Improper Payments Information Act Report

This report follows the format prescribed by the Office of Management and Budget (OMB) in Circular A-136, Financial Reporting Requirements.

I. Describe your agency's risk assessment(s), performed subsequent to compiling your full program inventory. List the risk-susceptible programs (i.e., programs that have a significant risk of improper payments based on OMB guidance thresholds) identified through your risk assessments. Be sure to include the programs previously identified in the former Section 57 of OMB Circular A-11.

Risk assessments were completed for FYs 2004, 2005, and 2006 using a model developed by the Department. HHS did not identify any new high-risk programs in its FY 2006 risk assessment work.

Seven HHS programs were previously identified as high-risk programs in OMB Circular A-11, Section 57. These seven programs are: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Foster Care, Head Start and Child Care Development Fund. The sections below contain information on HHS activities related to estimating and reducing improper payments in these programs. The Department has been reporting on Medicare fee-for-service since 1996. This year, HHS began work on developing a methodology for the Medicare Advantage and Prescription Drug Benefit programs.

II. Describe the statistical sampling process and the methodology used to estimate the improper payment rate for each program identified.

A. Medicare Fee-For-Service—The Medicare fee-for-service (FFS) improper payment estimate is derived from two programs: the Comprehensive Error Rate Testing program (CERT), which reviews claims that account for approximately 60 percent of the total Medicare FFS payments, and the Hospital Payment Monitoring Program (HPMP), which reviews claims that comprise the remaining 40 percent. The CERT program calculates the error rate for Carriers, Durable Medical Equipment Regional Carriers, and non-Prospective Payment System inpatient Part A claims submitted to Fiscal Intermediaries. The HPMP calculates the error rate for Prospective Payment System inpatient hospital claims submitted to the Fiscal Intermediaries. The Medicare FFS improper payment methodology includes:

- Randomly selecting approximately 160,000 claims;
- Requesting medical records from providers on these claims;
- Reviewing the claims and medical records for compliance with Medicare coverage, coding and billing rules; and
- Treating non-response by a provider as an error.

B. Medicare Advantage—A methodology to estimate improper payments is in the initial stage of development. In FY 2007, HHS will perform a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Advantage program. HHS will conduct a measurement project on one of the areas identified and report the findings in the FY 2008 Performance and Accountability Report (PAR).

C. Medicare Prescription Drug Benefit—A methodology to estimate the improper payments is in the initial stage of development. In FY 2007, HHS will perform a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Prescription Drug Benefit program. HHS will conduct a measurement project on one of the areas identified and report the findings in the FY 2008 PAR.

D. Medicaid—Twenty-six states participated in the Payment Error Rate Measurement pilot project where each state reviewed a sample of 150 Medicaid claims from one quarter of the fiscal year. Each of the 26 states, including the District of Columbia, conducted their own measurement and measured claims in their FFS and/or managed care programs. States that reviewed both

FFS and managed care claims proportionally divided the 150 claims according to the program dollars spent in each component. The FFS claims were stratified based on type of service and were randomly selected. A medical review and data processing review was conducted on each of the FFS claims. The managed care claims were also randomly selected, but were not stratified. Only a data processing review was performed on the managed care claims. States also conducted an eligibility review on a sub-sample of 50 claims.

E. State Children's Health Insurance Program—Twenty-six states participated in the Payment Error Rate Measurement pilot project where each state reviewed a sample of 150 SCHIP claims from one quarter of the fiscal year. Each of the 26 states, including the District of Columbia, conducted their own measurement and measured claims in their FFS and/or managed care programs. States that reviewed both FFS and managed care claims proportionally divided the 150 claims according to the program dollars spent in each component. Both the FFS and managed care claims were randomly selected. A medical review and data processing review was conducted on each of the FFS claims and only a data processing review was performed on the managed care claims. States also conducted an eligibility review on a sub-sample of 50 claims.

F. Temporary Assistance for Needy Families—During FY 2006, HHS continued to engage in various activities to identify and reduce improper payments in the TANF program and finalized an error rate measurement plan. Activities HHS engaged in include:

1) Information Sharing—HHS developed a survey instrument to solicit information from states on state systems and practices for identifying and reducing improper payments in the TANF program. States were asked to voluntarily provide information on how they define improper payments, the process(es) used to identify such payments, and the actions taken to reduce improper payments. Twenty-four states responded to this voluntary improper payment survey. Of the 24 respondents, 17 of these states directly administered the TANF program and the other seven states locally administered the program with state oversight. In addition, eight of these states reported that they calculated improper payment rates. A repository of this information is posted on the HHS Administration for Children and Families' website at www.acf.hhs.gov and is available for review by all states.

2) Public Assistance Reporting Information System (PARIS)—This system is a voluntary project that enables participating states' public assistance data to be matched against several databases to help maintain program integrity and detect and deter improper payments in several programs (TANF, Medicaid, and U.S. Department of Agriculture's Food Stamp program). In FY 2006, HHS engaged in a number of activities to improve the data match capability and usefulness of this system as well as to increase state utilization. These activities included: actively encouraging states to participate in the PARIS match process; making a conference contract award to enable all participating states to meet in Washington, DC for HHS training in utilizing the system to its fullest capability; making Phase II PARIS Partnership Grant Awards to 10 states as incentive for states to join; and administering last year's award to a contractor to evaluate the system, formulate recommendations for improving and enhancing its usefulness, and develop a uniform reporting format.

