A (Note 26)					
As of January 1, 2014	$ 16,542	$ 20,365	$ (3,823)	$ 205	$ (3,618)
Reasons for change					
Change in the valuation period	610	812	(202)	(14)	(216)
Change in projection base	(38)	44	(82)	6	(77)
Changes in the demographic assumptions	3	38	(35)	-	(35)
Changes in economic and health care assumptions	784	30	755	-	755
Changes in law	-	(201)	201	-	201
Net changes	1,360	724	636	(8)	628
As of January 1, 2015	$ 17,902	$ 21,089	$ (3,187)	$ 197	$ (2,990)
SMI - Part B (Note 26)					
As of January 1, 2014	$ 24,311	$ 24,311	$ -	$ 74	$ 74
Reasons for change					
Change in the valuation period	1,054	1,054	-	(3)	(3)
Change in projection base	360	360	-	(3)	(3)
Changes in the demographic assumptions	82	82	-	-	-
Changes in economic and health care assumptions	(2,168)	(2,168)	-	-	-
Changes in law	356	356	-	-	-
Net changes	(316)	(316)	-	(6)	(6)
As of January 1, 2015	$ 23,995	$ 23,995	$ -	$ 68	$ 68
SMI - Part D (Note 26)					
As of January 1, 2014	$ 9,312	$ 9,312	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	443	443	-	-	-
Change in projection base	852	852	-	-	-
Changes in the demographic assumptions	63	63	-	-	-
Changes in economic and health care assumptions	(500)	(500)	-	-	-
Changes in law	(13)	(13)	-	-	-
Net changes	844	844	-	-	-
As of January 1, 2015	$ 10,156	$ 10,156	$ -	$ 1	$ 1

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

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

January 1, 2013 to January 1, 2014

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2013	$ 46,779	$ 51,550	$ (4,772)	$ 288	$ (4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	-	(139)
Changes in economic and health care assumptions	1,293	521	772	-	772
Changes in law	50	(57)	108	-	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	$ 50,166	$ 53,988	$ (3,823)	$ 280	$ (3,542)
HI - Part A (Note 26)					
As of January 1, 2013	$ 16,192	$ 20,963	$ (4,772)	$ 220	$ (4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	-	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	-	772
Changes in law	-	(108)	108	-	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	$ 16,542	$ 20,365	$ (3,823)	$ 205	$ (3,618)
SMI - Part B (Note 26)					
As of January 1, 2013	$ 21,377	$ 21,377	$ -	$ 66	$ 66
Reasons for change					
Change in the valuation period	894	894	-	3	3
Change in projection base	(391)	(391)	-	4	4
Changes in the demographic assumptions	(203)	(203)	-	-	-
Changes in economic and health care assumptions	2,638	2,638	-	-	-
Changes in law	(2)	(2)	-	-	-
Net changes	2,935	2,935	-	8	8
As of January 1, 2014	$ 24,311	$ 24,311	$ -	$ 74	$ 74
SMI - Part D (Note 26)					
As of January 1, 2013	$ 9,211	$ 9,211	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	450	450	-	-	-
Change in projection base	170	170	-	-	-
Changes in the demographic assumptions	428	428	-	-	-
Changes in economic and health care assumptions	(999)	(999)	-	-	-
Changes in law	53	53	-	-	-
Net changes	102	102	-	-	-
As of January 1, 2014	$ 9,312	$ 9,312	$ -	$ 1	$ 1

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

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

The accompanying financial statements include activities and operations of the United States Department of Health and Human Services (HHS or the Department).

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

Organization and Structure of HHS

HHS is composed of the Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) with diverse missions and programs. OS and the OpDivs are each responsible for carrying out a mission, conducting a major line of activity or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center is a responsibility segment and reports separately because its business activities encompass offering services to other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department's top management and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

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

HHS partners with other agencies to accomplish its mission. One such partnership is with the Department of Homeland Security (DHS) for the Biodefense Countermeasures Fund. It is reported on HHS financial statements under the OS responsibility segment.

Pursuant to Public Law 113-128, Section 491 of the *Workforce Innovation and Opportunity Act* (WIOA), ACL received three groups of programs from the Department of Education, Office of Special Education and Rehabilitation Services. These programs are the National Institute on Disability, Independent Living and

Rehabilitation Research programs; the Independent Living programs; and the Assistive Technology programs. The transfer was effective March 30, 2015. Through the transfer of these programs, HHS received the appropriations that fund the programs and has full administration, monitoring and reporting responsibilities of the program objectives.

B. Basis of Accounting and Presentation

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

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize budgetary resources that have been provided to an agency through various means, such as appropriations, reimbursable activity, or fee-based services, and the status of those funds throughout the consumption cycle. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 250 appropriations and related fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets and Statements of Net Cost and Changes in Net Position. The Combined Statement of Budgetary Resources is presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from these statements. Supplemental information is accumulated from the OpDivs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. government, a sovereign entity. One implication of this is that liabilities cannot be created or liquidated without legislation providing budgetary authority and resources for HHS.

C. Use of Estimates in Preparing Financial Statements

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

D. Parent/Child Reporting

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

HHS received an exception to the parent/child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from DHS to HHS for the Biodefense Countermeasures Fund for FY 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the *Affordable Care Act*, HHS has established a child relationship with the Internal Revenue Service (IRS) of the Department of the Treasury (Treasury) for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

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

E. Reclassifications and Adjustments

Certain FY 2014 balances have been reclassified to conform to FY 2015 financial statement presentations. The effects are immaterial.

F. Funds from Dedicated Collections

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

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

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

Medicare Hospital Insurance (HI) Trust Fund – Part A

Section 1817 of the *Social Security Act of 1935* (*Social Security Act*) established the Medicare HI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for hospital in-patient services, hospice and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans (previously known as Managed Care Plans) is also charged to this fund. The financial statements include the HI Trust Fund activities administered by the Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contributions Act* (FICA) (26 U.S.C. Ch 21) and *Self Employment Contributions Act of 1954* (SECA) (Ch 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their self-employment income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security

from the SSA records of wages. The SSA uses the wage totals reported by employers to the IRS via the Employer's Quarterly Federal Tax Return, as the basis for its quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, laboratory services, hospital outpatient services and rehabilitation, ambulatory surgical centers, end stage renal disease treatment, rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by Treasury. The SMI Trust Fund has permanent indefinite authority.

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

Medicare SMI Trust Fund – Part D

The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (*Medicare Modernization Act* or MMA) established the Medicare Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. Beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to fee-for-service Medicare; and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

Medicare Integrity Program

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which includes a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, HHS contracts with eligible entities to perform medical and utilization reviews, fraud reviews, and cost report audits. In addition, the Department educates providers and beneficiaries, about payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

G. Revenue and Financing Sources

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

Appropriations

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

Permanent Indefinite Appropriations

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

Borrowing Authority

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next FY. HHS has two programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program and the Health Center Loan Program.

HHS reports loans in accordance with the *Federal Credit Reform Act*. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

Exchange Revenue

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

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

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

Non-Exchange Revenue

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

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

Imputed Financing Sources

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

H. Intragovernmental Transactions and Relationships

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

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

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

I. Entity and Non-Entity Assets

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

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

J. Fund Balance with Treasury (FBwT)

HHS maintains its available funds with Treasury. The FBwT is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury. HHS FBwT accounts are reconciled with those of Treasury on a regular basis.

K. Custodial Activity

In accordance with guidance set forth in OMB Circular A-136, HHS reports custodial activities on its Consolidated Balance Sheets. The majority of the custodial collections are received by ACF from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. Since custodial activities are immaterial to HHS and incidental to its operations, HHS does not prepare a separate

Statement of Custodial Activity; the amount of custodial collections and dispositions in the current FY is reported in Note 21.

L. Investments, Net

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

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon Treasury to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semi-annually (June and December) by Treasury and at FY-end is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

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

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

The *Children's Health Insurance Program Reauthorization Act* (CHIPRA) established the Child Enrollment Contingency Fund to provide additional funding to states that experience shortfalls in their CHIP. The *Affordable Care Act* extended the availability of the fund through 2015, and the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) extended the availability of the fund through 2017. This fund is invested in Non-Marketable, Market-Based Bills issued by the Bureau of the Fiscal Service. These investments will be redeemed as funds are needed by the states to cover short-term shortfalls in the program.

M. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible amounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments, Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties (CMP) & Other Restitutions, state phased-down contributions, Medicaid/CHIP

overpayments, audit disallowances, and the recognition of Medicare Secondary Payer (MSP) accounts receivable, and monies due for Affordable Insurance Marketplaces (Marketplace) activities.

Accounts Receivable, Net from the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, HHS calculates the allowance for uncollectible amounts based on the collection activity and the age of the debt for the most current FY, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the states.

N. Advances and Accrued Liabilities

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

HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." "Grants Not Subject to Grant Expense Accrual" represents formula grants (also referred to as "block grants"). Expenses are recorded on the cash-basis of accounting, as the grantees draw funds. For "Grants Subject to Grant Expense Accrual," commonly referred to as "non-block grants," grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an unreported grant expenditure estimate (accrual) based on historical spending patterns of the grantees.

As of September 30, 2015, other accrued liabilities include expenses accrued for the risk adjustment and reinsurance programs that are administered by CMS under the *Affordable Care Act* (see Note 1.Y). These amounts represent estimates of payments due to those participating in the Marketplace activities. Related contributions due from other health insurers in the Marketplace are reported in Accounts Receivable.

O. Inventory and Related Property, Net

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

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

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

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian

pandemic declaration. The stockpile contains several million doses of vaccine in bulk, which is stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.

P. General Property, Plant and Equipment, Net

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

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

HHS has commitments under various operating leases with private entities and General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years. The GSA leases, in general, are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

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

In accordance with Statement of Federal Financial Accounting Standard (SFFAS) Number 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal use software costs for appropriated fund accounts is $1.0 million and the threshold for revolving fund accounts is $500 thousand. Costs below the threshold levels are expensed. Software is amortized using the straight line method over a period of 7 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

Q. Stewardship Land

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

The Indian Trust lands used by IHS are held as separate and distinct reflecting the long-term trust responsibility. IHS has built health care facilities on these Trust lands. Trust lands, when no longer needed by the IHS in connection with its general use PP&E, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

HHS asset accountability reports differentiate Indian Trust land parcels from General PP&E situated thereon. Note 20 provides additional information on HHS's Stewardship Land.

R. Liabilities

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

Liabilities Covered by Budgetary Resources

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

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for the *Federal Employees' Compensation Act of 1916* (FECA) (5 U.S.C. 751) disability payments. The actuarial FECA liability determined by the DOL but not yet billed is also included in this category.

S. Accounts Payable

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

T. Accrued Payroll and Benefits

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

U. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare, Medicaid and CHIP owed to the public for medical services Incurred But Not Reported (IBNR) as of the end of the reporting period. The Medicare and Medicaid programs are the largest entitlement programs in HHS.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;

- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current FY but paid in the subsequent FY;
- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid and CHIP

The Medicaid and CHIP estimates represent the net federal share of expenses incurred by the states but not yet reported to HHS. This estimate is developed based on historical relationships between prior net payables to the states and current activity.

V. Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits.

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

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees' Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has three parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes 1 percent of each employee's pay to the Thrift Savings Plan

and matches the first 3 percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

The Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, and other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. HHS does, however, recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

W. Contingencies

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

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

HHS has no material obligations related to cancelled appropriations for which we have a contractual commitment for payment or for contractual arrangements, which many require future financial obligations.

X. Statement of Social Insurance

The Statement of Social Insurance presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. The basis for projections in this report has changed since last year due to the enactment of MACRA. This law terminated the sustainable growth rate (SGR) formula that both set physician fee schedule payments and required payment reductions that were overridden by Congress for every year from 2002 through 2015. The projections in this report (with one exception related to depletion of the HI Trust Fund), are based on current law; that is, they assume that laws on the books will be implemented and adhered to with

respect to scheduled taxes, premium revenues, and payments to providers and health plans. The estimates depend on many economic, demographic, and health care-specific assumptions. These include changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2015*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

Y. *Affordable Care Act*

In FY 2010, President Barack Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while helping to reduce health care costs. Further information is available at www.HealthCare.gov.

The *Affordable Care Act* contains the most significant changes to health care coverage since the passing of the *Social Security Act*. The *Affordable Care Act* provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include the Marketplace and other programs listed below. A brief description of these programs and their impact on the financial statement is presented below.

Affordable Insurance Marketplaces

Grants have been provided to the states to establish Affordable Insurance Marketplaces. The initial grants were made by the HHS to the states "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS. All Marketplaces were launched on October 1, 2013.

To help make health insurance more affordable to consumers, HHS makes advance payments of the premium tax credits (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are included in the IRS financial statements are a critical component of the Marketplace, and $30.0 billion has been allocated for these payments. In addition to these payments on behalf of consumers, HHS collects Marketplace user fees from issuers participating in the Federally-facilitated Marketplace (FFM).

Basic Health Program

The Basic Health Program (BHP) gives states the ability to provide more affordable coverage for low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels. Through the BHP, states can provide coverage to individuals who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level (FPL). A state that operates a BHP will receive federal funding equal to 95 percent of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in Qualified Health Plans through the Marketplace. Similar to APTC and CSR payments, BHP payment amounts are included in the IRS financial statements.

Consumer Operated and Oriented Plan Program

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets. Under this program, HHS provides assistance to organizations applying to become qualified non-profit health insurance issuers through loans to assist in meeting start-up costs and to assist the applicant meet state solvency requirements. In accordance with regulations as well as legislative requirements, start-up loans shall be repaid within five years and the solvency loans within 15 years after disbursement, considering state reserve requirements and solvency regulations.

Transitional Reinsurance Program

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators, on behalf of some self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Marketplace. The Transitional Reinsurance program is a critical element in helping to ensure a stabilized individual market in the first years of the Exchange operation of the Marketplace.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual market and small group market plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against risk selection and adverse selection. States may operate risk adjustment programs and CMS will operate a risk adjustment program for each state that does not operate its own. In 2014 and 2015, Massachusetts is the only state that operated its own risk adjustment program.

Risk Corridor Program

The temporary Risk Corridors program will operate during the years 2014 through 2016. This program applies to qualified health plans in the individual and small group markets, inside and outside the Marketplaces and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and qualified health plans to help ensure stable health insurance premiums.

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

	2015	2014
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ 8	$ 8
Accounts Receivable	3	-
Total Non-Entity Intragovernmental Assets	11	8
Accounts Receivable With the Public	27	20
Total Non-Entity Assets	38	28
Total Entity Assets	528,757	482,287
Total Assets	**$ 528,795**	**$ 482,315**

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2015	2014
Trust Funds	$ 45,056	$ 19,551
Revolving Funds	1,433	1,275
Appropriated Funds	170,155	155,736
Special Funds and Other Funds	2,815	396
Total	**$ 219,459**	**$ 176,958**
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 23,828	$ 29,423
Unavailable	41,796	8,458
Obligated Balance not yet Disbursed	214,439	204,896
Non-Budgetary Fund Balance with Treasury	(60,604)	(65,819)
Total	**$ 219,459**	**$ 176,958**

The FBwT are funds primarily available to pay current expenditures and liabilities. Special Funds include the *Affordable Care Act* Risk Programs of $2.2 billion and Other Funds include balances in deposit, Management Funds, and related non-spending accounts. The Unobligated Balance Available includes funds that are restricted for future use and not apportioned for current use of $14.5 billion and $12.4 billion as of September 30, 2015 and September 30, 2014, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, CHIP, CMS Program Management, and State Grants and Demonstrations.

Note 4. Investments, Net (in Millions)

2015	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 261,585	$ -	$ 2,408	$ 263,993	$ 263,993
Non-Marketable: Market-Based	5,825	(194)	27	5,658	5,658
Total, Intragovernmental	**$ 267,410**	**$ (194)**	**$ 2,435**	**$ 269,651**	**$ 269,651**

2014	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 270,598	$ -	$ 2,688	$ 273,286	$ 273,286
Non-Marketable: Market-Based	5,779	(193)	28	5,614	5,614
Total, Intragovernmental	**$ 276,377**	**$ (193)**	**$ 2,716**	**$ 278,900**	**$ 278,900**

HHS investments consist primarily of Medicare Trust Fund (funds from dedicated collections) investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2016 through June 30, 2029, with interest rates ranging from 2.0 percent to 5.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2016, with an interest rate of 2.125 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature in FY 2016 through FY 2020. The Market-Based Notes paid from 1.0 percent to 3.875 percent during October 1, 2014 to September 30, 2015 and 1.0 percent to 4.125 percent during October 1, 2014 to September 30, 2015. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds held during the 12 months of FY 2015 yielded from 0.005 percent to 0.2253 percent depending on the date purchased and the time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of $2.1 billion as of September 30, 2015 are short term Non-Marketable Market-Based Bills purchased at a discount which are fully amortized at the maturity date.

Note 5. Accounts Receivable, Net (in Millions)

2015	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 1,002	$ -	$ 1,002	$ -	$ 1,002
Non-Entity	3	-	3	-	3
Total, Intragovernmental	**$ 1,005**	**$ -**	**$ 1,005**	**$ -**	**$ 1,005**
With the Public					
Entity					
Medicare	$ 8,806	$ -	$ 8,806	$ (2,031)	$ 6,775
Other	16,713	269	16,982	(1,869)	15,113
Non-Entity	-	53	53	(26)	27
Total With the Public	**$ 25,519**	**$ 322**	**$ 25,841**	**$ (3,926)**	**$ 21,915**

2014	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 919	$ -	$ 919	$ -	$ 919
Non-Entity	-	-	-	-	-
Total, Intragovernmental	**$ 919**	**$ -**	**$ 919**	**$ -**	**$ 919**
With the Public					
Entity					
Medicare	$ 7,881	$ -	$ 7,881	$ (1,649)	$ 6,232
Other	5,558	7	5,565	(1,658)	3,907
Non-Entity	-	40	40	(20)	20
Total With the Public	**$ 13,439**	**$ 47**	**$ 13,486**	**$ (3,327)**	**$ 10,159**

As of September 30, 2015, the other accounts receivable is primarily related to collections for Marketplace activities.

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

	2015	2014
Inventory Held for Current Sale, Net	$ 7	$ 8
Operating Materials and Supplies Held for Use	73	120
Stockpile Materials Held for Emergency or Contingency	9,436	8,478
Inventory and Related Property, Net	**$ 9,516**	**$ 8,606**

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

			2015		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 53	$ -	$ 53
Construction in Progress	-	-	650	-	650
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,140	(2,788)	3,352
Equipment	Straight Line	3-20 Yrs	1,922	(1,134)	788
Internal Use Software	Straight Line	7-10 Yrs	1,955	(965)	990
Assets Under Capital Lease	Straight Line	1-30 Yrs	126	(59)	67
Leasehold Improvements	Straight Line	*Life of Lease	51	(34)	17
Totals			**$ 10,897**	**$ (4,980)**	**$ 5,917**

			2014		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 53	$ -	$ 53
Construction in Progress	-	-	549	-	549
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,122	(2,615)	3,507
Equipment	Straight Line	3-20 Yrs	1,858	(1,149)	709
Internal Use Software	Straight Line	7-10 Yrs	1,827	(860)	967
Assets Under Capital Lease	Straight Line	1-30 Yrs	119	(55)	64
Leasehold Improvements	Straight Line	*Life of Lease	51	(32)	19
Totals			**$ 10,579**	**$ (4,711)**	**$ 5,868**

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

Note 8. Other Assets (in Millions)

	2015	2014
Intragovernmental		
Advances to Other Federal Entities	$ 178	$ 95
With the Public		
Travel Advances & Emergency Employee Salary Advances	$ 5	$ -
Other Payments & Deferred Changes	28	21
Direct Loan	1,112	769
Other	9	20
Total With the Public	**$ 1,154**	**$ 810**

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

	2015	2014
Intragovernmental		
Accrued Payroll and Benefits	$ 58	$ 60
Other	1,699	748
Total Intragovernmental	**$ 1,757**	**$ 808**
Federal Employee and Veterans' Benefits (Note 11)	12,072	11,979
Accrued Payroll and Benefits	632	620
Contingencies and Commitments (Note 14)	9,105	11,332
Other Accrued Liabilities (Note 12)	10,419	-
Other	210	152
Total Liabilities Not Covered by Budgetary Resources	$ 34,195	$ 24,891
Total Liabilities Covered by Budgetary Resources	117,193	99,250
Total Liabilities	**$ 151,388**	**$ 124,141**

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

	2015	2014
Medicare FFS	$ 45,268	$ 41,311
Medicaid Advantage/Prescription Drug Program	20,953	16,280
Medicaid	36,758	32,275
CHIP	773	923
Other	4,397	248
Totals	**$ 108,149**	**$ 91,037**

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

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for

payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current FY but paid in the subsequent FY and (e) an estimate of retroactive settlements of cost reports. The September 30, 2015 and 2014 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2015. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2015.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

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

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

	2015	2014
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 11,227	$ 11,154
PHS Commissioned Corp Post-retirement Health Benefits	574	537
Workers' Compensation Benefits (Actuarial FECA Liability)	271	288
Total Federal Employee and Veterans' Benefits	**$ 12,072**	**$ 11,979**

PHS Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,668 active duty officers and 6,595 retiree annuitants and survivors. As of September 30, 2015, the actuarial accrued liability for the retirement benefit plan was $11.2 billion and $0.6 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

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

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2015 and September 30, 2014, were:

	2015	2014
Interest on federal securities	4.44 percent	4.65 percent
Annual basic pay scale increase	2.68 percent	2.93 percent
Annual inflation	2.18 percent	2.43 percent

The following shows key valuation results as of September 30, 2015 and 2014, in conformance with the actuarial reporting standards set forth in the SFFAS Number 5, *Accounting for Liabilities of the Federal Government* and SFFAS Number 33. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2015, and actuarial assumptions. The September 30, 2015 valuation includes an increase in liabilities of $110 million resulting from an increase in costs and an actuarial loss from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. To mitigate the impact of this volatility, SFFAS Number 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

	2015	2014
Beginning Liability Balance	$ 11,691	$ 11,273
Expense		
Normal Cost	321	274
Interest on the liability balance	508	517
Actuarial (Gain)/Loss		
From experience	(98)	(63)
From assumption changes		
Change in discount rate assumption	326	2
Change in inflation/salary increase assumption	(508)	44
Change in Others	31	99
Net Actuarial (Gain)/Loss	(249)	82
Total expense	$ 580	$ 873
Less amounts paid	(470)	(455)
Ending Liability Balance	**$ 11,801**	**$ 11,691**

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. In FY 2015, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2015, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior four years; for FY 2014, discount rates were based on the TNC Yield Curve for one year. Interest rate assumptions utilized for discounting as of September 30, 2015 and September 30, 2014 follow.

	2015	2014
Wage Benefits	3.134% in Year 1 3.134% in Year 2 and thereafter	3.455% in Year 1 3.455% in Year 2 and thereafter
Medical Benefits	2.496% in Year 1 2.496% in Year 2 and thereafter	2.855% in Year 1 2.855% in Year 2 and thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors, cost of living adjustments (COLA) and medical inflation factors such as consumer price index-medical (CPIM) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLA and CPIM used in projections are:

FY	COLA	CPIM
2015	N/A	N/A
2016	1.64%	2.94%
2017	1.47%	2.98%
2018	1.33%	3.09%
2019	1.43%	3.39%
2020	1.65%	3.69%

Note 12. Accrued Liabilities (in Millions)

	2015	2014
Estimated Accrual for Amounts Due to Grantees	$ 22,103	$ 21,641
Offsetting Grant Advances	(18,272)	(18,327)
Other Accrued Liabilities	10,419	-
Total Accrued Liabilities	**$ 14,250**	**$ 3,314**

Note 13. Other Liabilities (in Millions)

	2015		2014	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 118	$ 969	$ 109	$ 918
Advances from Others	446	720	339	106
Deferred Revenue	-	642	-	483
Custodial Liabilities	729	12	934	15
Legal Liabilities (Note 14)	941	-	707	-
Other	1,375	977	933	979
Total Other Liabilities	**$ 3,609**	**$ 3,320**	**$ 3,022**	**$ 2,501**

Note 14. Contingencies and Commitments

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

Medicaid Audit and Program Disallowances

The Medicaid amount of $7.5 billion ($8.5 billion in FY 2014) consists of Medicaid audit and program disallowances of $2.4 billion ($2.9 billion in FY 2014) and $5.1 billion ($5.6 billion in FY 2014) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. In all cases, the funds have been returned to HHS. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2015, 9,737 cases (9,311 in FY 2014) remain on appeal. A total of 3,473 new cases were filed (4,400 in FY 2014) and 9 cases were reopened (12 in FY 2014). The PRRB rendered decisions on 84 cases in FY 2015 (73 in FY 2014); and 2,972 additional cases (2,152 in FY 2014) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB receives no information on the value of cases that are settled prior to a hearing.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in Salazar v. Ramah Navajo Chapter, dated June 18, 2012, is likely to result in additional claims against the IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. An estimated loss related to this matter was accrued last year and the remaining unpaid accrued liability is included on the Consolidated Balance Sheet.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment of injury claims.

Note 15. Revenue (in Millions)

2015 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 122	$ 6,517	$ 1,026	$ 20	$ 7,685	$ (2,548)	$ 5,137
Exchange Revenue	(33)	(3,116)	(12)	(7)	(3,168)	2,344	(824)
Net Cost, *Intragovernmental*	$ 89	$ 3,401	$ 1,014	$ 13	$ 4,517	$ (204)	$ 4,313
With the Public							
Gross Cost	$ 13,978	$ 453,400	$ 621,810	$ 38,002	$ 1,127,190	$ -	$ 1,127,190
Exchange Revenue	-	(25,769)	(75,689)	(16)	(101,474)	-	(101,474)
Net Cost, *With the Public*	$ 13,978	$ 427,631	$ 546,121	$ 37,986	$ 1,025,716	$ -	$ 1,025,716
Total Gross Cost	$ 14,100	$ 459,917	$ 622,836	$ 38,022	$ 1,134,875	$ (2,548)	$ 1,132,327
Total Exchange Revenue	(33)	(28,885)	(75,701)	(23)	(104,642)	2,344	(102,298)
Total Net Cost of Operations	**$ 14,067**	**$ 431,032**	**$ 547,135**	**$ 37,999**	**$ 1,030,233**	**$ (204)**	**$ 1,030,029**

2014 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 158	$ 7,059	$ 1,052	$ 87	$ 8,356	$ (2,935)	$ 5,421
Exchange Revenue	(53)	(3,555)	(16)	(12)	(3,636)	2,741	(895)
Net Cost, *Intragovernmental*	$ 105	$ 3,504	$ 1,036	$ 75	$ 4,720	$ (194)	$ 4,526
With the Public							
Gross Cost	$ 13,025	$ 385,456	$ 589,581	$ 37,583	$ 1,025,645	$ -	$ 1,025,645
Exchange Revenue	-	(5,607)	(72,551)	(31)	(78,189)	-	(78,189)
Net Cost, *With the Public*	$ 13,025	$ 379,849	$ 517,030	$ 37,552	$ 947,456	$ -	$ 947,456
Total Gross Cost	$ 13,183	$ 392,515	$ 590,633	$ 37,670	$ 1,034,001	$ (2,935)	$ 1,031,066
Total Exchange Revenue	(53)	(9,162)	(72,567)	(43)	(81,825)	2,741	(79,084)
Total Net Cost of Operations	**$ 13,130**	**$ 383,353**	**$ 518,066**	**$ 37,627**	**$ 952,176**	**$ (194)**	**$ 951,982**

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $102.3 billion and $79.1 billion through September 30, 2015 and 2014, respectively. HHS's exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

Note 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the Statement of Budgetary Resources consist of Trust Funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement funds and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All Trust Fund receipts collected in the FY are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the FY that exceeds the amount needed to pay benefits and other valid obligations in that FY is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the FY collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation as needed. The entire Trust Fund balances in the amount of $201.1 billion as of September 30, 2015, ($225.0 billion in FY 2014) are included in Investments on the Consolidated Balance Sheets.

Exempt from Apportionment

This amount includes the FY 2015 recording of obligations required by law where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The *Anti-Deficiency Act* has not been violated, as "[t]he prohibitions contained in the *Anti-Deficiency Act* are directed at discretionary obligations entered into by administrative officers."
B-219161 (Oct. 2 1985).

Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

The Budget of the U.S. Government (also known as the President's Budget), with the actual amounts for FY 2015, has not been published, therefore, no comparisons can be made between FY 2015 amounts presented in the Statement of Budgetary Resources with amounts reported in the Actual column of the President's Budget. The FY 2017 President's Budget is expected to be released in February 2016 and may be obtained from OMB's website, www.whitehouse.gov/omb/budget, or from the Government Printing Office.

HHS reconciled the amounts of the FY 2014 column on the Statement of Budgetary Resources to the actual amounts for FY 2014 from the Appendix in the FY 2016 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2014	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
Statement of Budgetary Resources	$ 1,412,259	$ 1,374,378	$ 359,650	$ 1,297,031
Expired Accounts	(7,998)	77	-	64
Other	(934)	152	860	(170)
Budget of the U.S. Government	$ 1,403,327	$ 1,374,607	$ 360,510	$ 1,296,925

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Statement of Budgetary Resources and not in the President's Budget is the budgetary resources that were not available. The "Expired

Accounts" line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the President's Budget.

The "Other" differences in the budgetary resources and obligations incurred are due to gift funds are reported on the HHS Statement of Budgetary Resources but not in the President's Budget. Government-wide Treasury Account Symbol Adjusted Trial Balance System revision window adjustments were not included in the HHS Statement of Budgetary Resources but included in the President's Budget. In addition, return of cancelled year funds and adjustments made to reclassify recoveries.

Note 18. Apportionment Categories of Obligations Incurred and Undelivered Orders (in Millions)

	2015		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 95,359	$ 7,487	$ 102,846
Category B (Restricted and Distributed by Activity)	700,591	3,832	704,423
Exempt from Apportionment	670,199	13	670,212
Total Obligations Incurred	$ 1,466,149	$ 11,332	$ 1,477,481

	2014		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,625	$ 8,084	$ 102,709
Category B (Restricted and Distributed by Activity)	628,534	3,004	631,538
Exempt from Apportionment	640,113	18	640,131
Total Obligations Incurred	$ 1,363,272	$ 11,106	$ 1,374,378

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from OMB Circular Number A-11, *Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the Standard Form 133, *Report on Budget Execution and Budgetary Resources*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported $105.8 billion of budgetary resources obligated for undelivered orders as of September 30, 2015 and $117.0 billion as of September 30, 2014.

Note 19. Funds from Dedicated Collections (in Millions)

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

	2015		
Balance Sheet as of September 30	Medicare	Other	Total
Fund Balance with Treasury	$ 44,785	$ 6,598	$ 51,383
Investments	263,993	3,606	267,599
Other Assets	7,327	10,661	17,988
Total Assets	**$ 316,105**	**$ 20,865**	**$ 336,970**
Entitlement Benefits Due and Payable	$ 66,221	$ 4,195	$ 70,416
Accrued Liabilities (Note 12)	-	10,419	10,419
Other Liabilities	3,021	1,450	4,471
Total Liabilities	**$ 69,242**	**$ 16,064**	**$ 85,306**
Unexpended Appropriations	30,284	(100)	30,184
Cumulative Results of Operations	216,579	4,901	221,480
Total Liabilities and Net Position	**$ 316,105**	**$ 20,865**	**$ 336,970**
Statement of Net Cost for the Period Ended September 30			
Gross Program Costs	$ 622,836	$ 26,545	$ 649,381
Less: Exchange Revenues	75,701	23,813	99,514
Net Cost of Operations	**$ 547,135**	**$ 2,732**	**$ 549,867**
Statement of Changes in Net Position for the Period Ended September 30			
Net Position Beginning of Period	$ 237,110	$ 6,656	$ 243,766
Non-Exchange Revenue	252,045	338	252,383
Other Financing Sources	304,843	539	305,382
Net Cost of Operations	(547,135)	(2,732)	(549,867)
Change in Net Position	$ 9,753	$ (1,855)	7,898
Net Position End of Period	**$ 246,863**	**$ 4,801**	**$ 251,664**

	2014		
Balance Sheet as of September 30	**Medicare**	**Other**	**Total**
Fund Balance with Treasury	$ 19,189	$ 3,581	$ 22,770
Investments	273,286	3,513	276,799
Other Assets	7,225	221	7,446
Total Assets	**$ 299,700**	**$ 7,315**	**$ 307,015**
Entitlement Benefits Due and Payable	$ 57,591	$ -	$ 57,591
Other Liabilities	4,999	659	5,658
Total Liabilities	**$ 62,590**	**$ 659**	**$ 63,249**
Unexpended Appropriations	$ 16,315	$ (100)	$ 16,215
Cumulative Results of Operations	220,795	6,756	227,551
Total Liabilities and Net Position	**$ 299,700**	**$ 7,315**	**$ 307,015**
Statement of Net Cost for the Period Ended September 30			
Gross Program Costs	$ 590,633	$ 1,109	$ 591,742
Less: Exchange Revenues	72,567	2,655	75,222
Net Cost of Operations	**$ 518,066**	**$ (1,546)**	**$ 516,520**
Statement of Changes in Net Position for the Period Ended September 30			
Net Position Beginning of Period	$ 242,714	$ 5,751	$ 248,465
Non-Exchange Revenue	242,701	307	243,008
Other Financing Sources	269,761	(948)	268,813
Net Cost of Operations	(518,066)	1,546	(516,520)
Change in Net Position	$ (5,604)	$ 905	$ (4,699)
Net Position End of Period	**$ 237,110**	**$ 6,656**	**$ 243,766**

Note 20. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 35 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. The Department did not receive any additional stewardship land in FY 2015 or FY 2014. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight. In FY 2014, this information was included in the RSI.

The table below presents stewardship land held by HHS in number of sites:

Indian Trust Land by Number of Sites and Location

	2015/2014
Albuquerque	4
Bemidji	2
Billings	7
Great Plains	9
Navajo	35
Oklahoma City	1
Phoenix	12
Portland	3
Tucson	5
Total	78

Note 21. Incidental Custodial Collections

HHS reports custodial activities on the Consolidated Balance Sheets; however, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

The majority of the custodial collections is funding ACF receives from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds.

In FY 2015, the Department had custodial collections of $2.1 billion of which $1.9 billion was related to ACF. The Department made disbursements of $2.1 billion of which $1.9 billion was related to ACF.

Note 22. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2015	2014
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,477,481	$ 1,374,378
Spending Authority from Offsetting Collections and Recoveries	(60,006)	(50,799)
Obligations Net of Offsetting Collections and Recoveries	1,417,475	1,323,579
Distributed Offsetting Receipts	(380,187)	(359,650)
Net Obligations	$ 1,037,288	$ 963,929
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	1,332	(445)
Total Resources Used to Finance Activities	**$ 1,038,620**	**$ 963,484**
Resources Used to Finance Items Not Part of the Net Cost of Operations:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ (10,625)	$ 21,765
Resources That Fund Expenses Recognized in Prior Periods	43	33
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	9,965	(6,715)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	2,092	1,389
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	3,405	3,114
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	4,880	19,586
Total Resources Used to Finance the Net Cost of Operations	**$ 1,033,740**	**$ 943,898**
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	$ (2,884)	$ 3,399
Components Not Requiring or Generating Resources	(827)	4,685
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	(3,711)	8,084
Net Cost of Operations	**$ 1,030,029**	**$ 951,982**

Note 23. Combined Schedule of Spending

The Schedule of Spending presents an overview of how departments or agencies are spending (i.e., obligating) money. The Schedule of Spending presents total budgetary resources and total obligations incurred for the reporting entity. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Statement of Budgetary Resources.

The Office of Management and Budget (OMB) makes available a searchable website, www.USAspending.gov[5], that provides information on Federal awards of contracts and grants and is accessible to the public at no cost. When

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

comparing www.USAspending.gov data to the Schedule of Spending one must take into account that the website has a fundamentally different purpose and, as such, there are differences due to object classes not reported to www.USAspending.gov that include but are not limited to personnel compensation, travel, utilities and leases, intra-departmental and interagency spending, and various other categories of financial awards. In addition, the reporting entity between the financial statements and www.USAspending.gov differs for awards resulting from funding allocations between agencies, and/or HHS OpDivs. As a result, www.USAspending.gov data will differ from the Schedule of Spending.

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

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

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

Combined Schedule of Spending
As of September 30, 2015 and 2014
(in Millions)

What Money is Available to Spend:	2015	2014
Total Resources	$ 1,543,105	$ 1,412,259
Less Amount Available but Not Agreed to be Spent	23,828	29,423
Less Amount Not Available to be Spent	41,796	8,458
	$ 1,477,481	$ 1,374,378
Who did the Money Go To:		
Federal	$ 8,142	$ 10,954
Non-Federal	1,469,339	1,363,424
	$ 1,477,481	$ 1,374,378

Combined Schedule of Spending

As of September 30, 2015 and 2014

(in Millions)

How was the Money Spent/Issued:

	2015	2014
Medicaid	**$ 378,897**	**$ 329,020**
Grants, Subsidies, and Contributions	375,142	325,548
Supplies and Materials	3,637	3,357
Other Contractual Services	101	96
Other	17	19
Medicare Hospital Insurance	**285,074**	**278,971**
Financial Assistance Direct Payments	277,004	272,336
Financial Transfers	8,068	6,630
Other	2	5
Medicare Supplementary Medical Insurance	**281,640**	**264,059**
Financial Assistance Direct Payments	276,841	258,024
Financial Transfers	4,755	5,982
Other	44	53
Payments to Trust Funds	**262,902**	**258,726**
Grants, Subsidies, and Contributions	195,385	225,295
Financial Transfers	67,445	33,431
Other	72	-
Medicare Prescription Drug Benefit (Medicare Part D)	**80,583**	**71,581**
Financial Assistance Direct Payments	80,429	71,581
Financial Transfers	154	-
Taxation on Old-Age Survivors and Disability Insurance Benefits, HI	**20,208**	**18,066**
Grants, Subsidies, and Contributions	20,208	18,066
Temporary Assistance for Needy Families	**16,717**	**16,759**
Grants, Subsidies, and Contributions	16,657	16,702
Other	60	57
State Children's Health Insurance Program	**11,496**	**10,112**
Grants, Subsidies, and Contributions	11,486	10,054
Other	10	58
Children and Families Services	**10,545**	**9,894**
Grants, Subsidies, and Contributions	10,121	9,455
Other Contractual Services	262	280
Personnel Compensation and Benefits	143	141
Other	19	18
Transitional Reinsurance Program	**8,249**	**-**
Financial Assistance Direct Payments	8,249	-
Foster Care and Permanency	**7,387**	**7,428**
Grants, Subsidies, and Contributions	7,360	7,393
Other	27	35
Indian Health Service	**5,702**	**5,429**
Grants, Subsidies, and Contributions	2,834	2,756
Personnel Compensation and Benefits	1,332	1,298
Other Contractual Services	803	813
Other	733	562
National Cancer Institute	**5,386**	**4,997**
Grants, Subsidies, and Contributions	3,609	2,981
Other Contractual Services	1,178	1,424
Personnel Compensation and Benefits	504	492
Other	95	100
Primary Health Care	**5,112**	**3,929**
Grants, Subsidies, and Contributions	4,794	3,652
Other Contractual Services	233	199
Other	85	78
Other Agency Budgetary Accounts	**97,583**	**95,407**
Grants, Subsidies, and Contributions	51,517	50,566
Other Contractual Services	23,778	25,301
Other	12,630	12,325
Financial Assistance Direct Payments	9,658	7,215
Total Amounts Agreed to be Spent	**$ 1,477,481**	**$ 1,374,378**

Note 24. Statement of Social Insurance (Unaudited)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel.

