SECTION IV:

APPENDICES




Section IV Contents

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APPENDIX A – FY 2005 TOP MANAGEMENT CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL

Management Issue 1: Implementation of the Medicare Modernization Act (MMA)

Management Challenge:

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108-173) sets forth the most comprehensive changes to the Medicare program since its inception in 1965. Implementation of this new statute is a huge undertaking involving massive amounts of dollars and new benefit programs.

As a result, the Department of Health and Human Services (HHS) has acquired numerous new responsibilities. These include developing and implementing new programs, issuing regulations, conducting a variety of studies through surveys and audits, preparing and submitting reports to Congress, and enforcing program rules. Numerous components within HHS, including the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Inspector General (OIG) have specific responsibilities set forth under the MMA. Thus, implementation of the MMA requires a high level of collaboration and coordination that extends across the Department to ensure these new programs and changes are implemented in such a way to guard against opportunities for waste, fraud, and abuse.

Prescription Drugs

Perhaps most significantly, the MMA established a new Medicare prescription drug benefit, known as Medicare Part D, which becomes available on January 1, 2006. The MMA also provides a voluntary and temporary Prescription Drug Discount Card program (drug card program) to be in effect until the Part D benefit becomes available.

While the Part D drug benefit will not become available until 2006, OIG has begun work related to oversight of this new benefit and the drug card program. For example, OIG evaluated beneficiary education issues under the drug card program for the purpose of maximizing similar efforts for the Part D benefit. In addition, OIG reviewed drug card prices and transitional assistance billings under the drug card program. OIG has also provided legal guidance for drug card sponsors related to the anti-kickback statute. In addition, OIG has begun work on the Part D benefit, including a review of the employer drug subsidy and, per CMS's request, reviews of the data systems being developed for Part D to ensure that the technological infrastructure will function properly when the benefit becomes effective. OIG also plans to review initial implementation steps at selected plans contracted by CMS to provide the Part D benefit, as well as controls in the systems and processes CMS intends to use to pay the plans.
Based on vulnerabilities identified by OIG, the Government Accountability Office (GAO), and through fraud investigations, the MMA also changed the basis of Medicare Part B drug reimbursement for most drugs to an average sales price (ASP). These changes require significant oversight. The MMA requires Part B drugs to be reimbursed at 106 percent of their ASP as reported to CMS by drug manufacturers. Pursuant to the MMA, OIG is required to monitor the widely available market prices for Part B drugs and subsequently compare these and other price points to reported ASPs. If the differences between the price points and ASPs for any drugs exceed a certain threshold, the MMA directs the Secretary to modify the reimbursement amounts for the drugs. The MMA also directs OIG to review the adequacy of this new ASP-based reimbursement rate for certain physician specialties. As part of its prudent oversight, OIG is also conducting audits of manufacturers' calculations of ASP.

Other Medicare Programs

In addition, the MMA sets forth numerous changes to other programs, including a revised managed care program (Medicare Advantage), certain payment reforms including durable medical equipment, rural

health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform. With respect to contractor reform, the Secretary has indicated in his statutorily required report to the Congress (February 7, 2005, "Medicare Contracting Reform: A Blueprint for a Better Medicare") that such reforms call for, and will include, modernization of Medicare information systems.

OIG has conducted previous work in many of these areas that identify potential challenges to consider for implementation of MMA changes. For example, OIG work played an important role in the price changes for durable medical equipment. OIG has also identified concerns regarding Medicare managed care, including unnecessary payments to plans, claims for excessive administrative costs, inadequate and inconsistent information provided to beneficiaries, and problematic data reporting. Likewise, OIG has previously identified numerous concerns with the administrative appeals process. The MMA transfers this function from the Social Security Administration to HHS and requires other changes to the appeals process. Implementation of all of these Medicare changes, particularly in light of previously identified vulnerabilities in these programs, warrants significant attention and oversight. Additionally, OIG has reviewed prior Medicare information systems initiatives and provided recommendations and suggestions, where warranted.

Assessment of Progress in Addressing the Challenge:
The Secretary has included MMA implementation in his 500-day plan, stating that he will concentrate on successfully implementing the MMA by "energizing broad participation, emphasizing preventative care, reaching out to those eligible for low-income subsidies and stimulating a competitive market."

To address the challenges in implementing the numerous responsibilities for HHS under the MMA, HHS has established MMA implementation teams and a tracking database. In addition, HHS components have set up various working groups to address MMA implementation issues. Components within HHS have already provided substantial assistance to one another with regard to implementation of the MMA and will continue to coordinate HHS-wide to ensure that the Department has fulfilled its responsibilities.

An example of such coordination and cooperation are the recent MMA training conferences developed by OIG, which utilize the combined expertise of OIG, CMS, FDA, the Department of Justice, the Department of Labor, and the Social Security Administration. These conferences have focused on the careful implementation of the Part D benefit program so as to protect Medicare beneficiaries and the new benefit.

CMS bears the primary responsibility for implementing the new MMA-mandated Medicare programs and reforms and has made important progress toward that end. Most notably, CMS has implemented the drug card program and has promulgated regulations relating to the Part D prescription drug benefit, Medicare Advantage plans, and the reporting and calculation of ASPs. Likewise, CMS has begun the contractor reform process by initiating procurements to competitively replace durable medical equipment carriers and consolidate the existing 15 Medicare Data Centers.

Implementation of all provisions of this law requires continued diligence, scrutiny, and oversight. Based on OIG's historical experience in auditing, evaluating, and investigating payment for, or practices relating to, prescription drugs under HHS programs (i.e., Medicare, Medicaid, 340B Drug Pricing Program), these areas warrant particular attention. Given the magnitude of potential expenditures, tight implementation deadlines, reliance on numerous contractors, program complexity, and impact of these programs on beneficiaries, it is critical that the new Part D drug benefit and Part B drug reimbursement methodology are implemented efficiently and effectively and that HHS oversight of these programs is vigilant.