3) TANF A-133 Audit Pilot—During FY 2006, HHS obtained agreement from three states (Indiana, Montana, and Nebraska) to engage voluntarily in a pilot to undergo a more in-depth review of TANF expenditures as part of their audits required under OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. The objective of the pilot was to explore the viability of estimating improper payments in the A-133 audit process. The sample size and review methods varied among the pilot states. HHS has no authority under the A-133 process to require participation by the states or to standardize the methodology among the volunteer states.

4) Finalized TANF Measurement Plan—HHS has determined that the most promising course of action going forward is to work with the Office of Inspector General (OIG). Under this plan, the OIG will conduct pilot reviews in some of the largest states in FY 2007 to determine the extent of the improper payments in the TANF program. The OIG will continue these reviews in FY 2008 by randomly selecting eight states to conduct the review.

G. Foster Care—Title IV-E Foster Care eligibility reviews, promulgated in regulations at 45 Code of Federal Regulations 1356.71(c), are conducted to ensure that Federal title IV-E funds are used only for eligible children who are placed with licensed providers. Since FY 2000, HHS has systematically conducted more than 80 title IV-E reviews (over 7,000 foster care cases reviewed) in 50 states, the District of Columbia, and Puerto Rico. HHS determined an estimate of improper payments for the title IV-E Foster Care program using the data collected in these reviews as well as data from state quarterly fiscal reports from FYs 2001 to 2005.

During these reviews, a team comprised of Federal and state staff validates the accuracy of a state's IV-E claims for reimbursement of payments made on behalf of eligible children placed in licensed homes and institutions. Each review draws from the state's overall title IV-E caseload for its six-month Period Under Review (PUR). The review identified the number of cases in error and the amount of payment in error. An error case is defined as a case in which a payment is made on behalf of an ineligible child during the six-month PUR. Payment errors may include payments for error cases, "ineligible" payments made to non-error cases, which failed to meet an eligibility criterion outside the six-month PUR, and "unallowable" payments for services not covered by title IV-E (e.g. therapy).

While the focus of these reviews is on eligibility and compliance with Federal regulations, the information gathered in the reviews may be used to correct improper payments regardless of whether they are underpayments or overpayments. In FY 2005, HHS began to systematically identify and record underpayments as part of the current review structure. The identification of underpayments was fully implemented during the FY 2006 reviews. In FY 2006, HHS worked to develop a review methodology to examine whether states accurately claim and properly allocate costs for administering the title IV-E Foster Care program. HHS is continuing to develop an administrative review component of the Foster Care improper payment estimate and expects to begin pilot testing in FY 2007.

H. Head Start—HHS is legislatively required to perform reviews of each Head Start program every three years. The Head Start program began reporting an estimate of improper payments in FY 2004.

The design of the sample for the Erroneous Payments Study of Head Start programs is a three-stage element sample. Since each program is reviewed once every three years, the first stage of the sample is to identify the programs up for review. The second stage of the sample is to select the programs to be reviewed. Programs are selected through a stratified random sample, where programs are divided into five quintiles. The number of programs sampled within each stratum is roughly proportional to the number of children represented in each stratum, using the most recent Program Information Report funded enrollment data available for the program. The third stage of the sample selects the records to be reviewed in each selected program, using a systematic sampling scheme.

In FY 2006, 50 programs from 18 states were reviewed and a total of 10,939 records were examined. The focus of these reviews is to determine whether the child was income eligible. A payment error in the Head Start program is defined as a payment for an enrolled child from a family whose income exceeds the allowable limit (in excess of the 10 percent program allowance for families above the income limit). To make this determination, reviewers were required to look at each sample child's folder and determine if the child was ineligible, either because there was not, as required by 45 CFR Part 1305.4(e), a signed statement by a Head Start employee stating the child was eligible to participate or there was income documentation in the child's folder that, in the reviewer's judgment, suggested the child was not Head Start eligible.

In FY 2007, Head Start intends to review the methodology that has been used for the last three years to determine if it continues to be the best method for calculating what percentage of ineligible children are being served in Head Start or if there may be ways to refine this methodology that could more accurately capture this information.

I. Child Care and Development Fund—During FY 2004, HHS initiated an improper payment pilot project to assess the efforts of states to prevent and reduce improper payments in their Child Care program and to measure improper payments. A total of nine states have participated or are participating in the measurement portion of this pilot project. To date four states have com-

pleted their improper payment measurement. Currently, five states are in the process of piloting the improper payment measurement methodology.

As part of the improper payment measurement component of the pilot project, site visits were conducted in the nine volunteer states. One hundred and fifty cases (children) in each state were randomly selected for review. During these visits, reviewers studied client eligibility, specifically, the states' ability to verify information received from clients during the initial eligibility process or otherwise to establish eligibility correctly. The sample size of 150 was estimated to achieve a six percent precision level at the 90 percent confidence interval. In addition, a desk review of each case was completed to determine compliance with Federal and state eligibility guidelines. Data collected yielded four error rate measures: percentage of cases with an error, percentage of cases with a payment error, average amount spent in error per child, and percentage of payments made in error. During FY 2006, HHS continued to work with the states to identify an appropriate strategy for determining estimates of payment errors in the Child Care program. To assist states in their efforts to identify and reduce the occurrence of improper payments due to administrative error, HHS adapted the Government Accountability Office's Internal Control Management and Evaluation tool for use with the Child Care Development Fund program and piloted it in one state. This assessment tool provides: 1) a systematic way to assess the adequacies of internal controls; and 2) a basis to establish corrective actions to address issues that may, or actually have already, contributed to improper payments. HHS will pilot the instrument in eight additional states during FY 2007.