The basis for the projections in the Trustees Report has changed since last year due to the enactment of the MACRA. The projections shown in last year's report reflected a projected baseline scenario, which assumed an override of the SGR payment provisions used to set physician fee schedule payments. Since MACRA repealed the SGR formula and replaced it with specified payment updates for physicians, the projections in this year's report are based on current law.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on July 22, 2015, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the General Fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from state governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

The Part A present values in the Statement of Social Insurance exclude the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are uninsured because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the Statement of Social Insurance is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the Statement of Social Insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to

become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

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

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

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

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on July 22, 2015, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, and the CPI, fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2015 Statement of Social Insurance actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2015. Specific assumptions are made for each of the different types of service provided by the Medicare program (e.g., hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more

detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at www.cms.hhs.gov/CFOReport.[6]

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2015

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2015	1.91	1,465,000	771.3	3.18	3.38	0.20	3.3	−0.9	2.2	2.5	2.1
2020	2.04	1,395,000	730.1	1.73	4.43	2.70	2.7	4.2	5.9	5.7	2.4
2030	2.00	1,190,000	667.6	1.23	3.93	2.70	2.1	4.4	4.9	5.1	2.9
2040	2.00	1,135,000	615.0	1.20	3.90	2.70	2.2	4.9	4.1	4.9	2.9
2050	2.00	1,110,000	568.9	1.21	3.91	2.70	2.1	3.9	3.7	4.8	2.9
2060	2.00	1,095,000	528.2	1.16	3.86	2.70	2.0	3.7	3.7	4.6	2.9
2070	2.00	1,085,000	492.2	1.11	3.81	2.70	2.1	3.9	3.7	4.5	2.9
2080	2.00	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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

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

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2015-2011

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2015	2.0	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9
FY 2014	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 13th year of the projection period.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[4]Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in Table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

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

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This scenario assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain the price reductions for those providers impacted by the productivity adjustments and the specified updates to physician payments will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions, and physician payments would be 30 percent lower than they would have been under the SGR. Before such an outcome would occur, lawmakers would likely intervene to

prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments and specified physician updates, as lawmakers have done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2024, physician payments transition from a payment update of 0.0 percent to an increase of 2.3 percent. In addition, the illustrative alternative also assumes that requirements for the Independent Payment Advisory Board would not be implemented.[7] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

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

Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$17,902	$17,929
Part B	23,995	29,605
Part D	10,156	10,246
Expenditures		
Part A	21,089	25,824
Part B	23,995	29,605
Part D	10,156	10,246
Income less expenditures		
Part A	(3,187)	(7,895)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2015 Trustees Report.
[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.1 percent reduction in annual cost growth each year for these providers. If the productivity adjustments were gradually phased out and physician updates transitioned to the Medicare Economic Index update of 2.3 percent, as illustrated under the alternative scenario,

[7] The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the SGR was replaced earlier this year.

the estimated present value of Part A and Part B expenditures would be higher than the current law projections by roughly 22 percent and 23 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 23 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor impact is the result of a slight change in the discount rates that are used to calculate the present values.

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

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

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future noninterest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2014 to the period beginning on January 1, 2015, and the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

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

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

Assumptions Used for the Statement of Changes in Social Insurance Amounts

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

Period beginning on January 1, 2014 and ending January 1, 2015
Present values as of January 1, 2014 are calculated using interest rates from the intermediate assumptions of the 2014 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2015. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2014 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2015 Trustees Report.

Period beginning on January 1, 2013 and ending January 1, 2014
Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2014. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015
The effect on the 75-year present values of changing the valuation period from the prior valuation period (2014-88) to the current valuation period (2015-89) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2014 and replaces it with a much larger negative net cash flow for 2089. The present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2014-88 to 2015-89. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2014 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014
The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2013 and replaces it with a much larger negative net cash flow for 2088. The present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2013-87 to 2014-88. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior

valuation for the year 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in Projection Base

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015
Actual income and expenditures in 2014 were different than what was anticipated when the 2014 Trustees Report projections were prepared. Part A income was very slightly lower and expenditures were very slightly higher than anticipated, based on actual experience. Part B total income and expenditures were also higher than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2014 and January 1, 2015 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014
Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015
The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2015) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2012 and preliminary data for 2013 indicated lower birth rates than were expected in the prior valuation. In this year's projections the total fertility rate reaches the ultimate in 2027, which is eleven years earlier than in last year's projections.
- Incorporating mortality data obtained from Medicare experience at ages 65 and older for 2012 resulted in slightly higher death rates for 2012 and a slightly slower rate of decline in mortality over the next 25 years than were projected last year. Incorporating mortality data obtained from the National Centers for Health Statistics at ages under 65 for 2011 resulted in slightly lower death rates for 2011 and a slightly faster rate of decline in mortality over the next 25 years than were projected last year.
- Historical legal immigration was revised to include single age data (rather than 5-year age groups); including more recent marriage, legal immigration, and other-than-legal immigration data; historical data since 2001 was revised to be more consistent with the most recent estimates from the Census Bureau.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014
The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2014) are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Preliminary birth rate data for 2012 indicated lower birth rates than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.

There was one change in demographic methodology:

- The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first three years of the projection period before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015
The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2015), there was one change to the ultimate economic assumptions.

- The ultimate real-wage differential is assumed to be 1.17 percent in the current valuation period, compared to 1.13 percent in the previous valuation period.

The higher real wage differential assumption is more consistent with recent experience and expectations of slower growth in employer sponsored group health insurance premiums from the Office of the Actuary at the CMS. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The ratio of average taxable earnings to the average wage averages about 0.6 percentage point higher during the long-range period, compared to the previous valuation period.
- The projected suspense file contains fewer wage items, which is consistent with having fewer workers (many of whom are undocumented immigrants) with wages on the suspense file and more of these workers with earnings in the underground economy, compared to the previous valuation.

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

- Lower long-range growth rate assumptions.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Lower assumed hospice spending.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Introduction of high-cost specialty drugs used to treat hepatitis C.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B and Part D, these changes decreased the present value of estimated future expenditures (and also income).

For the period beginning on January 1, 2013 and the period beginning on January 1, 2014
The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:

- The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values, and the way these values transition to the ultimate assumptions, were changed.

- The ratio of average taxable earnings to the average wage index is lower by 1.9 percent in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cash flows by about the same amount as the related change in the demography methodology increased the present value of future cash flows.)

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

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of estimated future expenditures (and also income) for Part D.

Changes in Law

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Although Medicare legislation was enacted since the prior valuation date, some of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The *Veteran's Access, Choice, and Accountability Act of 2014* established a temporary program that allows eligible veterans to receive hospital care and medical services from eligible providers outside of the Department of Veterans Affairs (VA) system, rather than waiting for a VA appointment or traveling to a VA facility. The *Improving Medicare Post-Acute Care Transformation Act of 2014* standardized the collection of data for post-acute providers and aligned the inflation of the hospice aggregate cap with that of hospice reimbursement. The *Tax Increase Prevention Act of 2014* accelerated the start date for the payment adjustment of misvalued codes under the physician fee schedule from 2017 to 2016, and delayed inclusion of oral-only end-stage renal disease (ESRD)-related drugs into the ESRD bundled payment system from 2024 to 2025. MACRA included many provisions affecting Medicare spending, including the repeal of the SGR formula for determining payments under the

physician fee schedule, the continuation of extensions for several provisions from prior legislation, a reduction in payment updates for most post-acute providers in 2018, the replacement of a 3.2 percent reduction to inpatient hospitals in 2018 with a 0.5 percent reduction in 2018 through 2023, and a revision to the income thresholds for determining the income-related monthly adjustment amounts under Part B and Part D.

Overall these provisions resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) only very slightly.

For the period beginning on January 1, 2013 to the period beginning on January 1, 2014

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The *Continuing Appropriations Resolution of 2014* included several provisions that had an impact on the MACRA program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the *Protecting Access to Medicare Act of 2014* extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the ESRD prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2015

Responsibility Segment Program	2015	2014	2013	2012	2011
National Institutes of Health					
Research Training and Career Development	$ 1,631	$ 1,541	$ 1,621	$ 1,858	$ 1,920
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	828	660	766	705	761
Other Investments in Human Capital					
Other	14	8	6	6	11
Totals	$ 2,473	$ 2,209	$ 2,393	$ 2,569	$ 2,692

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

National Institutes of Health

The NIH Research Training and Career Development Programs address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's major research training and career development programs include eight institutional training grants, five individual fellowships, 13 research career development awards, two research education grants, five loan repayment programs, and a variety of other training related programs. The 27 NIH institutes and centers administer NIH's major research training and career development programs. NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research depends upon the continued development of new, highly trained investigators.

Health Resources and Services Administration

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs holistically support a diverse, culturally competent workforce by addressing components including: education and training; recruitment and retention; financial support for students, faculty, practitioners, and supporting institutions; data analysis, and evaluation and coordination of global health workforce activities. These efforts support development of a skilled health workforce serving in areas of the nation with the greatest need. In FY 2015, BHW awarded more than $1.0 billion to organizations and individuals. These funds were distributed among BHW's scholarships, loans, and loan repayment programs, health professions training programs, and programs supporting graduate medical education. Funding also supported the collection and analysis of health workforce data, which inform policies regarding health workforce supply and demand.

Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants are awarded to public and private non-profit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. ACL also administers the Administration for Intellectual and Developmental Disabilities program. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

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

Investment in Research and Development (in Millions)

For the Year Ended September 30, 2015

Responsibility Segments	Basic	Applied	Develop-mental	2015 Total	2014	2013	2012	2011	Grand Total
AHRQ	$ -	$ 167	$ -	$ 167	$ 250	$ 372	$ 401	$ 333	$ 1,523
CDC	73	391	26	490	394	457	408	457	2,206
FDA	123	-	6	129	103	94	80	58	464
NIH	16,856	11,237	-	28,093	27,719	29,328	30,681	32,902	148,723
Other	3	23	-	26	3	1	2	7	39
Totals	$ 17,055	$ 11,818	$ 32	$ 28,905	$ 28,469	$ 30,252	$ 31,572	$ 33,757	$ 152,955

The research and development programs in HHS include the following:

Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence based decision making.

Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Health Promotion and Environmental Health and Injury Prevention were the primary areas where CDC's research and development was invested.

Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct scientific studies, FDA does not consider this type of research as "research and development" because it is used to support FDA's regulatory policy and decision making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device, or medical food that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the U.S.

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

National Institutes of Health

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational and population-based research, behavioral research and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches, and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

NIH issues yearly research highlights in December each year. The highlights cover Clinical Advances/Breakthroughs, Promising Medical Advances, and Insights from the Lab. In 2014, NIH-funded research resulted in top scientific honors which includes one Nobel laureate in chemistry, and four NIH-funded recipients received awards from the Lasker Foundation. For more information on the yearly highlights, visit www.nih.gov/research-training/nih-research-highlights.

DID YOU KNOW

The 2015 Nobel Prize in chemistry was awarded to National Institutes of Health grantees Paul Modrich, Ph.D., of the Howard Hughes Medical Institute and the Duke University School of Medicine, Durham, N.C.; and Aziz Sancar, M.D., Ph.D., of the University of North Carolina, Chapel Hill, N.C., for having mapped, at a molecular level, how cells repair damaged DNA and safeguard the genetic information. NIH's National Institute of General Medical Sciences has supported the work of Dr. Sancar since 1982 and continuously supported the work of Dr. Modrich since 1972. Dr. Sancar's work has also been supported by the National Institute of Environmental Health Sciences, while the National Cancer Institute has also supported the work of Dr. Modrich.

Other Investments in Research and Development

ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children, so that they may lead healthier and more productive lives. HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision making. HRSA's basic research supports the causes, diagnosis, prevention, and cure of Hansen's disease.

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2015

	CMS					
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 1,375	$ 36,503	$ 37,878	$ 3
Recoveries of Prior Year Unpaid Obligations	13	-	22,148	4,219	26,380	-
Other Changes in Unobligated Balance	-	-	1	20,175	20,176	-
Unobligated Balance from Prior Year Budget Authority, Net	13	-	23,524	60,897	84,434	3
Appropriations (Discretionary and Mandatory)	285,049	270,457	351,098	519,003	1,425,607	-
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	50
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	12	11,183	763	20,973	32,931	80
Total Budgetary Resources	**$ 285,074**	**$ 281,640**	**$ 375,385**	**$ 600,873**	**$ 1,542,972**	**$ 133**
Status of Budgetary Resources:						
Obligations Incurred	$ 285,074	$ 281,640	$ 375,051	$ 535,585	$ 1,477,350	$ 131
Unobligated Balances, End of Year:						
Apportioned	-	-	205	26,244	26,449	-
Exempt from Apportionment	-	-	-	(2,621)	(2,621)	-
Unapportioned	-	-	129	41,665	41,794	2
Total Unobligated Balance, End of Year	-	-	334	65,288	65,622	2
Total Status of Budgetary Resources	**$ 285,074**	**$ 281,640**	**$ 375,385**	**$ 600,873**	**$ 1,542,972**	**$ 133**
Change in Obligated Balance:						
Unpaid Obligation:						
Unpaid Obligations, Brought Forward, Oct 1	$ 29,502	$ 22,816	$ 35,406	$ 128,442	$ 216,166	$ 998
Obligation Incurred	285,074	281,640	375,051	535,585	1,477,350	131
Outlays (Gross)	(281,947)	(280,975)	(346,737)	(521,325)	(1,430,984)	(754)
Actual Transfers, unpaid obligations (net)	-	-	-	196	196	-
Recoveries of Prior Year Unpaid Obligations	(13)	-	(22,148)	(4,219)	(26,380)	-
Unpaid Obligations, End of Year	**$ 32,616**	**$ 23,481**	**$ 41,572**	**$ 138,679**	**$ 236,348**	**$ 375**
Uncollected Payments:						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ -	$ -	$ -	$ (11,838)	$ (11,838)	$ (430)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	-	(11,172)	-	886	(10,286)	270
Uncollected Payments from Federal Sources, End of Year	**$ -**	**$ (11,172)**	**$ -**	**$ (10,952)**	**$ (22,124)**	**$ (160)**
Memorandum (non-add) Entries:						
Obligated Balance, Start of Year	$ 29,502	$ 22,816	$ 35,406	$ 116,604	$ 204,328	$ 568
Obligated Balance, End of Year	$ 32,616	$ 12,309	$ 41,572	$ 127,727	$ 214,224	$ 215

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $3.9 billion and net outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Combining Statement of Budgetary Resources (Continued) (in Millions)

	CMS					
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 285,061	$ 281,640	$ 351,861	$ 539,976	$ 1,458,538	$ 130
Actual Offsetting Collections (Discretionary and Mandatory)	(13)	(10)	(763)	(22,474)	(23,260)	(350)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	(11,172)	-	886	(10,286)	270
Budget Authority, Net (Discretionary and Mandatory)	**$ 285,048**	**$ 270,458**	**$ 351,098**	**$ 518,388**	**$ 1,424,992**	**$ 50**
Outlays, Gross (Discretionary and Mandatory)	$ 281,947	$ 280,975	$ 346,737	$ 521,325	$ 1,430,984	$ 754
Actual Offsetting Collections (Discretionary and Mandatory)	(13)	(10)	(763)	(22,474)	(23,260)	(350)
Outlays, Net (Discretionary and Mandatory)	281,934	280,965	345,974	498,851	1,407,724	404
Distributed Offsetting Receipts	(29,813)	(349,381)	-	(993)	(380,187)	-
Agency Outlays, Net (Discretionary and Mandatory)	**$ 252,121**	**$ (68,416)**	**$ 345,974**	**$ 497,858**	**$ 1,027,537**	**$ 404**

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 54,176	$ 54,176	$ 49,542
ACL	1,936	1,936	1,680
AHRQ	400	400	174
CDC	14,319	14,319	10,800
CMS	459,411	459,411	383,999
FDA	5,590	5,590	2,331
HRSA	11,189	11,189	9,126
IHS	7,251	7,251	4,532
NIH	34,681	34,681	29,233
OS	6,167	6,167	2,810
PSC	1,958	1,958	488
SAMHSA	3,795	3,795	3,143
Totals	**$ 600,873**	**$ 600,873**	**$ 497,858**

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $3.9 billion and net outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Deferred Maintenance and Repairs

For the Years Ended September 30, 2015 and 2014

The Federal Accounting Standards Advisory Board (FASAB) issued SFFAS No. 42, *Deferred Maintenance and Repairs*: Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32 effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices, and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repairs activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service, meets applicable building codes, and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred. CDC, NIH, and FDA all use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include PP&E location, age, design etc. Prior year numbers have been adjusted to conform to SFFAS No. 42 and the current year presentation.

	Estimated Cost to Return to Acceptable Condition (in Millions)	
Category of Asset	2015	2014
General PP&E		
Buildings	$ 2,216	$ 1,773
Equipment	13	12
Other Structures	21	11
Total	$ 2,250	$ 1,796

Social Insurance

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

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

RSI material is generally drawn from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The basis for the projections has changed since last year due to the enactment of the MACRA. This law repealed the SGR formula that set physician fee schedule payments, which were usually modified. In the 2014 report, the income, expenditures, and assets for Part B reflected the *projected baseline* scenario, which assumed an override of the SGR payment provisions and an increase in the physician fee schedule equal to the average of the most recent 10 years of SGR overrides (through March 2015) or 0.6 percent. Since the new legislation replaced the SGR system with specified payment updates for physicians, the projections in this year's report are based on current law.

While the physician payment updates and new incentives put in place by MACRA avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of $500 million per year for one group of physicians and 5 percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048 and will continue to worsen thereafter. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012*; the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections also incorporate the effects of the Patient Protection and *Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *Affordable Care Act*, contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

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

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the physicians' payment levels expected under the MACRA payment rules and the *Affordable Care Act*-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes legislative changes that result in: (i) physician payment updates that transition from the update specified in current law for 2024 to the rate of growth in the Medicare Economic Index of 2.3 percent for 2039 and later; (ii) a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates; and (iii) an elimination of the cost-saving actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[8] and *Affordable Care Act*[9] cost-reduction measures prove problematic and new legislation scales them back.

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

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from www.cms.hhs.gov/ReportsTrustFunds.[10]

[8] Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.3 percent per year in the long range.

[9] Under the *Affordable Care Act*, Medicare's annual payment rate updates for most categories of providers would be reduced below the increase in providers' input prices by the growth in economy-wide private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI-U) and CPI-medical increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

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

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the "factors contributing to growth" model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection. The Trustees' methodology is consistent with Finding III-2 and Recommendation III-2 of the 2010-2011 Medicare Technical Review Panel[11] and incorporates refinements and improvements based on research conducted by the CMS Office of the Actuary.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).[12] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act* baseline cost growth assumption for Medicare to GDP plus 1.4 percent.

- The "factors contributing to growth" model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[13] It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach.

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

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits,

[11] The Panel's final report is available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TechnicalPanelReport2010-2011.pdf.

[12] For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

[13] Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276-1284.

facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[14] The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in economy-wide private nonfarm business multifactor productivity,[15] which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care providers:

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

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 4.0 percent in 2039, or GDP plus 0.0 percent, declining gradually to 3.6 percent in 2089, or GDP minus 0.3 percent.

(ii) ***Physician services***

Payment rate updates are 0.75 percent per year under the assumption that all physicians would be participating in alternative payment models (APMs). The year-by-year per capita growth rates for physician payments are assumed to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

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

Such services include durable medical equipment,[16] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

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

These Part B outlays constitute an estimated 15 percent of total Part B expenditures in 2024 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[17] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.9 percent in 2039, or GDP plus 0.9 percent, declining to 4.4 percent by 2089, or GDP plus 0.5 percent.

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[14] Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the *Affordable Care Act*, the law did not specify any such adjustments after 2009.

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

[16] Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

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

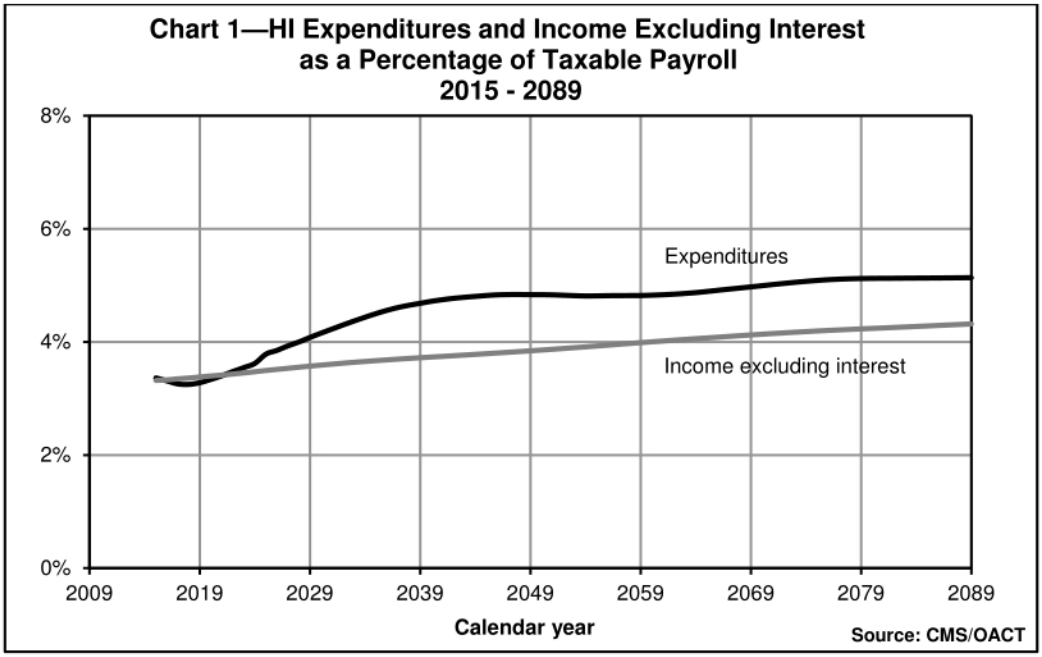
In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will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

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 3.8 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.0 percent over this same time period or GDP minus 0.0 percent, while the growth rate in 2089 is 3.7 percent or GDP minus 0.2 percent.

HI Cash Flow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2015 report are lower than those from the 2014 report for all years in the long range, primarily due to modified income-technology and price elasticity assumptions.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income, as a percentage of taxable payroll, is estimated to remain constant at 2.90 percent. In addition, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to

such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

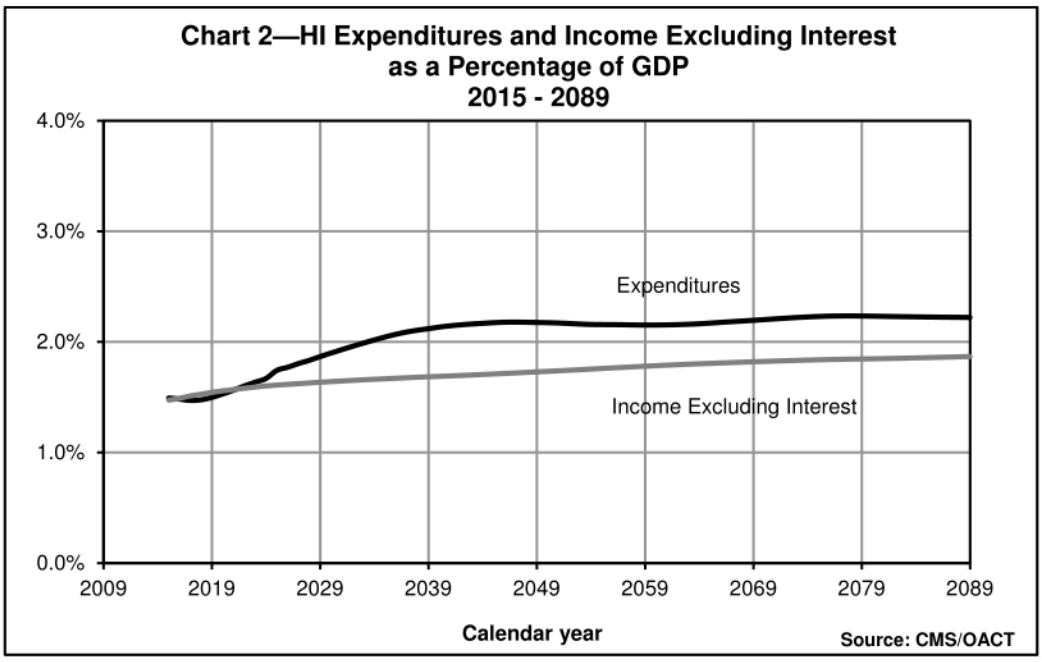
As indicated in Chart 1, the cost rate is projected to decline through 2018, largely due to: (i) expenditure growth that was constrained in part by the sequester and low payment updates; and (ii) a rebound of taxable payroll growth from recession levels. After 2018, the cost rate is projected to rise primarily due to retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 1.0 percent through 2024 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.8 percent in 2035 and 8.1 percent in 2085. These levels are about 7 percent and 58 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the U.S. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2014, the expenditures were $269.3 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.6 percent in 2089.

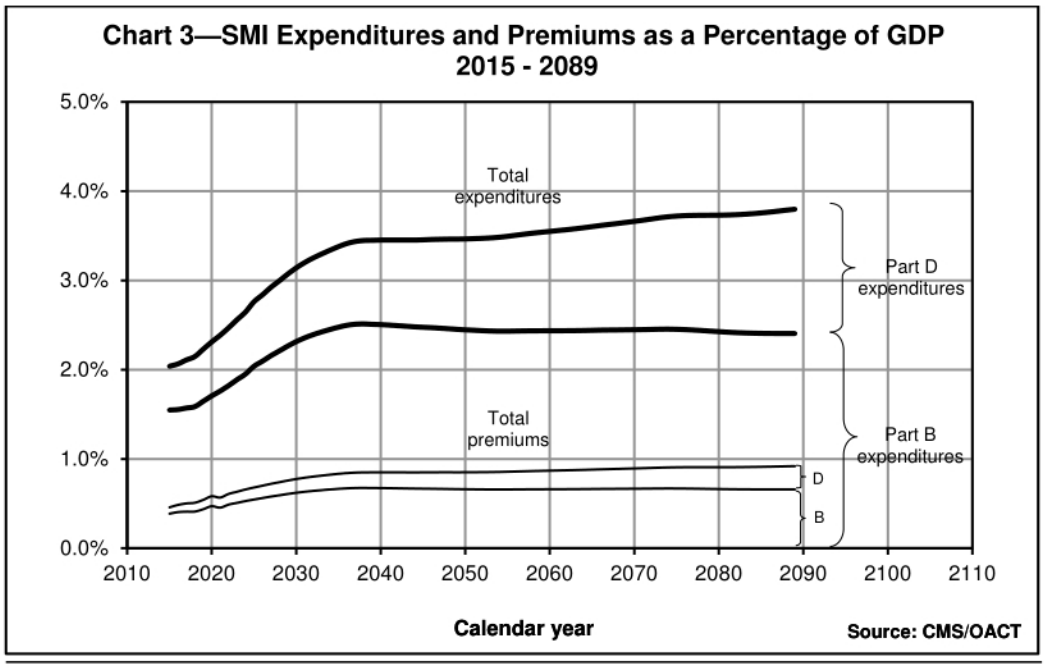


SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

In 2014, SMI expenditures were $344.0 billion, or about 2.0 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.8 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2089 would be 5.4 percent of GDP.)

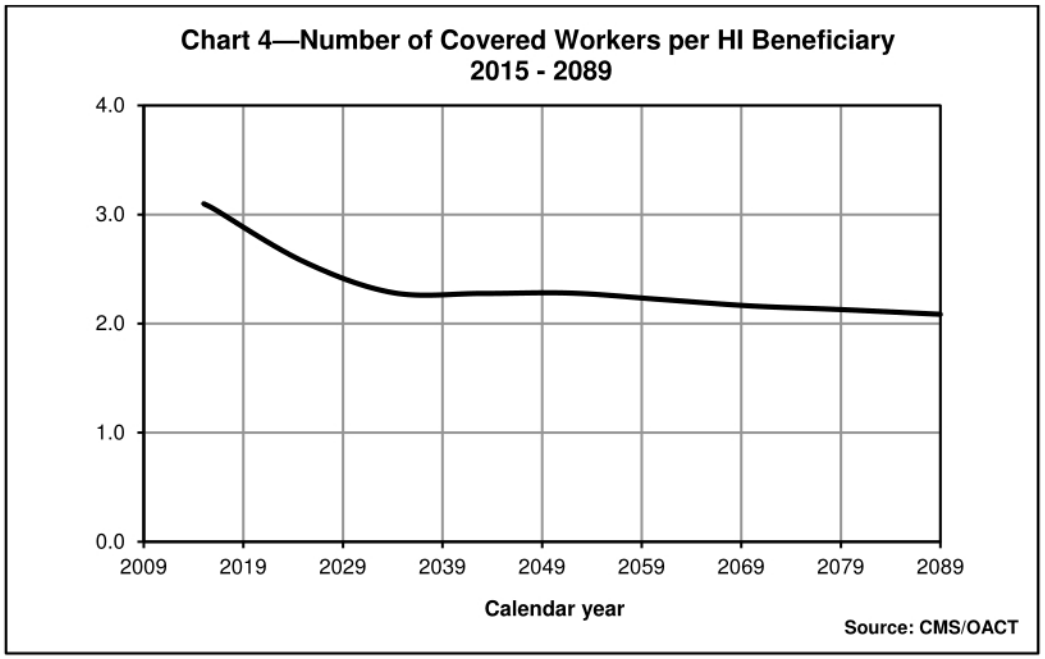


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2015 by about 4.3 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the states' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2014, every beneficiary had 3.2 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2089.



Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[18] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[19]

[18] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

[19] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

For this analysis, the intermediate economic and demographic assumptions in the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2015 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

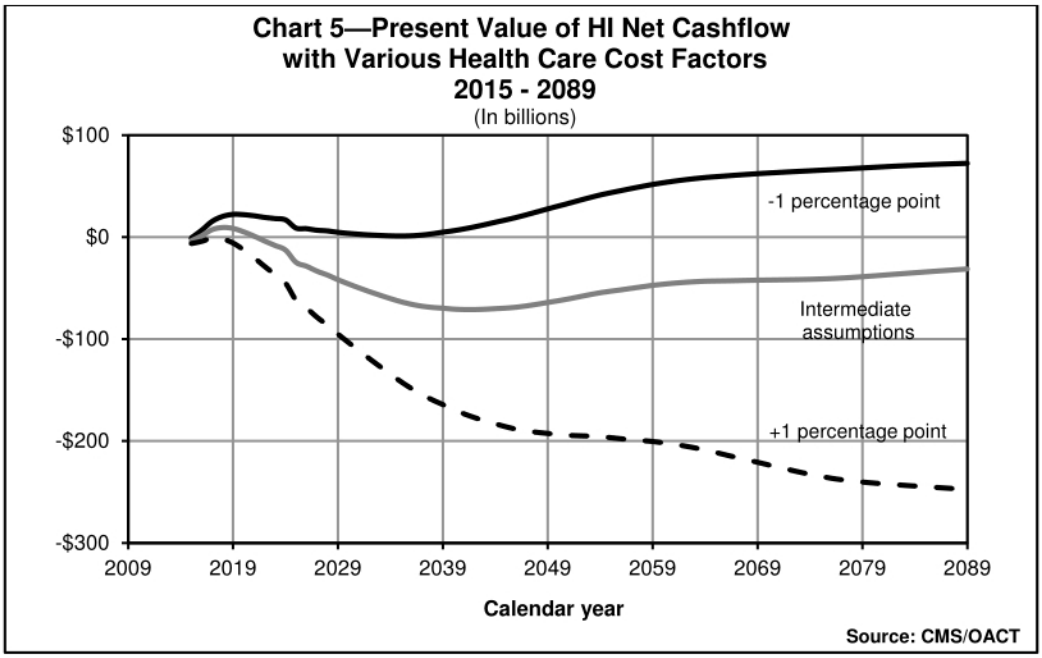
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$2,743	−$3,187	−$12,594

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,930 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,407 billion.

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



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI trust fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[20] In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 percent, respectively.

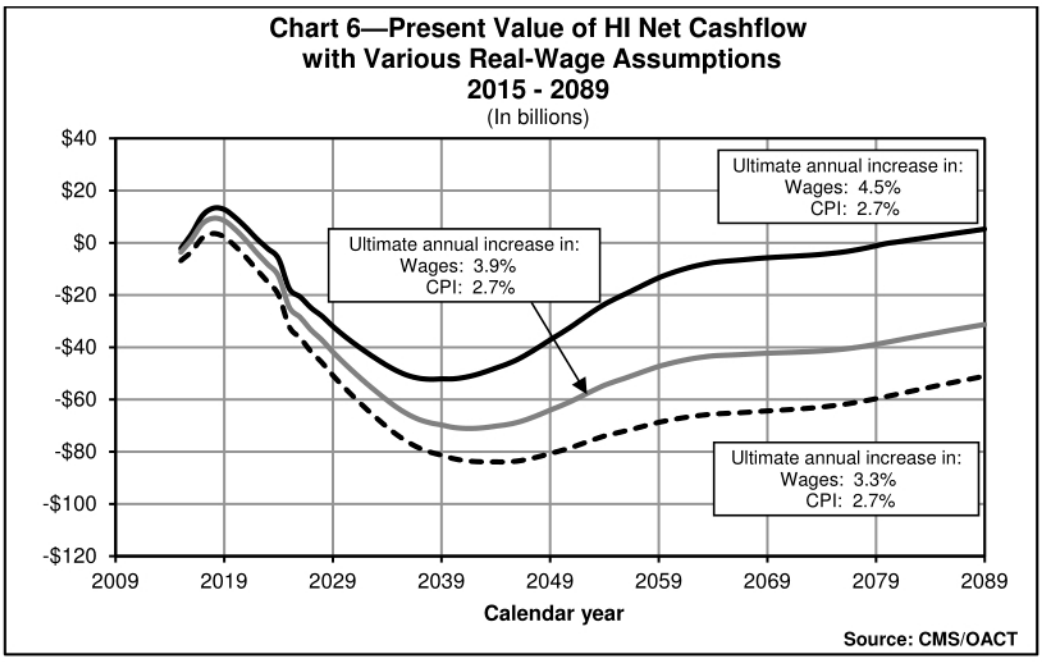
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	3.3 – 2.7	3.9 – 2.7	4.5 – 2.7
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	–$4,365	–$3,187	–$1,326

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

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $1,550 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $980 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage differential assumptions presented in Table 2.



As illustrated in Chart 6, faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the *Affordable Care Act* and MACRA depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong possibility that certain payment changes will not be viable in the long range.

Consumer Price Index

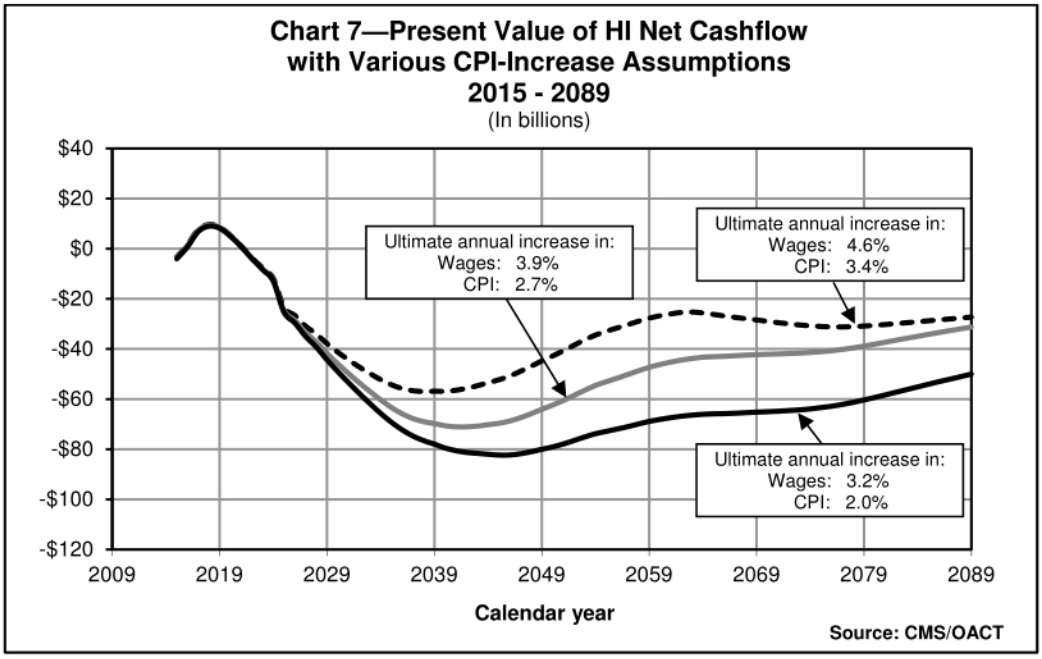
Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages – CPI	4.6 – 3.4	3.9 – 2.7	3.2 – 2.0
Income minus expenditures (in billions)	–$2,386	–$3,187	–$4,221

Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.6, 3.9, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by $801 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,034 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.



As Chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The relative insensitivity of the projected present values of HI cash flow to different levels of general inflation occurs because inflation tends to proportionately affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required by the *Affordable Care Act* for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

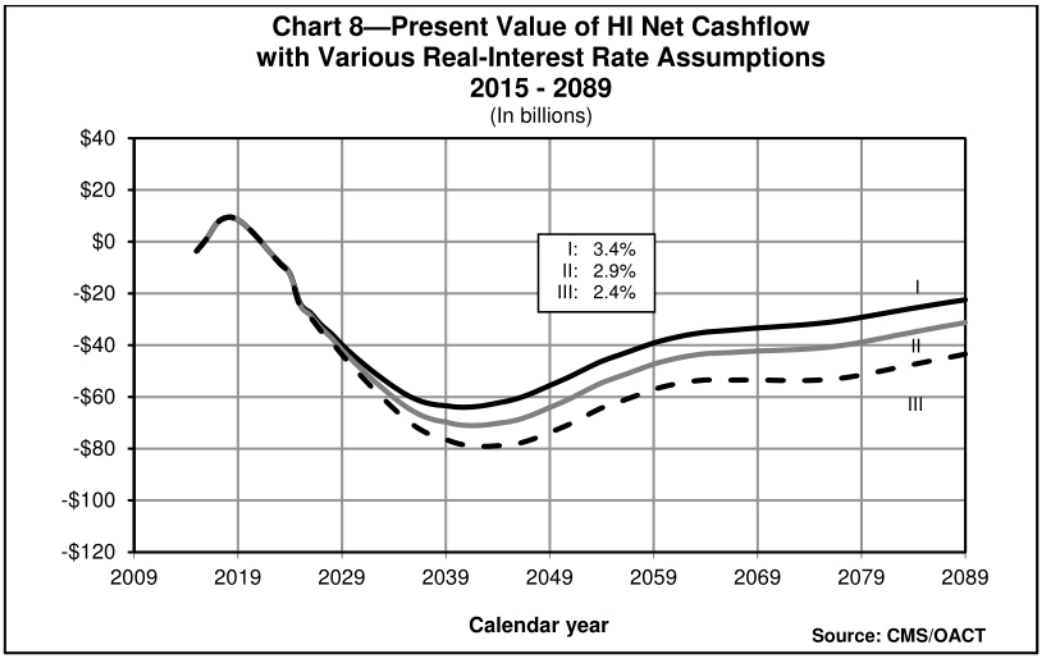
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 percent, respectively.

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

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures (in billions)	−$3,774	−$3,187	−$2,704

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $105 billion.

Chart 8 shows projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.



As shown in Chart 8, the projected HI cash flow, when expressed in present values, is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

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

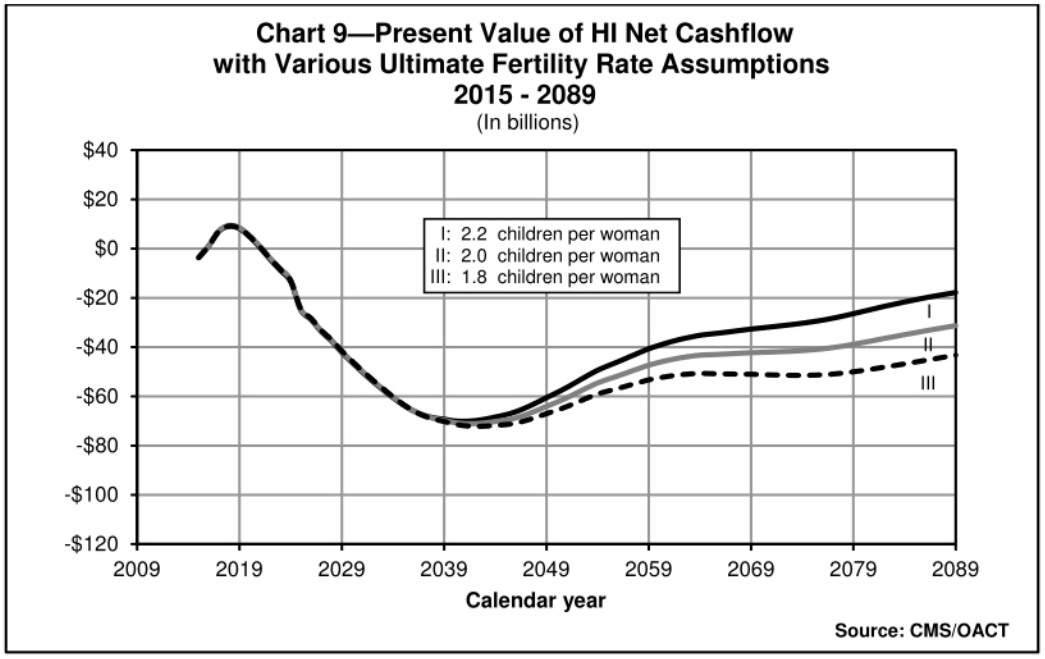
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures (in billions)	−$3,547	−$3,187	−$2,793

[1]The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $375 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.



As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cash flows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

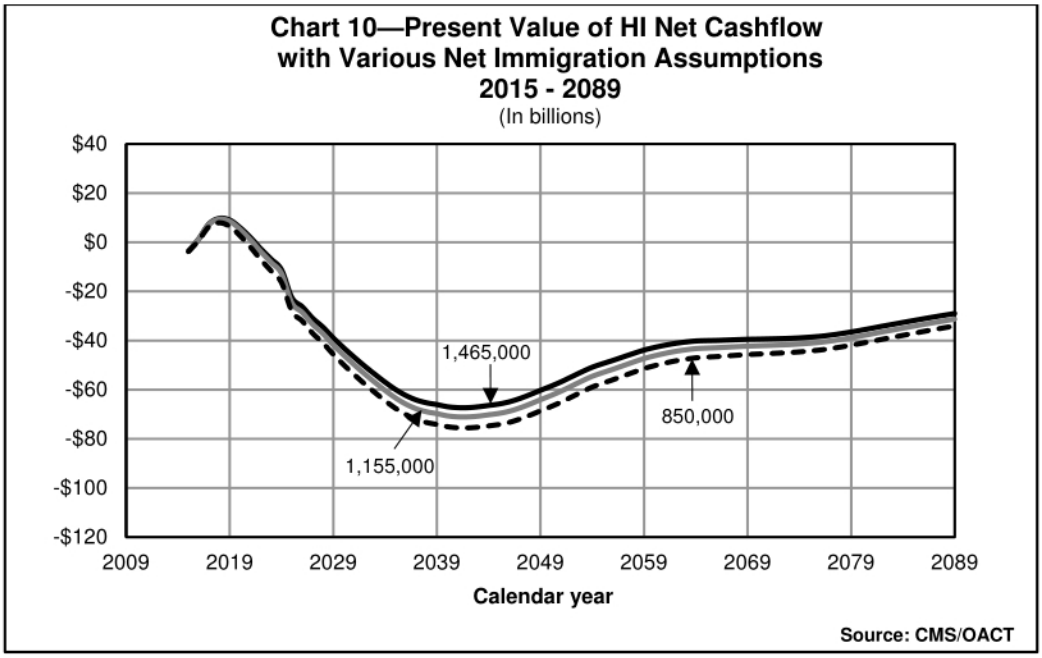
Table 6 shows the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 850,000 persons, 1,155,000 persons, and 1,465,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	850,000	1,155,000	1,465,000
Income minus expenditures (in billions)	−$3,455	−$3,187	−$2,981

As indicated in Table 6, if the average annual net immigration assumption is 850,000 persons, the deficit—expressed in present-value dollars—increases by $268 billion. Conversely, if the assumption is 1,465,000 persons, the deficit decreases by $206 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.



Higher net immigration results in smaller HI cash flow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is about the same as projected in last year's annual report, as factors causing improved finances are offset by other changes. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2030, the same as in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI tax income in 2014 was somewhat higher than last year's estimate, mostly due to adjustments for prior years,[21] but is projected to be slightly lower through 2019; after 2019, however, projections of earnings throughout the period are higher mostly due to assumptions of slower projected growth in employer-sponsored health insurance—a factor that increases wages. Although HI expenditures in 2014 were nearly equal to the previous estimate, projected expenditures are higher at the end of the 10-year period than shown in last year's report, largely due to increases in provider payment update assumptions that reflect recent trends.

HI expenditures have exceeded income annually since 2008. However, the Trustees project slight surpluses in 2015 through 2023, with a return to deficits thereafter until the trust fund becomes depleted in 2030. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2015 is adequate to cover 2015 expected expenditures but would need to be increased in future years in order to restore the financial status of the Part B account to a satisfactory level.[22] Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

[21] Initial appropriations of payroll taxes are made on an estimated basis, and then each year adjustments are made to the appropriations for prior years to reflect actual tax receipts.

[22] In 2016, a hold-harmless provision that restricts Part B premium increases for most beneficiaries is expected to cause a substantial increase in the Part B premium rate for other beneficiaries.

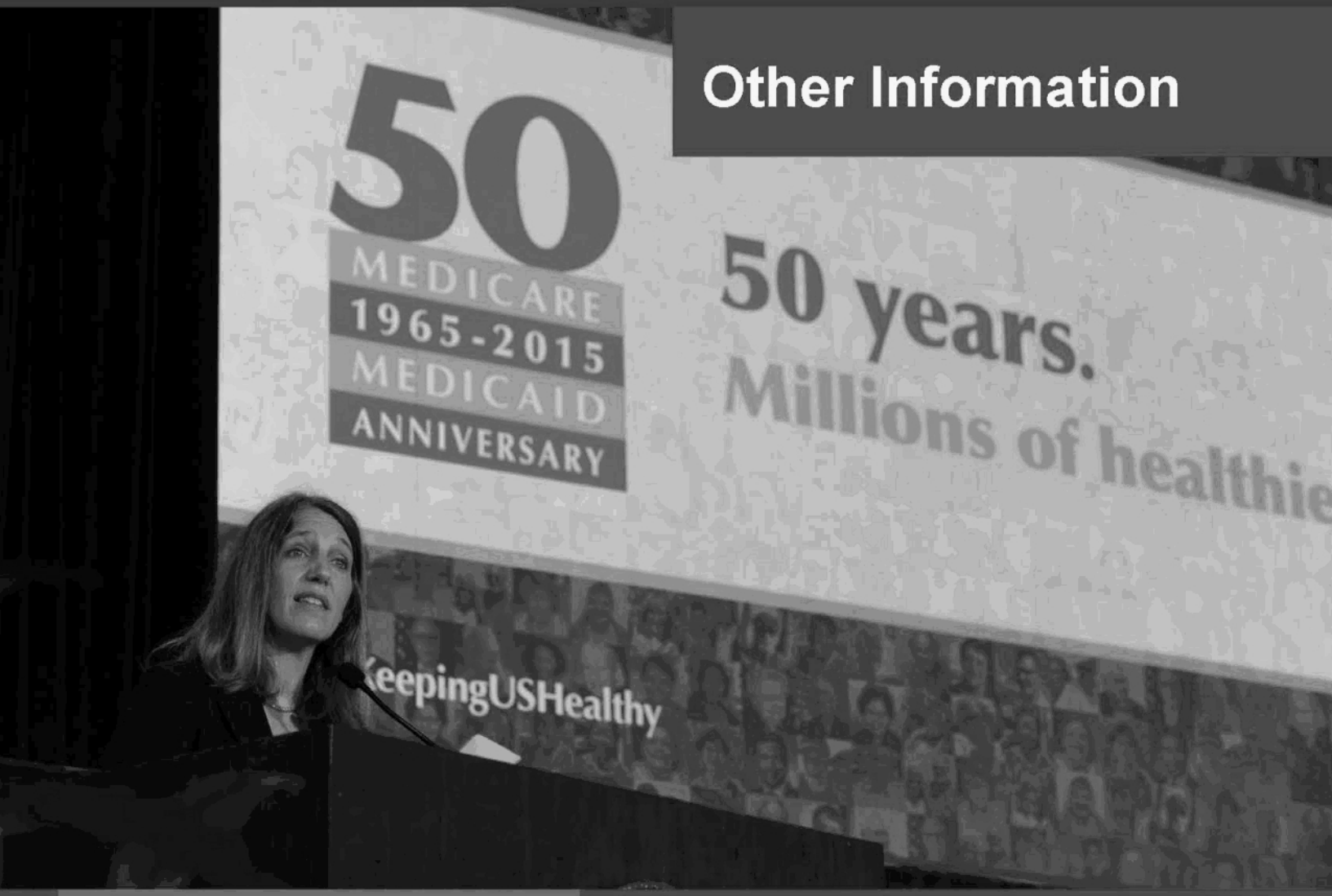
Medicare Overall

The *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources[23] is projected to exceed 45 percent of total Medicare outlays under current law within the next seven fiscal years (2015-2021). If this level is attained within the seven year timeframe, federal law requires a determination of projected excess general revenue Medicare funding. For the 2015 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2015-2021 (the first seven years of the projection), and therefore the Trustees are not issuing this determination.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2015 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

[23]Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

Other Information



About the photo

Secretary Burwell speaking at the 50th Medicare and Medicaid Anniversary celebration at the HHS Headquarters.

In This Section

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OTHER FINANCIAL INFORMATION

Combined Schedule of Spending By Object Class

As of September 30, 2015

(in Millions)

The Combined Schedule of Spending presented below includes HHS's spending for all programs with spending greater than $1 billion to increase transparency.

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2015
Medicaid	$ 375,142	$ -	$ 101	$ 17	$ 3,637	$ 378,897
Medicare Hospital Insurance	-	277,001	2	-	8,071	285,074
Medicare Supplementary Medical Insurance	-	276,841	44	-	4,755	281,640
Payments to Trust Funds	195,385	72	-	-	67,445	262,902
Medicare Prescription Drug Benefit (Medicare Part D)	-	80,429	-	-	154	80,583
Taxation on OASDI Benefits, HI	20,208	-	-	-	-	20,208
Temporary Assistance for Needy Families	16,657	-	58	2	-	16,717
State Children's Health Insurance Program	11,486	-	4	-	6	11,496
Children and Families Services	10,121	-	262	143	19	10,545
Transitional Reinsurance Program	-	8,249	-	-	-	8,249
Foster Care and Permanency	7,360	-	26	-	1	7,387
Indian Health Services	2,834	-	803	1,332	733	5,702
National Cancer Institute	3,609	-	1,178	504	95	5,386
Primary Health Care	4,794	-	233	70	15	5,112
Allergy and Infectious Diseases	3,043	-	1,492	310	83	4,928
Child Support Enforcement and Family Support	3,637	-	710	-	-	4,347
Medicare Health Information Technology Incentive	-	4,282	-	-	-	4,282
Low Income Home Energy Assistance	3,392	-	3	-	-	3,395
Heart, Lung, and Blood Institute	2,237	-	551	152	33	2,973
Child Care Entitlement to States	2,929	-	17	-	-	2,946
Mental Health	1,982	-	348	97	20	2,447
Child Care and Development Block Grant	2,396	-	39	-	-	2,435
Ryan White HIV/AIDS Program	2,199	-	83	27	9	2,318
General Medical Sciences	2,141	-	103	29	2	2,275
Substance Abuse Treatment	2,024	-	146	10	7	2,187
Risk Adjustment Program Payment	-	2,141	-	-	-	2,141
Public Health and Social Services	455	-	1,085	119	304	1,963
Aging Services Programs	1,850	-	35	27	4	1,916
Health Care Fraud and Abuse	-	-	1,775	55	7	1,837
Diabetes and Digestive and Kidney Diseases	1,417	-	206	112	23	1,758
Social Services Block Grant	1,648	-	11	1	-	1,660
Service and Supply Fund	-	-	980	261	372	1,613
Neurological Disorders and Stroke	1,205	-	207	85	22	1,519
Refugee and Entrant Assistance	1,247	-	137	10	4	1,398
Child Health and Human Development	961	-	313	98	20	1,392
Medicare and Medicaid Innovation	595	63	649	61	3	1,371
Public Health Preparedness and Response	633	-	273	104	343	1,353
National Institute on Aging	1,094	-	151	68	16	1,329
HHS Service and Supply Fund	-	-	974	150	98	1,222
Disease Control Research and Training	605	-	332	151	115	1,203
Chronic Disease Prevention and Health Promotion	764	-	301	128	8	1,201
HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention	751	-	185	166	16	1,118
National Institute on Drug Abuse	723	-	222	66	13	1,024
Other Agency Budgetary Accounts	11,589	3,172	12,450	6,449	2,372	36,032
Total Amounts Agreed to be Spent	**$ 699,113**	**$ 652,250**	**$ 26,489**	**$ 10,804**	**$ 88,825**	**$ 1,477,481**

Combined Schedule of Spending By Object Class

As of September 30, 2014

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Financial Assistance Direct Payments	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2014
Medicaid	$ 325,548	$ -	$ 96	$ 17	$ 3,359	$ 329,020
Medicare Hospital Insurance	-	272,336	5	-	6,630	278,971
Medicare Supplementary Medical Insurance	-	258,024	53	-	5,982	264,059
Payments to Trust Funds	225,295	-	-	-	33,431	258,726
Medicare Prescription Drug Benefit (Medicare Part D)	-	71,581	-	-	-	71,581
Taxation on OASDI Benefits, HI	18,066	-	-	-	-	18,066
Temporary Assistance for Needy Families	16,702	-	55	2	-	16,759
State Children's Health Insurance Program	10,054	-	21	-	37	10,112
Children and Families Services	9,455	-	280	141	18	9,894
Transitional Reinsurance Program	-	-	-	-	-	-
Foster Care and Permanency	7,393	-	35	-	-	7,428
Indian Health Services	2,756	-	813	1,298	562	5,429
National Cancer Institute	2,981	-	1,424	492	100	4,997
Primary Health Care	3,652	-	199	68	10	3,929
Allergy and Infectious Diseases	2,744	-	1,336	302	75	4,457
Child Support Enforcement and Family Support	3,569	-	756	-	-	4,325
Medicare Health Information Technology Incentive	-	6,809	-	-	-	6,809
Low Income Home Energy Assistance	3,375	-	26	-	-	3,401
Heart, Lung, and Blood Institute	2,229	-	578	147	36	2,990
Child Care Entitlement to States	2,916	-	30	-	-	2,946
Mental Health	2,096	-	305	95	21	2,517
Child Care and Development Block Grant	2,336	-	35	-	(1)	2,370
Ryan White HIV/AIDS Program	2,192	-	97	24	2	2,315
General Medical Sciences	2,252	-	119	28	2	2,401
Substance Abuse Treatment	2,024	-	141	8	8	2,181
Risk Adjustment Program Payment	-	-	-	-	-	-
Public Health and Social Services	238	-	871	113	333	1,555
Aging Services Programs	1,663	-	32	21	3	1,719
Health Care Fraud and Abuse	-	-	1,546	51	4	1,601
Diabetes and Digestive and Kidney Diseases	1,512	-	255	108	27	1,902
Social Services Block Grant	1,647	-	10	1	-	1,658
Service and Supply Fund	7	-	966	247	344	1,564
Neurological Disorders and Stroke	1,298	-	201	84	21	1,604
Refugee and Entrant Assistance	1,411	-	109	6	2	1,528
Child Health and Human Development	892	-	302	96	24	1,314
Medicare and Medicaid Innovation	564	116	452	45	4	1,181
Public Health Preparedness and Response	627	-	272	105	398	1,402
National Institute on Aging	925	-	147	65	17	1,154
HHS Service and Supply Fund	-	-	825	151	66	1,042
Disease Control Research and Training	-	-	-	-	-	-
Chronic Disease Prevention and Health Promotion	764	-	289	124	8	1,185
HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention	741	-	193	165	18	1,117
National Institute on Drug Abuse	799	-	231	63	13	1,106
Other Agency Budgetary Accounts	11,746	290	15,176	6,264	2,587	36,063
Total Amounts Agreed to be Spent	$ 672,469	$ 609,156	$ 28,281	$ 10,331	$ 54,141	$ 1,374,378

Consolidating Balance Sheet by Budget Function

As of September 30, 2015

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 9,925	$ 151,312	$ 44,785	$ 13,437	$ 219,459	$ -	$ 219,459
Investments, Net (Note 4)	-	5,658	263,993	-	269,651	-	269,651
Accounts Receivable, Net (Note 5)	92	2,632	85,026	3	87,753	(86,748)	1,005
Other Assets (Note 8)	16	192	24	15	247	(69)	178
Total Intragovernmental Assets	10,033	159,794	393,828	13,455	577,110	(86,817)	490,293
Accounts Receivable, Net (Note 5)	-	14,724	6,775	416	21,915	-	21,915
Inventory and Related Property, Net (Note 6)	-	9,516	-	-	9,516	-	9,516
General Property, Plant and Equipment, Net (Note 7)	-	5,609	308	-	5,917	-	5,917
Other Assets (Note 8)	-	1,151	3	-	1,154	-	1,154
Total Assets	$ 10,033	$ 190,794	$ 400,914	$ 13,871	$ 615,612	$ (86,817)	$ 528,795
Stewardship Land (Notes 1 and 20)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 21	$ 260	$ 86,757	$ -	$ 87,038	$ (86,729)	$ 309
Other Liabilities (Note 13)	2	3,272	9	414	3,697	(88)	3,609
Total Intragovernmental Liabilities	23	3,532	86,766	414	90,735	(86,817)	3,918
Accounts Payable	12	482	75	5	574	-	574
Entitlement Benefits Due and Payable (Note 10)	-	41,928	66,221	-	108,149	-	108,149
Accrued Liabilities (Note 12)	698	12,965	(63)	650	14,250	-	14,250
Federal Employee and Veterans Benefits (Note 11)	3	12,062	7	-	12,072	-	12,072
Contingencies and Commitments (Note 14)	-	9,095	10	-	9,105	-	9,105
Other Liabilities (Note 13)	19	2,258	1,035	8	3,320	-	3,320
Total Liabilities	755	82,322	154,051	1,077	238,205	(86,817)	151,388
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(100)	30,284	-	30,184	-	30,184
Unexpended Appropriations - All Other funds	9,200	94,120	-	12,769	116,089	-	116,089
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	4,901	216,579	-	221,480	-	221,480
Cumulative Results of Operations - All Other funds	78	9,551	-	25	9,654	-	9,654
Total Funds from Dedicated Collections	-	4,801	246,863	-	251,664	-	251,664
Total All Other Funds	9,278	103,671	-	12,794	125,743	-	125,743
Total Net Position	9,278	108,472	246,863	12,794	377,407	-	377,407
Total Liabilities and Net Position	$ 10,033	$ 190,794	$ 400,914	$ 13,871	$ 615,612	$ (86,817)	$ 528,795

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2015

(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations: Cost (-)	Intra-HHS Eliminations: Revenue	Consolidated Totals
ACF	$ 12,312	$ -	$ -	$ 37,999	$ 50,311	$ (57)	$ 15	$ 50,269
ACL	1,755	-	-	-	1,755	(9)	9	1,755
AHRQ	-	179	-	-	179	(18)	197	358
CDC	-	10,246	-	-	10,246	(126)	223	10,343
CMS	-	366,691	547,135	-	913,826	(521)	15	913,320
FDA	-	3,189	-	-	3,189	(269)	12	2,932
HRSA	-	9,207	-	-	9,207	(138)	51	9,120
IHS	-	4,871	-	-	4,871	(160)	196	4,907
NIH	-	29,724	-	-	29,724	(617)	229	29,336
OS	-	2,949	-	-	2,949	(574)	719	3,094
PSC	-	684	-	-	684	(21)	542	1,205
SAMHSA	-	3,292	-	-	3,292	(38)	136	3,390
Net Cost of Operations	$ 14,067	$ 431,032	$ 547,135	$ 37,999	$ 1,030,233	$ (2,548)	$ 2,344	$ 1,030,029

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2015

(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	$ 122	$ (57)	$ 65	$ (31)	$ 15	$ (16)	$ 50,235	$ (15)	$ 50,269
ACL	20	(9)	11	(9)	9	-	1,744	-	1,755
AHRQ	53	(18)	35	(197)	197	-	324	(1)	358
CDC	807	(126)	681	(367)	223	(144)	9,836	(30)	10,343
CMS	1,407	(521)	886	(27)	15	(12)	1,010,464	(98,018)	913,320
FDA	1,250	(269)	981	(33)	12	(21)	3,244	(1,272)	2,932
HRSA	253	(138)	115	(51)	51	-	9,043	(38)	9,120
IHS	815	(160)	655	(207)	196	(11)	5,503	(1,240)	4,907
NIH	1,604	(617)	987	(314)	229	(85)	28,998	(564)	29,336
OS	936	(574)	362	(777)	719	(58)	2,812	(22)	3,094
PSC	317	(21)	296	(1,019)	542	(477)	1,659	(273)	1,205
SAMHSA	101	(38)	63	(136)	136	-	3,328	(1)	3,390
Totals	$ 7,685	$ (2,548)	$ 5,137	$ (3,168)	$ 2,344	$ (824)	$ 1,127,190	$ (101,474)	$ 1,030,029

Freeze the Footprint

For the Year Ended September 30, 2015

	Freeze the Footprint Baseline Comparison (in Square Footage)		
	2012 Baseline	2014 Year End	+/- Change
Total Leased	13,603,974	13,593,265	(10,709)
Total Owned	6,112,229	6,457,747	345,518
Total	19,716,203	20,051,012	334,809

	Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)		
	2012 Baseline	2014 Year End	+/- Change
Operation and Maintenance Costs	$ 83.3	$ 84.7	$ 1.4

Consistent with Section 3 of the OMB Memorandum - 12-12, *Promoting Efficient Spending to Support Agency Operations* and OMB Management Procedures Memorandum 2013-02, the "Freeze the Footprint" policy implementing guidance, all *Chief Financial Officers Act of 1990* departments and agencies shall not increase the total square footage of their domestic office and warehouse inventory compared to the FY 2012 baseline. Compared to the FY 2012 Baseline, the HHS inventory of office and warehouse space increased by 334,809 square feet in FY 2014, an overall increase of 1.7%. This is consistent with our projections in the September 2014 HHS Freeze the Footprint Plan. Because of known projects currently underway, HHS continues to project that it will be the end of FY 2016 when we can meet the FY 2012 Baseline. HHS will accomplish this through aggressively pursuing space and cost savings in office and warehouse space, through implementation of the HHS 170 useable square feet per person utilization rate policy for office space and through targeted consolidation projects for both office and warehouse space.

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

The United States Department of Health and Human Services (HHS or the Department) *FY 2015 Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA); OMB Circular A-136; and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.0)
- Risk Assessments (Section 2.0)
  - *Affordable Care Act* Risk Assessment (Section 2.10)
- Statistical Sampling Process (Section 3.0)
  - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (CAPs) (Section 4.0)
  - Corrective Actions for High-Priority Programs (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- Progress and Achievements (Section 8.0)
  - FY 2015 Progress (Section 8.10)
  - FY 2015 Achievements (Section 8.20)
- Improper Payment Reduction Outlook (Section 9.0)
  - Accompanying Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs Notes (Section 9.10)
  - Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes (Section 9.20)
- Improper Payment Root Cause Categories (Section 10.0)
- Program-Specific Reporting Information (Section 11.0)
  - Medicare Fee-for-Service (FFS) (Parts A and B) (Section 11.10)
  - Medicare Advantage (Part C) (Section 11.20)
  - Medicare Prescription Drug Benefit (Part D) (Section 11.30)
  - Medicaid (Section 11.40)
  - Children's Health Insurance Program (CHIP) (Section 11.50)
  - Temporary Assistance for Needy Families (TANF) (Section 11.60)
  - Foster Care (Section 11.70)
  - Child Care and Development Fund (CCDF) (Section 11.80)
- Internal Control Over Payments (Section 12.0)
- Recovery Auditing Reporting (Section 13.0)
- Do Not Pay Initiative (Section 14.0)
- Superstorm Sandy Reporting Information (Section 15.0)
  - Head Start (Section 15.10)
  - Social Services Block Grant (SSBG) (Section 15.20)
  - Family Violence Prevention and Services (FVPS) (Section 15.30)
  - Assistant Secretary for Preparedness and Response (ASPR) Research (Section 15.40)
  - Centers for Disease Control and Prevention (CDC) Research (Section 15.50)
  - Substance Abuse and Mental Health Services Administration (SAMHSA) (Section 15.60)
  - National Institutes of Health (NIH) Research (Section 15.70)

1.0 Program Descriptions

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

OMB-Determined Risk-Susceptible Programs:

1. **Medicare FFS** - A federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
2. **Medicare Part C** - A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
3. **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. **CHIP** - A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
6. **TANF** - A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
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. **CCDF** - A joint federal/state program, administered by the states, that provides child care financial assistance to low income working families.

Superstorm Sandy Risk-Susceptible Programs:

9. **Head Start** - A federal program that provides comprehensive developmental services for America's low-income children from birth to five years of age, and their families.
10. **SSBG** - A joint federal/state program, administered by the states, which supports programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services.
11. ***FVPS Act*** - A federal funding stream dedicated to the prevention of domestic violence as well as support of emergency shelters and related assistance for victims of domestic violence and their children.
12. **ASPR Research** - A federal initiative to build a strong scientific research dataset and to support research that will aid in the response to, and recovery from, Superstorm Sandy.
13. **CDC Research** - A federal effort to improve and enhance the emergency preparedness system to protect life and property from disasters.
14. **SAMHSA** - A joint federal/state initiative to provide continued and enhanced mental health and substance abuse treatment to affected parties.
15. **NIH Research** - A federal initiative to restore investment in biomedical research and infrastructure that was severely damaged or destroyed by Superstorm Sandy.

2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments and those required to be measured under the Superstorm Sandy *Disaster Relief Appropriations Act of 2003* (*Disaster Relief Act*), HHS also reviews other programs to determine if they are susceptible to significant improper payments. From FY 2012 through FY 2014, HHS's risk assessment approach to meet the improper payment risk assessment requirements under IPERIA, and OMB Circular A-123, Appendix C, was part of a larger, agency-wide program

integrity process. In late FY 2015, HHS incorporated the improper payment risk assessment requirements into a new, qualitative risk assessment tool. As a result, for FY 2015, HHS conducted risk assessments under both approaches.

Per OMB Circular A-123, Appendix C, Part I.A.9.b, the new risk assessment tool—or questionnaire—contains nine factors that shall be taken into account during a risk assessment, including:

1. Whether the program reviewed is new to the agency;
2. The complexity of the program reviewed, particularly with respect to determining correct payment amounts;
3. The volume of payments made annually;
4. Whether payments or payment eligibility decisions are made outside of the agency, for example, by a state or local government, or a regional federal office;
5. Recent major changes in program funding, authorities, practices, or procedures;
6. The level, experience, and quality of training for personnel responsible for making program eligibility determinations or certifying that payments are accurate;
7. Inherent risks of improper payments due to the nature of agency programs or operations;
8. Significant deficiencies in the audit reports of the agency including, but not limited to, HHS Inspector General or Government Accountability Office (GAO) audit report findings, or other relevant management findings that might hinder accurate payment certification; and
9. Results from prior improper payment work.

In addition to these risk factors, the improper payment risk assessment questionnaire includes information on specific risks identified by the program that may lead to improper payments, as well as controls that may help mitigate those risks. By examining both the required risk factors and additional internal control information, the new risk assessment tool provides a comprehensive review and analysis of selected programs' operations to determine if a risk exists and the nature and extent of the risks identified.

In FY 2015, HHS reviewed three programs under the previous integrated risk assessment approach: Administration for Community Living (ACL) State Plan Development for Mandatory Grant Programs; Indian Health Service (IHS) Special Diabetes Initiative; and the National Partnership for Action to End Health Disparities. HHS also reviewed nine programs under the new risk assessment approach: Adoption Assistance; Nutrition Services; Health Costs, Quality, and Outcomes; National Breast and Cervical Cancer Early Detection; Food and Drug Administration (FDA) Grants; Ryan White HIV/AIDS Part B; IHS Interagency Agreements; Internal and National Emergency Ebola Response and Preparedness; and Access to Recovery Grants. HHS determined that all of the programs reviewed under the two risk assessment approaches were not at-risk for significant improper payments. The Centers for Medicare & Medicaid Services (CMS) did not complete an improper payment risk assessment in FY 2015, but has instead begun working on a comprehensive improper payment risk assessment to evaluate health insurance marketplace and related programs created under the *Patient Protection and Affordable Care Act* (see *Section 2.10* for more information on the *Affordable Care Act* risk assessment).

HHS also reviewed OMB guidance and departmental activities related to the oversight of employee pay and charge cards to determine if existing activities could be leveraged to meet IPERIA's requirement to assess the risk in these two payment categories. After determining that some of these processes could be leveraged—particularly for employee pay—HHS began planning to conduct qualitative risk assessments of employee pay and charge cards at the Program Support Center (PSC) and the following Operating Divisions (OpDivs): FDA, IHS, NIH, and the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) in FY 2016. HHS will review these OpDivs because they comprise the vast majority of charge card program expenses and cardholders. HHS will report the risk

susceptibility for improper payments related to employee pay and charge cards in the FY 2016 Agency Financial Report (AFR).

2.10 *Affordable Care Act* Risk Assessment

The Department of Health and Human Services (HHS) and the Department of the Treasury each have responsibilities for ensuring payment accuracy in programs created under the *Affordable Care Act*. Performing comprehensive risk assessments is critical to establishing an effective program for achieving payment accuracy in future years. In FY 2015, both Departments finalized plans for and began to perform comprehensive improper payment risk assessments to determine areas that might affect Advance Premium Tax Credit (APTC), Premium Tax Credit (PTC), Cost-sharing Reduction and Basic Health Plan payment accuracy. Both Departments are leveraging the same Federally Funded Research and Development Center (FFRDC) to assist with conducting these risk assessments, which will facilitate interagency coordination and provide a comprehensive assessment of risk that takes into account activities by the Marketplaces, HHS, and the Internal Revenue Service. An update on the status and preliminary results of the FFRDC supported risk assessments will be reported in the FY 2016 AFR. In addition, both Departments have established internal controls to provide for effective program operations, reliable financial reporting, and compliance with laws and regulations.

3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 11.0: Program-Specific Reporting Information* or *Section 15.0: Superstorm Sandy Reporting Information*. Unless otherwise stated in *Section 11.0* or *Section 15.0*, all programs that reported an error rate estimate complied with the requirement that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments. In addition, seven of the eight programs that OMB determined are susceptible to significant improper payments are reporting error estimates calculated by a statistical contractor.

3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Tables 1A and 1B in *Section 9.0: Improper Payment Reduction Outlook* present each at-risk or Superstorm Sandy program's gross and net error rates.

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

4.0 Corrective Action Plans (CAPs)

Each program's CAP for reducing the estimated rate of improper payments can be found in *Section 11.0: Program-Specific Reporting Information* or *Section 15.0: Superstorm Sandy Reporting Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all out-year error rate targets. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

4.10 Corrective Actions for High-Priority Programs

Under Executive Order (EO) 13520 and its implementing guidance, OMB identifies programs that have more than $750 million in annual estimated improper payments and that contribute substantially to the government-wide improper payment estimate. These programs, known as high-priority programs, are required to perform certain activities, including: selecting Accountable Officials to oversee the agency's improper payment efforts; posting improper payment information to www.PaymentAccuracy.gov; and developing supplemental measures in addition to the annual error rate measures.

HHS has five programs that OMB deemed high-priority programs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP. Accordingly, HHS has worked to meet the EO's additional requirements for its high-risk programs, and information on HHS's efforts can be found on www.PaymentAccuracy.gov. In addition, while root causes of errors in the Department's programs can fluctuate from year to year, HHS remains focused on reducing the annual error rates for its high-priority programs, and is taking many actions to prevent and reduce improper payments (see *Section 11.0* for more information on HHS's corrective actions).

5.0 Accountability in Reducing and Recovering Improper Payments

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

6.0 Information Systems and Other Infrastructure

Section 11.0: Program-Specific Reporting Information details each program's information systems and other infrastructure.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Section 11.0: Program-Specific Reporting Information reports each program's statutory or regulatory barriers, if any, to reduce improper payments.

8.0 Progress and Achievements

8.10 FY 2015 Progress

As of FY 2013, OMB no longer requires Head Start to report annual improper payment estimates, due to the strong internal controls, monitoring systems, and low reported error rates from FY 2009 through FY 2012 for the program. In lieu of an annual error rate measurement, HHS provides oversight through Head Start's existing internal controls and monitoring systems, and annually reports to OMB on its internal controls. For FY 2015, HHS continued to enhance onsite monitoring, mandatory annual visits, and the oversight activities of the Monitoring Disallowance Review Board. In addition, 45 Code of Federal Regulations (CFR) 1305 went into effect in March 2015 and requires more detail and accountability of eligibility practices. Overall, FY 2015 onsite monitoring results indicate the number of grantees with erroneous payments related to eligibility remained consistently low, even with an increase in the number of in-depth reviews to determine noncompliance with eligibility regulations.

8.20 FY 2015 Achievements

8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2015, HHS strengthened its efforts to reduce and recover improper payments in Medicare and Medicaid. While a few of these efforts are highlighted below, more detailed information on the FY 2015 Medicare and Medicaid programs' performance and corrective actions can be found in *Section 11.0: Program-Specific Reporting Information*.

CMS Program Integrity Board

As part of HHS's efforts to reduce improper payments, CMS established an agency-wide Program Integrity Board (the Board) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in its programs. The Board is comprised of CMS executive leaders, all of whom share the mutual objective to identify and prevent improper and fraudulent payments. After identifying high-priority vulnerabilities, the Board directs corrective actions and tracks issues to resolution.

Affordable Care Act Provider Enrollment Moratorium

Section 6401 of the *Affordable Care Act* added new Section 1866(j)(7) to the *Social Security Act*, which provides HHS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, HHS launched the first temporary (six month) enrollment moratorium under the *Affordable Care Act* for Miami-area and Chicago-area home health agencies (HHAs) and ground ambulance suppliers in the Houston-area. On January 30, 2014, HHS extended the original moratoria for these locations and expanded the enrollment moratoria to include HHAs in the Ft. Lauderdale, Detroit, Dallas, and Houston areas. HHS also expanded the moratoria for ground ambulance suppliers into the Philadelphia area. Since that expansion, the moratoria have been extended three times in six-month increments for all areas, with the most recent moratoria extension effective July 29, 2015. The focus of these efforts is to prevent and deter fraud, waste, and abuse in high-risk services and areas across the country while ensuring beneficiary access to care.