HHS Management Response:

In FY 2005, CMS issued final rules (January 28, 2005) to establish the Medicare Prescription Drug Benefit and the Medicare Advantage (MA) Program. Under the Medicare Prescription Drug Benefit, every

Medicare beneficiary will be able to choose from a range of Prescription Drug Plans (PDP). Title I rules specify the requirements for Prescription Drug Plans and how payments for drugs will be made.

The CMS completed the contracting process with PDPs and is on schedule to timely implement the program on January 1, 2006. The contracting process included an extensive review and approval of PDP formulary, benefit, and bid submissions. To provide industry and other stakeholders with information, CMS published numerous guidance documents (formulary review guidelines, marketing guidelines, prescription drug event data, reporting requirements, etc.) and held weekly teleconferences with PDPs to discuss time sensitive issues and to provide live technical assistance. Because of these efforts, Medicare beneficiaries all over the country will be able to choose prescription drug coverage that will cost less than originally expected, including plans with premiums of $20 per month or less. Options will also include plans offering zero deductibles or deductibles lower than $250 annually, and plans that provide some coverage in addition to the "standard" Medicare drug benefit. The CMS is validating a Part D data monitoring system that will provide us with an extensive analytical tool to monitor for fraud, abuse, and waste.

The MA Program addressed in Title II revises the Medicare Managed Care Program, based on provisions in the MMA. Most significantly, the final Title II rule replaced the adjusted community rate system with a bid submission process. As the law specifies, CMS required MA organizations to submit bids no later than the first Monday in June (June 6, 2005) for each MA plan they intend to offer in the following year, beginning with contract year 2006. The CMS issued both an advance notice of Methodological Changes for Calendar Year 2006 for MA Payment Rates and Payment Methodology for the new Part D program, as well as announcing the calendar year (CY) 2006 MA Payment Rates earlier this year.

The CMS also issued a call letter to the MA plans in April 2005 addressing a number of topics in the final rules to establish the MA program. Beyond the bidding and payment process, the call letter touched upon areas related to the new MA plans such as the Special Needs Plans and related areas of payment and enrollment.

In FY 2006, CMS will focus its efforts on continuing implementation of payment and enrollment operations and the information systems supporting those operations. Changes to enrollment operations include changes to election period provisions, addition of new plan types and the possibility of concurrent enrollments in certain types of MA plans and stand-alone PDPs. Changes to payment operations include introduction of Part D payments to PDPs and MA-PDs (a hybrid type that provides both Part C and Part D benefits). Beyond Part D, payment operations need to be adapted to accommodate the new bid-based payment rates in 2006. Other provisions include the new Low Income Subsidy (for premiums and cost sharing) and a beneficiary election to have premiums withheld by SSA.

The CMS continues to conduct weekly meetings across the Agency to ensure an effective implementation of the information systems. This includes staff articulating and testing business requirements. Moreover, staff meet routinely via conference calls with various plans regarding system requirements and implementation. Additionally, CMS has looked closely at its past experience with the drug card program to mitigate any potential problems that could arise for Part D. Finally, CMS continues to analyze program data as a method for focusing resources as appropriate.

The CMS has worked to effectively develop and implement an oversight program for Part D to ensure compliance with the new MMA regulations and guidelines. The CMS is in the process of implementing an oversight program for regional Preferred Provider Organizations and Special Needs Plans based on the new requirements within MMA. To provide consistency and guidance to the industry, CMS developed and conducted training programs specifically to address compliance and oversight.

The MMA requires Part B drugs to be reimbursed at 106 percent of their average sales price (ASP) as reported to CMS by drug manufacturers. The CMS implemented the new ASP payment methodology on January 1, 2005. The CMS is now in the fourth quarter of paying under this methodology and prices generally have been stable. The CMS continues to work with manufacturers to ensure quality of

reporting of data. The new Part B reimbursement methodology is bringing significant savings to the program and to beneficiaries. In addition, CMS has published two rules to implement the competitive acquisition program (CAP) and is scheduled to implement this program by July 2006. The CAP will provide physicians with an option on how to acquire drugs they use in their practices. The CMS continues to work with the OIG on several tasks that are critical for ensuring the success of the ASP methodology.

Rural Health Care Improvements

Provider Outreach – The CMS has developed a number of educational products specifically targeted to rural health providers. The CMS' most recent "rural health products" include (1) a series of fact sheets for rural health providers including sole community hospitals, Federally Qualified health centers, rural health clinics, and critical access hospitals; and (2) a comprehensive Rural Health Guide, which provides coverage and billing information for rural health providers as well as additional resources to help them navigate the Medicare Program. The CMS aggressively markets its educational materials through national associations and its Medicare fee-for-service contractors, who also conduct training on these issues.

Medicare Contractor Reform

The CMS is actively engaged in the implementation of the Medicare contracting reform provisions of the MMA. In April 2005, CMS released the first Medicare Administrative Contractor (MAC) Request for Proposals (RFP) for Durable Medical Equipment claims processing pursuant to the MMA. In October 2005, CMS released the second MAC RFP for a combined Part A and Part B MAC in Jurisdiction 3. Additionally, a small group within CMS has been charged with integrating the many changes occurring within CMS and its contractor community as a result of procuring MACs. This team reviews project plans, funding and timing issues to recommend best strategies for completion of the many contracting reform projects.

Management Issue 2: Accountability of Medicaid Funds

Management Challenge:

The Federal share of Medicaid outlays in fiscal year (FY) 2004 exceeded $176 billion and is expected to exceed $192 billion in FY 2006. Because Medicaid is a matching program, improper payments by states always cause corresponding improper Federal payments. However, because the Federal Government does not routinely examine individual provider claims, inappropriate claims by states for a Federal share are not always easily identified.