In FY 2006, HHS also developed a voluntary survey to obtain information from states about the design and scope of their Child Care Development Fund systems for managing improper payments. Twenty-four responded to this survey. A repository of this information will be posted on the HHS Administration for Children and Families' website at www.acf.hhs.gov and will be available for review by all states.

III. Describe the corrective action plans for reducing the estimated rate of improper payments. Include in this discussion: the causes of the improper payments identified, the actual amount of improper payments the agency expects to recover and how it will go about recovering them, actions taken to correct those causes, and the results of the actions taken to address those causes. Part of this discussion shall include the portion of payment errors attributable to insufficient of lack of documentation if applicable. If efforts are already underway, and/or have been ongoing for some length of time it is appropriate to include that information in this section.

A. Medicare FFS—The primary causes of improper payments, as identified in the Medicare FY 2006 FFS Improper Payments report, included medically unnecessary services, incorrect coding, and insufficient documentation. The identified improper payments will be recovered by the Medicare contractors through the standard payment recovery methods.
HHS developed an Error Rate Reduction Plan that outlines actions the agency will implement in an effort to prevent/reduce improper payments. These actions include:

- Educate providers about the Comprehensive Error Rate Testing program so that providers are not hesitant about supplying medical records
- Modify the medical record request letters to clarify the components of the record needed for Comprehensive Error Rate Testing review and to encourage the billing provider to forward the request to the appropriate location if the medical record is not on-site
- Customize the second chance letters to list the parts of the medical record that are needed to complete the review
- Complete and distribute an extensive workbook designed to be a resource for hospitals in their compliance efforts and activities
- Task each Carrier, Durable Medical Equipment Regional Carrier, and Fiscal Intermediary with developing an Error Rate Reduction Plan that targets medical necessity errors in their jurisdiction

- Develop national and state-specific models for predicting payment errors to help increase understanding of areas prone to payment error and where Quality Improvement Organizations should focus corrective actions
- Form a workgroup to address the high provider compliance error rate by examining causes of the errors and developing recommendations for corrective actions
- Release a list of over-utilized codes to show error rates and improper payments by service
- Conduct a demonstration in three states to see if using recovery auditing contractors can help lower the error rates in these states by (1) improving provider compliance more quickly than states that do not have recovery auditing contractors, and (2) allowing regular contractors to spend fewer resources on post-payment review and focus more time and effort on prepayment review and education
- Consider contractor-specific error rates when evaluating contractors
- Increase and refine one-on-one educational contacts with providers who are billing in error
- Develop and install new correct coding edits

As a result of these corrective actions, the reported Medicare paid claims error rate decreased from 5.2 percent ($12.1 billion), to 4.4 percent ($10.8 billion) from FY 2005 to FY 2006. The FY 2006 paid claims error rate of 4.4 percent was lower than the HHS Medicare FFS error rate Government Performance and Results Act goal of 5.1 percent. Medicare identified $15.5 million in actual improper payments and will recover these monies through the Medicare contractor's standard recovery process. The portion of errors attributed to lack of documentation was 0.6 percent. The portion of errors attributed to insufficient documentation was .6 percent. This accounts for 1.2 percent of the overall payment error rate.

B. Medicare Advantage— A methodology to estimate improper payments is in the initial stage of development. In FY 2007, HHS will perform a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Advantage program. HHS will conduct a measurement project on one of the areas identified and report the findings in the FY 2008 PAR.

C. Medicare Prescription Drug Benefit— A methodology to estimate the improper payments is in the initial stage of development. In FY 2007, HHS will perform a comprehensive risk assessment to determine potential areas vulnerable to payment error in the Medicare Prescription Drug Benefit program. HHS will conduct a measurement project on one of the areas identified and report the findings in the FY 2008 PAR.

D. Medicaid—The primary causes of improper payments, as identified by the states in the Medicaid pilot project, are as follows:

- Insufficient documentation (medical reviews of FFS claims)
- Policy violations (medical reviews of FFS claims)
- Improper pricing (data processing reviews of FFS claims)
- Payment issued for incorrect rate cell (data processing reviews for managed care claims)
- Ineligible for program (eligibility reviews)

Although the Payment Error Rate Measurement pilot project did not track recoveries, the recoveries of Medicaid improper payments due to medical and data processing errors is governed by Section 1903(d)(2) of the Social Security Act and related regulations at Part 433, Subpart F under which states must return the Federal share of overpayments. States reimburse the Federal share on the CMS-64 form which contains a line item for collections. Payments based on Medicaid eligibility errors are addressed under Section 1903(u) of the Social Security Act.

Based on the Payment Error Rate Measurement pilot findings, HHS developed a corrective action plan that contained suggested corrective actions states could take to reduce improper payments. These actions include:

- Document payment policies
- Develop a quality control system
- Monitor the claims processing system to ensure edits and pricing changes are correct
- Sample and review FFS claims on a routine basis to ensure the beneficiary is not enrolled in managed care
- Provide providers with easier access to policies, coverage, coding, and billing guidelines and educate providers on an individual basis
- Conduct pre-payment and post-payment medical reviews
- Provide adequate training for eligibility caseworkers and ensure that they have the necessary materials to make accurate eligibility determinations
- Maintain adequate staffing levels
- Conduct second level reviews of eligibility determinations

The results of the corrective actions will not be able to be assessed until the improper payment measurement is fully implemented in all states.