Fraud Prevention System

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010* (SBJA). The FPS analyzes all Medicare FFS claims prior to payment using risk-based algorithms developed by HHS and the private sector. HHS uses the FPS to target investigative resources, generating alerts for suspect claims or providers in priority order, to further investigate the most egregious, suspect, or aberrant activity. HHS and its

program integrity contractors use the FPS information to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

During the third implementation year of the FPS, defined in the SBJA as January 1, 2014 through December 31, 2014, HHS took administrative action against 1,093 providers resulting in an estimated $454.0 million in identified savings. These savings were 80 percent higher than the savings from the previous implementation year, with a nearly 10 to 1 return on investment. The FPS also generated leads for 276 new investigations, and augmented information for 336 ongoing investigations. Information on these and other actions initiated through the FPS can be found in the FPS Reports to Congress, available at www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html.

National Benefit Integrity Medicare Drug Integrity Contractor

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performs data analysis to proactively fight fraud, waste, and abuse in the Medicare Part C and D programs. The NBI MEDIC identifies improper payments as a result of data analysis and assists HHS with recovering the improper payments. NBI MEDIC referrals to law enforcement have resulted in sentences ordering restitution of $41.4 million, forfeitures of $13.6 million, and $12.2 million in civil settlements according to FY 2015 notifications from law enforcement. As a result of the NBI MEDIC's data analysis projects, HHS recovered $23.54 million in FY 2015 from Part D sponsors.

Medicaid Integrity Program

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

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

HHS analyzed Medicaid recoveries, which show there has been a strong focus on Medicaid integrity since the enactment of the DRA. For example, the Medicaid Integrity Program has provided the assistance of federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance resulted in $656.89 million in total collections in FY 2015. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014 to 2018 is available at www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf.

8.22 Public Assistance Reporting Information System

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

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) partnered to advance the PARIS project at no cost to states. The DOD's Defense Manpower Data Center (DMDC) provides computer resources to produce a match file, using Social Security numbers submitted by the states, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by executing Computer Matching Agreements and coordinating the quarterly matches. Since its

establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, two states reported that PARIS led to reported savings or cost avoidance of approximately $99.3 million in FY 2015 alone. More information on this effective partnership can be found at: www.acf.hhs.gov/programs/paris.

9.0 Improper Payment Reduction Outlook FY 2014 through FY 2018

The following tables (Table 1A, Table 1B, and Table 1C) display HHS's improper payment results for the current year (CY) FY 2015, the prior year (PY) FY 2014, and targets for FYs 2016 through 2018. The tables include the following information by year and program, as applicable: FY outlays, the error rate or future reduction target (IP%), and dollars paid or projected to be paid improperly (IP$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments (CY net IP$), when available.

Table 1A includes improper payment information for HHS's OMB-determined risk-susceptible programs. Table 1B includes the FY 2015 improper payment results for the programs that received *Disaster Relief Act* funding and does not include out-year reduction targets for programs where all of the funds have been expended. Table 1C presents the Department's aggregate improper payment information.

Table 1A

Improper Payment Reporting for OMB-Determined Risk-Susceptible Programs

FY 2014 - FY 2018 (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	360,173 Note (a)	12.7	45,754	358,348.60 Note (b)	12.09 Note (1)	43,325.61	42,068.35	1,257.26	11.39	40,811.09	393,521.05 Note (c)	11.50	45,254.92	414,857.11	10.40	43,145.14	436,331.52	9.40	41,015.16
Medicare Part C	135,513 Note (d)	9.0	12,229	148,593.71 Note (e)	9.50	14,117.00	10,265.04	3,851.96	4.32	6,413.08	204,161.00 Note (f)	9.14	18,660.32	204,215.00	8.79	17,950.50	201,568.00	8.79 Note (2)	17,717.83
Medicare Part D	58,493 Note (g)	3.3	1,931	62,003.91 Note (h)	3.60	2,234.25	1,825.75	408.50	2.29	1,417.25	96,504.00 Note (i)	3.40	3,281.14	99,806.00	3.30	3,293.60	97,389.00	3.20	3,116.45
Medicaid	261,613 Note (j)	6.7	17,492	297,672.02 Note (k)	9.78 Note (3)	29,124.61	28,627.51	497.10	9.45	28,130.41	336,988.39	11.53 Note (4)	38,854.76	365,842.60	10.48	38,340.30	364,453.62	7.36	26,823.79
CHIP	9,469 Note (l)	6.5	612	9,293.91 Note (m)	6.80 Note (5)	632.11	626.27	5.84	6.68	620.43	10,556.74	6.81 Note (4)	718.91	15,426.10	6.23	961.05	16,615.49	5.90	980.31
TANF	16,327 Note (n)	N/A	N/A	16,215.32 Note (o)	N/A Note (6)	N/A	N/A	N/A	N/A	N/A	17,160.38	N/A	N/A	17,129.20	N/A	N/A	17,034.92	N/A	N/A
Foster Care	1,198 Note (p)	5.5	66.2	841.01 Note (q)	3.65	30.68	28.20	2.48	3.06	25.72	728.70	3.60	26.23	823.40	3.55	29.23	841.01	3.50	29.44
Child Care	5,239 Note (r)	5.7	299	5,420.32 Note (s)	5.74	311.13	284.89	26.24	4.77	258.65	5,420.26	8.50 Note (7)	460.72	5,376.50	8.50	457.00	5,360.38	8.50	455.63
SUB-TOTAL Note (t)	831,698	9.4	78,383	882,173.48	10.18	89,775.39	83,726.01	6,049.38	8.81	77,676.63	1,047,880.14	10.24	107,257.00	1,106,346.71	9.42	104,176.82	1,122,559.02	8.03	90,138.61

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

9.10 Accompanying Improper Payment Reporting for OMB Determined Risk-Susceptible Programs Notes

a) Medicare FFS PY outlays are from the FY 2014 Medicare FFS Improper Payments Report (based on claims from July 2012 – June 2013).
b) Medicare FFS CY outlays are from the FY 2015 Medicare FFS Improper Payments Report (based on claims from July 2013 – June 2014).
c) Medicare FFS CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays current law (CL)).
d) Medicare Part C PY outlays reflect 2012 Part C payments, as reported in the FY 2014 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY outlays reflect 2013 Part C payments, as reported in the FY 2015 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays (CL)).
g) Medicare Part D PY outlays reflect 2012 Part D payments, as reported in the FY 2014 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2013 Part D payments, as reported in the FY 2015 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (Medicare Benefit Outlays (CL)).
j) Medicaid PY outlays (based on FY 2013 expenditures) are from the FY 2015 Midsession Review and exclude CDC Vaccine for Children program funding.
k) Medicaid CY (based on FY 2014 expenditures) and CY+1, CY+2, CY+3 outlays (Medicaid - Outlays (CL) exclude CDC Vaccine for Children program funding), are from the FY 2016 Midsession Review.
l) CHIP PY outlays (based on FY 2013 expenditures) are from the FY 2015 Midsession Review.
m) CHIP CY (based on FY 2014 expenditures) and CY+1, CY+2, CY+3 outlays (CHIP Total Benefit Outlays with *Children's Health Insurance Program Reauthorization Act* (CHIPRA) Bonus and Health Care Quality Provisions (CL)), are from the FY 2016 Midsession Review.
n) TANF PY outlays amount is based on the FY 2015 Midsession Review.
o) TANF CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
p) Foster Care PY outlays are based on the FY 2015 Midsession Review, and reflect the federal share of maintenance payments.
q) Foster Care CY, and CY+1, CY+2, CY+3 outlays are based on the FY 2016 Midsession Review, and reflect the federal share of maintenance payments.
r) Child Care PY outlays are based on the FY 2015 Midsession Review.
s) Child Care CY, and CY+1, CY +2, CY+3 outlays are based on the FY 2016 Midsession Review.
t) The "Total" does not represent a true statistical estimate for the agency, and does not include information for TANF.

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

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.38 percentage points to 12.09 percent or $43.33 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166 – 167 of HHS's FY 2012 AFR (available at: www.wayback.archive-it.org/3922/20131030171234/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

2. The Medicare Part C targets for CY+2 and CY+3 are held constant based on the uncertainty of out-year trends. The target for CY+3 will be re-evaluated after the FY 2016 reporting period.
3. HHS calculated and is reporting the national Medicaid error rate based on measurements that were conducted in FYs 2013, 2014 and 2015. The national Medicaid error component rates are: Medicaid FFS: 10.59 percent and Medicaid managed care: 0.12 percent. The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent as described in *Section 11.40* below.
4. The Medicaid and CHIP CY+1 IP% reduction target increased from the CY IP%. As described in *Section 11.41*, although all states are included in the improper payment rates, HHS only reviews 17 states each year. In FY 2014, HHS reported a rate reflecting the first 17 states measured under new requirements, which are described in *Section 11.42* and *11.52* as drivers of the Medicaid and CHIP improper payment rates. The FY 2015 improper payment rates reflect the second group of 17 states subject to new requirements for a total of 34 states. In FY 2016, HHS will report a rate that reflects the measurement of the final group of 17 states subject to new requirements, and will be the first baseline improper payment rate reflecting measurement of all states under the new requirements. HHS expects to see a decrease in the following years due to corrective actions as states are measured again.
5. HHS calculated and is reporting the national CHIP error rate based on measurements that were conducted in FYs 2013, 2014, and 2015. The national CHIP error component rates are: CHIP FFS: 7.33 percent and CHIP managed care: 0.37 percent. The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent as described in *Section 11.50* below.
6. The TANF program is not reporting an error rate for FY 2015. Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. Please see *Section 11.60* for additional information on statutory limitations to establishing a TANF improper payment measurement.
7. The *Child Care and Development Block Grant Act of 2014* (CCDBG) reauthorized the Child Care and Development Fund program for the first time since 1996. HHS measures one-third of the Child Care grantees each year. HHS established a slight increase in the improper payment target rates to accommodate all reporting cohorts' implementation of the sweeping policy and procedure changes under the new CCDBG statute. As each reporting cohort completes reviews in the next three years, HHS anticipates that error rates will increase as new policies are implemented and reviewed. Future targets may be adjusted as well, depending on future performance.

Table 1B

Improper Payment Reporting for Superstorm Sandy Programs

FY 2014 - FY 2018 (in Millions)

Program or OpDiv	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 $
ACF Head Start	3.93	0	0	16.38	0.38	0.0616	0.0616	0	0.38	0.0616	49.02	0.34	0.167	25.26	0.30	0.076	N/A	N/A	N/A
ACF Social Services Block Grant	67.03	13.5	9.04	209.14	0.22 Note (8)	0.464	0.458	0.006	0.22	0.452	79.55	0.21	0.17	79.55	0.20	0.16	N/A	N/A	N/A
ACF Family Violence Prevention and Services	0.14	4.4	0.006	0.893	0.89	0.00794	0.00794	0	0.89	0.00794	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ASPR Research	0 Note (9)	0	0	1.55	0	0	0	0	0	0	3.055	0	0	N/A	N/A	N/A	N/A	N/A	N/A
CDC Research	1.82	0	0	4.6	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SAMHSA	0.42	12.7	0.05	1.32	1.38	0.0182	0.0101	0.0081	0.15	0.002	0.60 Note 10	1.00	0.006	N/A	N/A	N/A	N/A	N/A	N/A
NIH Research	32.05	0.002	.000741	38.60	2.29	0.885	0.885	0	2.29	0.885	9.73	2.29 Note 11	0.223	N/A	N/A	N/A	N/A	N/A	N/A
Sub-Total Note (12)	105.39	8.63	9.10	272.483	0.53	1.437	1.423	0.014	0.517	1.409	141.955	0.40	0.566	104.81	0.23	0.24	N/A	N/A	N/A

9.20 Accompanying Improper Payment Reporting for Superstorm Sandy Programs Notes

8. ACF SSBG's FY 2014 reviews consisted only of a case record review in New Jersey. For the FY 2015 review period, HHS completed case record and vendor payment reviews for Connecticut, New York, and New Jersey. In FY 2015, the case record component error rate was 1.18 percent, and the vendor payment error rate was 0.18 percent. Additional information on the error rate for the case record reviews and vendor payments—both of which comprise the national error rate – can be found in *Section 15.20*.
9. ASPR Research's FY 2014 and FY 2015 measurement period was based on the previous FY. ASPR Research reported $0 in PY outlays since they awarded grants late in FY 2013 and their grantees did not begin expending funds until FY 2014.

10. SAMHSA's CY+1 outlays are based on remaining funds that could potentially be spent by grantees. This total may be restated in the FY 2016 AFR.
11. NIH Research is projecting to maintain its error rate of 2.29 percent in FY 2016. NIH expects that its error rate will remain constant in FY 2016 due to projected difficulties obtaining documentation from grantees, and the Disaster Relief Act's requirement that all funding be expended within two years.
12. The "Total" does not represent a true statistical estimate for the agency.

Table 1C
Improper Payment Reporting for All Programs
FY 2014 - FY 2018 (in Millions)

Name	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 $
Sub-Total of OMB Determined Risk-Susceptible Programs from Table 1A	831,698	9.4	78,383.20	882,173.48	10.18	89,775.39	83,726.01	6,049.38	8.81	77,676.63	1,047,880.14	10.24	107,257.00	1,106,346.71	9.42	104,176.82	1,122,559.02	8.03	90,138.61
Sub-Total of Superstorm Sandy Programs from Table 1B	105.39	8.63	9.10	272.483	0.53	1.437	1.423	0.014	0.517	1.409	141.955	0.40	0.566	104.81	0.23	0.24	N/A	N/A	N/A
TOTAL ALL PROGRAMS Note (12)	831,803.39	9.4	78,392.30	882,445.963	10.17	89,776.827	83,727.433	6,049.394	8.80	77,678.039	1,048,022.095	10.23	107,257.566	1,106,451.52	9.42	104,177.06	1,122,559.02	8.03	90,138.61

10.0 Improper Payment Root Cause Categories

Appendix C to OMB Circular A-123, which was updated and released in October 2014, requires the reporting of improper payment root causes by agencies with high-risk programs. The following tables display HHS's improper payment root causes for FY 2015 for each high-risk program. There is a separate column for each program. The tables include categories of improper payments and the amount of overpayment or underpayment associated with each improper payment category. Additional information on the root causes, and corrective actions, for each high-risk program can be found in each program-specific reporting section.

Table 2A
Medicare Improper Payment Root Cause Category Matrix
FY 2015 (in Millions)

Reason for Improper Payment		Medicare FFS		Medicare Part C[Note 1]		Medicare Part D [Note 2]	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue							
Inability to Authenticate Eligibility							
Failure to Verify:	Death Data						
	Financial Data						
	Excluded Party Data						
	Prisoner Data						
	Other Eligibility Data (explain)						
Administrative or Process Error Made by:	Federal Agency						
	State or Local Agency						
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	$4,850.21	$1,257.03		$3,851.96		$408.50
Medical Necessity		$7,502.84	$0.23				
Insufficient Documentation to Determine		$29,715.30		$10,265.04		$1,825.75	
TOTAL		$42,068.35	$1,257.26	$10,265.04	$3,851.96	$1,825.75	$408.50

Notes:

1. Underpayments in the Medicare Part C program occur when plans do not submit relevant diagnosis information for payment, but are subsequently found by HHS during medical record review.
2. Underpayments in the Medicare Part D program are mainly due to discrepancies in prescription drug event documentation.

Table 2B
Medicaid and CHIP Improper Payment Root Cause Category Matrix
FY 2015 (in Millions) [Note 3]

Reason for Improper Payment		Medicaid		CHIP	
		Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue					
Inability to Authenticate Eligibility		$8,509.11	$244.17	$371.71	$4.05
Failure to Verify:	Death Data				
	Financial Data				
	Excluded Party Data				
	Prisoner Data				
	Other Eligibility Data (explain)				
Administrative or Process Error Made by:	Federal Agency				
	State or Local Agency	$16,718.23	$263.51	$169.02	$1.63
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	$795.46	$14.49	$15.40	$0.35
Medical Necessity		$1.36		$0.09	
Insufficient Documentation to Determine		$2,603.35		$70.05	
TOTAL		$28,627.51	$522.17	$626.27	$6.03

Notes:

3. The Medicaid and CHIP underpayment totals reported in this table are greater than the underpayment totals displayed in Table 1A, which excludes underpayments that may have also been counted as overpayments.

Table 2C
Foster Care and Child Care Improper Payment Root Cause Category Matrix
FY 2015 (in Millions)

Reason for Improper Payment		Foster Care		Child Care	
		Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue					
Inability to Authenticate Eligibility					
Failure to Verify:	Death Data				
	Financial Data				
	Excluded Party Data				
	Prisoner Data				
	Other Eligibility Data (explain)				
Administrative or Process Error Made by:	Federal Agency				
	State or Local Agency	$28.20	$2.48	$226.74	$26.24
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)				
Medical Necessity					
Insufficient Documentation to Determine				$58.15	
Other Reason (a) (explain)					
Other Reason (b) (explain)					
TOTAL		$28.20	$2.48	$284.89	$26.24

Table 2D
ACF Superstorm Sandy Improper Payment Root Cause Category Matrix
FY 2015 (in Millions)

Reason for Improper Payment		Head Start		Social Services Block Grant		Family Violence Prevention and Services	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue							
Inability to Authenticate Eligibility							
Failure to Verify:	Death Data						
	Financial Data						
	Excluded Party Data						
	Prisoner Data						
	Other Eligibility Data (explain)						
Administrative or Process Error Made by:	Federal Agency						
	State or Local Agency	$0.0616		$0.2488	$0.000021	$0.00794	
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)			$0.0603	$0.006381		
Medical Necessity							
Insufficient Documentation to Determine				$0.1484			
TOTAL		$0.0616		$0.458	$0.006	$0.00794	

Table 2E
ASPR, CDC, SAMHSA, and NIH Superstorm Sandy Improper Payment Root Cause Category Matrix
FY 2015 (in Millions)

Reason for Improper Payment		ASPR Research		CDC Research		SAMHSA		NIH Research	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Program Design or Structural Issue									
Inability to Authenticate Eligibility									
Failure to Verify:	Death Data								
	Financial Data								
	Excluded Party Data								
	Prisoner Data								
	Other Eligibility Data (explain)								
Administrative or Process Error Made by:	Federal Agency								
	State or Local Agency								
	Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)					$0.0101	$0.0081		
Medical Necessity									
Insufficient Documentation to Determine								$0.885	
TOTAL						$0.0101	$0.0081	$0.885	

11.0 Program-Specific Reporting Information

11.10 Medicare FFS (Parts A and B)

11.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a stratified random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the error category. Approximately 49,600 claims were sampled during the FY 2015 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166 – 167 of HHS's FY 2012 AFR, available at: http://wayback.archive-it.org/3922/20131030171234/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf.

The Medicare FFS gross improper payment estimate for FY 2015 is 12.09 percent or $43.33 billion. The FY 2015 net improper payment estimate is 11.39 percent or $40.81 billion. The factors contributing to improper payments are complex and vary from year to year.

The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 51.38 percent in FY 2014 to 58.95 percent in FY 2015 due to the documentation requirements to support the medical necessity of the services.

Insufficient documentation was also common for Skilled Nursing Facility (SNF) claims. The improper payment rate for SNF claims increased from 6.94 percent in FY 2014 to 11.04 percent in FY 2015.

11.12 Medicare FFS CAP

The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or Insufficient Documentation to Determine errors (68.6 percent). The other causes of improper payments are classified as Medical Necessity errors (17.3 percent) and Administrative or Process Errors Made by Other Party (14.1 percent), due to incorrect coding errors. HHS is committed to reducing improper payments in the Medicare FFS program. HHS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, HHS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. While some corrective actions have been implemented, others are in the early stages of implementation. HHS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

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

- First, HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services.
    - HHS issued a final rule, CMS-1611-F (79 FR 66031, November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year

2015. In this rule, HHS finalized changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. HHS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare programs. Specifically, HHS amended the HHA regulation to remove the requirement for the physician narrative as part of the certification of patient eligibility for the benefit, which was required to certify that the home health patient eligibility criteria have been met. Now reviewers can consider all entries in the medical record as supporting documentation when determining medical necessity.

  - HHS created voluntary draft paper and electronic clinical templates for ordering physicians and ordering hospitals to serve as progress notes and discharge summaries. These templates are currently in the clearance process. The templates will help physicians and hospital staff capture the information needed to complete the face-to-face encounter documentation and will become part of the medical record upon completion.
  - On October 1, 2015, HHS's Medicare Administrative Contractors (MACs) began pre-payment reviews of home health claims for episodes beginning on or after August 1, 2015, using a Probe and Educate strategy designed to help HHAs understand the new patient certification requirements.

- Second, HHS proposed an update to the "Two Midnight" rule CMS-1633-P (70 FR Volume 80, Number 130, July 8, 2015) regarding when hospital admissions are appropriate for payment under Medicare Part A. At the same time, HHS notified the public of the following two upcoming changes in education and enforcement strategies.
  - Beginning on October 1, 2015, the Quality Improvement Organizations (QIOs) assumed responsibility to conduct initial patient status review of providers to determine the appropriateness of Part A payment for short stay inpatient hospital claims. From October 1, 2015 through December 31, 2015, short stay inpatient hospital reviews conducted by the QIOs will be based on Medicare's current payment policies.
  - Beginning on January 1, 2016, QIOs and Recovery Audit Contractors (RACs) will conduct patient status reviews in accordance with policy changes finalized in the Hospital Outpatient Prospective Payment System rule (CMS-1613-P) and effective in calendar year 2016. Effective January 1, 2016, RACs may conduct patient status reviews only for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies.
- Third, HHS issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially could be subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that would be subject to a prior authorization process.
- Fourth, HHS expanded the use of prior authorization in the Medicare FFS program.
  - On September 1, 2012, HHS instituted a prior authorization demonstration program in seven states with the expectation of reducing improper payments for power mobility devices (PMDs). This demonstration project led to a decrease in the expenditures for PMDs in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of August 14, 2015, monthly expenditures for the PMD codes included in the demonstration project decreased from $10 million in September 2012 to $3 million in June 2015 in the non-demonstration states and from $22 million to $5 million in the demonstration states. Prior authorization reviews are being performed timely and feedback from the industry and beneficiaries has been largely positive. HHS leveraged this success by expanding the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana,

Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19. HHS also extended the demonstration to August 31, 2018 in FY 2015.

- Fifth, in FY 2015 HHS implemented two demonstration projects to test whether prior authorization in Medicare FFS reduces expenditures while maintaining or improving quality of care for certain non-emergent services. These projects will also ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims.
    - In December 2014, HHS implemented a prior authorization demonstration program for repetitive, scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. Section 515 of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) expands the prior authorization model for repetitive scheduled non-emergent ambulance transports effective no later than January 1, 2016 to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia.
    - HHS implemented a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey. Providers in Michigan could begin submitting prior authorization requests on March 1, 2015, and providers in Illinois and New Jersey could begin submitting prior authorization requests on July 14, 2015.

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

Corrective Actions to Address Root Causes:

Root Cause: Administrative or Process Errors Made by Other Party

- Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify many inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, HHS correctly pays submitted claims nearly 100 percent of the time. For example, HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. This program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The use of the NCCI edits saved the Medicare program $681.9 million in FY 2014.
- The *Affordable Care Act* required HHS to revalidate all existing Medicare providers and suppliers. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. HHS has requested the revalidation of all 1.6 million existing Medicare providers to ensure that only qualified and legitimate providers and suppliers can deliver health care items and services to Medicare beneficiaries. These revalidation efforts alone resulted in the deactivation of more than 307,388 provider and supplier practice locations as well as the revocation of 17,655 providers' and suppliers' billing privileges.
- HHS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including federal and state partners, private payers, associations, and law enforcement exchange data and anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.
- HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error prone claim types, such as home health, hospital outpatient, and skilled nursing facility (SNF) claims.

Root Cause: Medical Necessity and Insufficient Documentation to Determine

- HHS contracted with a Supplemental Medical Review/Specialty Contractor (SMRC) to perform medical reviews focused on vulnerabilities identified by HHS internal data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2015 the SMRC performed post payment reviews on certain durable medical equipment items, such as continuous positive airway pressure devices, portable oxygen concentrators, and nebulizer medications and equipment. The SMRC also reviewed high cost diagnostic imaging and blepharoplasty procedures. The results of these reviews are used to improve billing accuracy.
- HHS continues to allow review contractors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. In February 2014, HHS announced a number of changes to the Medicare FFS RAC program that will take effect with the new contract awards as a result of stakeholder feedback. HHS believes that these improvements will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. For further information on these changes, refer to www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/downloads/RAC-program-improvements.pdf.
- HHS issues Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the state and across the nation.
- HHS published CMS-6010-F, "Medicare and Medicaid Programs: Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements and Changes in Provider Agreements" (77 FR 25283), on April 27, 2012. Effective January 6, 2014, this rule requires physicians and other professionals who order and certify certain covered items and services for Medicare beneficiaries, including the following: home health, clinical laboratory, imaging and DMEPOS, to be a Medicare participating provider. Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

11.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified by the CERT program during the FY 2015 report period were $39,710,413.13. The identified overpayments are recovered by the MACs via standard payment recovery methods. As of the report publication date, MACs reported collecting $30,684,727.80 or 77.27 percent of the actual overpayment dollars identified in the report.

11.14 Medicare FFS Information Systems and Other Infrastructure

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

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

Current law limits HHS's authority to conduct prior authorization on services that account for a large portion of the overall Medicare FFS improper payments. Section 1834(a)(15) of the *Social Security Act* authorizes the Secretary to develop and periodically update a list of DMEPOS determined, on the basis of prior payment experience, to be subject to unnecessary utilization and to develop a prior authorization process for these items. However, current law does not allow for prior authorization of any other claim types or services. As a result, the FY 2016 President's Budget proposed amending Section 1893 of the *Social Security Act* to give the Secretary the discretion to select items or services for prior authorization without rulemaking where the items or services involve high cost, high utilization, patient risk, and/or high improper payment rates.

11.16 Medicare FFS Best Practices

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

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

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

- HHS coordinates provider outreach and education task forces. These task forces consist of Medicare Administrative Contractors (MAC) medical review professionals who meet regularly to develop provider education strategies and materials addressing areas prone to improper payments. The task forces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public at the MLN website: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo.
- HHS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- HHS revises medical record request letters, as needed, to clarify the components of the medical record required for CERT review. The letter serves as a checklist for the provider or supplier to ensure their

record submission is complete. Follow-up medical record request letters have also been developed to explain what missing documentation needs to be submitted.

- When a supplier is contacted for documentation, the CERT program notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, the CERT program contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a hospital that possesses the record for professional services provided by a billing physician while the beneficiary was hospitalized.

11.20 Medicare Advantage

11.21 Medicare Advantage Statistical Sampling Process

The FY 2015 Medicare Part C gross improper payment estimate is 9.50 percent or $14.12 billion. The FY 2015 net improper payment estimate is 4.32 percent or $6.41 billion. The increase from the prior year's reported error estimate was due to a reduction in the magnitude of risk adjusted diagnoses that were not submitted by Medicare Advantage (MA) Organizations for payment.

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

The FY 2015 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2013, 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.

11.22 Medicare Advantage CAPs

The root causes of FY 2015 Medicare Part C improper payments resulted from errors due to Insufficient Documentation to Determine (72.7 percent) and Administrative or Process Errors Made by Other Party (the Medicare Advantage (MA) organizations) (27.3 percent).

Corrective Actions to Address Root Causes:

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

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

- *Contract-Level Audits*: HHS is proceeding with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. RADV audits are HHS's primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. RADV audits of payment year 2011, which began in

FY 2014, will be the first HHS reviews to recoup funds based on extrapolated estimates. In addition, payment year 2012 audits were initiated in FY 2015, and plans have been selected for audit.

- *New Regulatory Provisions*: In CMS-4159-F, "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program" (79 FR 100), HHS codified the *Affordable Care Act* requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-F, "The Calendar Year 2015 OPPS/ASC Rule" (79 FR 66769), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by an MA organization.

11.23 Medicare Advantage Program Improper Payment Recovery

The Part C error estimate is based on a national sample of beneficiaries across all MA plans. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery had been initiated until FY 2012, when HHS recovered approximately $3.4 million for the first five plans involved in the 2007 RADV audits. Payment recovery for the pilot audits has been completed and totaled $13.7 million ($5.4 million was recovered in FY 2014, $5.0 million in FY 2013, and $3.4 million in FY 2012)[24]. Once the appeals process is complete, adjustments to the overpayment recoveries will be made. In addition, in FY 2015, MA organizations have reported and returned approximately $650 million in overpayments, which appears to be the result of the sentinel effect of the RADV audits, as well as the 'report and repay' requirement, outlined above.

11.24 Medicare Advantage Information Systems and Other Infrastructure

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

11.25 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.

11.26 Medicare Advantage Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Part C program, including the corrective actions that were outlined earlier in *Section 11.22*.

11.30 Medicare Prescription Drug Benefit

11.31 Medicare Prescription Drug Benefit Statistical Sampling Process

The Medicare Part D gross improper payment estimate for FY 2015 is 3.60 percent or $2.23 billion. The FY 2015 net improper payment estimate is 2.29 percent or $1.42 billion. The primary factor that drove the program's increase from the prior year's reported error estimate was an increase in the prescription drug event data validation component of the error rate.

[24] Values do not total due to rounding.

The FY 2015 Part D Composite Payment Error Rate combines four component payment error measures:

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

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

The FY 2015 national Part D improper payment rate for each component is:

- *PELS*: 0.09 percent
- *PEMS*: 0.22 percent
- *PEPV*: 3.21 percent
- *PEDIR*: 0.09 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from previous years. A description of the methodology is on pages 173 - 175 of HHS's FY 2012 AFR (www.wayback.archive-it.org/3922/20131030171234/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

11.32 Medicare Prescription Drug Benefit CAP

The root causes of the FY 2015 Part D improper payments are Insufficient Documentation to Determine (81.7 percent) and Administrative or Process Error made by Other Parties (18.3 percent).

Corrective Actions to Address Root Causes:

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

HHS conducted the following corrective actions to address errors:

- *Training:* HHS will continue its national training sessions for Part D sponsors on Part D payment and data submission.
- *Outreach:* Formal outreach to plan sponsors will continue for invalid/incomplete documentation.
    - HHS distributed Plan Sponsor Summary Reports to all plans participating in the PEPV component of the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all other participating plan sponsors.
    - HHS distributed notices of non-compliance to plan sponsors who failed to provide documentation for the PEPV component of the national payment error estimate.
    - In December 2014, HHS conducted a listening session with several stakeholders from the Long Term Care and Long Term Care Pharmacy industry to get feedback on how to resolve a trend of missing or invalid signatures on Long Term Care medication orders selected for the PEPV audit.
- *New Regulatory Provisions:* HHS codified the *Affordable Care Act* requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor (See *Section 11.22* for more information on the rules).

11.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2015 for each error rate component:

- *PELS Component*: Further investigation must be done to better determine how to conduct payment recovery.
- *PEMS Component*: Application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify beneficiary-level payments that HHS could recover.
- *PEPV Component*: The FY 2015 Prescription Drug Event (PDE) validation is based on a national sample of PDEs and the imputation of these results onto the Part D population; therefore, payment errors cannot be linked to specific beneficiaries for payment recovery purposes.
- *PEDIR Component*: The data used to develop the FY 2015 error rate were based on 2013 audits. Plans submit updates to their reported direct and indirect remuneration amounts throughout the year. HHS will, therefore, address payment recovery through the 2013 Part D reconciliation.

In addition, in FY 2015, approximately $11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the 'report and repay' requirement described in the prior section.

11.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

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

11.35 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.

11.36 Medicare Prescription Drug Benefit Program Best Practices

In addition to the corrective actions outlined in *Section 11.32*, HHS has taken steps to ensure payment accuracy in the Medicare Part D program, including: (1) contacting plans before and during the PEPV data collection and validation process, which provides an open forum for improving instructions for data submission, and (2) extending the data collection period, which increased response rates.

11.40 Medicaid

11.41 Medicaid Statistical Sampling Process

The national FY 2015 Medicaid improper payment rate is based on measurements conducted in FYs 2013, 2014, and 2015. Medicaid improper payments are estimated on a federal fiscal year (FY) 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. The eligibility component measurement is currently on hold as described in the eligibility component section that follows.

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

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 292 and 966 claims per state and the managed care sample size was between 230 and 280 payments per state. The sample sizes were based on each state's historical FFS and managed care improper payment rate data. When a state's FFS component or managed care component accounted for less than two percent of the state's total Medicaid expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in six states.

Eligibility Component

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS will update the eligibility component measurement methodology and related PERM program regulation to reflect these changes. In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM. During this time period, the national Medicaid eligibility improper payment rate will be held constant at the FY 2014 reported rate of 3.11 percent.

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

Calculations and Findings

The national Medicaid program improper payment rate represents the combination of each state's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual state improper payment rate components are combined to calculate the national improper payment rates for each component. National component improper payment rates and the Medicaid program improper payment rate are weighted by state size, so that a state with a $10 billion program "counts" 10 times more toward the national rate than a state with a $1 billion program. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted." Additionally, HHS incorporates state-level error rate recalculations for the states measured in FY 2013 and FY 2014 into the national Medicaid improper payment rate. Eight state-level FFS error rates were recalculated subsequent to FY 2014 reporting and are incorporated into FY 2015 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2015 is 9.78 percent or $29.12 billion. The FY 2015 net improper payment estimate is 9.45 percent or $28.13 billion. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.42.*

The FY 2015 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 10.59 percent
- *Medicaid managed care*: 0.12 percent

The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent.

Eligibility Pilot Review Findings

The eligibility review pilots identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html.

11.42 Medicaid CAPs

States reviewed for the FY 2015 AFR measurement were the same states reviewed in FY 2012.

The improper payment rate for these states increased from 5.79 percent in FY 2012 to 14.25 percent in FY 2015, causing an increase in the FY 2015 national Medicaid error rate. The FFS component reported the greatest increase, rising from 3.34 percent to 18.63 percent. However, the managed care component dropped from 0.26 percent to 0.08 percent.

Similar to FY 2014, the primary reason for the FY 2015 improper payments was errors related to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states with Medicaid programs that were previously measured, and all states measured in FY 2015 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS is actively engaging with states to proactively address these root causes by conducting outreach during off-cycle PERM time frames to address issues identified in CAPs, facilitating national best practice calls to share ideas across states, offering ongoing technical assistance, and providing additional guidance as needed.

Corrective Actions to Address Root Causes:

Root Causes:

1) Administrative or Process Errors Made by State or Local Agency

Administrative or Process Errors Made by State or Local Agency mainly consist of errors caused by state difficulties bringing systems into compliance with new requirements as described above. Since the Medicaid improper payment rate was primarily driven by these errors, state CAPs will focus on systems changes to reduce these errors. Methods will include implementing new claims processing edits, converting to a more sophisticated claims

processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

2) Administrative or Process Errors Made by Other Party

Administrative or Process Errors Made by Other Party mainly consist of provider billing and coding errors. State CAPs also include provider education, training, communication, and outreach efforts to help reduce these errors.

3) Insufficient Documentation to Determine

Because insufficient documentation is another contributor to the Medicaid FFS improper payment rate, state CAPs have also focused on provider communication and education to reduce errors related to this category. These methods included holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs and the ongoing corrective actions reported on pages 177 – 178 of HHS's FY 2014 AFR (www.hhs.gov/afr/fy2014-other-information.pdf), HHS has implemented additional efforts to lower improper payments rates:

- HHS completed a "mini-PERM audit" in one state and continued a mini-PERM audit in two states. Mini-PERM audits are voluntary state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease Medicaid improper payments.
- As of the end of FY 2015, 47 states and the District of Columbia had implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs, but one of these states ended its RAC program when HHS approved an exception due to high managed care penetration. Four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high managed care penetration.
- HHS aligned state Program Integrity Reviews with off-cycle PERM reviews to maintain pressure on states to continuously correct errors.
- HHS allows states to rely on Medicare's enrollment screening of providers to help prevent PERM-related enrollment errors. For example, state Medicaid agencies may rely on Medicare's site visits, in specific circumstances where the provider is enrolled in Medicare and Medicaid.
- HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements.
- HHS provides ongoing education and outreach to states on federal requirements for Medicaid enrollment and screening.

11.43 Medicaid Program Improper Payment Recovery

Through the PERM program, HHS identified $152,967.74; $618,550.41; and $4,399,202.90 in Medicaid overpayments eligible for recovery for FYs 2013, 2014 and 2015, respectively. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2013 and 2014 was amended from information previously reported in HHS's FY 2014 AFR to reflect changes made during state-level error rate recalculations.

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

year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment.

11.44 Medicaid Information Systems and Other Infrastructure

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

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

HHS also developed the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of state MSIS submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce state data requests.

One state moved from MSIS to T-MSIS in FY 2015, and all remaining states will submit data in the T-MSIS file format in FY 2016.

11.45 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.

11.46 Medicaid Program Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states.

In addition to the ongoing measures reported on page 179 of HHS's FY 2014 AFR (www.hhs.gov/afr/fy2014-other-information.pdf). HHS continues to offer training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2015, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 6,200 enrollments in 136 courses and nine workgroups at no cost to the states.

11.50 CHIP

11.51 CHIP Statistical Sampling Process

The national FY 2015 CHIP improper payment rate is based on measurements conducted in FYs 2013, 2014, and 2015. CHIP improper payments are estimated on a federal FY 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. The eligibility component measurement is currently on hold as described in the eligibility component section below.

CHIP utilizes the same state sampling process as Medicaid. HHS determined that CHIP can be measured in the same states selected for Medicaid review each FY with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid will be measured in the same states each year, each state will be measured for CHIP once every three years. For information on how HHS grouped states into three cycles, refer to page 183 of HHS's FY 2012 AFR (www.wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 299 and 959 claims per state and the managed care sample size was between 68 and 300 payments per state. When a FFS component or managed care component for a state accounted for less than two percent of the state's total CHIP expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred for claims in three states.

Eligibility Component

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the *Affordable Care Act*, HHS will update the eligibility component measurement methodology and related PERM program regulation to reflect these changes. In August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM. During this time, the national CHIP improper payment rate will be held constant at the FY 2014 reported rate of 4.22 percent.