Payment Error Rates

Payment accuracy in the Medicaid program helps ensure fairness across all state Medicaid programs and is critical to maximizing Federal and state health care dollars. Until recently, little was known about payment error rates in the Medicaid program. This lack of information represents a substantial vulnerability in preventing fraud, waste, and abuse perpetrated by health care providers. Understanding errors is particularly difficult due to the diversity of state programs and their unique administrative and control systems.

State Financing Mechanisms

In addition to payment accuracy, OIG has found significant problems in state Medicaid financing arrangements involving the use of intergovernmental transfers. Specifically, OIG found that some states inappropriately inflated the Federal share of Medicaid by billions of dollars by requiring public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments are returned, funds cannot be tracked, and they may be used for purposes unrelated to

Medicaid. Although this abusive practice could potentially occur with any type of Medicaid payment to public facilities and is not legally prohibited, OIG identified serious problems with this practice in Medicaid supplemental payments available under upper payment limits, disproportionate share hospital payments, and payments for school-based services. These Federal/State payments are made to public providers who then return the monies to the states through intergovernmental transfers. This practice shifts the cost of Medicaid to the Federal Government, contrary to Federal and state cost–sharing principles.

Assessment of Progress in Addressing the Challenge:

Payment Error Rates

In July 2001, CMS invited states to participate in a demonstration project to develop a payment accuracy measurement (PAM) methodology for Medicaid, i.e., a single methodology that can produce both state-specific and national level payment error estimates for Medicaid and the State Children's Health Insurance Program. The PAM model was later modified to comply with the new requirements of the Improper Payments Information Act of 2002 (IPIA) (Public Law 107-306). FY 2004 was the final year for reporting the results of the PAM pilots.

The PAM project will be renamed the Payment Error Rate Measurement (PERM) program, which will be submitted for clearance as a final interim rule. In late FY 2005, CMS will begin competing and awarding contracts using a national contracting strategy to produce a Medicaid fee-for-service error rate. The FY 2005 Performance and Accountability Report (PAR) will include the results from year three of the PAM pilots (FY 2004). For FY 2006, CMS will report the results of the PERM pilot in the PAR. The FY 2007 PAR will include a national Medicaid fee-for- service error rate for FY 2006 based on a statistically valid sample of states and claims within those states. CMS expects to be fully compliant with the IPIA requirements by FY 2008.

OIG is planning to include reviews to oversee the Medicaid error rate process. In addition, the current OIG work plan includes various reviews to identify payment error vulnerabilities in the Medicaid managed care program.

State Financing Mechanisms

To curb abuses in state Medicaid financing arrangements, CMS issued Final Rules (effective March 13, 2001, November 5, 2001, and May 14, 2002) which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory actions created three aggregate upper payment limits, one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. CMS projects that these revisions combined will save $79.3 billion in Federal Medicaid funds over the 10-year period 2002-2011.

However, when fully implemented, these regulatory changes will only limit, not eliminate, the amount of state financial manipulation of the Medicaid program because the regulations do not require that the targeted facilities retain the enhanced funds to provide medical services to Medicaid beneficiaries.

The CMS has been working with states to halt the inappropriate use of intergovernmental transfers that artificially inflate the Federal share of the Medicaid program. CMS identified 33 states that were using inappropriate intergovernmental transfers. According to CMS, 26 of the 33 states have halted the practice.

OIG believes that CMS should continue to work to ensure that all states eliminate the use of inappropriate intergovernmental transfers involving supplemental payments available under the upper payment limits, disproportionate share hospital payments, payments for school-based services, or any other type of Medicaid payment to a public provider. OIG believes that CMS should take actions to permanently eliminate, by law or regulation, the inappropriate use of inappropriate financing

mechanisms. This change would be in addition to the regulatory changes cited above and would help to ensure that Medicaid funds are used to provide services to Medicaid beneficiaries.

HHS Management Response:

On October 5, 2005, an interim final rule was published in the Federal Register which indicated that CMS will measure Medicaid and SCHIP fee-for-service error rates and is committed to developing an approach to measure the Medicaid and SCHIP managed care and eligibility error rates. The CMS expects to be fully compliant with IPIA by FY 2008.

This interim final rule addresses some of the states' concerns with cost and burden since the Federal government will conduct and fund the medical and data processing components of the project. In the interim final rule, CMS stated the principles that: (1) the methodology used to select the states will ensure that each state is selected at least every three years but that no state is sampled more than once every three years; and, (2) the error rates produced by this selection methodology will provide the state with a state-specific error rate estimated to be within 3 percent precision at the 95 percent confidence level. In FY 2006, states will be randomly selected.

The CMS has established an eligibility workgroup to make recommendations on the best approach to conduct Medicaid and SCHIP eligibility reviews. The plan is to have recommendations from the workgroup in FY 2006 so that eligibility reviews can commence in FY 2007 for error rate reporting in the FY 2008 Performance and Accountability Report.

State Financing Mechanisms

Since August 2003, CMS has been requesting detail information from states regarding how states are financing their share of the Medicaid program costs under the Medicaid reimbursement SPA review process. During this SPA review process, CMS had identified questionable practices where some states are utilizing financing techniques that do not comport with the spirit of the Federal-state partnership. Specifically, CMS has discovered that several states make claims for Federal matching funds associated with certain Medicaid payments which the health care providers ultimately are not allowed to retain. The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (a payment for which Federal funding was made available based on the full payment), and the state and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or to help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the Federal Government bears a greater level of Medicaid program costs, which is inconsistent with the Federal medical assistance percentages specified in the Medicaid statute.

The CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the spirit of the Federal-state partnership. In addition, follow-up audits are conducted for any questionable financing practice that is discovered as part of the Medicaid reimbursement SPA review.

The CMS is working with states to terminate such practices, which many states have agreed to stop as of the end of their 2005 state fiscal year. As of September 30, 2005, 26 states have terminated 62 such financing practices effective with the end of their state fiscal year 2005.

Because of these efforts, CMS has noticed a decreasing desire on the part of states to make supplemental payments up to their upper payment limit (UPL). It appears that requiring states to pay their share of the supplemental payments and requiring that qualifying providers retain 100 percent of the payment has effectively decreased the interest/trend to maximize the UPL. Moreover, while some states have revised financing mechanisms to continue making supplemental payments, other states have dropped their supplemental payments altogether.

Management Issue 3: Integrity of Medicare Payments

Management Challenge:

The Medicare program's size and complexity place it at high risk for payment errors. In FY 2004, the Medicare benefit payments totaled about $300 billion, which represents payments for health care services provided to approximately 42 million Medicare beneficiaries. To help ensure that beneficiaries have continued access to appropriate and high-quality Medicare services, as well as to protect the financial integrity of the program and the solvency of the Trust Funds, continuing efforts must be made so that correct and appropriate payments are made for properly rendered services.

From FY 1996 through FY 2002, OIG developed and reported on the annual Medicare fee-for-service paid claims error rate. In FY 2003, CMS assumed responsibility for the error rate development. In its 2004 financial report, CMS reported a gross paid claims error rate of 10.1 percent ($21.7 billion) and a net paid claims error rate of 9.3 percent ($19.8 billion) for the FY.[1]

Targeted audits and evaluations by OIG and CMS continue to identify improper payments and problem areas in specific parts of the program. These reviews have revealed payments for unallowable services, improper coding, excessive payments, and other types of improper payments. For example, to date OIG found over $149 million in improper payments in CYs 1999 and 2000 for equipment and supplies separately billed by suppliers for beneficiaries residing in skilled nursing facilities. OIG and CMS discovered substantial abuses of medical equipment suppliers billing Medicare for power wheelchairs that were never delivered, equipment that was medically unnecessary, and billing for high-cost equipment when lesser-cost equipment was provided. Similarly, OIG found that some providers had manipulated the Medicare rules for outlier payments, receiving a disproportionate share of these payments because of dramatic increases in billed charges.

OIG audits continue to show that Medicare has serious internal control weaknesses in its financial systems and processes for producing financial statements. For example, the reporting mechanism that Medicare contractors use to reconcile and report funds expended depends heavily on inefficient, labor-intensive, manual processes subject to the increased risk of submitting inconsistent, incomplete, or inaccurate information to CMS. These serious internal control weaknesses persist.

Assessment of Progress in Addressing the Challenge:

The FY 2004 gross paid claims error rate of 10.1 percent was 3.7 percentage points lower than the 13.8 percent reported in FY 1996 but higher than the 6.3 percent in 2001. The CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, CMS has worked with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documented services, and the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly.

The CMS has taken a number of steps to strengthen Medicare coverage and reimbursement requirements to help curb inappropriate payments. For example, CMS has agreed to establish or enhance billing controls to ensure compliance with the consolidated billing provision, identify "best practices" in both consolidated billing and postacute care transfers, and aggressively scrutinize new applications for durable medical equipment supplier numbers.

The CMS received an unqualified opinion on its 2004 financial statements. However, the lack of a fully integrated financial management system and insufficient oversight of the Medicare contractors continued to impair the reporting of accurate financial information. Weaknesses were identified in general and in application controls at Medicare contractors, at data centers where Medicare claims are processed, at sites that maintain the "shared" application system software used in claims processing,

[1] CMS's performance target for FY 2005 is 7.9 percent and 6.9 percent for FY 2006.

and at the CMS central office. In addition, although there were improvements in CMS's oversight of Medicare contractors, continuing weaknesses affected its ability to analyze and accurately report financial information on a timely basis.

To address these problems, CMS has initiated steps to implement the Healthcare Integrated General Ledger Accounting System, expected to be fully operational at the end of FY 2009. In the interim, corrective action is needed to address persistent weaknesses in internal controls throughout the Medicare system.

HHS Management Response:

Improving the integrity of Medicare payments is a top management priority at CMS and significant progress has been made during FY 2005. The Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Measurement Program (HPMP) programs provide CMS with a rigorous set of data that is used to manage Medicare contractors, identify errors, educate Medicare billing providers, and prevent future errors from occurring. The CMS focused attention on these activities during the last year resulted in a dramatic reduction in payment errors by more than 50 percent based on last year's error rate. The CMS analysis for FY 2005 indicated that the paid claims gross error rate was 5.2 percent or $12.1 billion in gross improper payments.

The CMS also increased efficiencies in financial management by implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS) at four Medicare contractor sites. The CMS continues to make progress toward the full implementation of HIGLAS, which is a key element of the agency's strategic vision to implement a complete, financial management system that integrates CMS accounting systems with those of its Medicare contractors

Management Issue 4: Payment for Medicaid Prescription Drugs

Management Challenge:

OIG and GAO have consistently found that the Medicaid program pays too much for prescription drugs compared to prices available in the marketplace. The CMS estimates that Medicaid expenditures for prescription drugs in CY 2004 totaled more than $30 billion, a substantial increase over the $9 billion spent in CY 1994. Both states and the Federal Government share in these expenditures.

Under Federal law, states have substantial discretion in setting reimbursement rates for drugs covered under Medicaid. In general, Federal regulations require that each state's reimbursement for a drug not exceed the lower of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual and customary charge for the drug. In addition, CMS sets Federal upper limits and many states implement maximum allowable costs for certain multiple source (generic) drugs that meet specific criteria.