The Payment Error Rate Measurement pilot project tracked insufficient support and a lack of documentation only for FFS claims. The portion of errors attributable to insufficient or lack of documentation accounted for 26 percent of the gross of overpayments and underpayments.

E. State Children's Health Insurance Program—The primary causes of improper payments, as identified by the states in the SCHIP pilot project, are as follows:

- Insufficient documentation (medical reviews of FFS claims)
- Policy violations (medical reviews of FFS claims)
- Improper pricing (data processing reviews of FFS claims)
- Incorrect payment amounts to managed care organizations (data processing reviews for managed care claims)
- Ineligible for program (eligibility reviews)

Although the Payment Error Rate Measurement pilot project did not track recoveries, the recoveries under the SCHIP program are governed by Section 2105(e) of the Social Security Act and related regulations at Part 457. States reimburse the Federal share on the CMS-21 form which contains a line item for collections.

Based on the Payment Error Rate Measurement pilot findings, HHS developed a corrective action plan that contained suggested corrective actions states could take to reduce improper payments. These actions include:

- Document payment policies
- Develop a quality control system
- Monitor the claims processing system to ensure edits and pricing changes are correct
- Sample and review FFS claims on a routine basis to ensure beneficiary is not enrolled in managed care

- Provide providers with easier access to policies, coverage, coding, and billing guidelines and educate providers on an individual basis
- Conduct pre-payment and post-payment medical reviews
- Ensure staff is trained to assess applicant's potential for Medicaid eligibility
- Review cases when household circumstances change
- Monitor payment of co-payments, coinsurance and premiums

The results of the corrective actions will not be able to be assessed until the improper payment measurement is fully implemented in all states.

The Payment Error Rate Measurement pilot project tracked insufficient and a lack of documentation only for FFS claims. The portion of errors attributable to insufficient or lack of documentation accounted for 25 percent of the gross of overpayments and underpayments.

F. Temporary Assistance for Needy Families—The primary causes of improper payments in the TANF program, as identified through the three A-133 pilots and supplemental information provided by survey states that calculated an improper payment rate, are as follows:

- Improper calculation by the agency; child support income not considered; assistance provided beyond 60 months; lack of adequate caseworker oversight
- Failure of the agency to impose sanctions, conduct timely reviews, and implement procedures to monitor the 5 year time limitation
- Client non-reporting; failure to meet work requirements; and over 18 and not in school or working
- Child age and relationship not established
- Income not budgeted

The auditors provided recommendations for corrective actions and the state TANF agency is required to correct errors under the expanded audit, as they are for a regular A-133 audit. States implement corrective actions based on the completed findings. The results of the corrective actions cannot be assessed until the improper payment measurement process is implemented. The varying reporting formats of the audit reports do not permit an exact determination of the proportion of documentation errors; however, it is estimated in one of the states that one-third of the errors were documentation errors.

G. Foster Care—The primary causes of improper payments identified through the Foster Care improper payment measurement include eligibility errors and other unallowable payments. The following six types of improper payments occurred most frequently in the composite review sample (the composite sample includes the most recent rate from the 50 states, the District of Columbia, and Puerto Rico) and accounted for 83 percent of all improper payments found in the title IV-E reviews:

- Permanency finalization not timely (171 errors)
- Provider not licensed or approved (126 errors)
- No reasonable efforts to prevent removal (91 errors)
- Criminal records check not completed (64 errors)
- Not AFDC eligible at time of removal (55 errors)
- Unallowable payments (59 errors)

In addition, over half of states had at least one provider licensing/approval error. Thus, placing title IV-E foster care children with licensed or approved providers appears to be the most common challenge across states receiving title IV-E funds.

In order to report a final rate in the FY 2006 Performance and Accountability Report, HHS is revising the Foster Care reporting period, beginning next year, to August 1 through July 31. Therefore, in FY 2006 HHS is reporting on the nine reviews completed between October 1, 2005 and July 31, 2006.

For the nine finalized reviews, HHS has identified and imposed disallowances to recover a total of $673,393 in Federal funds for the title IV-E Foster Care program. Recovery of funds occurs through states' reduction of claims for the disallowed amount in subsequent quarters or the state has the option of paying the disallowed amount to HHS directly.

HHS policies and procedures for subrecipient monitoring and oversight are consistent with what is allowed by the Foster Care legislation, related program and grant regulations, and provided for in Circular A-133. In addition, the states compliance in meeting the requirements necessary for Federal financial participation in the title IV-E program is monitored through the existing protocol associated with the title IV-E Foster Care eligibility reviews, promulgated in regulations at 45 Code of Federal Regulations 1356.71(c). Related activities to prevent/reduce improper payments include:

- HHS performs onsite and post-site reviews to effectively validate the accuracy of a state's claim for reimbursement of payments made on behalf of children and their foster care providers.
- States are required to develop and execute state specific Program Improvement Plan.
- Program Improvement Plans that target corrective action to the root cause of payment errors in the state. These plans generally are approved for a period of one year, and the state submits quarterly progress reports to an HHS regional office for monitoring purposes.
- HHS provides onsite training and technical assistance to states to develop and implement program improvement strategies.
- HHS works toward heightening judicial awareness of, and investment in, the Child and Family Services Reviews.
- HHS works closely with the Court Improvement Program in states where judges require training and court orders warrant modification in order to meet title IV-E requirements and reduce the error rate for judicial determinations.
- HHS conducts secondary reviews for states that are not determined to be in substantial compliance as a result of their primary reviews, and takes appropriate disallowances consistent with the review findings.