In place of FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

Calculations and Findings

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

rate. Seven state-level FFS error rates were recalculated subsequent to FY 2014 reporting and are incorporated into FY 2015 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2015 is 6.80 percent or $632.11 million. The FY 2015 net improper payment estimate is 6.68 percent or $620.43 million. This rate increased from prior years due to an increase in the FFS component, as discussed in *Section 11.52.*

The FY 2015 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 7.33 percent
- *CHIP managed care* – 0.37 percent

The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent.

Eligibility Pilot Review Findings

The eligibility review pilots identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html.

11.52 CHIP CAPs

States reviewed for the FY 2015 AFR measurement were the same states reviewed in FY 2012. The improper payment rate for these states increased from 8.16 percent in FY 2012 to 9.03 percent in FY 2015, causing an increase in the FY 2015 national CHIP error rate. The FFS component reported the greatest increase, rising from 6.93 percent to 13.13 percent.

Overall, the largest reason for the FY 2015 improper payments were errors related to state difficulties bringing systems into compliance with the new requirements described in the Medicaid section. While these requirements will ultimately strengthen the integrity of the program, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance.

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. HHS received CAPs from all states with CHIP programs that were previously measured, and all states measured in FY 2015 are developing CAPs for submission to HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. In addition, states also take steps to reduce errors identified during the measurement. HHS is actively engaging with states to proactively address these root causes through activities like: conducting outreach to states during off-cycle PERM time frames to follow-up on the status of state corrective actions for improvement with requirements, and to offer additional guidance as needed.

Corrective Actions to Address Root Causes:

Root Causes:

1) Administrative or Process Errors Made by State or Local Agency

Administrative or Process Errors Made by State or Local Agency mainly consist of errors caused by state difficulties bringing systems into compliance with new requirements as described above. Since the CHIP improper payment rate was primarily driven by these errors, state CAPs will focus on systems changes to reduce these errors. Methods include: implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

2) Administrative or Process Errors Made by Other Party

Administrative or Process Errors Made by Other Party mainly consist of provider billing and coding errors. State CAPs also include provider education, training, communication, and outreach efforts to help reduce these errors.

3) Insufficient Documentation to Determine

Because insufficient documentation is also a contributor to the CHIP improper payment rate, the state CAPs also focused on strengthening provider communication and education to reduce errors related to these categories. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs and the ongoing corrective actions reported on page 181 of HHS's FY 2014 AFR (www.hhs.gov/afr/fy2014-other-information.pdf), HHS has implemented additional efforts to lower improper payment rates:

- HHS completed a "mini-PERM audit" with three states. Mini-PERM audits are voluntary, state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during years states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease CHIP improper payments.
- HHS allows states to rely on Medicare's enrollment screening of providers to help prevent PERM-related enrollment errors.
- HHS shares Medicare data to assist states with meeting screening and enrollment requirements.
- HHS provides ongoing education and outreach to states on federal requirements for enrollment and screening.

11.53 CHIP Program Improper Payment Recovery

HHS identified $161,763.63; $688,941.56; and $1,909,778.03 in CHIP overpayments eligible for recovery for FYs 2013, 2014, and 2015 respectively. In addition, the amount of CHIP overpayments eligible for recovery for FYs 2013 and 2014 was amended from information previously reported in HHS's FY 2014 AFR to reflect changes made during state-level error rate recalculations.

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

11.54 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the state level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the state level. Please refer to *Section 11.44: Medicaid Information Systems and Other Infrastructure* for information on HHS and state-led efforts to modernize information and data systems at the national and state level.

11.55 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.

11.56 CHIP Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the states, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a state's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the states. In addition, other ongoing measures are reported on page 182 of HHS's FY 2014 AFR (www.hhs.gov/afr/fy2014-other-information.pdf).

11.60 TANF

11.61 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 2015. In the meantime, the Department is engaging with OMB to explore potential options to develop an alternative approach that could bring TANF into compliance with the law and reporting requirements.

11.62 TANF CAPs

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

- HHS works with states to analyze Single Audit material non-compliance findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the federal level and is working to mitigate these programmatic risks.
- HHS monitors a TANF Program Integrity Innovation Grant funded from OMB's Partnership Fund for Program Integrity Innovation. The state human service agency grantee is conducting a pilot project designed to reduce improper payments and improve administrative efficiency in the state's TANF program. The grant is scheduled to end in November 2015 and the final report will be issued in early 2016. This report will include lessons learned and valuable information for developing guidance that will improve TANF program integrity in other states.
- HHS implemented revisions to the TANF financial reporting form in order to require states to provide more accurate information about how states are using TANF block grants and meeting their Maintenance-of-Effort obligations. The changes took effect in FY 2015, and include a revised and expanded list of

spending categories as well as a change to the accounting method to accurately track actual expenditures that occur in a FY.

- In February 2014, HHS published a Notice of Proposed Rulemaking regarding "State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations." The proposed regulations would require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any electronic benefit transfer transaction in specified locations. The locations, specified in the *Middle Class Tax Relief and Job Creation Act of 2012*, are: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. HHS anticipates that the final regulation will be published in the last quarter of calendar year 2015.

11.63 TANF Improper Payments Recovery

Statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. As a result, HHS is not reporting an error rate or any results from improper payment recoveries for FY 2015.

11.64 TANF Information Systems and Other Infrastructure

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

11.65 TANF Statutory or Regulatory Barriers

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

11.66 TANF Program Best Practices

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

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

11.70 Foster Care

11.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for Title IV-E Foster Care in FY 2015, but as described below, there were changes to the number of states reviewed. Because current regulations require that programs be reviewed every three years for compliance, this program has taken the review cycle already in place (in compliance with *45 CFR 1356.71*, Foster Care Eligibility Reviews) and, with OMB approval, leveraged the existing review cycle to provide a rolling three-year average improper payment rate. Under this approved approach, the Foster Care improper payment estimate is calculated each year using data collected in the most recent Foster Care Eligibility Review for each state. A random sample is drawn from the state's universe of cases having at least one Title IV-E Foster Care maintenance payment during the six-month period under review (PUR). A review of the sample items identifies the number of error cases and amount of payment errors. Since each state is reviewed every three years, each year's data incorporates new review data for about one-third of the states. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, refer to pages 189 - 190 of HHS's FY 2012 AFR (www.wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

However, an increasing number of time-limited demonstration projects will temporarily reduce the number of jurisdictions subject to review and inclusion in the program error rate estimate for the duration of the demonstration projects. These child welfare waiver demonstration projects, authorized by Section 1130 of the *Social Security Act*, waive many program eligibility requirements and allow flexible use of Title IV-E funds to encourage innovative practices and improved child and family outcomes, while ensuring federal cost-neutrality. The authorizing law (section 1130(d)(2)) requires that all demonstration projects be completed by September 30, 2019. Because the demonstration waiver terms and conditions explicitly permit states to use Title IV-E funds for purposes, populations, and activities not normally allowed to be claimed as Title IV-E Foster Care maintenance or administration, states with statewide demonstration waivers will not be subject to Title IV-E eligibility reviews for the duration of the implementation of their demonstration projects. States with non-statewide demonstration projects will continue to undergo Title IV-E eligibility reviews; these reviews will examine data for that part of each state (i.e., geographic areas or populations) continuing to operate as a traditional IV-E program. States not participating in waiver demonstrations will also continue to undergo Title IV-E eligibility reviews on the regular three-year cycle.

Given the temporary nature of the waiver demonstrations and in the interest of maintaining a program estimate that is consistent not only with previously reported improper payment estimates but also across statewide and non-statewide waivers, HHS will treat jurisdictions with operational waivers as it has in the past:

- The program error rate estimate will include data from the most recent review for states with statewide waivers until the year when each state would normally have been reviewed again and when its data would normally be replaced with data from a new review (i.e., within three years and three months).
- The program error rate estimate will include data from the most recent review for states with non-statewide waivers, including subsequent reviews conducted on the non-waiver populations in those states following waiver implementation. The state error rate is based on review data for a sample receiving traditional Title IV-E services, and the sample rate is applied to overall state payments for those traditional IV-E services (i.e., excluding payments for the counties or other populations participating in demonstration projects).

This approach, which was approved by OMB, maintains continuity in the error rate while permitting consistent treatment of states with statewide and non-statewide waivers. Following this approach, the FY 2015 estimate is based on review data for 49 states operating traditional Title IV-E programs.[25]

The Foster Care gross improper payment estimate for FY 2015 is 3.65 percent or $30.68 million. The FY 2015 net improper payment rate is 3.06 percent or $25.72 million. The primary factor that drove the program's decrease from the prior year's estimate was the improved performance of one very large state that was reviewed in this cycle. This state lowered its state-level error rate from 22.15 percent, the highest rate of any state, to 3.43 percent.

11.72 Foster Care CAPs

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

Corrective Actions to Address Root Cause:

Root Cause: Administrative or Process Error Made by State or Local Agency

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

HHS continues to monitor review results and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2015, the most common payment errors included:

- Underpayments (28 percent of errors),
- Provider not licensed or approved (10 percent of errors),
- No safety documentation for institutional caregiver staff (10 percent of errors),
- Provider criminal records check not completed (9 percent of errors),
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (7 percent of errors), and
- Reasonable efforts to finalize permanency plan not timely (6 percent of errors).

Together these six items account for 70 percent of Foster Care payment errors. Although underpayments represent just over one-quarter of all errors in terms of frequency, the dollar amount of the underpayments is quite small and, in fact, continued to decrease in 2015 as the underpayment rate improved from 0.31 percent in FY 2014 to 0.30 percent in FY 2015.

In FY 2015, HHS undertook the following key action to reduce improper payments:

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

[25] The FY 2015 estimate excludes data for three states that were due for a review but are operating statewide demonstration waivers: Florida, Utah, and Wisconsin.

In addition, HHS continued the following ongoing corrective actions:

- HHS conducts onsite and post-site review activities to validate the accuracy of state claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the state agency to positively affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the state agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for states that exceed the error threshold.
- HHS requires non-compliant states (those that exceed the error threshold) to develop and execute state-specific PIPs that link corrective actions to the root cause of payment errors. The PIP identifies the specific action steps necessary to target and correct error root causes, and each action strategy is required to have a projected completion within one year from the date HHS approved the plan. PIPs are an effective strategy, as reflected in the decrease of the national Title IV-E error rate by nearly two-thirds since FY 2004.
- HHS provides training and technical assistance to states to develop and implement program improvement strategies, even when states are not required to develop a PIP. This assistance helps states expand organizational capacity and promote more effective program operations.
- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings, including an extrapolated disallowance if the state is found not in substantial compliance. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to states to improve compliance.

11.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 12 states during the 12-month period between July 2014 and June 2015, HHS recovered nearly $1 million in Title IV-E improper payments. The recovered funds are comprised of $569,458 in disallowed maintenance payments and $421,329 in disallowed administrative payments.

Improper payment recovery occurs through post-payment review, through both eligibility reviews as well as audit reviews. The Foster Care program does not systematically track cost recovery through Office of Inspector General (OIG) reviews or Single Audit reports; rather, the program obtains this information from HHS reports generated as part of the audit clearance process. Specifically, the program identifies and tabulates audit findings where the audit has been closed and a recommended cost recovery has been sustained for the Title IV-E Foster Care program. These recovery amounts are in addition to the amounts identified through the eligibility reviews and are presumed to be recovered in the FY when the audit is closed. Recoveries of improper payments through audits may include Title IV-E Foster Care maintenance assistance payments, administration, training, and automated systems development costs. See *Section 13.0* for further information on payment recovery.

11.74 Foster Care Information Systems and Other Infrastructure

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

11.75 Foster Care Statutory or Regulatory Barriers

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

11.76 Foster Care Best Practices

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

Concurrent with these efforts to continually refine its identification and reporting of improper payments, HHS works with state child welfare agencies to improve administrative procedures for tracking and documenting eligibility. As a result, a number of states have developed knowledgeable and experienced eligibility teams that monitor foster care cases for changes in eligibility, work effectively with front-line staff, and identify emerging issues and trends to maintain strong performance. HHS also works with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders. These efforts have yielded reductions in eligibility errors and improper payments, as well as the recovery of $20.35 million in improper payments for the FY 2004 through FY 2015 reporting periods.

11.80 CCDF

11.81 CCDF Statistical Sampling Process

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

The current methodology incorporates the following: (a) drawing a statistical sample from a universe of paid cases, (b) measuring improper payments, and (c) requiring states with error rates exceeding 10 percent to submit a CAP. The error rate methodology and reporting requirements focus on administrative errors associated with client eligibility. The CCDF gross improper payment estimate for FY 2015 is 5.74 percent or $311.13 million. The FY 2015 net improper payment estimate is 4.77 percent or $258.65 million. There were several contributing factors to the slight increase in the improper payment rate from 5.7 percent in FY 2014, which are more fully explained in the root causes section that follows. The reporting cohort for FY 2015—referred to as Year Two States—also has historically higher error rates than the prior reporting cohort. Since the methodology is a rolling three-year cycle, FY 2015 is only updating one-third of the data.

11.82 CCDF CAPs

Administrative or process errors represent approximately 80.6 percent of errors found in the reviews. These errors consist of the failure to apply policy correctly, including:

- Income calculation (10 states),
- Units of care authorized (4 states),
- Parent fee calculation (4 states), and
- Change reports (i.e., when eligibility staff update case records in response to family status changes) (4 states).

Insufficient Documentation errors account for an estimated 19.4 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. The most frequently cited errors due to missing or insufficient documentation include:

- Paystubs or income verification (5 states),
- Need for care (such as work or school schedules) (4 states),
- Birth certificates or other documentation (3 states), and
- Application or redetermination forms (3 states).

Corrective Actions to Address Root Causes:

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

HHS and states have established corrective actions targeting both error types. States reporting in FY 2015 plan the following actions:

Year Two States, as described in *Section 11.83*, identified the following implementation actions to correct improper payment error causes:

- Ongoing case reviews or audits,
- Trainings with eligibility staff on CCDF policies and procedures,
- Upgraded or enhanced information technology (IT) systems,
- Changes or update to state eligibility policies and procedures,
- Ongoing technical assistance to eligibility staff to address specific causes of errors, and
- One-on-one trainings with eligibility staff in response to audit findings.

HHS's corrective actions have been consistent over time and assist states in reducing error rates. In addition to this ongoing work, the FY 2015 corrective actions include the following activities:

- Conduct remote or onsite joint case reviews to ensure implementation of the HHS approved state review tools (6 states),
- Conduct site visits with states needing assistance to address root causes of errors (3 states),
- Provide technical assistance to states around policy and procedure changes to meet new requirements under the *Child Care and Development Block Grant Act of 2014* (*CCDBG Act*) (all states),
- Deliver technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors (10 states), and
- Provide individual reporting cohort training on the methodology that allows states to learn best practices from each other as they conduct the reviews (34 states).

11.83 CCDF Improper Payment Recovery

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

The cumulative FY 2015 CCDF improper overpayment amount is $346,186. The overall improper payment estimate is comprised of three review periods: FYs 2013, 2014, and 2015. The improper payments are as follows for each period:

- Year One States (reported in FY 2014) - $50,736,
- Year Two States (reported in FY 2015) - $93,153, and
- Year Three States (reported in FY 2013) - $202,297.

The FY 2015 review cycle represents the third time that Year Two States have conducted the error rate measurement. In FY 2012, the last time this cycle of states was measured, the states reported an improper over authorization amount of $146,914, and they anticipated and realized a recovery of approximately 18 percent, or $26,896, of this total. Year Two States reported improper payments of $93,153 in FY 2015, and anticipate recovering 29 percent, or $27,144, of these payments. Reports submitted in FY 2018 will address any amounts recovered based on the FY 2015 reviews.

11.84 CCDF Information Systems and Other Infrastructure

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

- *Increase access to client information*: including data synced with other assistance programs, quality control case reviews or reports, and system flags and blocks to avoid duplication or errors.
- *Increase access to provider information*: including automated billing reports, payment management tracking, provider licensing information, and automated payment rate determination.
- *Assist with eligibility determinations*: including access to data in other assistance programs' systems to obtain or confirm eligibility information, increased automation of eligibility processes, system flags, and blocks to avoid errors, automated copay calculation, and document storage.

11.85 CCDF Statutory or Regulatory Barriers

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

The *CCDBG Act*, signed into law in November 2014, reauthorized CCDF for the first time since 1996. The statute improves the quality and access to care for children across the country by requiring states to change eligibility to a minimum of 12 months, revise redetermination policies, update provider payment rates and payment practices, and increase health and safety standards for providers. States will be required to create new policies and procedures to enact the requirements of the law, which will likely increase errors as the changes are implemented. The improper payment targets identified in Table 1A reflect the anticipated brief rise in errors while states adjust to the changes.

11.86 CCDF Best Practices

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

- *Trainings for review staff*: trainings helped review staff to be well informed of CCDF policy and practices, error definitions, and the process for reviewing and documenting errors.

- *Coordination between review staff and child care policy staff*: ongoing communication and coordination between reviewers and CCDF staff (sometimes located in different departments or agencies) was useful during this review cycle.
- *Timely review process*: for example, starting early or conducting real time reviews.
- *Staffing changes*: expanding the review team or reassigning personnel to certain tasks improved the review process.
- *Updated eligibility systems*: new or upgraded IT systems made it easier to select cases and gather information for reviewers.
- *HHS webinars*: attendance at HHS webinars helped states successfully complete the reviews and required submissions.

HHS best practices included:

- Targeted technical assistance for methodology implementation.
- Group and individual technical assistance for peer-to-peer sharing of review findings and best practices to improve the reviews.
- Technical assistance to states around policy and procedure review and revision to address changes under the new CCDBG law.

12.0 Internal Control Over Payments

Appendix C to OMB Circular A-123, which was updated and released in October 2014, established the requirement that agencies with programs susceptible to significant improper payments and that are reporting improper payment estimates summarize the status of their internal control processes. The establishment of a robust internal control system can prevent and detect improper payments, and recover any improper payments that were made. The following tables display HHS's status of internal control over payments for the high-risk programs that report annual error rate estimates. The tables include an assessment of the status of internal control over payments against five internal control standards for each program.

Table 3A
FY 2015 Medicare Status of Internal Controls

Internal Control Standards	Medicare FFS	Medicare Part C	Medicare Part D
Control Environment	4	4	4
Risk Assessment	4	4	4
Control Activities	3	3	3
Information and Communication	4	4	4
Monitoring	3	3	3

Legend:
4 = Sufficient controls are in place to prevent Improper Payments (IPs)
3= Controls are in place to prevent IPs but there is room for improvement
2 = Minimal controls are in place to prevent IPs
1= Controls are not in place to prevent IPs

HHS continues to improve and evaluate its internal control activities in the programs susceptible to significant improper payments. A summary of the efforts by program are described below.

Generally, as described below, the Medicare FFS, Medicare Part C, and Medicare Part D programs have adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to identify and reduce such payments and strengthened the control environment. HHS has implemented effective control activities to prevent improper payments in the Medicare programs—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities in place to prevent improper payments include:

- MACs administer the Medicare program and HHS provides numerous guidelines and policies to the contractors to ensure effectiveness and efficiency. In particular, HHS requires that the MACs comply with Chapter 7 – Internal Control Requirements of the Medicare Financial Management Manual that outlines the Control Objectives (including processes such as Information Systems, Claims Processing, Medical Review, Provider Audit and Provider Enrollment) that contractors must follow to assist them in maintaining and strengthening their internal control procedures.
- HHS follows a strict review and approval process before processing Medicare claims, both manual and automated. The Medicare claims processing systems track each claim from receipt to final resolution. The systems check each claim, adjustment, and any other transaction for validity and, in accordance with HHS instructions, rejects such claims, adjustment, or other transaction failing such validity check. Each claim is adjudicated in accordance with HHS instructions.
- HHS has developed prior authorization demonstrations for items and services that historically experience high incidences of improper payments, such as PMDs, to ensure that services are provided in compliance with applicable Medicare coverage, coding, and payment rules before the services are rendered and claims are paid.
- HHS follows a strict review and approval process before issuing Medicare Part C and Part D payments. HHS Plan Payment Validation (PPV) activities are conducted each month to validate payments to MA plans, prescription drug plans, Programs of All-Inclusive Care for the Elderly (PACE), certain demonstrations and cost plans.

- HHS independently recalculates payments using data from source systems. Analysis is performed to further validate the accurate application of correct input data for payment calculations.
- HHS uses the NCCI to stop claims that never should be paid, such as a hysterectomy for a man or a prostate exam for a woman.

The kinds of key control activities in place to identify improper payments after the payments are made include:

- For the Medicare FFS program, MACs are responsible for identifying improper payments and adjusting benefit payments as appropriate. HHS regulations require timely and aggressive efforts to collect overpayments which include locating the debtor, demanding repayment, initiating benefit offset, establishing repayment schedules and referral to Treasury for cross servicing via the Treasury Offset Program (TOP).
- HHS utilizes various types of contractors including MACs, RACs, SMRC, and CERT contractors to identify and correct Medicare improper payments and promote provider compliance in the Medicare program. These contractors conduct post payment medical reviews focused on the agency's improper payment vulnerabilities to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements.
- HHS conducts certification of PDE and risk adjustment data for payment on an annual basis after the end of each coverage year. In their attestations, MA organizations and Part D sponsors attest to the accuracy, completeness, and truthfulness of the information submitted to HHS and acknowledge that PDE and risk adjustment data directly affects the calculation of their payments and that misrepresentation to HHS may result in federal civil action and/or criminal prosecution.
- HHS performs various financial reviews for the Part C and D programs to ensure the validity of payments made and to calculate risk sharing. These include but are not limited to the following: (1) monthly reconciliations as part of the plan validation process; (2) risk adjustment reconciliation in which HHS calculates final risk adjustment factors for the year based on newly submitted diagnostic data and any changes in enrollment, long-term institutional and low-income subsidy status; and (3) plan-to-plan (P2P) reconciliation that ensure accurate payments to and by plans.

The Medicare program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Each year, HHS establishes program policies, leads special initiatives, oversees compliance, and establishes performance monitoring practices, which are then carried out by the Regional Offices.
- HHS publishes articles in the Medicare Learning Network Medicare Quarterly Provider Compliance Newsletter. The articles discuss documentation requirements, CERT findings, and common errors.
- Similar to the CBRs, HHS continues to develop and issue Program for Evaluating Payment Patterns Electronic Report (PEPPER) to support hospitals or facilities compliance efforts by identifying where its billing patterns are different from the majority of other providers in the nation.
- HHS has contracted with program integrity contractors known as MEDICs, which primarily assist in outreach, education, data analysis, and case referrals to law enforcement.
- MA Organizations (MAOs) receive regular payment reports to review against their records. These reports inform the MAO of the payments made for the beneficiaries and/or underlying data which is used by the MARx payment system to make payments. It includes information on enrollment and enrollee risk scores used for payment.
- PDE Reports, which provides Part D sponsors with reports on the quality, timeliness, and accuracy of PDE data and error resolution efforts.

- PDE Analysis initiative, which addresses data quality issues on accepted PDE records in advance of the Part D payment reconciliation. PDEs are posted for Part D sponsor review and action, which may include (1) providing a written response with an explanation if the PDE data are valid, or (2) adjusting or deleting the PDE accordingly if the PDE data are invalid.

The Medicare program also conducts a variety of monitoring and assessment activities such as:

- In reference to Chapter 7 – Internal Control Requirements mentioned above - HHS conducts various reviews and attestations to ensure that Medicare contractors are complying with internal control requirements. First, each Medicare contractor provides assurance that internal controls are in place via their Certification Package for Internal Controls (CPIC). The CPIC includes a self-certification representation that the contractor's internal controls are in compliance with *Federal Managers' Financial Integrity Act of 1982* (FMFIA) expectations. Second, each Medicare contractor will engage an independent public accounting firm who will conduct an assessment of the contractor's internal controls in accordance with Statement on Standards for Attestation Engagements (SSAE) No. 16 Reporting on Controls at a Service Organization. This 'audit' in addition to other internal control reviews conducted on the contractor, ensures that internal controls are in place and operating effectively.
- HHS performs contractor oversight such as providing broad direction on medical review policy and annual medical review strategies; facilitating compliance with legislation and regulations; conducting continuous monitoring and evaluation of Medicare contractors' performance; and providing feedback to contractors regarding the Medicare program and medical review issues.
- HHS monitors the MAC performance in recovering overpayments and in documenting and reporting these recovery efforts, as detailed in the Medicare Financial Management Manual.
- HHS conducts a comprehensive MA Oversight Program that is fueled by data provided by the Plan Sponsors and beneficiaries. The goals of HHS's oversight strategy are to identify MA program vulnerabilities, assure strict adherence to MA regulatory and program requirements, and detect and prevent fraud, waste, and abuse. HHS also has a similar Part D oversight program.

HHS continues to improve and evaluate its internal control activities in the Medicare FFS, Medicare Part C, and Medicare Part D programs to prevent improper payments.

Table 3B
FY 2015 Medicaid and CHIP Status of Internal Controls

Internal Control Standards	Medicaid	CHIP
Control Environment	3	3
Risk Assessment	4	4
Control Activities	3	3
Information and Communication	3	3
Monitoring	3	3

Legend:
4 = Sufficient controls are in place to prevent IPs
3= Controls are in place to prevent IPs but there is room for improvement
2 = Minimal controls are in place to prevent IPs
1= Controls are not in place to prevent IPs

Since Medicaid and CHIP are state-administered programs, both HHS and states are responsible for ensuring appropriate payments in the Medicaid and CHIP programs. Generally, as described below, the Medicaid and CHIP programs have adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper Medicaid and CHIP payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to identify and reduce such payments and strengthened the control environment. HHS has implemented control activities to prevent improper payments in the Medicaid and CHIP programs—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities in place at HHS to prevent improper payments include:

- The Medicaid State Plan is the official Medicaid program contract between a state and HHS and is used to establish and determine what benefits or services are covered, who is eligible for those benefits, and how services are paid. Changes to the Medicaid State Plan are proposed by states through State Plan Amendments (SPAs) and are reviewed and approved by HHS. States are not allowed to claim federal-matching funds based upon a SPA until HHS approval.
- On an annual basis, the Federal Medical Assistance Percentage (FMAP) for each state is obtained from the Federal Register and hard coded into a web-based system to be used on the State's Quarterly Expense Report to ensure accuracy and prevent overpayment to the states.
- HHS follows a strict review and approval process before issuing quarterly grant awards to states. The states will submit a Medicaid Program Budget Report to HHS that provides a statement of the state's Medicaid funding requirements for a certified quarter and estimates for two FYs, and the state must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. Similarly for CHIP funding, the states will submit a CHIP Program Budget Report. HHS uses the information to prepare the grant awards to states to ensure that the appropriate level of federal payments for state expenditures are made in accordance with the CHIP legislative provisions and to monitor and evaluate the number of children served by the Medicaid and CHIP programs.
- The HHS Payment Management System (PMS) is responsible for processing Medicaid payments to states. HHS relies on financial information provided by PMS to account for the payments to states for the Medicaid program. HHS developed internal controls to ensure that the financial data as provided by PMS is accurately and completely reflected in HHS's financial records.
- States are responsible for determining eligibility, enrolling providers and beneficiaries, setting payment rates, contracting with plans, adjudicating claims, and claiming expenditures. States are also responsible

for ensuring that Medicaid and CHIP program operations, including those relating to provider payments, are consistent with the *Social Security Act* and implementing regulations.

The kinds of control activities in place to identify improper payments after the payments are made include:

- States are required to submit a summary of actual expenditures derived from source documents including payment vouchers, cost reports, and eligibility records. This information will inform HHS on the disposition of Medicaid grant funds for the quarter and any prior period adjustments. It also accounts for any overpayments, underpayments, refunds received by state Medicaid agencies, and income earned on grant funds. HHS conducts a thorough review and approval process of this information.
- HHS will issue state disallowances or deferrals as a result of audits or quarterly reviews.
- HHS implemented the Comprehensive Medicaid Integrity Program to reduce improper payments by utilizing contractors to review provider activities, audit claims, identify overpayments, and conduct provider education; and provide effective support and assistance to the states in their efforts to combat provider fraud and abuse.
- HHS operates the PERM program to identify Medicaid and CHIP improper payments that do not meet all state, Medicaid and CHIP coverage, coding, and medical necessity requirements.
- States are responsible for determining eligibility, enrolling beneficiaries, and adjudicating claims. Additionally, states are required to operate a Medicaid fraud and abuse control unit that is separate from the state Medicaid agency unless the state demonstrates that there is minimal fraud in its Medicaid program and that beneficiaries will be protected from abuse and neglect.

The Medicaid and CHIP programs also have various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Each quarter, HHS prepares and issues guidelines and instructions for the preparation of the Quarterly Medicaid Program Budget Report, which states use to provide a statement of the states' Medicaid funding requirements for a quarter and estimates underlying assumptions for the current FY. The data in the Medicaid Program Budget Report provides a variety of information that is essential to HHS in determining historical expenditure and estimating trends, and in developing federal Medicaid regulations, policy, and budgets.
- HHS senior officials are briefed monthly on the status of and issues resulting from review of state financial management reviews; including monetary and non-monetary findings, for program compliance and status of progress toward resolution.

The Medicaid and CHIP programs also conduct a variety of monitoring and assessment activities such as:

- HHS performs various financial reviews for the Medicaid program, including quarterly reviews of the states' submissions of budget and expenditure reports and focused financial management reviews, which are used to perform in-depth and focused analysis of a specific area of a state's Medicaid program.
- HHS operates the PERM program to identify Medicaid and CHIP improper payments. States are required to develop CAPs to address errors identified in the PERM measurements.
- HHS performs audit resolution and reviews audit findings to ensure they conform to existing Medicaid and CHIP regulations and policies. Following these efforts, HHS initiates the collection of monies due and/or negotiates an agreed upon course of corrective action with the state.

Table 3C
FY 2015 Foster Care and Child Care Status of Internal Controls

Internal Control Standards	Foster Care	Child Care
Control Environment	3	3
Risk Assessment	4	3
Control Activities	4	3
Information and Communication	4	3
Monitoring	4	3

Note: TANF is not included in this section since HHS is not reporting an improper payment estimate.

Legend:
4 = Sufficient controls are in place to prevent IPs
3= Controls are in place to prevent IPs but there is room for improvement
2 = Minimal controls are in place to prevent IPs
1= Controls are not in place to prevent IPs

Generally, as described below, the Foster Care program has sufficient controls in place to prevent improper payments. Although, as a Federally funded, state-administered program, HHS does not have management control over state agencies, HHS's reporting and analyses of improper Foster Care payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of a number of strategies to identify and reduce such payments and has strengthened the control environment. These strategies and the associated control environment are tailored to the nature of Foster Care improper payments resulting from administrative and documentation errors rather than from fraud and abuse. HHS has implemented effective control activities to prevent improper payments in the Foster Care program—preventive controls—and identify payments after the payments are made—detective controls. The kinds of key control activities to prevent improper payments include:

- Establishing Foster Care improper payments as an important management priority within HHS, with clear lines of accountability and responsibility within the agency.
- Providing support and feedback to states to support implementation of program improvement efforts, such as instituting specialized eligibility units to prevent eligibility errors or enhancing edits in automated systems to prevent billing errors.
- Working with the judiciary (e.g., through the Court Improvement Program) to enhance understanding of required documentation and timing of judicial hearings to prevent eligibility errors related to judicial determinations.
- Enhancing financial reporting requirements and guidance to auditors to obtain more information and improve the utility of single audit procedures.

The kinds of key control activities in place to identify improper payments after the payments are made include:

- Regular cycle of eligibility reviews, authorized by regulation, conducted by joint federal-state teams on a three-year cycle, to examine eligibility and allowability of federal IV-E payments to states.
- Recovery of all (100 percent) ineligible payments identified in eligibility reviews through disallowance of subsequent federal payment to states.
- Analyses of factors contributing to program improper payments each year, including examination of relative contributions to overall program improper payments. This yields information regarding priority areas to inform risk assessment and guide corrective action planning.
- Provision of matching funds and technical assistance for the development and enhancement of statewide automated child welfare information system (SACWIS) eligibility and financial management modules designed to improve the consistency, timeliness, and documentation available to support allowability for Title IV-E claims.

The Foster Care program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Communication and technical assistance to support continuous quality improvement by states, including updates on eligibility criteria and promising practices.
- Timely written report of review findings sent to each state agency following an eligibility review. This report includes detailed, case-level descriptions of all ineligible payments, underpayments, disallowances, promising practices, areas needing improvement, and next steps for the state.
- Required PIPs, which must identify all planned corrective actions and a timeline for completion, for all states found not in substantial compliance in an eligibility review. States must also provide regular updates on progress towards completion of the PIP, and complete it in a specified timeframe.
- Annual reports to program leadership summarizing findings across all state eligibility reviews conducted during the year, and identifying common elements related to strengths, areas needing improvement, and innovative practices.

The Foster Care program also conducts a variety of monitoring and assessment activities such as:

- Regular eligibility reviews conducted by joint federal-state teams, governed by a standard review instrument and detailed procedures outlined in the Eligibility Review Guide.
- Secondary reviews of all states found to be not in substantial compliance on a primary eligibility review.
- Validation of incoming review data to ensure data integrity prior to developing annual updated estimates of program error rate and improper payments following OMB-approved methodology for the federally-funded, state-administered Foster Care program.

HHS continues to improve and evaluate its internal control activities in the Foster Care program to prevent improper payments by participating in annual OIG audits of improper payments activities and incorporating audit recommendations as feasible within program regulatory constraints.

Generally, as described below, the CCDF program has adequate controls in place to prevent improper payments. HHS's reporting and analyses of improper CCDF payments to determine the nature, extent, magnitude, and root cause(s) of improper payments has led to the implementation of several strategies to help states identify and reduce such payments and strengthened the control environment. HHS has implemented effective control activities to help states prevent improper payments in the CCDF program—preventive controls—and identify

payments after the payments are made—detective controls. The kinds of key control activities in place to prevent improper payments include:

- Targeted technical assistance to all states to assist with the reduction of errors.
- States implement system enhancements to provide worker edits (i.e., forcing workers to correct information that is entered incorrectly such as in the wrong format or location) and monitoring reports.
- States design tools to reduce errors, such as calculation tables or spreadsheets.

The kinds of key control activities in place to identify improper payments after the payments are issued include:

- States conduct ongoing case reviews.
- States conduct supervisory, peer, and quality assurance team reviews to support accuracy.

The CCDF program also has various techniques in place to use, share, and communicate information to prevent improper payments and ensure the information is timely, accurate, and reliable. The source of information, method of distribution, and type of communication can vary widely and includes:

- Annual information brief on error rate data, root causes of errors, and best practices to address the issues.
- Regular cohort training to facilitate methodology implementation, and best practices to address findings.

The CCDF program also conducts a variety of monitoring, technical assistance, and assessment activities such as:

- Training to implement the error rate measurement methodology.
- Site visits to assist grantees in addressing the root causes of errors and designing their policy and procedure mitigations.

HHS continues to improve and evaluate its internal control activities in the CCDF program to prevent improper payments.

13.0 Recovery Auditing Reporting

HHS developed a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS focuses on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS's outlays in FY 2015. HHS is progressing in recovering improper payments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described below.

Medicare FFS RACs

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 states no later than January 1, 2010. The current RACs are under contract to continue their active recovery auditing work through December 31, 2015. HHS currently allows the Recovery Auditors to review a variety of claim types with the exception of hospital patient status reviews. HHS has been working through the procurement process for the next Recovery Auditor contracts since 2013. Due to multiple pre- and post-award protests delaying the new contracts, HHS withdrew the Request for Proposal for this procurement in June 2015. HHS has restarted the procurement process and expects to issue revised Requests For Proposal in early FY 2016.

In FY 2015, the Medicare FFS RAC program identified approximately $390.85 million and recovered $359.73 million in overpayments by the end of the FY. Policy changes regarding the payment and treatment of inpatient hospital claims and a delay in awarding new Medicare FFS contracts resulted in the reduction of the number of FY 2015 reviews compared to previous years. Meanwhile, amounts that were identified in previous years continued to be collected. During FY 2015, the majority of Medicare FFS RAC collections were from Diagnosis Related Group

validations and DMEPOS provided in inpatient settings. HHS continues to monitor and make continuous improvements to the Medicare FFS RAC program activities.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2015, HHS released four Provider Compliance Newsletters that offered detailed information on 17 findings identified by the Medicare FFS RACs. Also, HHS used these findings to implement local and/or national system edits as internal controls to prevent improper payments. More information on the Medicare FFS RAC program can be found at: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program.

Medicare Secondary Payer RACs

The Medicare Secondary Payer (MSP) RAC began full recovery operations at the end of FY 2013 and operates as the MSP Commercial Repayment Center (CRC). The CRC reviews HHS information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP). When that information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). The debtors for these MSP debts do not have formal appeal rights, but do have the opportunity to dispute the debt through the established "defense" process.

In FY 2015, the CRC identified approximately $292.20 million and collected $149.60 million in mistaken payments. In FY 2016, the CRC workload will expand to include the recovery of certain Non-Group Health Plan (NGHP) conditional payments where an NGHP entity has or had primary payment responsibility. More information on the CRC can be found at: www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/Group-Health-Plan-Recovery.html.

Medicare Part C and Part D RACs

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. As part of the procurement process to secure a Medicare Part C RAC, HHS posted a Request for Quote in June 2014; however, no responses were received as a result of that solicitation. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2016.

The Part D RAC became fully operational in FY 2012, and is currently reviewing prescription drug event data for calendar years 2010 through 2013. Since its launch, the Part D RAC recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers or filled at excluded pharmacies. The Part D RAC recouped approximately $5.2 million in FY 2015. Additionally, in FY 2015, the Part D RAC identified improper payments for improper refills of Drug Enforcement Agency (DEA) scheduled drugs for calendar years 2010 through 2011. Notifications of improper payment were sent to plan sponsors in February 2015, totaling approximately $2.8 million and recoupments are expected to occur in FY 2016.