While states must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries, they often lack access to pharmacies' actual market prices. Due to this lack of pricing data, states rely on estimates to determine Medicaid reimbursement. Most states base their calculation of estimated acquisition costs on published Average Wholesale Prices (AWPs). AWPs are not defined by law or regulation and are compiled in drug compendia such as Medical Economics' "Red Book" and First Databank's "Blue Book." OIG reports have demonstrated that the published AWPs states use to determine their Medicaid drug reimbursement amounts generally bear little resemblance to the prices incurred by retail pharmacies.

In June 2005, OIG released three additional reports indicating that published prices used by Medicaid to calculate prescription drug reimbursement amounts do not approximate pharmacy acquisition costs. One report addresses how prices for drugs set under the Medicaid Federal Upper Limit (FUL) program

compare to reported Average Manufacturer Prices (AMP) and estimates potential savings if FUL amounts were based on reported AMPs. The other two reports compare how the prices that most states currently use to set Medicaid reimbursement, i.e., AWP and wholesale acquisition cost (WAC), compare to statutorily defined prices based on actual sales transactions, such as ASP and AMP.

These three OIG reports provide additional supportive evidence that the current Medicaid payment rules result in excessive payments for prescription drugs and emphasize the need for reform that could significantly impact Medicaid expenditures. Furthermore, OIG recommends that CMS work with Congress to restructure Medicaid pharmacy payments so that drug prices more accurately reflect actual costs.

In addition to paying too much up front for Medicaid prescription drugs, state Medicaid programs may not be receiving the proper amount of drug rebates that they are entitled to receive. The statutory drug rebate program, which became effective in January 1991, allows Medicaid to receive pricing benefits commensurate with its position as a high-volume purchaser of prescription drugs. Medicaid requires that rebates be based on AMPs, which are values developed by drug manufacturers. Both OIG and GAO reviews have shown that manufacturers make inconsistent interpretations as to what sales are included in AMPs. OIG suggests that additional clarification of the definition of AMP be provided by CMS.

Assessment of Progress in Addressing the Challenge:

Previous work by OIG, GAO, and others revealed that states have wide latitude in setting their Medicaid prescription reimbursement amounts and that, in general, the Medicaid program pays too much for prescription drugs. Until the passage of the MMA in 2003, Medicare Part B also used AWP as the basis for most drug reimbursements. Based upon provisions in the MMA, Medicare Part B now generally uses ASP, a statutorily defined price based on actual sales transactions, to help lower excessive Medicare prescription payment levels. However, the MMA did not address the AWP vulnerabilities in Medicaid prescription drug reimbursement. Thus, most state Medicaid programs continue to reimburse for pharmaceuticals based on the same inflated AWPs that once plagued Medicare.

A major responsibility of Federal and state governments is to ensure that Medicaid reimbursement for prescription drugs is paid correctly and accurately. Drug reimbursement should reliably reflect the actual costs of drugs to pharmacies and be based on pricing data that can be validated. It is also essential that all manufacturers report consistent and accurate information for the rebate process to work as intended. Therefore, CMS needs to be especially attentive in its oversight of Medicaid drug rebates and payment for prescription drugs.

HHS Management Response:

The CMS has shared the findings of the numerous reports on pharmacy acquisition costs with the states and has encouraged states to review their estimates of acquisition cost in light of the respective findings. Additionally, CMS continuously monitors states' estimated acquisition costs and provides a quarterly update which is listed on the CMS website. These actions have resulted in states submitting an increased number of state plan amendments to lower the states estimate of acquisition costs.

In regard to initiating a review of Medicaid rebates, the President's 2006 budget proposes the use of average sales prices (ASP) so Medicaid drug prices will reflect actual costs. In the FY 2006 budget, the President proposed to require drug manufacturers to report the ASP for each drug and to cap Federal payment at an aggregate level to ASP plus 6 percents. As long as state relies on prices that are not based on true prices paid to manufacturers, states have no means to set appropriate payment amounts. Current wholesale acquisition cost and average wholesale price (AWP) cost are greatly inflated and this inflation is encouraged by setting Medicaid payment in relation to these inflated prices. Requiring manufacturers to report true prices and to limit Medicaid payment to a reasonable amount above these prices will eliminate the opportunity for manufacturers and pharmacies to gain through report of inflated prices,

yield substantial state and Federal government savings, and retain flexibility for states to set prices for individual drugs as they find appropriate within the overall cap.

The OIG and GAO concluded that there is a variation in the methods that manufacturer use to determine the Medicaid AMP. The CMS continues to believe that the drug rebate law and rebate agreement already established a methodology for computing AMP. The CMS continuously re-examines current policy to assure that it is clear that manufacturers have not appropriately excluded prices from AMP, as required by section 1927 of the Act. The CMS also issues manufacturer releases to clarify policy when an area is identified where manufacturers did not follow the current policy. Also, CMS continues to work with OIG to provide policy guidance to them to conduct audits of manufacturers' calculations of AMP.

Management Issue 5: Quality of Care in Long-Term Care Services

Management Challenge:

With the large number of people approaching retirement, ensuring quality of care on behalf of long term care beneficiaries warrants significant attention so that Federal dollars can be well spent purchasing appropriate care. This new generation of consumers will demand much more from their long term care service, not only in terms of quality, but also in the venue of care delivery. While there will always be a need for nursing homes services, the expectation is that care will continue to shift to more community-based services, encompassing the beneficiaries' homes or other social settings. This shift may increase utilization of alternatives to institution-based care, such as home health and hospice services, more than any other time in the past. Thus, it is imperative that HHS continues to monitor quality of care for long term care beneficiaries in all settings.