As a result of corrective actions the reported Foster Care error rate decreased from 8.6 percent ($152 million) to 7.68 percent ($134 million) from FY 2005 to FY 2006. Data from the first nine reviews conducted from October 1, 2005 through July 31, 2006 to update the composite sample indicates that HHS has made positive progress in reducing eligibility errors for the title IV-E Foster Care program. Specifically:

Comparison of the November 2005 composite sample to the July 2006 composite sample reveals a reduction in most types of eligibility errors. Only one of 16 error types exhibited a noticeable increase. Overall, there was a 17 percent reduction in the number of errors.

Reduction in eligibility errors may reflect the positive impact of HHS' efforts to train state staff in eligibility criteria, as well as states' increased focus on the review process (e.g., conducting internal reviews).

The nearly 25 percent reduction of eligibility errors related to judicial determinations suggests that efforts to work with the judiciary to improve court operations to reduce related eligibility errors are having a positive impact.

States are given every opportunity to provide documentation to support a child's eligibility and the validity of their claims. The identification of error cases is rarely, if ever, based upon lack of documentation.

H. Head Start—The primary cause of improper payments in the Head Start program is the absence of signed income verification statements in grantee records. The Head Start program did not recover funds from grantees that made improper payments as a result of this measurement process in FY 2006. However, HHS has recovered a significant amount of misspent funds, unallowable per the applicable Office of Management and Budget Cost Principles, from its Head Start grantees in FY 2006. As a result of the improper payment findings identified in the A-133 audit reports, HHS disallowed over $1 million during FY 2006.

Head Start grantees are required to implement corrective action necessary to comply with the findings identified in the onsite reviews. In addition, HHS has taken the following actions:

- Mandated a review of a sample of grantee records to verify compliance with income eligibility determination requirements
- Increased grantee's emphasis for on-going monitoring through training and development of a monitoring protocol to review management systems

In FY 2007, HHS will issue an Information Memorandum reminding grantees of the documentation requirements and advise regional offices to apply more oversight in this area.

Data from the FY 2006 sample indicates that approximately 3.1 percent of enrolled children are over income eligibility limits. As a result of the actions taken by HHS, in both FY 2005 and FY 2006, onsite monitoring teams found that the grantee's compliance with HHS income eligibility regulations improved. In FY 2006, 1.5 percent of the 3.1 percent error rate was attributable to insufficient documentation for cases that did not have a signed income eligibility verification statement in the files, as required.

I. Child Care and Development Fund—The primary causes of improper payments, as identified through the improper payment measurement pilot projects are missing documentation and improper income or incorrect parental fee calculations. Since this was a pilot project, the states did not identify amounts they were expecting to recover and did not address approaches for recovery.

HHS and the states are working together to address potential errors identified during pilot activities. In those areas where problems or issues were identified in the pilot states, HHS regional office staff is working in collaboration with state staff to:

- Reexamine monitoring processes
- Provide training
- Clarify policies and procedures

HHS will continue to review the biennial Child Care Development Fund plans and regular reports from states, territories, and Tribes that detail how they implement the Child Care Development Fund program, how they spend their allotment of funds, and the nature of services provided (e.g., children and families served, number and types of providers). Through review of these plans and reports, staff monitors the performance of grantees and work with grantees where problems arise. In addition, formal complaints are investigated as they are received, according to procedures set by the Child Care Development Fund regulations. The results of the corrective actions cannot be assessed until the improper payment measurement process is fully implemented for all states.

As stated above, missing documentation was a primary cause of errors in some states. However, the pilot project did not require states to separately report this information, therefore it was not tracked. This information will be reported and tracked in the future.

IV. The table below is required for each reporting agency. Agencies must include the following information: (1) all risk susceptible programs must be listed in this chart whether or not an error measurement is being reported; (2) where no measurement is provided, agency should indicate the date by which a measurement is expected; (3) if the Current Year (CY) is the baseline measurement year, indicate by either footnote or by "n/a" in the Prior Year (PY) column; (4) if any of the dollar amount(s) included in the estimate correspond to newly established measurement components in addition to previously established measurement components, separate the two amounts to the extent possible; (5) include outlay estimates for CY +1, +2, and +3; and (5) agencies are expected to report on CY activity, and if not feasible, then PY activity is acceptable.

Future year outlay estimates (CY+1, +2 and +3) should match the outlay estimates for those years as reported in the most recent President's Budget.

Note that over-and under-payments should be indicated if this information is available. The absolute value of the dollars and the rates should be shown – do not net the figures.

Also included is a statement of how the agency plans to reduce improper payments from the baseline rate over the next three fiscal years provided the agency has estimated a baseline improper payment rate for that program.