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

State Medicaid RACs

Section 6411(a) of the *Affordable Care Act* required states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012. Thus, FY 2015 is the third full federal FY of reporting State Medicaid RAC recoveries. As states continue to implement their State Medicaid RAC programs, State Medicaid RAC federal-share recoveries totaled $57.71 million in FY 2015. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

HHS regulations align the State Medicaid RAC requirements to existing Medicare FFS RAC program requirements, where feasible, and provide each state the flexibility to tailor its RAC program where appropriate. As of the end of FY 2015, 47 states and the District of Columbia had implemented Medicaid RAC programs, but one of those states ended its RAC program when HHS approved an exception due to high managed care penetration. Four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high managed care penetration.

HHS provides guidance as the States administer the Medicaid RAC program. In September 2012, HHS launched a tool to encourage transparency and monitoring called the State Medicaid RACs At-A-Glance website, which is located at: w2.dehpg.net/RACSS/Map.aspx. The website contains state-reported information on each State's Medicaid RAC program, the name of each RAC vendor and Medical Director, and contact information for the state program integrity staff.

Recovery Auditing Reporting Tables

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

Table 4
Improper Payment Recaptures with and without Audit Programs
FY 2015 (in Millions)

	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total		Overpayments Recaptured Outside of Payment Recapture Audits	
Program or Activity	Amount Identified	Amount Recaptured	CY Recapture Rate *Note (2)*	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	CY Recapture Rate *Note (1)*	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Medicare FFS Error Rate Measurement													$39.71	$30.68
Medicare FFS Recovery Auditors	$390.85	$359.73	92.04%	85.00%	85.00%						$390.85	$359.73		
Medicare Secondary Payer Recovery Auditor Note (2)	$292.20	$149.60	51.20%	85.00%	85.00%						$292.20	$149.60		
Medicare Contractors Note (3)													$14,523.62	$11,554.30
Medicare Part C Note (4)													$648.84	$648.84
Medicare Part C Recovery Auditors Note (5)														
Medicare Part D Note (4)													$11.57	$11.57
Medicare Part D Recovery Auditors	$2.76	$5.16	186.96%	85.00%	85.00%						$2.76	$5.16		
Medicare C RADV Audits Note (6)														
Medicaid Error Rate Measurement													$4.40	$1.02
CHIP Error Rate Measurement													$1.91	$0.81
Medicaid Integrity Contractors-Federal Share Note (7)													$22.13	$8.23
State Medicaid Recovery Auditors – Federal Share Note (8)						N/A	$57.71	N/A	N/A	N/A	N/A	$57.71		
Foster Care Eligibility Reviews-Post Payment Reviews													$0.99	$0.99
Foster Care OIG Reviews													$0.00	$0.00

	Payment Recapture Audits of Contracts					Payment Recapture Audits of Benefits					Total			Overpayments Recaptured Outside of Payment Recapture Audits	
Program or Activity	Amount Identified	Amount Recaptured	CY Recapture Rate *Note (2)*	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured	CY Recapture Rate *Note (1)*	CY + 1 Recapture Rate Target	CY + 2 Recapture Rate Target	Amount Identified	Amount Recaptured		Amount Identified	Amount Recaptured
Foster Care Single Audits														$0.82	$0.05
Child Care Single Audits														$0.99	$0.00
Child Care Error Rate Measurement Note (9)														$0.14	$0.02
Head Start OIG Reviews														$0.11	$0.00
Head Start Single Audits														$2.55	$0.19
TOTAL	$685.81	$514.49	75.02%	85.00%	85.00%		$57.71				$685.81	$572.20		$15,257.78	$12,256.70

Notes:

1. The amount reported in the CY Recapture Rate column is the amount recovered in FY 2015, regardless of the year the overpayment was identified.
2. The Medicare Secondary Payer recovery auditor maintains all debts established under prior MSP recovery programs; consequently, the reported collections is the amount recovered in FY 2015, regardless of the year the mistaken payment was identified.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program and the Medicare FFS Error Rate Measurement program, which are reported separately in this table.
4. The values in the Medicare Part C and Medicare Part D rows represent overpayments reported and returned by Medicare Advantage organizations and Part D sponsors, respectively.
5. HHS expects to award a contract for a Medicare Part C RAC program in FY 2016.
6. During FY 2015, HHS continued the contract-level RADV audits based on calendar year 2011 and launched the calendar year 2012 audits. As such, there were no RADV payment amounts identified or recovered in FY 2015.
7. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the federal and state shares. However, HHS has reported here only the actual federal share across audits.
8. For state Medicaid recovery auditor programs, states are only required to report the amount of recoveries on the CMS-64, and not amount of improper payments identified or recovery rates or targets.
9. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recaptured 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. Data reported in FY 2015 represent improper payments recovered by the Year Two states based on improper payments identified in FY 2012.

Table 5
Disposition of Funds Recaptured Through Payment Recapture Audits
FY 2015 (in Millions)

Program or Activity	Amount Recovered	Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose Note (1)	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$359.73	Contract	$75.62	$20.25	N/A	$182.89	N/A	N/A
Medicare Secondary Payer Recovery Auditor	$149.60	Contract	$2.49	$22.06	N/A	$125.05	N/A	N/A
Medicare Part D Recovery Auditors	$5.16	Contract	N/A	$0.62	N/A	$4.54	N/A	N/A
State Medicaid Recovery Auditors – Federal Share Note (2)	$57.71	Benefits	N/A	N/A	N/A	N/A	N/A	$57.71
Total	$572.20		$78.11	$42.93	N/A	$312.48	N/A	$57.71

Notes:
1. Funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors "Original Purpose" cell also takes into consideration underpayments to providers that were identified and corrected ($80.96 million).
2. The state Medicaid recovery auditors row only includes information on the federal share of recoveries, which are returned to Treasury. States do not report information to HHS on how the state portions of recoveries are used.

Table 6
Aging of Outstanding Overpayments Identified in the Payment Recapture Audits
FY 2015 (in Millions)[Note (1)]

Program or Activity	Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)	Amount Determined to Not be Collectable
Medicare FFS Recovery Auditors	Contract	$61.43 Note (2)	$26.16	$1,056.56	N/A
Medicare Secondary Payer Recovery Auditor Note (3) and (4)	Contract	$92.81	$87.68	$0.00	$0.00
Medicare Part D Recovery Auditors	Contract	N/A Note (5)	N/A	N/A	N/A
Total		$154.24	$113.84	$1,056.56	$0.00

Notes:

1. The state Medicaid recovery auditors are not included in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts that are currently outstanding.
2. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
3. The Medicare Secondary Payer recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
4. The amount of outstanding payments identified by the Medicare Secondary Provider recovery auditor included in this table reflect the outstanding balances on debts identified in FY 2015 only as of the end of FY 2015.
5. Recoupments of FY 2015 overpayments will not begin on the Medicare Part D recovery auditors' overpayments until the appeals process is complete. The appeals process is ongoing, but is expected to be completed during FY 2016.

14.0 Do Not Pay Initiative

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

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

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

Since the Presidential memorandum was issued, and IPERIA was enacted, HHS has worked diligently to implement the DNP initiative. HHS and CMS established a Computer Matching Agreement (CMA) with Treasury under the DNP initiative in FY 2014. The CMA allows HHS to match electronic files against restricted content (such as Social Security Number, Date of Birth, or Taxpayer Identification Number (TIN)) in some of the data sources, simultaneously reducing the time to complete the matches while also producing more accurate results. HHS has continued to receive information through the CMA that was established in FY 2014 and began working to establish additional CMAs in FY 2015. In addition, several of our Divisions are continuing to use DNP to check for recipients or potential recipients' eligibility and to prevent the issuance of improper payments.

Treasury-disbursed payments are matched against the DMF and the excluded parties' elements of SAM in the DNP portal to identify improper payments on a daily basis. While the Department has identified 530 potential improper payments over the past year as part of these daily matches (as shown in Table 7), there was only one confirmed improper payment for $6,521.00.

Table 7

Results of the Do Not Pay Initiative in Preventing Improper Payments

FY 2015

	Number (#) of payments reviewed for possible improper payments	Dollars ($) of payments reviewed for possible improper payments	Number (#) of payments stopped	Dollars ($) of payments stopped	Number (#) of potential improper payments reviewed and determined accurate	Dollars ($) of potential improper payments reviewed and determined accurate.
Reviews with the IPERIA specified databases Note (1)	1,182,453 Note (2)	$362,611,594,950	0 Note (3)	0 Note (3)	530 Note (4)	$97,753,865 Note (4)
Reviews with databases not listed in IPERIA	N/A	N/A	N/A	N/A	N/A	N/A

Notes:

1. This row shows payments that are disbursed through Treasury and matched against IPERIA specified databases. However, Medicare FFS payments are not disbursed by Treasury but are also matched against databases listed in IPERIA. HHS is currently developing the systems requirements to automate the capture of this information for Medicare FFS payments, and will report this data in the FY 2016 AFR.
2. HHS data included 1,962 payment records which contained missing or invalid information.
3. "Payments Stopped" refers to payments for which the agency has implemented Stop Payment Rules or a similar method of disbursement prevention during the pre-payment stage. It does not include post-payment reclamations, collections, or offsets.
4. This includes information on payments that were flagged as potentially improper, but were determined proper after further review.

15.0 Superstorm Sandy Reporting Information

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

In response to this disaster, Congress passed the *Disaster Relief Act*, which was signed into law on January 29, 2013 and provided $50.5 billion in aid for Sandy disaster victims and their communities. HHS received $747 million, allocated among multiple programs across five Divisions: ACF, ASPR, CDC, SAMHSA, and NIH. Because funding of this type and magnitude often carries additional risk, the *Disaster Relief Act* and OMB guidance state that all federal programs or activities receiving funds are automatically considered susceptible to significant improper payments, regardless of any previous improper payment risk assessment results, and are required to calculate and report an improper payment estimate. Accordingly, HHS developed methodologies to estimate improper payments in the programs that received *Disaster Relief Act* funding. Information on the *Disaster Relief Act* programs' improper payment methodologies, results, and corrective actions can be found on subsequent pages.

15.10 Head Start

15.11 Head Start Statistical Sampling Process and Results

Head Start received approximately $95 million in *Disaster Relief Act* funding to provide services, training and oversight, and construction assistance to affected grantees. Every grantee who spends Superstorm Sandy funds receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon thereafter as possible. Superstorm Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. Additional information on Head Start's statistical sampling process can be found on pages 198 - 199 of HHS's FY 2014 AFR, available at: www.hhs.gov/afr.

The FY 2015 review period consisted of transactions representing funds expended by grantees between July 1, 2014 and June 30, 2015. HHS expects FY 2015 to have the largest number of Head Start Superstorm Sandy transactions because during this period, awardees were completing minor repairs and renovations, re-supplying centers and classrooms, providing mental health services, implementing major facilities renovations, and re-building seriously damaged or destroyed centers.

The Head Start gross and net improper payment estimate for FY 2015 is 0.38 percent or $61,626.36.

15.12 Head Start Root Causes and CAPs

Corrective Actions to Address Root Cause

Root Cause: Administrative or Process Error Made by Local Agencies

All of the identified Head Start erroneous payments were administrative or process errors made by the grantees (100 percent). Most of the identified erroneous payments were caused by human error, such as transposed numbers. The largest single error amount identified was for $22,772 and was due to an error in the allocation of the salary and fringe benefits for a supervisory employee. For this error, the grantee neglected to adjust its cost allocation methodology to reflect the change in duties for the employee once her Sandy-related duties ended. Additionally, some of the erroneous payments were self-identified by the grantee as part of their internal monitoring processes. Technical assistance to grantees has consequently emphasized the need for ongoing internal monitoring of transactions by grantees and comparison of amounts paid to source documentation.

15.13 Head Start Improper Payment Recovery

All improper payments made to Head Start awardees have been recovered through direct repayment or offset against subsequent Superstorm Sandy awards.

15.20 SSBG

15.21 SSBG Statistical Sampling Process and Results

The SSBG program received $474.5 million in *Disaster Relief Act* funding to address necessary expenses resulting from Superstorm Sandy. These expenses include social, health, and mental health services for individuals, and repair, renovation and rebuilding of health care facilities (including mental health facilities), childcare facilities, and other social services facilities. These SSBG *Disaster Relief Act* funds were allocated to five states directly affected by Superstorm Sandy: Connecticut, Maryland, New Jersey, New York, and Rhode Island. HHS selected three of the five states that received SSBG *Disaster Relief Act* funds (Connecticut, New Jersey, and New York) to calculate improper payment error rates, since their allocations represent 99 percent of all SSBG *Disaster Relief Act* funds.

Because the states determine the types of services and eligibility for these services, as permitted by the SSBG law and regulations, there is considerable variation among states in their application of these funds. To account for this variation, HHS developed a two-fold (bifurcated) improper payment methodology to review the use of SSBG *Disaster Relief Act* funds in Connecticut, New Jersey, and New York. The two approaches are a case record review process and a vendor payment review process. The case record review examines payments or benefits provided to or on behalf of individuals, families or households (i.e., cases) based on specific eligibility criteria. The vendor payment review examines individual payments made to service vendors and assesses if the vendors provided adequate documentation (e.g., applications, authorizations) necessary to meet the eligibility requirements for these payments.

For the FY 2015 review period (July 1, 2014 to June 30, 2015), HHS completed case record and vendor payment reviews in Connecticut, New Jersey, and New York. HHS consolidated its review findings and calculated a national SSBG Superstorm Sandy *Disaster Relief Act* error rate from the aggregate findings across all three states.

In FY 2015, HHS used an error rate estimate of 10 percent to determine sample sizes for the case record and vendor payment reviews with a 90 percent confidence interval of +/-2.5 percent. HHS continued to estimate a base error rate of 10 percent when establishing sample sizes for FY 2015, despite calculating a national SSBG error rate for FY 2014 at 13.48 percent.

FY 2014 improper payment reviews consisted only of a case record review in New Jersey. This was due both to a lack of applicable expenditures in Connecticut and New York, and to the vendor payment review remaining under development at the time of the FY 2014 improper payment reviews. A majority of funds in error in FY 2014 (74 percent) were attributed to a single vendor within New Jersey's Sandy Homeowner and Renter Assistance Program (SHRAP), which accounted for approximately 92 percent of all expenditures reviewed in FY 2014. Many of the recorded errors were due to missing documentation at the time of the review. The state ultimately retrieved much of the documentation missing at the time of the review, which would have reduced the calculated error rate to approximately five percent. However, the state was unable to provide this documentation in time to reassess the established SSBG error rate for FY 2014.

While the FY 2014 SSBG *Disaster Relief Act* error rate was greater than the initially estimated 10 percent, HHS felt it was inappropriate to adjust its SSBG *Disaster Relief Act* error rate estimate for all reviews in all states based on the results of a case record review occurring in one state. As such, HHS retained a base error estimate of 10 percent when generating samples for the FY 2015 improper payment reviews.

HHS reviewed a total of 1,152 records in FY 2015. For the case record review, HHS reviewed 580 case records across the three states – 53 cases in Connecticut, 383 cases in New Jersey, and 144 cases in New York. For the vendor payment review, HHS reviewed 572 vendor payments across the three states – seven payments in Connecticut, 224 payments in New Jersey, and 341 payments in New York.

The SSBG gross improper payment estimate for FY 2015 is 0.22 percent or $0.46 million. The FY 2015 net improper payment estimate is 0.22 percent or $0.45 million.

The error rate for the case record reviews was 1.18 percent, while the error rate for the vendor payments was 0.18 percent.

15.22 SSBG Root Causes and CAPs

Of the 1,152 records reviewed, 45 records had an improper payment.

Five errors (representing 53.4 percent of the estimated improper payments) were categorized as Administrative or Process Errors due to State or local agencies. These errors included: (1) missing signatures on payment processing forms required as part of payment approval; or (2) clerical errors in calculating payment amounts based on vendor claims.

Eight errors (representing 14.8 percent of the estimated improper payments) were categorized as Administrative or Process Errors due to other parties (i.e., non-Federal, non-State, and non-local agencies). These errors included: (1) clients receiving incorrect benefit amounts (greater or lesser) based on documented need; (2) clients receiving benefits before providing all necessary eligibility documentation; (3) clients receiving benefits despite documentation indicating ineligibility for service; or (4) benefit payments being made on behalf of someone outside of the client's household.

Thirty-two errors (representing 31.8 percent of the estimated improper payments) were categorized as Insufficient Documentation to Determine. These errors included: (1) case records missing necessary eligibility documentation (e.g., driver's license, passport); or (2) records missing necessary documentation of proper payment processing (e.g., proof of payment, payment approval forms, copies of bills/invoices to be paid).

Corrective Actions to Address Root Causes:

HHS implemented a series of monitoring and oversight activities in all states to address problems of burden, information exchange, and organization of review materials highlighted in the FY 2014 improper payment findings. HHS has worked with the state to address issues related to document processing and will continue to coordinate with the state on additional corrective actions including payment recapture where necessary. HHS activities have included drawing quarterly improper payment samples for review and formalizing a 30-day response period for states upon completion of each review. The 30-day response period allowed states to clarify payment policies or provide missing documentation that may have been mistakenly left out during the organization and assembly of files for review.

In response to FY 2015 improper payment findings, HHS will provide each state subject to review with a letter outlining the development of CAPs. These letters will be accompanied by itemized lists of unresolved errors from the FY 2015 review period (including descriptions of improper payment findings and amounts), and will establish a 30-day timeframe for states to respond with planned corrective actions. HHS will also hold calls with each state to answer any questions related to developing CAPs or establishing improper payment recovery amounts. In developing their responses, states may provide an explanation for recovery amounts to be sought for each error; however, HHS retains final discretion in determining total amounts of funds subject to recovery. Further information on specific root causes and corrective actions is located below.

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

To address administrative or process errors due to State or local agencies, HHS will develop strategies with states to monitor and provide oversight to the most error-prone agencies. These strategies will reinforce the importance of ensuring that all documentation required for payment processing is present and complete before payments are approved. These activities will also emphasize careful examination of receipts and invoices to ensure that payments made by the states properly reflect established payment schedules and reimbursement protocols. HHS will continue to work with states to examine where in their payment approval processes the greatest intervention is warranted.

Root Cause: Administrative or Process Errors Made by Other Party

To address administrative or process errors due to other parties, HHS will develop strategies with states to monitor and provide oversight to the most error-prone service providers. These strategies will reinforce the importance of: (1) collecting all client eligibility documentation prior to provision of service benefits; (2) ensuring that eligibility documentation is properly examined, and that ineligible individuals do not receive service benefits; and (3) ensuring that benefits provided to clients match their documented needs. HHS will continue to work with states to address how error-prone vendors can improve their client intake processes and improve processes for assessing and approving client benefits.

Root Cause: Insufficient Documentation to Determine

To address errors due to insufficient documentation, HHS will develop strategies with states to monitor and provide oversight to the most error-prone service agencies and providers. These strategies will reinforce the importance of record maintenance and organization. HHS will work with states to assess typical practices of record maintenance and organization.

15.23 SSBG Improper Payment Recovery

Of the total error findings, $457,434 was associated with overpayments. As states receive and review all unresolved errors from the FY 2015 review period, HHS will work with states to identify items for which additional corrective action will be taken (including obtaining additional documentation, making process adjustments, and the current state of improper payment recovery). Where additional action around improper payment recovery is warranted, HHS will work with states to focus recovery efforts on improper payments resulting from core eligibility errors, where benefits or payments should not have been paid.

15.30 FVPS

15.31 FVPS Statistical Sampling Process and Results

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

HHS determined that each state grantee would sample 45 percent of its financial alternative housing payments during each review period to generate a statistically valid estimate. If the number of payments in any review period is less than 110, then 100 percent of the payments will be reviewed. In FY 2015 (review period July 1, 2014 to June 30, 2015), FVPS reviewed 371 payments, with 220 payments coming from the NJDCF and 151 payments from the NYSOCFS.

FVPS' gross and net improper payment estimate for FY 2015 is 0.89 percent or $7,944.85.

15.32 FVPS Root Causes and CAPs

Of the 371 payments that were reviewed, HHS determined four payments were in error due to Administrative or Process Error Made by the State or Local Agency (100 percent). One of the improper payment errors was an overpayment by a NJDCF sub awardee due to an error made by the local awardee. The other three improper payment errors were overpayments made by NYSOCFS subawardees that resulted from the subawardees' failure to correctly classify ineligible or unallowable expenses. For example, multiple programs had unallowable expenses (purchases of household goods) due to misinterpretation of allowable expenses for "basic, essential items."

Corrective Actions to Address Root Cause:

Root Cause: Administrative or Process Error Made by State or Local Agency

To reduce the likelihood of future improper payments, HHS has: (1) shared the improper payment findings with NJDCF and NYSOCFS, and (2) provided technical assistance and clarification on allowable versus unallowable expenses with future supplemental funding. In addition, both states identified internal corrective actions to prevent errors. For example, NJDCF required that domestic violence provider agencies send a list of the "basic,

essential items" that a co-trauma victim was requesting prior to disbursement of funds. NJDCF then sent the request to HHS for approval to determine which items were allowable. In addition, NJDCF distributed a frequently asked question (FAQ) document on October 28, 2014 to all provider agencies in order to assist in reducing unallowable expenditures. This FAQ was developed by HHS as a technical assistance aid for both state grantees to reduce improper payments. NYSOCFS provided written notification of the improper payment findings to its sub-grantees with instructions to refund the specified amounts to NYOCFS.

The grant period for both awards ended on June 30, 2015. No further expenditures or reimbursements were made after that period; therefore, there will be no further monitoring or reporting on improper payments.

15.33 FVPS Improper Payment Recovery

It is estimated that all of the actual identified overpayments will be recovered by the grantees and will be returned to the Department of Treasury.

15.40 ASPR Research

15.41 ASPR Research Statistical Sampling Process and Results

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

Based on a review of over 1,000 transactions from FY 2014, the ASPR Research gross and net improper payment estimate for FY 2015 is 0 percent or $0 million.

15.42 ASPR Research Root Causes and CAPs

Corrective Actions to Address Root Cause:

Root Cause:

Although HHS has not identified any improper payments in the ASPR Research program in FY 2015, HHS established internal controls to prevent future improper payments from occurring. In FY 2015, no improper payments were found. However, ASPR will continue to monitor the *Disaster Relief Act* funding and related key processes. Major accomplishments in FY 2015 include:

- Revising the *Disaster Relief Act* sub-cycle memorandum to reflect updates within the process.
- Revised the improper payment methodology.

15.43 ASPR Research Improper Payment Recovery

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

15.50 CDC Research

15.51 CDC Research Statistical Sampling Process and Results

To date, CDC received approximately $8.2 million under the *Disaster Relief Act* to perform environmental health studies and provide public health support, of which approximately $7.2 million represents *Disaster Relief Act* funds awarded to grantees. The CDC's Notice of Award required awardees to include additional documentation to support the line items on the Federal Financial Report (FFR). This additional documentation includes grantees internally generated reports or extracts of expenses. Under its methodology, CDC reviewed these documents to identify improper payments due to causes including: unallowable costs, unallocable costs, and goods and/or services not received. The FY 2015 sampling methodology included quarterly reviews of draw down activity and transactions from July 1, 2014 through June 30, 2015 for each grantee that spent *Disaster Relief Act* funding during the review period, covering 1,050 transactions representing approximately $4.6 million in outlays.

The CDC Research gross and net improper payment estimate for FY 2015 is 0 percent or $0 million.

15.52 CDC Research Root Causes and CAPs

Corrective Actions to Address Root Cause:

Root Cause:

No improper or erroneous payments were identified during the FY 2015 review; therefore there is no root cause information. In FY 2014, CDC established internal controls to prevent future improper payments from occurring. Specifically, CDC developed a Risk Mitigation Plan for the CDC Research program that outlines steps to prevent improper payments in the Superstorm Sandy funding. The CDC continued to use their Risk Mitigation Plan during FY 2015 due to its success in preventing Superstorm Sandy improper payments.

15.53 CDC Research Improper Payment Recovery

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

15.60 SAMHSA

15.61 SAMHSA Statistical Sampling Process and Results

SAMHSA received $10 million under the *Disaster Relief Act*. SAMHSA awarded approximately $6.2 million to four programs and returned approximately $3.8 million because fewer organizations applied for the funding and applications received were for amounts significantly less than expected. The four funded programs were: 1) Behavioral Health Treatment; 2) Disaster Distress Helpline; 3) Resiliency Training for Educators; and 4) Medication Assisted Treatment of Opioid Addiction Restoration.

For FY 2015, SAMHSA's program universe subject to sampling consisted of four grants awarded to New York State ($798,339), New York City ($2,947,786), New Jersey ($329,120), and Links2Health ($2,100,000) for the four funded programs listed above. Between July 1, 2014 and June 30, 2015, SAMHSA had outlays of $1.3 million across 24 transactions. Due to the small number of transactions, SAMHSA reviewed all outlays for payment accuracy and used the results to calculate the total improper payments for the program.

SAMHSA's actual gross improper payments for FY 2015 is 1.38 percent or $18,166; the net improper payments estimate is 0.15 percent or $2,006.

15.62 SAMHSA Root Causes and CAPs

SAMHSA's improper payments identified during the review period were due to Administrative or Process Errors Made by the Grantees (100 percent). The total gross improper payments of $18,166 were due to errors in the calculation of direct and indirect expenses.

Corrective Actions to Address Root Cause:

Root Cause: Administrative or Process Errors Made by Other Party

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

15.63 SAMHSA Improper Payment Recovery

SAMHSA has corrected the entire $18,166 in improper payments. The $10,086 in overpayments was refunded to SAMHSA and the $8,080 in underpayments was subsequently drawn down by the grantee.

15.70 NIH Research

15.71 NIH Research Statistical Sampling Process and Results

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

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

Under its methodology, NIH completed two rounds of improper payment reviews in FY 2014 covering 12-months of expenditures in two semi-annual sampling periods: July 1, 2013 to December 31, 2013 and January 1, 2014 to June 30, 2014. For FY 2015, NIH reviewed 357 expenditure reports representing 242 grant awards and 18 different grantee institutions, and identified improper payments of $539,300. The improper payments were associated with one grantee institution.

The NIH Research gross and net improper payment estimate for FY 2015 is 2.29 percent or $884,550.

15.72 NIH Research Root Causes and CAPs

The root cause for all improper payments identified for the review period was due to Insufficient Documentation to Determine if the grantee's reported costs were allowable pursuant to NIH's grant terms and conditions of award (100 percent).

Corrective Actions to Address Root Cause:

Root Cause: Insufficient Documentation to Determine

NIH will implement the following corrective actions:

- Request that the grantee conduct a review of their accounting system and related policies to identify and correct any potential weaknesses in the grantee's accounting system or methods of charging accounts specifically related to cost transfers, allocation of costs, and adherence to special terms and conditions of grant award.
- Provide the grantee with technical assistance, as required, based on the outcome of the review.
- Determine whether there are recoveries of unallowable costs after further review of the findings.
- Include the grantee in all future Sandy improper payment testing.

15.73 NIH Research Improper Payment Recovery

After NIH conducts a further review of the grantee's subsequent corrective actions, NIH will be in a position to determine whether there are recoveries of unallowable costs.

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

Table 1: Summary of Financial Statement Audit

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

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

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

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

Resolved: The total number of material weaknesses that have dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., section 2 to a section 4 and vice versa).

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

***Reference:** OMB Circular A-136, *Financial Reporting Requirements*, August 4, 2015, page 150

Table 2: Summary of Management Assurances

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

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

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

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

FY 2015 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary

FROM: Inspector General

DATE: November 9, 2015

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2015

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 OlG's top management and performance challenges for fiscal year 2015 are:

1. Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse
2. Fighting Fraud, Waste, and Abuse in Medicare Parts A and B
3. The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology
4. Administration of Grants, Contracts, and Financial and Administrative Management Systems
5. Ensuring Appropriate Use of Prescription Drugs
6. Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care
7. Implementing, Operating, and Overseeing the Health Insurance Marketplaces
8. Reforming Delivery and Payment in Health Care Programs
9. Effectively Operating Public Health and Human Services Programs
10. Ensuring the Safety of Food, Drugs, and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Christopher Seagle, Director of External Affairs, at (202) 260-7006 or Christopher.Seagle@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

Management Challenge 1: Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse

Why This Is a Challenge

Protecting the integrity of Medicaid takes on heightened urgency as expenditures and beneficiaries served continue to grow. As of September 2015, 29 states and the District of Columbia are expanding Medicaid eligibility to include a larger group of qualifying adults pursuant to the *Patient Protection and Affordable Care Act* (*Affordable Care Act*) and Medicaid waivers. Further, states that have not expanded eligibility have also seen increases in Medicaid enrollment. Taking into account the obstacles associated with expanding eligibility, along with long-standing program integrity issues, Medicaid continues to be a top management challenge for the Department of Health and Human Services (Department or HHS).

Expansion of Medicaid Eligibility. As of August 2015, the Centers for Medicare & Medicaid Services (CMS) reported that enrollment in Medicaid and the Children's Health Insurance Program (CHIP) had increased by 13.6 million people since *Affordable Care Act*-expanded eligibility criteria went into effect in October 2013. To ensure effective management of the expanding program, updating eligibility systems to ensure appropriate eligibility determinations and applicable Federal Medical Assistance Percentage (FMAP) is imperative. A main source of Medicaid's 6.7 percent improper payment rate (as reported in fiscal year (FY) 2014) is attributed to payments made on behalf of ineligible individuals. (For more information on improper payments, see Management Challenge 4.) For example, eligibility errors occur when beneficiaries lose eligibility status because they are no longer residents of the state and/or failed to report a change in circumstances but remain enrolled in a state's Medicaid program. The Public Assistance Reporting Information System (PARIS) Medicaid Interstate Match program was designed to reduce these errors by identifying beneficiaries who are enrolled in multiple state Medicaid programs, but state participation in the match is limited and its effectiveness in reducing improper payments is inconsistent.

Improving Oversight of Medicaid Managed Care. As of 2011, approximately 75 percent of Medicaid beneficiaries nationwide are enrolled in managed care. To be effective, oversight must include robust program integrity measures, have and use accurate and timely data, and ensure that beneficiaries have sufficient access to services. In a December 2011 report, the Office of Inspector General (OIG) found that the predominant program integrity concerns of both states and plans are provider fraud – billing for services that were not provided, were medically unnecessary, or upcoded – and beneficiary fraud – including prescription drug abuse. Fraud or abuse by managed care plans themselves, such as manipulating bids to increase reimbursement, also pose program integrity challenges. States are required to collect and submit encounter data that document the managed care services that beneficiaries receive, but some states do not submit any data and others do not submit all of the required data elements. As a result, CMS does not have the data necessary to identify and address possible fraud, waste, and abuse. Further, OIG has identified issues that may impede beneficiaries' access to care, including limited appointment availability and varying state standards for access (e.g., states range from requiring one primary care provider for every 100 to 2,500 enrollees.).

Improving the Effectiveness of Medicaid Data and Systems. A functional, national Medicaid database is essential to effective oversight. However, national Medicaid data are not complete, accurate, or timely, and additional data are needed to enhance national program integrity activities. CMS still faces challenges in its attempts to improve the availability and quality of Medicaid data. Limited implementation by states has hindered CMS's Transformed Medicaid Statistical Information System (T-MSIS) initiative, which is CMS's key effort to modernize and enhance the usefulness of state Medicaid data. Other CMS attempts to improve data sharing between states have not been fully successful. For example, CMS established a data-sharing system to implement the *Affordable Care Act*

requirement that providers terminated for cause (i.e., for reasons of fraud, integrity, or quality) in one state Medicaid program, CHIP, or that have had their Medicare billing privileges revoked are terminated by all other state Medicaid programs. However, data within that system was often incomplete and did not provide useful information to states in order to carry out the *Affordable Care Act* requirement for terminating providers. OIG work found 12 percent of providers terminated for cause in one state Medicaid program in 2011 were still participating in other states' Medicaid programs as of January 2014. (For more information on data systems and information, see Management Challenge 3.)

State Policies That Inflate Federal Costs. Long-standing concerns exist about states' Medicaid policies that result in the federal government paying a greater share of Medicaid costs than the FMAP percentages dictate. Misalignment of costs and payments at certain state-operated facilities can inflate federal costs. For example, New York Medicaid payments to state-run developmental centers were inflated by more than $1 billion in FY 2009. In another example, Pennsylvania used a state tax on Medicaid managed care plans to draw down almost $1 billion in federal funds over a three-year period. Additionally, the lack of transparency related to state waiver programs present challenges to ensure that payments are consistent with efficiency, economy, and quality of care, and do not improperly inflate federal costs. The Government Accountability Office (GAO) has found that CMS's approval process for section 1115 waivers may increase federal costs, in part, because it is not clear how CMS determines whether a waiver is budget neutral.[26]

Ensuring Quality Care for Medicaid Beneficiaries. OIG work has demonstrated that children enrolled in Medicaid do not receive all required preventive screenings and has identified quality-of-care concerns regarding children's treatment with antipsychotic drugs. Some of the quality-of-care concerns included poor monitoring of the children's treatment with drugs, children being prescribed the wrong treatment, and children taking too many drugs. Furthermore, OIG has identified significant and persistent vulnerabilities related to Medicaid personal care services, which often includes ineffective program safeguards intended to ensure medical necessity, patient safety, and quality. (For more information on ensuring quality in nursing home, hospice, and home-and community-based care, see Management Challenge 6).

Progress in Addressing the Challenge

CMS is working to promote Medicaid expansion program integrity by providing technical assistance to the states, developing new procedures on eligibility determination and payment accuracy, and training state staff on reporting and accounting for expenditures of newly eligible individuals. For FYs 2014 – 2017, CMS required each state to implement an annual 50-State Medicaid and CHIP Eligibility Review Pilot program strategy.

If implemented, CMS's June 2015 Notice of Proposed Rulemaking (NPRM), which revises its Medicaid managed care regulations, may address several identified issues, including requirements for providers participating in Medicaid managed care to enroll in Medicaid, new standards for beneficiary access, more timely, complete and accurate submission of managed care encounter data to states, and increased safeguards against fraud, waste, and abuse. CMS also reports that it has updated its guidance on program integrity in Medicaid managed care.

CMS reports that it continues to improve its data and technology capabilities. In May 2015, CMS implemented T-MSIS with the first state. CMS reports that states are fully engaged in the transition from the Medicaid Statistical Information System (MSIS) to T-MSIS, which includes a CMS-led process to test implementation to address data gaps and other issues. However, CMS has not indicated when all states will be submitting T-MSIS data. CMS has also issued a NPRM to permit partial disallowance or deferral of Medicaid Management Information System

[26] GAO, *Medicaid Demonstrations: More Transparency and Accountability for Approved Spending are Needed*, June 24, 2015

(MMIS) expenditures if a state fails to produce all federally required program management data and information, including T-MSIS.

In response to the *Affordable Care Act* requirement regarding provider terminations, CMS reported that it implemented a new Medicaid provider termination notification system (TIBCO) in 2014. Under this new system, CMS reports that it is verifying state-submitted provider termination data before the data is made available to other states through TIBCO.

CMS is continuing to work with states to curb policies that inflate federal costs. CMS has approved a State Plan Amendment and entered into a $1.9 billion settlement with New York for the state to repay amounts associated with inflated costs for state-run developmental centers and other related costs. Finally, CMS issued a letter to state health officials on the treatment of health care-related taxes and their effect on federal matching funding.

In response to OIG's work, CMS reported that it plans to work with states to monitor the use of antipsychotic drugs, implement additional quality measures related to treatment of children with antipsychotic drugs, and encourage states to request their managed care programs to address quality-of-care concerns by conducting periodic reviews of medical records of children treated with antipsychotic drugs. CMS also reported that it has disseminated two strategy guides on required preventive screenings to states and providers, began developing a quality measure specific to vision screenings, held listening sessions with states, and provided training related to federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). CMS reported that it performed state-specific program integrity reviews, one of which focused on curbing fraud and abuse in personal care services.

What Needs To Be Done

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

CMS should continue to work with states to ensure the submission of complete, accurate, and timely T-MSIS data. If states fail to submit timely T-MSIS data, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel state participation. OIG is conducting work regarding CMS's and states' progress in implementing T-MSIS.

CMS should continue to improve the data available for states to terminate providers terminated from another state Medicaid agency, CHIP, or Medicare by implementing a mandatory state reporting requirement of all for cause provider terminations. Required reporting is a crucial part of creating a comprehensive data source and effective oversight.

CMS should strengthen its oversight of state Medicaid waivers, including monitoring the costs of such waivers, and ensure that any oversight actions taken are publicly reported.

CMS should continue to promote awareness of safe treatment and best practices for treating children with antipsychotic drugs and consider ways that states could implement periodic reviews of medical records of children who receive antipsychotic drugs. CMS should also continue its efforts to improve delivery of preventive screenings for children, particularly on required reporting of vision and hearing screenings.

Key OIG Resources

- OIG Testimony, Examining the Federal Government's Failure to Curb Wasteful State Medicaid Financing Schemes, July 2014

- OIG Report, CMS's Process for Sharing Information About Terminated Providers Needs Improvement, March 2014
- OIG Reports on Medicaid data and systems, OEI-09-11-00780, OEI-05-12-00610
- OIG Reports on Medicaid managed care, OEI-01-09-00550, OEI-02-11-00320
- OIG Reports on Medicaid quality of care, OEI-05-13-00690, OEI-07-12-00320

Management Challenge 2: Fighting Fraud, Waste, and Abuse in Medicare Parts A and B

Why This Is a Challenge

To secure the future of health care for Medicare beneficiaries, the Department must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. The Institute of Medicine estimated that 30 percent of U.S. health spending (public and private) in 2009 – roughly $750 billion – was wasted on unnecessary services, excessive administrative costs, fraud, and other problems.[27] Waste in health care programs is a multidimensional problem. HHS faces challenges – and opportunities – in each of the key areas of focus addressed below.

Reducing Improper Payments. CMS reported an improper payment rate of 12.7 percent for Medicare fee-for-service (Parts A and B), corresponding to an estimated $45.8 billion in improper payments in FY 2014. This measure includes payments for unnecessary services, billing or coding errors, and payments for claims that did not meet documentation or other Medicare coverage requirements. (For more information on improper payment rate measurement and reporting, see Management Challenge 4.)