OIG has raised longstanding concerns regarding payment and quality issues in nursing facilities. Prior OIG work found an increase in the number of deficiencies, and a large number of nursing homes had been cited for substandard care. States are required to refer case information to CMS for enforcement action when facilities are found to be out of compliance for designated time periods or have deficiencies that are considered to put residents in immediate jeopardy. Enforcement actions are mandatory to address particularly egregious cases of noncompliance. These enforcement actions can include termination of the facility's Medicare contract and denial of payment for new admissions. OIG continues to be concerned that enforcement mechanisms may not be working in a sufficiently effective manner to bring nursing homes with serious deficiencies back to compliance nor to effectively prevent nursing homes with egregious practices from continuing to provide substandard care to Medicare beneficiaries.

OIG work has found evidence that CMS and states are not using enforcement mechanisms. In one study, OIG found that states appropriately referred 92 percent of nursing home cases that warranted enforcement; but 8 percent of the cases were either not referred or were referred but the referral was not recognized as such by the CMS regional office. Another OIG report found that facility terminations did not occur as required in 55 percent of cases cited in 2000-2002, due to both late case referral by states and CMS's staff reluctance to impose this severe remedy. Additionally, CMS did not apply mandatory denial of payment remedies as required in 44 percent of cases in 2002, also primarily due to late referrals. These errors allowed facilities the opportunity to receive payment from Federal programs while out of compliance with resident care standards. Finally, OIG's report on collection of civil monetary penalties (CMPs) found that, as of March 2004, CMS did not fully collect 4 percent of the CMPs imposed in 2002 and collected another 8 percent well after their due dates. Responsibilities with CMS for CMP collections are neither clearly defined nor commonly agreed upon. OIG also found that the databases used for tracking CMP collections contained inaccurate and incomplete information, causing collection errors.

OIG also continues to find vulnerabilities in other programs that are intended to ensure quality of care and protect residents of nursing homes. For instance, in a report examining nurse aide registries, OIG found that most facilities check only their state nurse aide registry but not those in other states. This incomplete

compliance indicates that the facilities that are not checking other states' registries may be jeopardizing the safety of their residents.

OIG is also concerned about whether payments to nursing homes are correct and whether the funds are being used for patient care-related activities. It is now examining the adequacy of Medicaid payments to nursing facilities in states that have enhanced payment programs for public nursing facilities. As part of these studies, OIG is determining whether Medicaid reimbursements to states for nursing home care are being diverted from the nursing homes to other state programs. For instance, OIG examined nursing homes from each of three states, New York, Tennessee, and Washington, and found that these nursing homes were required by their state or county to return 90, 96, and 94 percent, respectively, of their enhanced funding. These nursing homes had received the most unfavorable ratings the states can issue. These homes might have provided better quality of care if they had been able to retain all the funding they initially received.

Some nursing home care problems are so serious that they constitute "failure of care" and thereby implicate the civil False Claims Act. OIG continues to work with U.S. Attorneys' Offices and the Department of Justice on development and settlement of these egregious cases. It develops exclusion actions against individuals and entities whose conduct cause the furnishing of poor care, with particular emphasis on higher-level officials of nursing facilities and chains. OIG continues to negotiate quality of care Corporate Integrity Agreements (CIA) as part of the settlement of such False Claims Act cases. All of these CIAs require an outside monitor and include effective enforcement remedies for breach of the CIA, such as specific performance, stipulated penalties, and exclusion. Currently there are 10 active quality of care CIAs that cover approximately 1,000 nursing facilities. Additionally, OIG ensures that long term care providers are implementing quality of care CIAs appropriately. OIG continues to fine tune provisions of the quality of care CIAs and to develop uniform guidelines and practices for quality monitors and means of measuring success of existing CIAs.

OIG continues to have concerns about the quality of care residents of nursing facilities receive and also about the adequacy of oversight in other long term care services such as home health and hospice. OIG has thus extended its oversight of long term care services and is currently determining the adequacy of quality of care oversight in hospices, as well as examining the access to and quality of care provided by home health agencies.

Assessment of Progress in Addressing the Challenge:

The CMS has chartered a Civil Monetary Penalty Quality Improvement Project based on its recognition that collection of CMPs needed improvement. The workgroup is tasked with developing guidelines that establish revised policies and procedures for collection of CMPs, as well as clarify roles and responsibilities. The CMS has also made changes to the "State Operations Manual," which clarify and enhance guidance about making double G determinations (reflective of substandard care with a scope and severity of actual harm or immediate jeopardy to residents) during the survey process involving nursing homes. CMS has implemented two data systems to manage survey and enforcement actions and complaint and incident-related activities. Increased dependence on these systems to manage and track survey, enforcement, and complaint actions, as well as increased national reporting capabilities of the two systems, is dependent upon timely and complete data entry.

CMS also issued a survey and certification letter to all states affirming the law and CMS policy that nursing homes employ qualified nurse aides who are properly trained, appropriately tested, and have no adverse findings of abuse, neglect or misappropriation of property against them. The guidance included instructions asking states to assess their compliance with the nurse aide registry requirements. CMS will analyze this information and plans follow-up activities to support improvements to this area. CMS has also initiated activities to conduct a Background Check Pilot Program, which requires that facilities and providers search any available registries that would likely contain disqualifying information about the prospective employee, as well as conducting a search of state and national criminal history records.

HHS Management Response:

The CMS has engaged several approaches to improve and refine the number of survey and certification actions, protocols, survey tools, and state agency guidance/instruction. The OIG has touched on a number of concerns ranging from enforcement actions, civil money penalty collection and nurse aide registries.