Improper Payment Reduction Outlook FY 2005 – FY 2009

Program	PY Outlays	PY IP %	PY IP$	CY Outlays	CY IP%	CY 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	234,100 Note (a)	5.2%	12,100 (11.2B over, .9B under)	246,800 Note (b)	4.4%	10,800 (9.8B over, 1.0B under	315,965 Note (c)	4.3%	13,586	324,224	4.2%	13,617	339,873	4.1%	13,935
Medicare MC	N/A	N/A	N/A	$55.365 Note (d)	N/A	N/A	71,987	N/A	N/A	79,821	N/A	N/A	90,650	N/A	N/A
Medicare Drug	N/A	N/A	N/A	$37,426 Note (e)	N/A	N/A	61,273	N/A	N/A	72,976	N/A	N/A	81,127	N/A	N/A
Medicaid	180,417 Note (f)	Note (1)	Note (1)	182,854	N/A	N/A	191,239	N/A	N/A	205,013	N/A	N/A	220,351	N/A	N/A
SCHIP	5,129 Note (g)	Note (2)	Note (2)	5,839	N/A	N/A	5,487	N/A	N/A	5,523	N/A	N/A	5,303	N/A	N/A
TANF	17,357	Note (3)	Note (3)	17,406	N/A	N/A	17,471	N/A	N/A	17,256	N/A	N/A	17,040	N/A	N/A
Head Start	6,842	1.6%	109	6,786	3.1%	210	6,786	1.4%	95	6,786	1.4%	95	6,786	1.4%	95
Foster Care	1,771	8.60% Note (4)	152	1,750	7.68% Note (5)	134	1,761	8.49%	150	1,760	7.57%	133	1,764	6.65%	117
Child Care	4,905	Note (6)	Note (6)	4,909	N/A	N/A	4,972	N/A	N/A	4,979	N/A	N/A	4,979	N/A	N/A

($ in millions)

Footnotes:
(a) PY Outlays for Medicare FFS are from the November 2005 Improper Medicare FFS Payments Report (based on CY 2004 claims).
(b) CY Outlays for Medicare FFS are from the November 2006 Improper Medicare FFS Payments Report (based on FY 2005 claims).
(c) Medicare FFS CY, CY+1, CY+2, CY+3 outlay numbers based on Mid-session review numbers.
(d) Medicare Advantage CY, CY+1, CY+2, CY+3 outlay numbers based on Mid-session review numbers.
(e) Medicare Prescription Drug Benefit CY, CY+1, CY+2, CY+3 outlay numbers based on Mid-session review numbers.
(f) Medicaid – PY and all CY Outlays based on FY 2007 Mid-session review numbers (Medicaid net outlays, excluding CDC program vaccine for children obligations)
(g) SCHIP – PY and all CY Outlays based on FY 2007 Mid-session review numbers (SCHIP total outlays)

NOTE:

(1) Payment error rates were determined by the States participating in the PERM pilot based on a sample size of 150 claims that were proportionally divided, based on expenditures, between the FFS component and the managed care component for those states that reviewed both components. The 150-claim sample was intended to test the methodology, not to produce State-level error rate estimates at a high level of precision. Although each State was able to calculate a State-level error rate, the findings of the PERM pilot show that the small sample sizes often resulted in very large confidence intervals, particularly among the FFS error rates. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe). Therefore, readers are cautioned that using these rates to draw conclusions about the program will not yield valid results. The following is a range of error rates for the Medicaid FFS and managed care components as reported by the States: (1) FFS - twenty-six States determined Medicaid FFS payment error rates from 0.14 percent to 28.41 percent; and (2) managed care - fifteen States determined Medicaid managed care payment error rates which ranged from 0.00 percent to 15.59 percent.

(2) Payment error rates were determined by the States participating in the PERM pilot based on a sample size of 150 claims that were proportionally divided, based on expenditures, between the FFS component and the managed care component for those states that reviewed both components. The 150-claim sample was intended to test the methodology, not to produce State-level error rate estimates at a high level of precision. Although each State was able to calculate a State-level error rate, the findings of the PERM pilot show that the small sample sizes often resulted in very large confidence intervals, particularly among the FFS error rates. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe). Therefore, readers are cautioned that using these rates to draw conclusions about the program will not yield valid results. The following is a range of error rates for the SCHIP FFS and managed care components as reported by the States: (1) FFS - twenty-six States determined SCHIP FFS payment error rates from 0.00 percent to 62.41percent; and (2) managed care - fifteen States determined SCHIP managed care payment error rates, which ranged from 0.00 percent to 40.37 percent.

(3) As previously noted, HHS is engaging in various activities to identify and reduce improper payments in the TANF program, but has not yet developed a standardized methodology. In FY 2006, three States volunteered to conduct expanded A-133 audits. The results of these audits were as follows:

	Case Error Rate	Payment Error Rate	Sample Size
State1	25.8%	5.2%	240
State 2	36.0%	24.6%	71
State 3	6.7%	2.32%	150

(4) The FY 2005 Foster Care error rate was not finalized prior to issuance of the FY 2005 Performance and Accountability Report, so a preliminary foster care error rate was reported. Upon completion of data collection and analysis, the preliminary error rate was revised accordingly. The FY 2005 Foster Care error rate was 8.6 percent.

(5) In order to produce a final error rate for publication in the FY 2006 Performance and Accountability Report, the Foster Care program has revised its reporting cycle. This composite error rate reflects the nine reviews that were completed between October 1, 2005 and July 31, 2006. Beginning in FY 2007, the reporting period will include a full 12 months, from August 1, 2006 through July 31, 2007.

(6) HHS has not yet developed a methodology for determining an estimate of improper payments for the Child Care program.

A. Medicare FFS—HHS plans to reduce improper payments through the continued efforts of the Medicare contractors responsible for FFS payments. HHS will work with the contractors to apply the data collected in the Comprehensive Error Rate Testing and Hospital Payment Monitoring Program programs to improve system edits, update coverage policies, direct provider education efforts, and guide fraud prevention. The corrective actions have allowed HHS to exceed its reduction targets for the past two years.