Challenges affect every stage of the payment process, from making the initial payment accurately (including implementing appropriate payment edits) to recovering overpayments. High Medicare improper payment rates exist for various services, including home health, skilled nursing, and evaluation and management services. Audits of hospitals have uncovered and sought to remedy improper billing and payments for myriad issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes. Furthermore, accurate billing by hospitals for short inpatient stays versus outpatient observation stays has been an area of considerable challenge and concern. CMS relies on contractors for most of these crucial functions; however, OIG has identified deficiencies in contractor performance and in CMS's oversight of these contractors. Medicare's recent transition to a new system of diagnosis codes, the ICD-10, may bring implementation challenges and potential increases in improper billing as providers and suppliers transition to the new codes. In the lead-up to implementation of ICD-10, CMS has issued guidance providing temporary flexibility in the claims auditing and quality reporting process in response to requests from the provider community.

The Department is facing significant challenges in adjudicating provider appeals of Medicare overpayments – which primarily include Parts A and B claims – including a substantial backlog of appeals at the administrative law judge (ALJ) level (third level of appeals, administered by the Office of Medicare Hearings and Appeals); inconsistent decisions among the ALJs and between the ALJs and Qualified Independent Contractors (second level of appeals, administered by CMS); and insufficient CMS participation in the appellate process.

Preventing and Deterring Fraud. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain Medicare services have been consistent targets. They include services provided by durable medical equipment (DME) suppliers, home health and hospice agencies,

[27] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, September 6, 2012. The Institute of Medicine report includes fraud and abuse as components of waste.

community mental health centers, clinical laboratories, ambulance transportation suppliers, outpatient therapy providers, and chiropractors. CMS's contractors play a key role in fighting Medicare fraud. However, CMS is not realizing the full potential of contractors to proactively identify fraud and address other program integrity concerns.

Fostering Economical Payment Policies. As a result of certain payment policies, Medicare pays significantly different amounts for the same services for similar patients in different settings. For example, Medicare pays significantly more for services performed in an outpatient hospital department than for the same services performed in an ambulatory surgical center (ASC). For low-risk patients who do not need hospital-level care at an outpatient hospital department, Medicare could save billions of dollars by paying for those services at ASC rates. In another example, Medicare could reduce expenditures by millions of dollars per year if infusion drugs administered in conjunction with DME were paid on the basis of average sales prices, as is the case with most other drugs covered by Medicare Part B.

Certain payment policies that create incentives for providers to bill for more expensive care instead of the appropriate levels of care result in billions of dollars in wasteful spending and compromised care for beneficiaries. For example, Medicare's payment policy for skilled nursing facility (SNF) beneficiaries who also need therapy give providers incentive to bill for higher levels of therapy than necessary.

Progress in Addressing the Challenge

Overall, the Department has taken steps, including implementing many of OIG's recommendations, to combat Medicare waste, including fraud, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. The Health Care Fraud and Abuse Control Program (a joint program of the Department, CMS, OIG, and the Department of Justice (DOJ) to fight waste, fraud, and abuse in Medicare and Medicaid) returned $7.70 for every $1 invested. In FY 2014, OIG audits and investigations resulted in expected recoveries of $4.9 billion in improperly spent federal health care dollars. In addition, OIG reported estimated savings of more than $15 billion from legislative, regulatory, and administrative actions supported by OIG recommendations.

CMS has moved to improve the integrity and accuracy of billing for numerous types of services. For example, CMS implemented a provision of the *Affordable Care Act* that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. CMS modified this requirement, effective January 1, 2015, and is continuing to work to improve this requirement's low rates of compliance. Additionally, CMS started a demonstration project that requires prior authorization for scooters and power wheelchairs in seven states with high incidences of fraud and improper payments, and in FY 2015 expanded this demonstration project to include an additional 12 states. CMS continues to work to address hospital billing for short inpatient stays and outpatient observation stays, which significantly affects Medicare spending, beneficiary cost-sharing, and hospital revenue.

CMS reports that it is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF Prospective Payment System (PPS). CMS initiated the SNF PPS Payment Model Research project and reports that it is working to identify potential alternative SNF payment models for further analysis.

In connection with the International Classification of Diseases, 10th Revision (ICD-10), CMS reports that it has established an ICD-10 Coordination Center for monitoring the implementation of ICD-10, identifying and triaging issues for resolution, and responding to inquiries. It also has named an ICD-10 ombudsman to help receive and deal with provider issues.

OIG noted reductions in Medicare billing and payments for certain services and geographic areas known for fraud risks. For example, following law enforcement activities and administrative actions by CMS, billing and payments for home health services and community mental health services declined significantly in fraud hot spots. CMS also instituted temporary moratoria on the enrollment of new home health agencies and ambulance transportation suppliers in select cities and known fraud hot spots. Additionally, CMS continues to develop its Fraud Prevention System (FPS), which had a $133 million in adjusted actual and projected savings in its third implementation year, and represented a positive return on investment of $2.84 for every $1 spent that was certified by OIG.

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

What Needs To Be Done

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

Key OIG Resources

- OIG Testimony, Fraud in Medicare, March 2015
- OIG Testimony, Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse, June 2014
- OIG Testimony, Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds, May 2014
- OIG Compendium of Unimplemented Recommendations, March 2015
- OIG Report, The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated, September 2015

Management Challenge 3: The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology

Why This Is a Challenge

In support of its mission and operations, the Department maintains and uses expanding amounts of sensitive information. Complete, accurate, and timely data can help ensure efficient operations of the Department and its programs, as well as support proactive program oversight. Similarly, the American health care system increasingly relies on health information technology (health IT) and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. However, the Department faces a number of significant challenges in this information-rich environment.

Ensuring Privacy and Security of Information. Safeguarding privacy and ensuring data security are, and should remain, top priorities for the Department. The Department must ensure that the data it creates and maintains are protected. Equally important is the need to ensure appropriate protection of health information when considering and implementing policies related to the adoption of health IT, and the exchange, storage, and use of electronic

health information. The frequency of notable data breaches has increased significantly, and data breaches can have serious consequences for the health care industry, the Department, and those the Department serves. Those consequences can include identity theft, which, in the health care context, can negatively affect the care that patients receive and lead to wasteful, including fraudulent, spending of public funds. Frequently identified weaknesses include inadequacies in access controls, patch management, encryption of data, and Web site security vulnerabilities at the Department, health care providers, and other entities that do business with the Department. Such weaknesses could result in unauthorized access to sensitive information.

Improving Information Flow. To make use of the benefits of the growing amounts of data in the health care context,[28] data must be available, subject to appropriate privacy and security safeguards, where and when needed. However, enabling and encouraging the flow of information remains a challenge for the Department. Several factors may impede the flow of information. These include technical barriers (e.g., lack of interoperability), the complex nature of federal and state privacy and security laws, financial considerations (e.g., the cost of health IT acquisition), and behavioral issues – such as information blocking[29] and consumer confidence – that relate to a willingness to share information.

Improving the appropriate flow of health information is critical to the success of many delivery reform and other initiatives, including the President's Precision Medicine Initiative. Without appropriate information sharing, those who participate in the initiatives may face challenges in coordinating care and meeting performance and other goals. Impediments to information sharing can also present patient safety concerns. For example, a patient could be subjected to additional invasive testing that could have been avoided had information about prior results held by a different provider been shared. (For more information on health delivery reforms, see Management Challenge 8.)

The flow of information is also important between the Department and others, including providers. For example, data created, maintained, or transmitted using EHRs or other health IT are used to ensure correct Medicare and Medicaid payments, including value-based payments. Participants in certain initiatives also receive Departmental data for their use in improving the care they furnish. Additionally, the Department increasingly uses and shares data as part of its program operations and program integrity efforts. It is critical that, as the flow of information improves, the information is complete, accurate, timely, and appropriately protected.

Ensuring a Return on Health IT Investments. The Department has made significant investments in health IT. However, the Department faces challenges in ensuring that the goals associated with investing in the widespread adoption and use of EHRs and other health IT are fulfilled. In addition to the challenge of improving the flow of information, challenges to ensuring a return on the Department's investments in health IT include preventing inappropriate payments to participants who do not meet program requirements; ensuring that the beneficial characteristics of EHRs, including efficiency and ease of storage and access, are not used as tools for fraud; and ensuring that patient safety benefits are realized. When addressing these challenges, the Department must ensure coordination among internal agencies, as well as other federal partners, with overlapping responsibility for various aspects of health IT to avoid potential gaps in policy and oversight that could undermine the promise of the investments.

[28] Sources of relevant health care data are ever increasing, particularly as the Internet of Things continues to expand. For more information about the Internet of Things, particularly related privacy and security issues, see FTC's Staff Report, *Internet of Things: Privacy and Security in a Connected World*, January 2015. See also, Federal Bureau of Investigation Public Services Announcement, *Internet of Things Poses Opportunities for Cyber Crime*, September 10, 2015.

[29] For more information on the topic of information blocking, see ONC's Report to Congress, *Report on Health Information Blocking*, April 2015.

Progress in Addressing the Challenge

The Department has made progress with respect to privacy and security of its systems and information. Like others in the federal government, the Department has participated in the U.S. Chief Information Officer's 30-day Cybersecurity Sprint, which aims to "further improve federal cybersecurity and protect systems against . . . evolving threats."

The Department has made great strides in developing a nationwide health IT infrastructure that supports the appropriate flow of information. As of September 2015, more than 548,000 eligible professionals, eligible hospitals, and critical access hospitals (CAH), are actively registered in the EHR incentive programs.[30] Additionally, the Office of the National Coordinator (ONC) recently issued $38 million in grants to encourage better information exchange for care coordination and population health.

Further, the Department's participation in the Healthcare Fraud Prevention Partnership (HFPP) has improved the flow of information to address program integrity issues. The HFPP, a public-private partnership, brings interested parties – including private insurers, law enforcement agencies, and others – together to share and use data and analytic tools to proactively address health care fraud.

The Department has continued to oversee the EHR incentive programs and has made a concerted effort to advance the national conversation about important health IT issues to ensure that the potential benefits of health IT investments are realized. Last year, ONC issued a document entitled "Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" (10-Year Vision Paper), which describes plans to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide interoperable health information infrastructure. More recently, ONC issued a document entitled "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0," which supports the vision laid out in the 10-Year Vision Paper. ONC has also issued an information-blocking report to Congress, a Health IT Safety Center Roadmap, and an updated Federal Health IT Strategic Plan for 2015–2020.

What Needs To Be Done

Threats to information privacy and security are evolving, and the Department must remain vigilant. While the Department has made progress with respect to protecting its own information, as highlighted in OIG work and a recent Congressional Report, more remains to be done. The Department also must use available policy levers to address health IT privacy and security issues, such as through the EHR incentive programs. OIG work will continue to focus on HHS systems' privacy and security to support the Department's efforts to mitigate the risk of unauthorized access to its sensitive information. OIG work will also focus on privacy and security issues in the regulated community and on the related agencies to address concerns about similar risks for health information. Future work may consider privacy and security issues that arise from the continuing expansion of the Internet of Things, such as connected medical devices.

To fully realize the value of health IT investments – which included, as of September 2015, over $31 billion through the EHR incentive programs – and achieve the goal of a learning health system identified in the 10-Year Vision Paper, the Department must do more to improve the flow of information, subject to appropriate privacy and security safeguards.

[30] CMS, "State Breakdown of Registration by Medicaid and Medicare Providers through September 30, 2015," September 2015.

Finally, given the magnitude of the investment in EHRs and other health IT programs, it will become increasingly important to measure the extent to which EHRs and health IT have achieved the Department's goals, which include improved health care and lower costs. As the Department progresses through the development and implementation of meaningful use stages and looks to implement the meaningful use portion of the Merit-based Incentive Payment System created in the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), it should continue to consider feedback from stakeholders to ensure that adopted policies advance the Nation toward the Department's stated goals, while appropriately reflecting the changing health IT landscape and balancing privacy and security considerations. Additional guidance and technical assistance should be issued to address adoption, meaningful use, interoperability barriers, and program integrity safeguards. It is also essential that privacy, security, and fraud prevention remain at the forefront of the Department's, ONC's, and CMS's health IT efforts. Ongoing OIG work is examining the accuracy of Medicare and Medicaid EHR incentive payments for meaningful use. Future work may examine health IT interoperability across providers (including those participating in accountable care organizations), across HHS, and between providers and patients, as well as examine outcomes from health IT investments.

Key OIG Resources

- OIG Reports on EHR Incentive Program Oversight, A-06-13-00047; OEI-09-11-00380; A-06-12-00041; OEI-05-11-00250; OEI-05-11-00080
- OIG Reports on EHR program integrity, OEI-01-11-00570, OEI-01-11-00571
- OIG Report, CMS Response to Breaches and Medical Identity Theft, October 2012
- OIG Summary Report, Information Technology Infrastructure and Operations Office Had Inadequate Information Security Controls, April 2015
- OIG Reports on hospital IT security, including HIPAA Security Rule Oversight, June 2011, OEI-09-10-00510, and OEI-09-10-00511

Management Challenge 4: Administration of Grants, Contracts, and Financial and Administrative Management Systems

Why This Is a Challenge

HHS is the largest grant-making organization and third-largest contracting agency in the federal government, with $402 billion and $21 billion awarded, respectively, in FY 2014. The *Affordable Care Act* provided additional grant and contract funding, adding to the Department's management and oversight responsibilities. Responsible stewardship of these program dollars is vital, and operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and protect resources remains a challenge for the Department.

Grants and Contracts Management. Across the Department, vulnerabilities have been identified in HHS grants, demonstrating the need for purposeful and consistent federal oversight. Awarding agencies lack a systematic method of and timing for sharing grantee risk information; sharing occurs infrequently; and oversight of grantee progress during the life of the grant needs improvement. Many grantees lack the robust financial management systems required to provide effective accountability for federal funds. For example, a community health center receiving *Affordable Care Act* grant assistance was not providing the services as described in its grant application and was unable to accurately account for how HHS funds were spent. Recent OIG investigations of HHS grantees reveal similar vulnerabilities in grants management. For example, in June 2014, four former officials of the Blackfeet Tribe's Po'ka Project, a multimillion-dollar HHS-funded effort to address the needs of troubled youth on the reservation, were convicted of fraud, embezzlement, and conspiracy and sentenced in federal court.

Previously identified weaknesses in the oversight of grantees, including late or absent financial reports and insufficient documentation on salaries and indirect costs, present challenges to the Department's implementation of the Office of Management and Budget's (OMB) Uniform Guidance.[31] Another challenge is implementation of the *DATA Act* that establishes governmentwide financial data standards related to expenditures of federal grants, contracts, and loans.

HHS is the second-largest payer under the Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs, awarding $680.7 million and $96.6 million, respectively, in such grants and contracts in FY 2014. Three significant issues exist with the programs: awardees who appeared not to meet eligibility requirements, inconsistent collection of information needed to evaluate commercialization success, and failures to check consistently for duplicative funding within the Department and across other agencies.

Given the high dollar amount and complexity of contracts, weaknesses in Department monitoring of the corrective actions taken, processes, oversight, and management is a concern. Oversight vulnerabilities have been identified through a range of issues across Departmental programs. For example, OIG has raised concerns about acquisition planning and procurement, contract monitoring, and payments to contractors related to the federal health insurance marketplaces operated by CMS. OIG has also identified weaknesses in CMS's oversight and performance measurement for its benefit integrity contractors. (For more information on specific contract management concerns, see Management Challenges 2 and 7.)

Financial Statement Audits. An audit of the Department's grant and contract systems, which are responsible for processing, awarding, and monitoring grants and contracts, uncovered multiple deficiencies in effective system controls. Deficiencies were related to segregation of duties, configuration management, and access to financial systems. The deficiencies represent a material weakness in internal controls – affecting the Department's ability to accurately manage financial information.

The financial statement audit also revealed challenges the Department continues to face in addressing violations of certain provisions of the *Anti-Deficiency Act* (ADA). These ADA violations highlight weaknesses in an agency's control over budgetary resources. Prior OIG audits of the National Institutes of Health (NIH) revealed ADA violations. The Department followed up with GAO regarding the violations. OIG will be doing a status report to assess and summarize the remedial actions taken by the Department to address the ADA violations.

Improper Payments. Improper payments cost federal programs billions of dollars annually. In FY 2014, the Department reported improper payments totaling almost $78.4 billion overall. Pursuant to the *Improper Payments Information Act of 2002* (IPIA), as amended, federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. In OIG's most recent audit of the Department's IPIA reporting, we found that the Department did not meet all IPIA requirements, including reporting an improper payment rate for the Temporary Assistance for Needy Families (TANF) program and performing a risk assessment of payments to employees and charge card payments. HHS asserts that it does not have the statutory authority to collect from states the data that is necessary for the calculation of a TANF improper payment rate.

Progress in Addressing the Challenge

The Department has worked to strengthen its grants and contracts program integrity efforts. New grant regulations were published at 45 CFR Part 75, implementing OMB's Uniform Guidance requirements. Pursuant to those rules, the Assistant Secretary for Financial Resources (ASFR) is implementing a single audit resolution tracking system -- scheduled for completion by September 30, 2017. These rules also create a 270-day

[31] Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (commonly referred to as the Uniform Guidance).

requirement to ensure all grant close out activities are complete. The Department is also serving as the governmentwide lead to identify the standardized data needed to meet the *DATA Act* requirements and has developed a Departmental implementation strategy to ensure adoption of approved data standards into business policies, processes, and systems.

The Department proposed an update to the HHS Acquisition Regulation (HHSAR) in March 2015 to supplement the Federal Acquisition Regulation. The HHSAR provides additional policy and procedural guidance to foster financial integrity and accountability across the acquisition lifecycle from the concept of need through contract close out. Additionally, HHS issued the Acquisition Strategy Directives in March 2015 and Acquisition Plan Directives in April 2015 which articulated the value and importance of HHS program offices adopting and implementing the acquisition lifecycle framework as a means to ensure business process/practices and mission/program needs drive requirements, and ensure the most appropriate vehicle is utilized to deliver critical results.

With respect to ADA violations related to systemic contract funding problems, the Department continues to provide its contracting workforce with an online reference tool for contract funding, formation, and appropriations law compliance. Further, the Department released a major update to its internal grants policies, featuring enhanced guidance on grants closeout, suspension and debarment, grants systems, and grants payments.

The Department has made efforts to assess grant program performance and improve grant and contract oversight. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has improved outcome measurements for its largest program, the Substance Abuse Prevention and Treatment Block Grant. The Indian Health Service (IHS) and OIG partnered to provide training on using single audit reports to improve oversight of tribal health care funds. Furthermore, the Department and OIG sponsored training for grants and contracts officers on identifying and reporting potential fraud, waste, and abuse across all programs, including the SBIR/STTR programs, and OIG has encouraged contractors to self-report contract fraud and overpayments.

The Department has increased its use of suspension and debarment authorities, resulting in an increase from 8 debarments and 8 suspensions in FY 2013 to 32 debarments and 7 suspensions in FY 2014 – preventing offenders from receiving federal funding.

The Department has taken corrective actions to resolve the IT-related deficiencies reported in the Agency Financial Report. The impact of this effort will be assessed during the FY 2015 audit of these systems.

With respect to IPIA, the Department has stated in its comments on our IPIA-compliance audit report pertaining to the Department's FY 2013 AFR that it would submit a legislative proposal to Congress that would allow for a TANF error rate measurement. The Department, however, did not do so. Instead, the Department has reported that it submitted legislative proposals to Congress to improve TANF's program integrity. Specifically, the Department noted that ACF's FYs 2015 and 2016 Budget requests for TANF included $10 million for program improvement initiatives, including technical assistance on strengthening state program integrity efforts. The requests also proposed to prohibit the use of non-governmental third-party expenditures in meeting state maintenance-of-effort (MOE) requirements, and limiting the expenditure of TANF and MOE funds to benefits and services to needy families. The Department asserts that both of these proposed legislative changes would strengthen state accountability to the purposes of the TANF statute. CMS reports that it has prioritized closing out contracts. Since February 1, 2014, CMS closed 2,077 contracts with an obligated value of $1.3 billion and de-obligated $29.95 million. In October 2014, CMS implemented a goal of closing out approximately 20 percent – or 2,250 – overdue contracts per year.

What Needs To Be Done

The Department needs to take more aggressive action to identify poorly performing grantees and those at risk of misspending federal dollars and either provide increased technical assistance and monitoring or prevent them from continuing to receive grant funds. Sustained focus is needed to monitor and address vulnerabilities, and the Department must continue diligent efforts to ensure that recipients use funds according to the award terms and consistent with the law. The Department has improved its contractor performance evaluation monitoring but is still underperforming compared to other government agencies.

The Operating Divisions (OpDiv) need to increase their monitoring efforts, including implementing program integrity initiatives, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues; resolving grantee audit findings; and sharing best practices across the Department. In accordance with the new Uniform Guidance, the Department must implement processes to ensure that grantees have appropriate internal controls, including improved use of single audit reports throughout the grant cycle to ensure proper stewardship of funds. The Department will need to develop tracking and monitoring mechanisms for audit findings and the audit resolution process to effectively carry out this responsibility. The Department must also prepare for implementation of *DATA Act* requirements.

The Department needs to develop an improper-payment estimate for TANF and submit a legislative proposal to Congress to require state participation in such a measurement. In addition, the Department needs to meet improper-payment reduction targets, and reduce improper payments to less than 10 percent for all programs. The Department needs to conduct thorough root cause analyses of significant improper payments and develop robust corrective action plans that target identified causes. The Department also needs to conduct a risk assessment of payments made to employees and charge cards. The Department should resolve all financial control weaknesses identified by OIG, GAO, and other internal and external auditors.

The Department and OIG should continue to provide training on identifying and pursuing misconduct in grants and contracts. Grant and contract officers should more actively coordinate with and refer potential fraud to OIG for investigation. The Department also needs to continue to refine its suspension and debarment procedures by streamlining the referral and decision process, to continue providing training and decrease the processing time of referrals. Moreover, the Department needs to implement a program to actively pursue fraud under the *Program Fraud Civil Remedies Act* (PFCRA).

Key OIG Resources

- OIG Report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did Not Fully Comply for Fiscal Year 2014, May 2015
- OIG Reports on grant oversight, OEI-04-12-00160, OEI-04-11-00530, OEI-07-12-00110, OEI-07-11-00190, A-03-14-03304

Management Challenge 5: Ensuring Appropriate Use of Prescription Drugs

Why This Is a Challenge

CMS provides prescription drug coverage for 41 million Medicare Part D (Part D) and 71 million Medicaid beneficiaries. Part D is the fastest growing component of the Medicare program. Since its inception in 2006, spending for Part D has more than doubled to $121 billion in 2014. Medicaid expenditures for prescription drugs are also increasing, influenced by Medicaid expansion and rising specialty drug costs. In 2014, Medicaid expenditures exceeded $44 billion and Medicaid beneficiaries in states that expanded the program filled

25 percent more prescriptions, compared with a 3 percent increase in non-expansion states.[32] The Department's oversight of its prescription drug programs faces numerous challenges affecting beneficiary and community safety and the integrity of the benefit itself.

Oversight. Ensuring the integrity of programs as expansive as Part D and Medicaid requires coordinated, constant, and proactive efforts. In Part D, CMS contracts with plan sponsors, which are responsible for paying claims, monitoring billing patterns, and establishing compliance plans. CMS also contracts with the Medicare Drug Integrity Contractor (MEDIC) to detect and prevent fraud, waste, and abuse in Part D. CMS oversees the plan sponsors and the MEDIC, defines their requirements for carrying out program integrity functions, and monitors their performance. Weaknesses continue to exist in the use of data to identify vulnerabilities as well as in the oversight by each of the three key players. For example, CMS does not require plan sponsors to report information on fraud and most have chosen not to voluntarily report. (For more information on Medicaid's oversight challenges, see Management Challenge 1.)

Drug Abuse and Diversion. The abuse and diversion of prescription drugs is an ongoing problem. As of May 2015, OIG has 540 pending complaints and cases involving Medicare and Medicaid prescription drug fraud, a 134 percent increase in the last 5 years. Pharmaceutical manufacturers and pharmacies accounted for more than 60 percent of Medicaid Fraud Control Units' cases that resulted in civil settlements and judgments in 2014. The Centers for Disease Control and Prevention (CDC) characterizes prescription drug abuse as an epidemic, reaching virtually all demographics and geographic locations. Drug diversion is the transfer of legitimate prescription drugs for unlawful purposes. The diversion of controlled substances is of particular concern because of its severe health risk and potential for abuse. In 2012, over 700,000 inpatient hospital stays were related to the overuse of opioids.

The diversion of noncontrolled substances is also a concern because these drugs are becoming more common in schemes that defraud Medicare and Medicaid. Schemes include billing for drugs that are not dispensed, combining prescribed drugs with opioids to create an enhanced euphoria, and illegal dispensing of expired or adulterated drugs. These schemes increasingly involve criminal networks ranging from informally connected street traffickers to complex criminal enterprises comprised of health care professionals, pharmacies, marketing companies, and even program beneficiaries. Criminal networks and others target brand-name, high-cost medications, including respiratory, HIV, and anti-psychotic medications.

Questionable and Inappropriate Utilization. The responsibility of overseeing prescription drugs also involves ensuring that safe and high-quality care is provided to seniors and children. Serious concerns surrounding the overprescribing of drugs exist. For example, Medicare spending for commonly abused opioids has grown faster than spending for all Part D drugs. Additionally, quality-of-care concerns were identified with the prescription drug treatment of children enrolled in Medicaid who have mental health conditions. (For more information on ensuring Medicaid quality of care, see Management Challenge 1.)

Several operating divisions within the Department are responsible for programs related to the safety and efficacy of drugs, drug abuse prevention and treatment, and the safety and quality of health care – including care involving drugs, biologics, and other therapies. Effectively coordinating all Department efforts and prioritizing initiatives are key to combating this complex epidemic. (For more information on challenges for the Food and Drug Administration (FDA) and Medicaid, see Management Challenges 10 and 1.)

[32] IMS Institute for Healthcare Informatics, *Medicine Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014*, April 2015.

Progress in Addressing the Challenge

CMS has taken steps to improve data coordination among the key players tasked with safeguarding Part D. Specifically, CMS has begun sharing plan sponsors' voluntarily reported fraud data with the MEDIC and has increased data sharing between plans. CMS is working to enroll over 400,000 prescribers of Part D drugs, addressing an OIG recommendation that CMS require Part D sponsors to verify prescribers' authority. These prescribers will be subject to risk-based screening requirements, and plan sponsors will be better able to deny Part D claims for drugs ordered by ineligible prescribers.

CMS is also taking steps to prevent pharmacy billing fraud and overutilization of prescription drugs. CMS regularly monitors pharmacy billing patterns and collaborates with Part D sponsors to perform audits or take other appropriate actions on high-risk pharmacies. CMS works with plan sponsors to prevent overutilization of certain prescribed medications and share information about beneficiaries that may over use prescription drugs. In April 2015, CMS launched a Web-based tool to allow CMS, law enforcement, and plan sponsors to share information and coordinate actions against high-risk pharmacies.

The Department has taken actions to restrict the manufacture, possession, or use of potentially dangerous controlled substances. The Food and Drug Administration (FDA) is working to reduce the abuse of opioids by encouraging formulations that make it more difficult to tamper with these products. Additionally, through coordination with the Drug Enforcement Administration (DEA), access to opioids is now better controlled because hydrocodone-combination products have been moved from Schedule III to the more restrictive Schedule II. Many state Medicaid programs have reported savings linked to implementing lock-in programs, which involves restricting certain beneficiaries to a limited number of pharmacies or prescribers. Additional benefits to lock-in programs include more appropriate beneficiary drug utilization and prevention of drug abuse and diversion. Additionally, CDC is developing guidelines to help primary care physicians improve the way they prescribe opioids to treat chronic pain, and CMS has established a new Medicaid initiative to undertake improvements in the delivery of care to beneficiaries with substance use disorder.

What Needs To Be Done

Despite progress in key areas, further actions are needed to achieve effective oversight. CMS needs to do more to monitor plan sponsors' fraud detection and compliance programs. For example, CMS should require plan sponsors to report the number of instances of probable fraud, waste, and abuse that they identify, and the actions they took to address them. Collecting and sharing this data would increase each players' ability to identify and address program vulnerabilities. Additionally, CMS should improve existing safeguards to prevent improper payments in Part D and its ability to recoup those payments when identified. When the MEDIC identifies inappropriate payments there are no established procedures to recommend recoupment other than referrals to law enforcement. While CMS does require plan sponsors to return overpayments that they self-identify, CMS has no mechanism to recover inappropriate payments identified by the MEDIC during its investigations.

The Department should continue to prioritize and coordinate efforts to reduce opioid misuse and abuse. For example, CMS and plan sponsors should monitor beneficiary use of a wider range of drugs susceptible to abuse than they do now. Also, more needs to be done to effectively deal with beneficiaries who may be abusing the program or inflicting harm on themselves by overusing drugs. This could be addressed by implementing a Medicare lock-in policy, which would require a legislative change to CMS's authority.

Key OIG Resources

- OIG Portfolio, Ensuring the Integrity of Medicare Part D, June 2015

- OIG Report, Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns, March 2015
- OIG Report, Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D, June 2015
- OIG Report, Medicaid Fraud Control Units Fiscal Year 2014 Annual Report, April 2015

Management Challenge 6: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care

Why This Is a Challenge

As Americans continue to live longer and with more chronic medical conditions, the Department must ensure that beneficiaries receive high-quality nursing home, hospice, and home- and community-based services (HCBS), including personal care services (PCS). Nursing home and HCBS programs provide ongoing assistance with daily living, as well as care for those who need temporary help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries and supports family and other caregivers.

Nursing Home and Hospice Care. Problems with nursing home and hospice care continue to be identified. Concerns raised include the frequency and severity of preventable adverse events because of substandard nursing home care, limited compliance with federal regulations for reporting abuse and neglect, lack of monitoring of nursing homes' resident hospitalization rates, failure to correct deficiencies identified during the survey process, and employment of caregivers who do not meet relevant licensure requirements. Additional concerns regarding hospice care include inadequate oversight of certification surveys and hospice-worker licensure requirements and fraudulent hospice enrollments undertaken without beneficiary consent.

Home- and Community-Based Services. HCBS programs serve several targeted populations, including people with mental illness, or physical, cognitive, or developmental disabilities. HCBS programs help beneficiaries avoid costly and disruptive facility-based care. These programs help promote beneficiary choice and preferences, but persistent payment, compliance, and quality vulnerabilities continue. Medicaid is the primary payer for PCS, a critical component of HCBS. Without effective PCS, the HCBS goals of keeping beneficiaries out of institutions cannot be achieved. Of significant note are vulnerabilities specific to PCS, such as delivery in private settings in which care may be harder to observe and oversee.

Progress in Addressing the Challenge

The Department continues efforts to improve the quality of nursing home, hospice, and HCBS programs, including PCS. CMS developed the CMS Adverse Drug Event Trigger Tool for use by nursing homes and state surveyors to improve medication safety and reduce medication-related adverse events. In July 2015, the Department published a proposed rule on Reform of Requirements for Long-Term Care Facilities. Along with other quality improvement initiatives, the proposed rule would implement section 6102 of the *Affordable Care Act*, which requires each nursing facility to have an operational compliance and ethics program that effectively promotes quality of care.

CMS made the following improvements to the *Five Star Quality Rating System* posted on the *Nursing Home Compare* Web site to improve beneficiaries' and consumers' ability to determine meaningful differences between nursing homes, incentivize increased quality, and ensure the accuracy of the information posted: added two Quality Measures (QM) for antipsychotic medication use; raised the threshold for nursing homes to achieve a high

rating on all measures in the QM dimension of the Five Star System; and expanded focused surveys nationwide to assess coding practices and its relationship to resident care in nursing homes to improve the accuracy of the QMs.

In August 2015, CMS finalized a rule for the PPS and Consolidated Billing for SNFs for FY 2016. This rule implemented section 6106 of the *Affordable Care Act*, which allows for greater oversight and increased accuracy for reporting of nursing home staffing on the *Nursing Home Compare* website and in the *Five Star Quality Rating System*. Also, this rule specified a SNF all-cause all-condition hospital readmission measure and adopts that measure for a new SNF Value-Based Purchasing (VBP) Program. Additionally, the rule will implement a new quality reporting program (QRP) for SNFs that authorizes CMS to reduce payments to nursing homes that do not report certain resident assessment items and establishes the plan to standardize certain elements of assessment tools and quality measures across post-acute care settings.

In July 2015, CMS published a proposed rule to improve the quality of nursing home care that updates Medicare requirements for long-term-care facilities. This proposed rule also would implement provisions of the *Affordable Care Act*, including requirements for facilities to implement a Quality Assurance and Performance Improvement (QAPI) program that would ensure that facilities continuously identify and correct quality deficiencies and promote and sustain performance improvement. Additional provisions would implement requirements for a Compliance and Ethics program, requirements for dementia and abuse prevention training, and requirements for reporting suspected crimes.

The Department continues efforts to improve access to hospice care. Traditionally, to qualify for hospice services, Medicare required beneficiaries to forego curative services. CMS, through the Medicare Care Choices model, is now testing allowing beneficiaries to receive hospice care to manage discomfort and receive end-of-life counseling while still allowing Medicare payment for treatments aimed at curing the underlying terminal illness. CMS has also taken steps to encourage patients and their physicians to discuss end-of-life issues to improve patients' quality of life and increase the likelihood that the end-of-life care the patients ultimately receive conforms to their informed wishes. As access improves, the Department must continue efforts to ensure that the quality of hospice care delivered to beneficiaries who select hospice meets quality standards.

Federal agencies, including OIG, DOJ, and CMS, continue to pursue enforcement actions against nursing homes, hospices, and HCBS providers, including PCS providers that render substandard care. In the past year, OIG launched an initiative to combat hospice fraud in regions identified as areas of particular concern. In the summer of 2015, OIG completed a national health care fraud takedown that included arrests of several Medicaid providers accused of committing HCBS fraud. CMS and OIG work closely with law enforcement partners at DOJ and through the federal Elder Justice Interagency Working Group to promote better care for older adults and to prosecute providers accused of abuse or neglect. State Medicaid Fraud Control Units (MFCU) devote substantial resources to the investigation and prosecution of abuse and neglect.

In addition to the Department's efforts to improve quality of care, OIG invests substantial efforts in helping providers improve. OIG has developed an innovative quality-oriented corporate integrity agreement process to work with nursing home providers so they may better serve beneficiaries. OIG has placed nearly 40 nursing home companies (covering more than 900 facilities) under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

Ensuring high-quality home- and community-based services and enabling beneficiaries to avoid institutionalization, relies heavily on appropriate personal care services. CMS is in the second year of a four-year cycle of grants to nine qualified states to test quality measurement tools and demonstrate the use of electronic tools in Medicaid community-based long-term services and supports. These tools are designed to establish standardized interoperable data sets for HCBS plans and assessment items measure the experience of care for beneficiaries and

test the use of personal health records. An experience-of-care tool has been designed, tested and is in the final stages of certification. The Department entered into a contract last year with the National Quality Forum and began work on the development of a national quality measure set for home- and community-based services. Domains of measures have been made and an environmental scan started to identify key measures as well as gaps in measures for domains that might not have been developed to date.

What Needs To Be Done

The Department should continue to prioritize quality of care in nursing homes and hospices as well as the care rendered as HCBS, with particular focus on PCS. The Department should monitor how often nursing home residents are hospitalized and develop resources that can be used to help nursing home staff reduce the incidence of adverse events in nursing homes. In addition, the Department should improve internal controls and offer better guidance and training for surveyors to ensure that nursing homes with recorded quality and safety issues correct their deficiencies. CMS should improve coordination with state agencies to ensure that care providers meet relevant licensure requirements. The Department should seek to link payments for services to meeting quality-of-care requirements and work with OIG to hold accountable the providers that have rendered substandard care, thereby preventing additional harm to vulnerable beneficiaries.

Lastly, the Department should ensure the integrity of Medicaid-funded PCS by establishing minimum federal qualification standards for providers based on needs of the individual being served; improving CMS's and states' ability to monitor billing and care quality; and issuing operational guidance for claims documentation, beneficiary assessments, person-centered plans of care, and supervision of personal care attendants when hired by an agency. For self-directed programs in which a beneficiary directs his/her own PCS, CMS and the states should improve oversight of controls to ensure individual health and welfare and financial integrity. The Department should also issue guidance to states regarding adequate prepayment controls and help states access data necessary to identify overpayments.

Key OIG Resources

- OIG Report, Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement – A Portfolio, November 2012
- OIG Report, The Medicare Payment System for Skilled Nursing Facilities Needs to Be Reevaluated, September 2015
- OIG Reports on hospice quality of care, OEI-02-14-00070, A-02-11-01024
- OIG Reports on home health quality of care, OEI-01-12-00390, OEI-07-14-00130
- OIG Reports on nursing home quality of care, OEI-07-13-00010, OEI-02-13-00611, A-09-13-02039, OEI-06-11-00370

Management Challenge 7: Implementing, Operating, and Overseeing the Health Insurance Marketplaces

Why This Is a Challenge

The health insurance marketplaces (marketplaces), also known as health insurance exchanges, are critical components of the health care reforms enacted through the *Affordable Care Act*. Implementation, operation, and oversight of the marketplaces were among the most significant challenges for the Department in FYs 2014 and 2015 and will continue to present a top management and performance challenge in FY 2016.

The Department must ensure effective communication and coordination between and among all internal and external parties with marketplace responsibilities, including within HHS and with contractors, issuers, and partners in state and federal government. Effective coordination with the Internal Revenue Service (IRS) is particularly important for sound administration of the premium tax credit program. In addition, CMS needs to ensure that state marketplaces comply with federal requirements and provide accurate, timely data used for federal payments. Further, CMS must take appropriate steps to promote compliance by Qualified Health Plans (QHP) with federal requirements, including network adequacy and nondiscrimination requirements. Key focus areas for the federal and state marketplaces include:

Payments. Ensuring sound expenditure of taxpayer funds for insurance affordability and other marketplace purposes poses a substantial management challenge, especially given the continued use of interim solutions and manual systems. For example, CMS's internal controls did not effectively ensure the accuracy of nearly $2.8 billion in advance premium tax credits and cost-sharing reductions. CMS must improve its financial systems to ensure accurate and timely initial payments and reconciliations of these payments. CMS must also prioritize effective management of the risk corridor, reinsurance, and risk adjustment programs. CMS must validate information received from issuers to ensure that it is timely, complete, and accurate for payment purposes. In addition, CMS must ensure the correct use of federal establishment grant funds by state marketplaces. (For general information about challenges associated with grants management and contract administration, see Management Challenge 4.)