In October 2004, CMS implemented, in all states, a new, electronic, automated enforcement manager (AEM) for all types of enforcement actions in nursing homes. The AEM data system will assist CMS and states in timely referral and imposition of mandatory enforcement actions and terminations and will help CMS monitor the timeliness of data entry into the system. The CMS continues to make investments in this critical program infrastructure. In addition, CMS has clarified the referral process and implemented a system fix that provides assurance that referrals are not missed. To address the issue of timely entry of enforcement data into the data system, CMS released guidance to states and regional offices on May 12, 2005. The CMS will finalize the timeframes once they have been in place for a period of time sufficient for us to evaluate their reasonableness and value. The CMS revised the state Operations Manual to clarify and enhance guidance about making double "G" determinations. This additional guidance, which was issued on May 21, 2004, is detailed and comprehensive. The CMS is reevaluating the effectiveness of the double "G" policy, while it is simultaneously redoubling efforts to make it work.

The CMS chartered the CMP Quality Improvement Project team, based on its own recognition that the tracking, collection and data system for CMPs needed improvement. As part of that effort, CMS (1) drafted policies and procedures to track and collect CMPs through the Civil Monetary Penalty Quality Improvement Project, (2) clarified the roles and responsibilities among internal components, and (3) mapped out a streamlined CMP collection process, including how to handle past due CMPs. However, implementation has been delayed as a result of several CMS cross-cutting, resource-intensive initiatives such as the Medicare Modernization Act. In particular the needed changes to the data tracking system have been put on hold until these other priorities have been satisfied and needed resources to make changes are available. In addition, CMS established regional office /State workgroup to develop a national CMP grid to provide written guidance on appropriate dollar ranges for individual ratings of scope and severity.

To address issues surrounding nurse aide registries, CMS:

- Issued uniform definitions through a survey and certification policy letter so that all states could use the same definitions in classifying behavior that constitutes abuse, neglect, or misappropriation of resident property.
- Developed and disseminated the "Abuse and Neglect Detection and Prevention Training Manual" to provide surveyors and other reviewers with an additional resource to support their work in detecting and preventing abuse and neglect.
- Issued a policy letter to states affirming the law and CMS policy, as well as the importance of nurse aide registries. The guidance included instructions that (1) all findings of abuse, neglect and misappropriation of resident property must be included in the nurse aide registry within 10 working days of the finding, (2) the names of nurse aides who have performed no nursing or nursing-related services for 24 consecutive months must be promptly removed from the nurse aide registry.
- Conducted a self-assessment survey regarding nurse aide registries.
- Issued a survey and certification letter on nursing home compliance with the requirements related to preventing abuse. The CMS will continue to monitor its responsibilities related to nurse aide registries.

Posted on Sharing Innovations in Quality a compilation of all State Nurse Aide Registry contact information. See http://www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp.

Management Issue 6: Grants Management

Management Challenge:

Departmental grants, totaling over $257.9 billion in FY 2005 ($38.5 billion discretionary and $219.4 billion mandatory), must be used appropriately to maximize their intended purposes.[2] Many HHS agencies rely on grants and cooperative agreements to meet mission objectives, such as providing critical health and social services to underserved individuals, researching the causes and treatments of diseases, elevating the social and economic status of vulnerable populations, and supporting the nationwide infrastructure for the health surveillance and prevention network. As such, it is paramount that HHS award these funds to the most qualified and competent organizations, while at the same time adequately monitoring program performance and results and ensuring grantees' appropriate use of Federal funds.

To help address this challenge, OIG has initiated a two-part grant management review plan. OIG is studying HHS agencies' grantmaking and oversight processes to identify vulnerabilities and to assess criteria and procedures for determining grantee risk and program performance. . OIG is also conducting reviews to assess individual grantees' program activities and stewardship of funds.

Discretionary Grants

In a review of the HIV/AIDS prevention grant-making process operated by the Centers for Disease Control and Prevention (CDC), OIG determined that improvements were needed in the agency's operating process. . OIG identified numerous deficiencies throughout the preaward, award, and postaward phases of CDC's grants management operations and concluded that CDC could not be assured that its grants management operations provided appropriate direction and oversight for the activities of grantees under the HIV/AIDS prevention program.

OIG has initiated two related reviews examining the adherence by the Health Resources and Services Administration (HRSA) and CDC with Departmental policies governing placement on and use of the Departmental Alert List. The Alert List contains the names of high-risk grantees and is used as a grants management tool by the Department to ensure that high-risk grantees are known to the various grant-making agencies within the Department and to help safeguard the Department's funds. . In a review of HHS agency compliance with the Department's malpractice reporting requirement of such information in the National Practitioner Data Bank (NPDB), OIG found that the Department under-reported as many as 474 cases to the NPDB. OIG recommended that each Departmental agency required to report take steps to: 1) implement a corrective action process to address the under-reported cases; 2) improve internal controls involving case files management; and 3) assign staff to assume responsibility for addressing practitioner questions/complaints and data entry of reports to the NPDB.

At the grantee level, reviews of HRSA Ryan White HIV/AIDS service providers indicated that overall the intended services were being provided, but certain aspects of grantee or subrecipient operations, such as service delivery and fiscal management, could be improved. For example, a provider of emergency housing served some clients beyond the time period established in agency guidelines, while other potential clients were on waiting lists. OIG also identified a number of providers who claimed costs at budgeted levels, rather than based on actual costs, as required by Federal cost principles. At National Institutes of Health (NIH) and university grantee sites, ongoing OIG work is determining whether costs transferred to NIH grants were allowable.

In addition, OIG has initiated reviews involving the Head Start Program. OIG has focused its work on reviewing underenrollment issues and procurement and construction practices within Head Start.

[2] The Medicaid budget was excluded from these figures and is addressed in a separate section of this document.