B. Medicare Advantage—Corrective action plans to reduce improper payments for identified risks will be developed and implemented once a baseline is established.

C. Medicare Prescription Drug Benefit—Corrective action plans to reduce improper payments for identified risks will be developed and implemented once a baseline is established.

D. Medicaid—Corrective action plans to reduce improper payments will be developed and implemented once a baseline is established.

E. State Children's Health Insurance Program—Corrective action plans to reduce improper payments will be developed and implemented once a baseline is established.

F. Temporary Assistance for Needy Families—Corrective action plans to reduce improper payments will be developed and implemented once a baseline is established.

G. Foster Care—HHS plans to reduce improper payments through implementation of its comprehensive corrective action plan, as outlined in section III. This comprehensive plan has allowed HHS to exceed its reduction targets for the past two years.

H. Head Start—HHS plans to reduce improper payments by emphasizing to grantees the need for ongoing monitoring of income eligibility determinations through training, protocol refinement, and software enhancements.

I. Child Care and Development Fund—Corrective action plans to reduce improper payments will be developed and implemented once a baseline is established.

V. Discuss your agency's recovery auditing effort, including a general description and evaluation of the steps taken to carry out a recovery auditing program; the total cost of the agency's recovery auditing program; the total amount of contracts subject to review, the actual amount of contracts reviewed, the amounts identified for recovery, and the amounts actually recovered in the current year; a corrective action plan to address the root causes of payment error; a general description and evaluation of any management improvement program carried out pursuant to the guidance outlined in Appendix C of OMB Circular A-123; a description and justification of the classes of contracts excluded from recovery auditing review by the agency head.

In July 2004, HHS awarded a contingency fee contract to a recovery auditing firm to review FY 2002 and FY 2003 contract payments. During FY 2006, HHS exercised an option under the contract for review of FY 2004 and FY 2005 contract payments. Planning for these reviews is underway and reviews are expected to be completed during FY 2007.

The result of the contractor's review of FY 2002 and FY 2003 contract payments is as follows:

Agency Component	Amount subject to Review for Reporting	Actual Amount Reviewed	Amounts Identified for Recovery	Amounts Recovered CY	Amounts Recovered PY(s)
HHS	$12.6 billion	$12.6 billion	$3.9 million[1]	$54,451	

[1] $1.3 million in payments identified were related to payments which had already been credited or voided.

As noted above, very in significant amounts of improper payments were identified (approximately .03% of FY 2002 and FY 2003 payments reviewed.) A corrective action plan was not prepared since no systemic causes were identified. HHS is taking action to recover payments identified for recovery.

VI. Describe the steps the agency has taken and plans to take (including timeline) to ensure that agency managers and accountable officers (including the agency head) are held accountable for reducing and recovering improper payments.

HHS has initiated a number of measures to ensure that agency managers and appropriate officers are held accountable for reducing and recovering improper payments. HHS' commitment to this initiative is illustrated through HHS' Top Twenty Department-Wide Objectives. One of HHS' top twenty objectives is to Eliminate Improper Payments. This objective demonstrates HHS' dedication to meeting the President's Management Agenda "green" standards for success.

This initiative is tracked quarterly by the Office of Management and Budget at the Department level using the President's Management Agenda scorecard. The Department's score reflects HHS' progress in achieving its improper payment goals. In addition, HHS issues interim scorecard ratings to each of the 11 HHS components during each quarter. These interim ratings help facilitate HHS leadership discussion and accountability as well as to help ensure that HHS will meet its quarterly goals. Further, HHS management performance plan objectives hold agency managers, beginning at the top of the leadership and cascading down through HHS Senior Executives (including component heads) and below, accountable for achieving progress in this initiative. As part of the semi-annual and annual performance evaluation, HHS Senior Executives are evaluated on the progress the agency achieves toward its stated goals.

VII. Describe whether the agency has the information systems and other infrastructure it needs to reduce improper payments to the levels the agency has targeted. If the agency does not have such systems and infrastructure, describe the resources the agency has requested in its most recent budget submission to Congress to obtain the necessary information systems and infrastructure.

A. Medicare Fee-For-Service—HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the levels that HHS has targeted. HHS has several systems that contain information that allows it to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with state and national rates. All the systems, both at the contractor level and at the central office level, are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. Transmissions are made nightly and include all claims processed during the preceding day.

B. Medicare Advantage—A methodology to estimate improper payments is in the initial stage of development.

C. Medicare Prescription Drug Benefit—A methodology to estimate improper payments is in the initial stage of development.

D. Medicaid—The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until implementation is complete and results are available.

E. State Children's Health Insurance Program—The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until full implementation is complete and results are available.

F. Temporary Assistance for Needy Families—HHS has not yet developed a standardized methodology for estimating payment errors in the TANF program. The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until a methodology has been developed, fully implemented, and results are available.

G. Foster Care—At this time, no additional information systems or infrastructure are needed to reduce improper Foster Care payments to the levels that HHS has targeted. HHS uses the Adoption and Foster Care Analysis and Reporting System for the regulatory reviews. Utilizing this existing source of data reduces the burden on states to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner.

H. Head Start—HHS has the information systems and infrastructure needed to reduce improper Head Start payments to the levels that HHS has targeted. HHS has two systems in place that identify grantees that are not complying with Head Start's income eligibility requirements. All review reports are processed centrally by the Office of Head Start as part of Head Start monitoring. Both systems allow HHS to identify grantees that fail to comply with income eligibility requirements.