Eligibility. Accurate eligibility determinations are critical. During the first open enrollment period, not all internal controls at certain marketplaces were effective in ensuring that individuals were properly determined eligible for QHPs, advance premium tax credits, and cost-sharing reductions. CMS reported a large number of unresolved inconsistencies in which applicants' self-reported data did not match other data sources. Effective internal controls and timely and accurate resolution of inconsistencies are critical to ensure that eligible consumers receive appropriate benefits and that ineligible individuals are not enrolled.

Management and Administration. Management and administration of the marketplaces requires, among other things, clear leadership, disciplined operations, and effective strategies and communication. OIG has raised concerns with, among other issues, CMS's acquisition planning and procurement, contract monitoring, and administration of payments for marketplace contracts. The Department also must ensure, to the greatest extent possible, that the government obtains specified products and services from its contractors on time and within budget.

Security. Protecting and ensuring the confidentiality and integrity of consumers' sensitive personal information and marketplace information systems is paramount. Effective operation of the marketplaces requires rapid, accurate, and secure integration of data from numerous federal and state sources, issuers, and consumers. The Department must vigilantly guard against intrusions and continuously assess and improve the security of marketplace-related systems, including, among others, the Data Services Hub and the Multidimensional Insurance Data Analytics System (MIDAS), a data warehouse and repository. (For more information on privacy and security, see Management Challenge 3.)

Progress in Addressing the Challenge

The Department has reported improvement in the operations of the federal marketplace. Following the initial launch of www.HealthCare.gov, CMS implemented several core management principles that enabled the organization to recover the Web site and improve agency management and culture. In addition, CMS has reported progress in marketplace operations, including publishing additional guidance regarding the use of federal establishment grant funds, implementing parallel processing and multiple levels of review of financial assistance payments information, working to develop a strategic and unified view of marketplace procurement and costs, and

developing of a strategy to improve marketplace program integrity. CMS has also reported regular communications with the IRS to validate payment information and the provision of technical and other support to the state marketplaces.

What Needs To Be Done

The Department must continue to improve the federal marketplace, particularly the eligibility, administrative, and financial management functions. CMS must ensure that all pathways for enrollment operate with integrity and that consumers' personal information is secure. Vigilant monitoring and testing and rapid mitigation of identified vulnerabilities are essential. Attention must be paid to sound operation of financial assistance and the risk corridor, reinsurance, and risk-adjustment programs. CMS must ensure that consumers and issuers receive accurate marketplace information, including information relevant for tax purposes, such as Form 1095A tax forms. Furthermore, marketplaces must continue to protect personally identifiable information and strengthen security controls.

CMS must continue to work with its state partners to improve state marketplace operations and to ensure compliance with federal requirements for marketplaces and QHPs. CMS must monitor for and address fraud, waste, and abuse risks in marketplace programs. CMS must respond quickly and effectively to fraud that is detected, working with partners at the federal and state level to hold those involved accountable.

Key OIG Resources

OIG has a broad portfolio of reviews examining various aspects of marketplace operations. For a complete list of these OIG reports, as well as OIG's Health Reform Oversight Plan, please see the Affordable Care Act Reviews section on the OIG Web site.

Management Challenge 8: Reforming Delivery and Payment in Health Care Programs

Why This Is a Challenge

As recently as 2011, almost none of the $558 billion spent on traditional Medicare was paid through alternative payment models (APM). Instead, CMS paid the majority of claims through the fee-for-service (FFS) system. The incentives created by the fee-for-service (FFS) system—which pays for health care on the basis of the volume of items or services furnished—have been linked to wasteful spending in health care, including unnecessary utilization and fragmented, poor quality care.

In January 2015, Secretary Burwell announced goals to foster better care, smarter spending, and healthier people and propel a transition to new models in Medicare. The ambitious goals are twofold. First, HHS aspires to tie 30 percent of traditional Medicare payments to APMs by the end of 2016, including bundled payment arrangements, and 50 percent of payments by the end of 2018. Second, HHS set a broader goal of tying 85 percent of traditional Medicare payments to quality or value – including not only APMs but also quality-based adjustments to fee-for-service payments – by 2016 and 90 percent by 2018. HHS is working with state Medicaid programs and private payers, including Medicare Advantage plans and others, to make comparable reforms for their providers and beneficiaries.

Reforms under *Affordable Care Act*, MACRA, and other statutes are embedding multiple new payment and delivery models into Medicare, requiring concurrent, sustained, and multifaceted efforts at planning and implementation. New models touch on virtually every aspect of the Medicare program – including, for example, hospital, physician,

home health, dialysis, and post-acute care payment – and experiment with a variety of payment structures, including shared savings, episode-based payments, population-based payments, and capitation. In addition, CMS must implement a new market-driven payment system for laboratory services beginning in 2017.

CMS must establish policy, infrastructure, data systems, and oversight mechanisms to successfully implement these substantial changes. The Center for Medicare and Medicaid Innovation (CMMI) has a 10-year budget of $10 billion dollars; the Department must ensure that Medicare realizes a return on the government's substantial investment in designing, testing, and implementing new models. Perhaps equally challenging is ensuring that models are viable in light of providers' substantial investments in infrastructure and care redesign.

Payment and delivery reforms are not exclusive to fee-for-service Medicare. The Department is promoting new models for Medicare Advantage (Part C). Medicare Advantage is a growing program with potential for increased efficiency and quality through better coordinated care, aligned incentives, and performance measurement. OIG work has identified challenges in the Medicare Advantage program with respect to use of data, payment accuracy, and program integrity, including addressing vulnerabilities at both the plan and provider levels. Ensuring a sound Medicare Advantage program is essential to enabling this program to meet its intended cost and quality goals. (For more information on improving the effectiveness of Medicaid managed care, please see Management Challenge 1.)

Progress in Addressing the Challenge

The Department reports that an estimated 20 percent of Medicare fee-for-service payments had shifted to APMs by the end of 2014. On its Web site, CMS is compiling a steady stream of early results from and evaluations of new programs and models. Recently, for example, CMS reported that Medicare accountable care organization (ACO) programs generated total program savings of more than $411 million for Medicare in 2014 and that ACOs qualified for shared savings payments of more than $422 million. CMS further reported that nine of 17 participants in the Independence at Home (medical home) Demonstration met the requirements for practice incentive payments in the model's first performance year.

CMS reported in its second biannual report to Congress that it had undertaken 22 models, including accountable care and bundled payment models, with more in development. CMS is also testing initiatives to speed adoption of best practices, accelerate development and testing of new models, and reform Medicaid and CHIP. These include large collaborations with private stakeholders, including the Million Hearts Program to advance heart health and the Partnership for Patients to improve hospital safety. The Department initiated the Health Care Payment Learning and Action Network to collaborate on aligning reforms across health care sectors.

Through its Medicaid Innovation Accelerator Program, CMS is providing technical support to state Medicaid agencies pursuing delivery system reform related to reducing substance use disorders; improving care for Medicaid beneficiaries with complex care needs and high costs; promoting community integration for beneficiaries using long-term services and supports; and physical and mental health integration.

CMS continues to issue a range of guidance to participants in new models and has begun the regulatory process for the new physician and laboratory payment systems. Additionally, CMS has taken steps to include in new models program integrity safeguards, including transparency of data and monitoring for indicators of abuse or gaming.

What Needs to Be Done

Much must be accomplished to meet the statutory and Department's reform goals and the promise of better quality of care at lower costs. CMS must manage a broad portfolio of complex models and reforms. CMS must continue to develop clear guidance for providers on program requirements; administer (or contract for) financial, beneficiary alignment, and other systems necessary for effective operations; and test, evaluate, and verify model progress and outcomes. The Department should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems—including inefficiencies and misaligned incentives. Further, CMS must clearly define actionable and meaningful quality measures and ensure that they, in fact, measure what CMS intends them to measure to achieve desired quality goals.

New models rely significantly on data, EHRs, and technology. CMS must ensure that data collected and provided for new payment models is timely, accurate, complete, and secure. Data from providers and others must be integrated and shared across models, as appropriate. (For more information on the challenges associated with electronic information and health IT, see Management Challenge 3.) To the extent that cost and quality performance are measured on the basis of Parts A and B claims data, CMS must ensure the soundness and reliability of such data. (For more information on fraud and abuse in Medicare Parts A and B, see Management Challenge 2).

CMS must monitor for program integrity risks in new models, incorporate safeguards tailored to specific risks in particular models, and assess the effectiveness of the safeguards it employs. Detected program integrity problems should be remediated promptly and safeguards strengthened to prevent program and patient abuse or gaming. Sharp attention to program integrity is especially important for models that introduce new payment incentives, which might lead to new fraud schemes, or for which waivers of payment or fraud and abuse laws may have been issued under sections 1899(f) or 1115A of the *Social Security Act*. As a critical element of program integrity, CMS must maintain accurate historical and real-time information identifying providers and beneficiaries in new models.

Finally, CMS must strengthen Medicare Advantage to ensure that benefits are provided only to eligible beneficiaries, that data from providers and the plans are available for fraud detection and prevention, and that plans have programs to address fraud and abuse. Ensuring the accuracy of risk- adjustment data used to establish payment rates is also critical to protect against gaming or abuse. CMS must also improve its use of data to review Medicare Advantage organizations' performance.

Key OIG Resources

- OIG Resources, Accountable Care Organization Resource Page
- OIG Report, Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012, April 2014
- OIG Report, Medicare Advantage Organizations' Identification of Potential Fraud and Abuse, February 2012
- OIG Report, CMS Regularly Reviews Part C Reporting Requirements Data, but Its Followup and Use of the Data are Limited, March 2014

Management Challenge 9: Effectively Operating Public Health and Human Services Programs

Why This Is a Challenge

The Department funds and operates public health and human services programs to promote health and economic and social well-being. These include programs to prevent, track, and treat acute and chronic diseases; respond to natural and man-made disasters; protect against hazardous biological agents; and protect, care for, and educate children. Many of these programs serve vulnerable populations. Effective management is essential to ensure that the programs achieve their goals and best serve the programs' intended beneficiaries.

Public Health Preparedness and Emergency Response. Effective protection against public health threats requires a well-coordinated public health infrastructure that can rapidly respond to emergencies at home and internationally. The Department must ensure that health care facilities and personnel are prepared and trained to address emerging infectious diseases and that the proper protocols are in place to foster response coordination with domestic and international partners. Experiences responding to natural disasters, such as Superstorm Sandy, illustrated the important service of first responders and other health care professionals, but also identified gaps in natural disaster emergency planning and execution. Shortcomings related to federal, state, and community organization collaboration; response team communication; shelter operations; and health care coverage were identified. Furthermore, the Department must ensure that select agents (e.g., anthrax, smallpox) remain safe and secure. CDC is tasked with overseeing the handling of select agents in private and government facilities. However, security vulnerabilities identified at many Department research facilities attest to the continuing problems with how these agents are inventoried and handled.

Access to and Quality of Services. The Department must ensure that intended beneficiaries of public health and human services have access to services and that these services meet quality standards. Access to quality services has proven especially challenging in IHS, where one hospital recently lost its Medicare provider enrollment after being found to pose immediate jeopardy to patients. Illustrating the challenges of adequately serving another vulnerable population, nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening, and the Administration for Children and Families (ACF) did not ensure that these children received the required screenings according to state schedules.

Protecting Vulnerable Populations. The health and safety of children served by ACF's Child Care and Development Fund (CCDF) program – serving approximately 1.6 million children – continues to be an unaddressed vulnerability for the Department. Vulnerabilities in states' standards for and monitoring of childcare providers jeopardize safety. A total of 454 violations of state licensing requirements were identified, including noncompliance with requirements related to physical conditions, inspection procedures, registration, criminal records or protective service checks, and child abuse and neglect registry checks. In addition, states' onsite monitoring of providers was infrequent, and states did not have enough inspectors to meet the national standard. In 2014, there was an unprecedented, and unpredicted, increase of unaccompanied children arriving in the United States, which required ACF's Office of Refugee Resettlement, in coordination with interagency partners, to implement emergency response measures to quickly expand capacity and provide shelter for a significant number of children. (For general information about challenges associated with grants management and contract administration, see Management Challenge 4.)

Progress in Addressing the Challenge

The Department is undertaking several initiatives to strengthen federal, state, and community disaster response. The Assistant Secretary for Preparedness and Response (ASPR) launched the Technical Resources Assistance Center and Information Exchange, an emergency preparedness information gateway designed to ensure that all stakeholders have access to information and resources to improve preparedness, response, recovery, and mitigation efforts. With respect to deficiencies in responding to homebound individuals dependent on electrically powered medical equipment, ASPR released the emPOWER map as a tool to help communities plan for the disaster needs of these individuals. CMS is also developing more comprehensive emergency preparedness requirements. In December 2014, CMS published a proposed rule establishing emergency preparedness requirements for Medicare- and Medicaid-participating providers.

The *Consolidated and Further Continuing Appropriations Act*, 2015, provided $2.7 billion in emergency funding to HHS for Ebola preparedness and response activities. Of this, $1.77 billion was allocated to CDC to prevent, prepare for, and respond to Ebola domestically and internationally. Through its Hospital Preparedness Program cooperative agreements, ASPR has designated nine health departments and associated partner hospitals to become special regional treatment centers for patients with Ebola or other severe, highly infectious diseases. Through the newly announced National Ebola Training and Education Center, CDC and ASPR will support health care provider and facility training and management of Ebola and other emerging infectious diseases.[33]

The Department has made progress in improving physical security and employee training related to safe and secure storage and handling of select agents. CDC has revised its Vaccines for Children (VFC) Operations Guide, published a *Storage and Handling Toolkit*, and provided additional grantee and provider training to improve vaccine storage and handling practices. CDC also now requires grantees to perform unannounced visits to providers' offices, which was the technique that the OIG used to initially identify VFC program storage and handling vulnerabilities.

The *Child Care and Development Block Grant Act of 2014* (P.L. No. 113-186) reauthorized the CCDF program and improved childcare health, safety, and quality requirements. The law requires states to perform an initial onsite monitoring visit and at least one annual unannounced onsite visit of licensed providers that have received CCDF subsidies, as well as annual inspections for license-exempt CCDF providers. The law also requires childcare providers to submit background checks at least once every 5 years for each childcare staff.

Since the sharp increase of unaccompanied children referred to HHS in the Spring/Summer of 2014, ACF has continued to support and participate in the DHS-led Unified Coordination Group, which monitors all aspects of unaccompanied children arrivals, including HHS and Department of Homeland Security (DHS) programs, along with the collaboration of other federal partners such as the Department of State and the Department of Defense. ACF has also awarded new contracts to support the operations of temporary surge shelters, should they need to be deployed in the future.

What Needs To Be Done

The Department should continue to promote federal, state, and community collaboration during major disasters. While it may not be possible to predict when and where disasters will strike, the Department should prepare for a range of potential emergency scenarios and be ready to rapidly and effectively respond. Additionally, improvements in the adoption and interoperability of health IT can facilitate medical care for displaced patients by

[33] Lead Inspector General Quarterly Progress Report on US Government Activities, *International Ebola Response and Preparedness*, June 30, 2015

ensuring continuity of access to health records. (For more information on the secure exchange of health information, see Management Challenge 3.)

The Department should move swiftly toward finalizing emergency preparedness regulations. In conjunction with these regulations, detailed and clear guidance should be developed for surveyors assessing compliance with federal regulations. In addition, clear guidance should be developed for the transport of Medicaid patients across state lines. The Department must ensure the sufficiency and training of medical staff for disasters and severe infectious diseases to prepare them to maintain patient care during periods of poor conditions.

The Department will need to continue efforts to improve its inventory control policies and procedures for select agents to resolve vulnerabilities.

ACF should expand the scope of its Child and Family Services Reviews to determine whether children in foster care receive required screenings according to the timeframes specified in states' plans. Furthermore, ACF should work with states to identify the barriers that prevent children in foster care from receiving required screenings and identify, disseminate, and implement strategies for overcoming those barriers. ACF must continue to effectively implement the *Child Care and Development Block Grant Act of 2014* to strengthen the Department's oversight of the health and safety of children. OIG continues to recommend that the Department continue coordination with partner agencies, such as the Department of Homeland Security, to improve its ability to adequately care for unaccompanied children.

Key OIG Resources

- OIG Reports on emergency preparedness and response, OEI-06-13-00260, OEI-04-13-00350
- OIG Report, Division of Unaccompanied Children's Services: Efforts to Serve Children, March 2008
- OIG Testimony, The Foundation for Success: Strengthening the Child Care and Development Block Grant Program, March 2014
- OIG Report, Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings, March 2015
- OIG Testimony, Continuing Concerns with the Federal Select Agent Program: Department Of Defense Shipments of Live Anthrax, July 2015

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

Why This Is a Challenge

The Department, through FDA, must ensure the safety, efficacy, and security of drugs, biologics, medical devices, dietary supplements, tobacco, feed, and much of our Nation's food supply. However, weaknesses exist. Areas of particularly high risk include drug compounding; the global supply chain; food safety; illegal marketing and promotion; and dietary supplements.

Compounded Drugs. Compounded drugs are produced outside of FDA's regulatory process designed to ensure the safety and efficacy of commercially manufactured drugs. The potential danger of compounded drugs drew national attention in 2012, when contaminated compounded sterile drug injections caused a fungal meningitis outbreak. The widespread use of compounded products in health care and FDA's limited ability to effectively oversee compounding entities, which number in the thousands and, generally, do not register with FDA, are causes for concern.

Imported Food and Drugs. Foreign sources account for about 40 percent of the drugs, 50 percent of the medical devices, 15 percent of the food, 85 percent of the seafood, and 50 percent of the fresh fruit used by Americans. The global nature and complexity of this supply chain complicates FDA's task of ensuring safety.

Food Facilities. Food-borne illnesses, such as those caused by salmonella, listeria and E. coli, pose a continuing public health threat. Despite legal requirements for food facilities to investigate and report adulteration and other serious food-safety concerns, food facilities' failures to comply impede the Department's ability to ensure the safety of the Nation's food supply.

Off-label Promotion and Kickbacks. Manufacturers of drugs, biologics, and medical devices gain approval for sale of their products for specific uses once FDA determines that the products are safe and effective for those uses. Once approved for sale, qualified medical providers may prescribe them for any use, including unapproved uses, commonly called "off-label uses." However, manufacturers are prohibited from promoting products for off-label uses. Manufacturers are also prohibited from paying kickbacks to physicians or other health care providers to promote the use of their drug, biologic, or medical device. OIG continues to identify illegal off-label promotion and kickbacks that put patients at risk of receiving inappropriate or harmful care and lead to fraudulent claims for payment from federal health care programs. (For more information on drug diversion and utilization of prescription drugs, see Management Challenge 5).

Dietary Supplements. Dietary supplement manufacturers use structure/function claims to persuade consumers to purchase and use their products. Structure/function claims can describe the effect of a dietary supplement on the structure and function of human bodies but may not claim to prevent, treat, mitigate, cure, or diagnose a disease. Reliable evidence must substantiate these claims as truthful and not misleading, but manufacturers are not required to submit the substantiation to FDA prior to marketing their products, and FDA has only voluntary standards for submission. Those substantiation documents submitted often do not reflect reliable evidence.

Progress in Addressing the Challenge

In 2013, the *Drug Quality and Security Act* (DQSA), amended the *Federal Food, Drug, and Cosmetic Act* to enhance FDA's authority to oversee compounding, including by providing a new pathway for compounders to register as "outsourcing facilities" to legally compound drugs. The Department continues to work to fully implement DQSA, and FDA has issued numerous policy and guidance documents and increased its inspection and enforcement efforts. FDA continues to inspect compounding facilities; oversee recalls of compounded drugs for contamination or lack of sterility assurance; and issue warning letters to compounders that violate the law.

To address risks associated with imported drugs, FDA has engaged in both outreach and enforcement actions. FDA has undertaken significant efforts to warn consumers, medical practitioners, and others about the risks associated with illegally buying drugs from foreign sources. In addition, FDA has continued to work with OIG and other law enforcement partners to investigate and prosecute physicians and drug suppliers that import unapproved drugs, most notably misbranded, unapproved chemotherapy drugs. Physicians who bill Medicare or Medicaid for such unapproved drugs can be subject to criminal liability under the *False Claims Act* and excluded from participating in federal health care programs. FDA continues to cooperate with international partners and has introduced improved border screening to enhance oversight of imported products.

FDA continues to implement its enhanced food-safety authorities statutorily granted in 2011 by the *Food Safety Modernization Act* (FSMA). In September 2015, FDA promulgated new food safety rules that will require U.S. manufacturers of both human and animal foods to make detailed plans to identify and prevent contamination risks in their production facilities. FDA's food scientists have helped improve genome sequencing technologies to better

detect and prevent foodborne illnesses, and FDA continues to work on improving nutrition and calorie labeling to better inform consumers.

OIG and its law enforcement partners have pursued numerous enforcement actions against drug, biologic, and device manufacturers for illegally promoting their products in ways that could harm patients and waste federal health care program money.

FDA endeavors to continue to make progress in addressing OIG recommendations to improve oversight of dietary supplements. In response to an OIG recommendation, FDA stated that it would consider seeking enhanced authority to review substantiation for structure/function claims.

What Needs To Be Done

The Department and FDA must continue issuing rules and guidance documents to fully implement FSMA, and DQSA, as well as the July 2012 *Food and Drug Administration Safety and Innovation Act* (FDASIA). FDA must continue to implement its new authorities to enhance oversight of drug compounders and better ensure the safety of compounded products, including by inspecting drug compounders and pursuing regulatory action when deficiencies are identified. OIG plans continued oversight of FDA's inspection of food facilities and monitoring of food recalls. OIG continues to recommend that FDA remedy identified weaknesses in its inspections and recall procedures and better ensure that states properly conduct contracted food facility inspections. The Department also must continue combating off-label promotion and illegal importation of unapproved drugs. OIG, in cooperation with DOJ and other law enforcement partners, will continue to employ investigative and enforcement authorities to protect federal health care programs and beneficiaries from these potentially dangerous products.

Key OIG Resources

- OIG Report, Penetration Test of the Food and Drug Administration's Computer Network, October 2014
- OIG Report, High-Risk Compounded Sterile Preparations and Outsourcing by Hospitals That Use Them, April 2013
- OIG Report, FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety, February 2013
- OIG Report, Dietary Supplements: Structure/Function Claims Fail to Meet Federal Requirements, October 2012

DEPARTMENT'S RESPONSE TO THE OFFICE OF INSPECTOR GENERAL TOP MANAGEMENT CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Mary K. Wakefield, Acting Deputy Secretary

Subject: FY 2015 Top Management and Performance Challenges Identified by the Office of Inspector General

Thank you for the Office of Inspector General's work in assessing the major management and performance challenges facing the Department as we begin the new fiscal year. We appreciate OIG's audit and investigative work throughout the year.

The suggestions you offer to address these challenges will help us drive progress on our Agency Priority Goals. The Department's Operating Divisions continue to focus on serving all Americans by protecting their health, providing essential human services, and promoting the well-being of individuals, families and communities. OIG's work will help us do this in the most effective and efficient way possible.

We are committed to focusing our resources on the issues related to these challenges as we work toward implementing our strategic plan in FY 2016.

/Mary K. Wakefield/

Mary K. Wakefield
Acting Deputy Secretary
November 13, 2015

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Appendices

About the photo

Secretary Burwell with Public Health Service Officers at the 2015 HHS "Night at the Ballpark" (Washington Nationals Stadium).

In This Section

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APPENDIX A: ACRONYMS

AA	Associate of Arts
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADA	*Anti-Deficiency Act*
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
ALJ	Administrative Law Judge
AOA	Administration on Aging
APG	Agency Priority Goal
APMs	Alternative Payment Models
APPs	Applications
APTC	Advance premium tax credits
ASA	Office of the Assistant Secretary for Administration
ASC	Ambulatory Surgical Center
ASFR	Office of the Assistant Secretary for Financial Resources
ASL	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATM	Accounting Treatment Manual
ATSDR	Agency for Toxic Substances and Disease Registry
BA	Bachelor of Arts
BARDA	Biomedical Advanced Research and Development Authority
BHP	Basic Health Plan
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
CAHs	Critical Access Hospitals
CAIVRS	Urban Development's Credit Alert Interactive Voice Response System
CAP(s)	Corrective Action Plan(s)
CAUTI	Catheter-Associated Urinary Tract Infections
CBRs	Comparative Billing Reports
CCDBG	*Child Care and Development Block Grant Act of 2014*
CCDF	Child Care Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CDER	Common Data Element Repository
CEAR	*Certificate of Excellence in Accountability Reporting*
CERT	Comprehensive Error Rate Testing
CFBNP	Center for Faith-Based and Neighborhood Partnerships
CFO	Chief Financial Officer
CFO Act	*Chief Financial Officers Act of 1990*
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CHIPRA	*Children's Health Insurance Program Reauthorization Act of 2009*
CIO	Chief Information Officer
CL	Current Law
CMA	Computer Matching Agreement
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
COLA	Cost of Living Adjustment
COTS	Commercial Off the Shelf
CPI	Consumer Price Index
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
CPIC	Certification Package for Internal Controls
CPIM	Consumer Price Index-Medical
CRC	Commercial Repayment Center
CSR	Cost-sharing reductions
CSRS	Civil Service Retirement System
CUSP	Comprehensive Unit-Based Safety Program
CY	Current Year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DEA	Drug Enforcement Agency
DHS	Department of Homeland Security
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics Orthotics and Supplies
DMF	Death Master File
DNP	Do Not Pay
DOD	Department of Defense
DOI	Department of the Interior
DOJ	Department of Justice
DOL	Department of Labor
DQSA	*Drug Quality and Security Act*
DRA	*Deficit Reduction Act of 2005*
DSWG	Data Standardization Working Group
EHR	Electronic Health Records
EO	Executive Order
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERM	Enterprise Risk Management
ES	Executive Secretariat
ESRD	End-Stage Renal Disease
FAQ	Frequently Asked Questions
FASAB	Federal Accounting Standards Advisory Board
FBIP	Financial Business Intelligence Program
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FDASIA	*Food and Drug Administration Safety and Innovation Act*
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees' Retirement System
FETP	Field Epidemiology Training Program
FFM	Federally Facilitated Marketplace
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFRDC	Federally Funded Research and Development Center
FFR	Federal Financial Report
FFS	Fee-for-Service
FGB	Financial Management Governance Board
FICA	*Federal Insurance Contributions Act*
FIFO	First-in/first-out
FISCAM	Federal Information Systems Control Audit Manual
FISMA	*Federal Information Security Management Act of 2002*
FITARA	*Federal Information Technology Acquisition Reform Act*
FMAP	Federal Medical Assistance Percentage
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FPL	Federal Poverty Level
FPS	Fraud Prevention System
FR	Final Rule
FSIP	Financial Systems Improvement Program
FSMA	*Food Safety Modernization Act*
FVPS	Family Violence Prevention and Services
FWA	Fraud, waste, and abuse
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GMRA	*Government Management Reform Act of 1994*
GPRA	*Government Performance and Results Act of 1993*
GSA	General Services Administration

HAIs	Healthcare-Associated Infections
HCBS	Home-and community-based- services
HEW	Health, Education, and Welfare
HFPP	Healthcare Fraud Prevention Partnership
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*
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HSOPS	Hospital Survey of Patient Safety
H5N1	Avian Influenza
IBNR	Incurred But Not Reported
ICD-10	International Classification of Diseases, 10th Revision
ICOFR	Internal Controls over Financial Reporting
ICUs	Intensive Care Units
IEA	Office of Intergovernmental and External Affairs
IEVS	Income Eligibility Verification System
IHS	Indian Health Service
IOS	Immediate Office of the Secretary
IP	Improper Payments
IPAB	Independent Payment Advisory Board
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPERIA	*Improper Payments Elimination and Recovery Improvement Act of 2013*
IPIA	*Improper Payments Information Act of 2002*
IRS	Internal Revenue Service
IT	Information Technology
LEIE	List of Excluded Individuals & Entities
LLP	Limited Liability Partnership
MA	Medicare Advantage or Part C
MACRA	*Medicare Access and CHIP Reauthorization Act*
MACs	Medicare Administrative Contractors
MAO	Medicare Advantage Organizations
MARx	Medicare Advantage Prescription Drug
MD&A	Management's Discussion and Analysis
MEDIC	Medicare Drug Integrity Contractors
MFCUs	Medicaid Fraud Control Units
MICs	Medicaid Integrity Contractors
MIDAS	Multidimensional Insurance Data Analytics System
MII	Medicaid Integrity Institute
MLN	Medicare Learning Network
MMA	*Medicare Prescription Drug, Improvement and Modernization Act of 2003*
MMIS	Medicaid Management Information Systems
MMWR	Morbidity and Mortality Weekly Report
MOE	Maintenance of Effort
MSIS	Medicaid Statistical Information Systems
MSP	Medicare Secondary Payer
MWWG	Material Weakness Working Group
NBI	National Benefit Integrity
NBS	NIH Business Systems
NCCI	National Correct Coding Initiative
NDNH	National Directory of New Hires
NGHP	Non-Group Health Plan
NHSC	National Health Service Corps
NHSN	National Healthcare Safety Network
NIH	National Institutes of Health
NIP	National Provider Identifier
NJDCF	New Jersey Department of Children and Families
NPRM	Notice of Proposed Rulemaking
NYSOCFS	New York State Office of Children and Family Services
OACT	Office of the Actuary
OASDI	Old-Age Survivors and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCR	Office for Civil Rights
OGA	Office of Global Affairs

OGC	Office of the General Counsel
OHR	Office of Health Reform
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPD	Orphan Products Development
OpDiv	Operating Division
OS	Office of the Secretary
PARIS	Public Assistance Reporting Information System
PCS	Personal Care Services
PDE	Prescription Drug Event
PEDIR	Payment Error related to Direct and Indirect Remuneration
PELS	Payment Error related to Low-Income Subsidy Status
PEMS	Payment Error related to Medicaid Status
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PEPV	Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PFCRA	*Program Fraud Civil Remedies Act*
PHD	Doctor of Philosophy
PHS	Public Health Service
PIP	Program Improvement Plan
PMDs	Power Mobility Devices
PMO	Program Management Office
PMS	Payment Management System
PP&E	Property, Plant and Equipment
PPS	Prospective Payment System
PPV	Plan Payment Validation
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PTC	Premium Tax Credit
PUPS	Prisoner Update Processing System
PUR	Period Under Review
PY	Prior Year
QAPI	Quality Assurance and Performance Improvement
QHP	Qualified Health Plans
QIO	Quality Improvement Organization
QM	Quality Measures
QRIS	Quality Rating and Improvement Systems
QRP	Quality Reporting Program
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
RMFOB	Risk Management and Financial Oversight Board
RSI	Required Supplementary Information
RSSI	Required Supplementary Stewardship Information
SACWIS	Statewide Automated Child Welfare Information System
SAM	General Service Administration's System for Award Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIR	Small Business Innovation Research
SBJA	*Small Business Jobs Act of 2010*
SE	Salmonella Enteritidis
SECA	*Self Employment Contribution Act of 1954*
SF	Standard Form
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SHRAP	Sandy Homeowner and Renter Assistance Program
SIR	Standard Infection Ratio
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review/Specialty Contractor
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SPA	State Plan Amendments
SSA	Social Security Administration
SSAE	Statement on Standards for Attestation Engagements

SSBG	Social Services Block Grant
SSF	Service and Supply Fund
StaffDiv	Staff Division
STEM	Science, Technology, Engineering and Mathematics
STTR	Small Business Technology Transfer
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TIN	Taxpayer Identification Number
T-MSIS	Transformed Medical Shared Information Saving Program
TNC	Treasury Nominal Coupon
TOP	Treasury's Offset Program
TREASURY	Department of the Treasury
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	U.S. Code
USDA	U.S. Department of Agriculture
USSGL	U.S. Standard General Ledger
VA	Department of Veterans Affairs
VBP	Value-Based Purchasing
VFC	Vaccines for Children
WIOA	*Workforce Innovation and Opportunity Act*

APPENDIX B: CONNECT WITH HHS

The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.

Thank you for your interest in HHS's FY 2015 AFR. We welcome your comments on how we can make this report more informative for our readers. Please send your comments to:

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

Email: HHSAFR@hhs.gov

Electronic copies of this report and prior years' reports are available through the Department's website: www.hhs.gov/AFR

You can also stay connected with HHS via the social media sites listed below:

Facebook: www.facebook.com/HHS

Twitter: www.twitter.com/hhsgov

YouTube: www.youtube.com/user/USGOVHHS

Flickr: www.flickr.com/photos/hhsgov

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GooglePlus: www.plus.google.com/+HHS/posts

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

877.696.6775 ● www.hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

November 16, 2015

The Honorable Tom Price
Chairman
Committee on Budget
United States House of Representatives
100 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the *Reports Consolidation Act*, I am pleased to submit the Fiscal Year 2015 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). The AFR is located on our website at http://www.hhs.gov/afr/.

I am proud to report that HHS obtained an unmodified or "clean" opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would influence underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2015 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board.

The Centers for Medicare & Medicaid Services (CMS), an Operating Division of HHS, published an audited annual financial report under separate cover. This report will go out for distribution on Monday, November 16, 2015 and will be available on CMS's website at http://www.cms.hhs.gov/CFOReport/.

Thank you for your continued interest in the Department's stewardship of taxpayer funds. If you have any questions, please contact me at (202) 690-6396.

Sincerely,

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

From:	Schlichting, Emily (HHS/ASL)
To:	Jim.Herz@mail.house.gov
Subject:	FY16 Agency Financial Report
Date:	Tuesday, November 15, 2016 5:25:00 PM
Attachments:	Tom Price - AFR Letter.pdf fy-2016-hhs-agency-financial-report.pdf

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Hello,

Attached please find a letter notifying your boss of the FY16 Agency Financial Report for HHS and the full report.

Thanks,
Emily

Emily Schlichting
Chief of Staff
Office of the Assistant Secretary for Legislation
U.S. Department of Health and Human Services
202-690-7414 | emily.schlichting@hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

November 15, 2016

The Honorable Tom Price
Chairman
Committee on Budget
United States House of Representatives
100 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I am delighted to submit the Fiscal Year 2016 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). In accordance with the *Reports Consolidation Act*, HHS is committed to delivering a quality AFR that displays summary performance results, accomplishments, and finances for the fiscal year. As you read HHS's AFR, you will see that the report provides the President, Congress, and the American people a comprehensive look into HHS's financial condition, as well as insight into how HHS carries out its mission and makes a difference for the American people. The AFR is located on our website at http://www.hhs.gov/afr/.

HHS obtained an unmodified or "clean" opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would influence underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2016 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board.

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Sincerely,

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

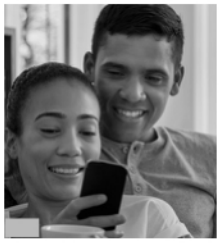
Department of Health and Human Services

Advancing the health, safety, and well-being of the nation















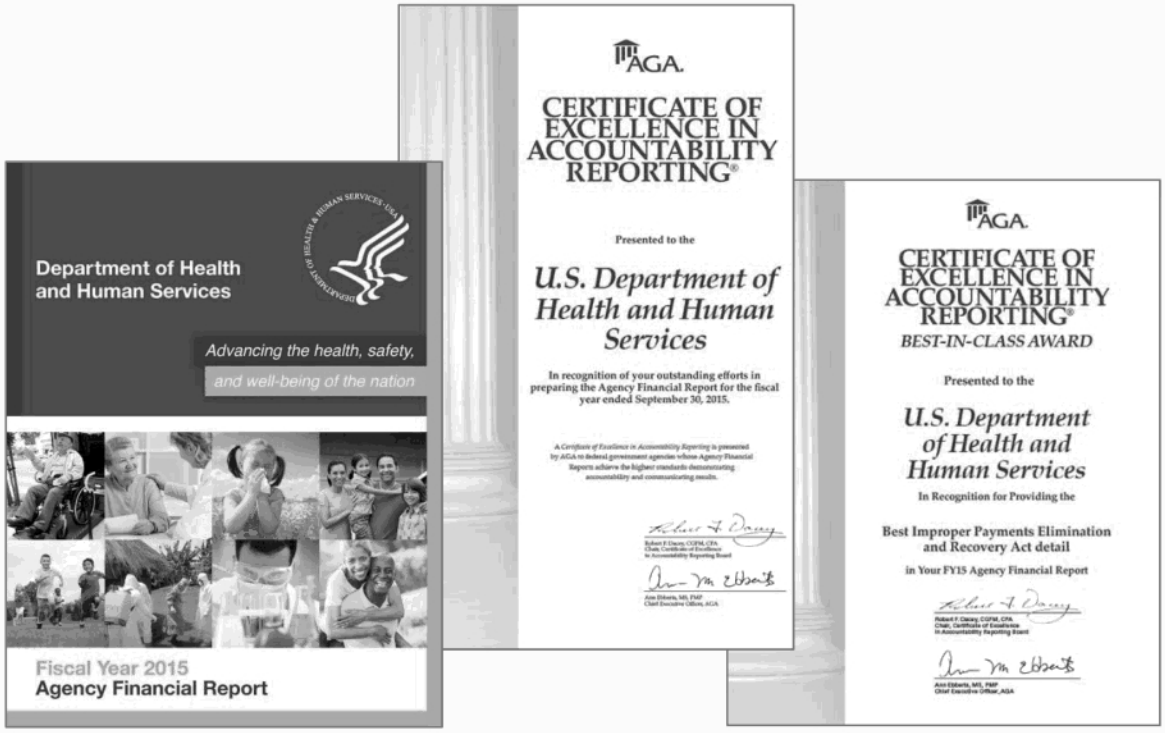

FY 2016

Agency Financial Report

Certificate of Excellence in Accountability Reporting

In May 2016, the U.S. Department of Health and Human Services (HHS) received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its Fiscal Year (FY) 2015 Agency Financial Report. The CEAR Program was established by the AGA in collaboration with the Chief Financial Officers Council and the U.S. Office of Management and Budget to further performance and accountability reporting. Through the program, agencies improve accountability by streamlining reporting and improving the effectiveness of such reports to clearly show what an agency accomplished with taxpayer dollars and the challenges that remain. FY 2015 marked the third consecutive year the Department received this prestigious award.

AGA also presented HHS with a Best in Class Award for the Best Improper Payments Elimination and Recovery Act Detail.



Note: This document is currently undergoing Section 508 remediation. Should you need assistance, please contact the HHS AFR Team at HHSAFR@hhs.gov.