I. Child Care and Development Fund—HHS has not yet developed a methodology for estimating payment errors in the Child Care program. The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until a methodology has been developed, fully implemented, and results are available.

VIII. A description of any statutory or regulatory barriers which may limit the agencies' corrective actions in reducing improper payments.

A. Medicare FFS—No statutory or regulatory barriers for limiting corrective actions have been identified.

B. Medicare Advantage—A methodology to estimate improper payments is in the initial stage of development.

C. Medicare Prescription Drug Benefit—A methodology to estimate improper payments is in the initial stage of development.

D. Medicaid—HHS has not fully implemented an error rate measurement program for Medicaid. States that have participated in the pilot project are implementing corrective actions on a state-by-state basis. Therefore, no program-wide statutory or regulatory barriers for limiting corrective actions have been identified.

E. State Children's Health Insurance Program—HHS has not fully implemented an error rate measurement program for SCHIP. States that have participated in the pilot project are implementing corrective actions on a state-by-state basis. Therefore, no program-wide statutory or regulatory barriers for limiting corrective actions have been identified.

F. Temporary Assistance for Needy Families—HHS has not yet developed a standard methodology for estimating payment errors in the TANF program. Therefore, no program wide statutory or regulatory barriers for limiting corrective actions have been identified.

G. Foster Care—Current program regulations define the corrective action plan. However, these regulations have not limited the states' corrective actions.

H. Head Start—No statutory or regulatory barriers for limiting corrective actions have been identified.

I. Child Care and Development Fund—HHS has not yet developed a methodology for estimating payment errors in the Child Care program. Therefore, no program wide statutory or regulatory barriers for limiting corrective action have been identified.

IX. Additional comments, if any, on overall agency efforts, specific programs, best practices, or common challenges identified, as a result of IPIA implementation.

HHS has been a leader in the area of monitoring and mitigating improper payments. In FY 1996, the HHS Office of Inspector General began estimating improper payments in the Medicare FFS program. In FY 2002, the Department took over the work and under a new error rate measurement methodology, the Hospital Payment Monitoring Program and Comprehensive Error Rate Testing programs, improved on the process and began obtaining more detailed management information. This new level of detail has been extremely valuable in identifying the causes for improper payments in the Medicare FFS program and for determining the corrective action needed to reduce the error rate. HHS reduced the reported Medicare paid claims error rate from 10.1 percent ($21.7 billion in gross payments) in FY 2004, to 5.2 percent ($12.1 billion in gross payments) in FY 2005, to 4.4 percent ($10.8 billion in gross payments) in FY 2006. The FY 2006 rate was lower than the target rate of 5.1 percent.

In the Foster Care program, HHS is reporting on the finalized error rate estimate from FY 2005. The FY 2005 error rate was 8.6 percent, well below the preliminary rate of 10.02 percent that was reported in HHS' FY 2005 Performance and Accountability Report and is reporting a final Foster Care rate of 7.68 percent for FY 2006, again the actual rate was lower than the target.

HHS has begun to implement the Medicaid Payment Error Rate Measurement program in FY 2006 using a national contractor to determine the Medicaid FFS payment error rate based on medical reviews and data processing errors. In FY 2007, HHS will fully implement the Payment Error Rate Measurement project by measuring error rates in its Medicaid and SCHIP programs. HHS will publish a Medicaid and SCHIP error rate in the FY 2008 Performance and Accountability Report.

Throughout FY 2006, HHS continued to engage in numerous activities to advance a TANF and Child Care improper payment methodology, despite the legal barriers to requesting information and/or requiring state participation in improper payment activities. Although it has been challenging to develop an improper payment measurement in these programs, HHS finalized a standard review methodology in the TANF program to be implemented by the Office of Inspector General in FY 2007. The Child Care program continues to make progress in developing a standard methodology and identifying strategies for implementation.

HHS has engaged in a Demonstration Project for Improving Program Integrity in Medicare. Under section 306 of the Medicare Prescription Drug Improvement Modernization Act of 2003, HHS was given the authority to conduct a demonstration project to demonstrate the use of recovery audit contractors in identifying improper payments and recouping overpayments for Medicare secondary payer and claim errors in the Medicare FFS program. HHS initiated this 3-year demonstration in March 2005 in the three states with the highest Medicare utilization rates. HHS provided the recovery audit contractors with $167 billion worth of claims submitted between FY 2002 and FY 2005 that are potentially subject to review. HHS is working on recovering $224 million in payments determined to be improper.

HHS' experience under the recovery audit contractors' demonstration program has proven to be successful in returning dollars to the Medicare Trust Fund and identifying monies that need to be returned to providers without unnecessarily burdening the provider community or the regular Medicare contractor workflow. Within 6 months of the end of the demonstration (March 2008), the Secretary is required to submit a report to Congress including information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

The successes that HHS has been able to achieve in its improper payment initiatives are due to a number of reasons, however two stand out. First, HHS leadership recognizes the importance of these initiatives in its overall stewardship responsibilities and has played an active role in ensuring the improper payment initiatives are appropriately prioritized and that related performance objectives are met. Second, HHS leadership recognizes the value that the HHS Office of Inspector General and the Office of Management and Budget can contribute to the HHS initiatives as it develops and implements strategies. HHS has ensured that the Office of Inspector General and the Office of Management and Budget are consulted appropriately as the work progresses. The commitment and involvement of HHS leadership has been instrumental to the progress HHS has been able to achieve in its improper payment initiatives.