Mandatory Grants

An OIG assessment of the methods used by states to monitor foster care subgrantees found that: (1) some states' systems were inadequate according to criteria OIG developed for the study based on Federal grants management requirements; (2) some states did not communicate required information to subgrantees; and (3) the Administration for Children and Families (ACF) paid minimal attention to oversight of states' subgrantee monitoring systems. OIG recommended that ACF hold states accountable for adhering to grant management requirements relating to subgrantees. OIG is also examining states' standards and capacities to track frequency and content of caseworker visits with children in the Foster Care Program.

OIG has also initiated several reviews involving the Foster Care and Adoption Assistance programs. Specifically, OIG has focused on the appropriateness of Federal reimbursement related to Foster Care and Adoption Assistance training and administrative costs and maintenance claims. OIG has also analyzed the ACF's plan to develop erroneous payments for Foster Care, Head Start, and Child Care as mandated by the Improper Payment Information Act of 2002 and OMB Memorandum on M-03-13.

Assessment of Progress in Addressing the Challenge:

Through the governmentwide Federal Grant Streamlining program, the HHS grant management environment is undergoing significant changes. The program is intended to implement the Federal Financial Assistance Management Improvement Act of 1999 (Public Law 106-107), which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. The initiative requires grant officials to examine the way they do business, focusing not only on streamlining the grant process but also on ensuring that results are achieved and Federal funds are used appropriately for the maximum benefit of program recipients. It is crucial that HHS agencies adequately manage and monitor their grantees and, to the extent possible, their subgrantees' program performance and to require fiscal accountability.

HHS Management Response:

Assistant Secretary for Budget, Technology, and Finance (ASBTF), Office of Grants:

The Office of Grants (OG), under the Office of the ASBTF, continues to conduct a variety of Departmental activities that complement the various studies being conducted by OIG. OG activities include targeted reviews of HHS grant programs, P.L. 106-107 activities to streamline the grants process, Grants.gov to allow grant applicants the ability to find and apply for grant opportunities in one place, balanced scorecard (BSC) surveys to measure the reliability of grant administration processes across the Department, collaboration with OIG to improve Agencies' use of the Alert List, and Departmental review of funding opportunity announcements.

OG has initiated targeted reviews to ensure that grant practices are in compliance with established Departmental grant policies and regulations. These reviews focus on evaluating pre-award processes, examining post-award monitoring activities (including performance and financial report submissions), improving consistency between Agencies, and identifying best practices to share across the Department. To date, the reviews have identified mismatches in policy documents and flawed business processes, as well as some Agency-specific practices that could serve as models across the Department. OG has worked collaboratively with OIG in conducting targeted reviews, so that each office is kept abreast of the various grant oversight activities and reviews being conducted. Early in FY 2006, OG will advise Agencies of those discretionary grant programs that have been designated for review in the upcoming fiscal year. The results of the OIG reviews and studies are being analyzed by OG so that appropriate strategies for generalizing solutions across programs can be developed and shared through effective training modules with Departmental staff responsible for monitoring grantee and subgrantee

performance-based outcomes and stewardship of funds. Through effective training, Departmental staff will be able to achieve improvement in these areas.

HHS' Grants Management Balanced Scorecard is a self-administered review protocol enabling HHS Agencies to assess perceptions of performance by soliciting feedback from a variety of internal and external users/customers. The results provide indicators as to how well an HHS Agency is performing a variety of pre-award and post-award grant monitoring activities, enabling HHS Agencies to develop and implement action plans to address areas targeted for improvement. In the second quarter of FY 2005, all HHS Agencies administered Phase One of the scorecard, (which consists of internal HHS Agency surveys; Phase Two consists of external surveys of grant recipients). HHS Agencies' results from this second initiation of BSC surveys will be compared to those results from the 2003 survey results (where applicable). HHS Agencies such as HRSA, AHRQ, and AoA, for example, developed and implemented process improvements after the 2003 surveys. Improvements from the 2003 surveys to the 2005 round of surveys are anticipated and will be confirmed upon a final comparison of the surveys to be completed during the first half of FY 2006.

Grants.gov is the government-wide electronic government (e-Gov) initiative managed by HHS, working in collaboration with the 26 Federal grant-making agencies. The deployment of the Grants.gov portal was a major step taken to migrate all Federal agencies to the system envisioned by the President's Management Agenda and P.L. 106-107. Deployment of the portal assists the Agencies, including HHS, in meeting their mission objectives by providing a common system to support interactions with the grants community, which includes potential applicants, applicants, and grantees. Grants.gov's *Find* functionality allows Federal agencies to post discretionary grant opportunities on Grants.gov and potential applicants to conduct a search of these opportunities. Since October 2003, all grant-making agencies have posted their discretionary funding opportunities on Grants.gov, and all of HHS's Operating Divisions are posting their grant opportunities. As of September 2005, over 7,000 Federal discretionary grant opportunities have been posted. HHS has posted approximately 2,247 opportunities since October 2003. Grants.gov's *Apply* functionality allows Federal agencies to post their application packages on Grants.gov, and allows applicants to download the application package and complete it offline based on agency instructions. After applicants have completed all required forms, they can electronically submit the package to Grants.gov. Upon receipt of the application, Grants.gov sends an electronic acknowledgment to the applicant and delivers the application to the Agency. The Grants.gov *Apply* functionality was launched in October 2003. As of September 2005, approximately 1,533 application packages have been posted by Federal agencies and over 16,650 electronic applications have been received from the grants community. HHS has posted 558 application packages and received 2,939 electronic applications. This utilization signals a marked increase from previous years, and underscores the growing adoption of Grants.gov as the single source for posting and applying for grants across the Federal government and throughout HHS. HHS has completed system-to-system integration testing with ACF, HRSA, OPHS, and NIH.

The Grants.gov Program Management Office (PMO) continues to work closely with OMB and the Federal grant-making agencies to establish government-wide grant application data sets and forms. This year, the Grants.gov PMO worked with OMB to establish a new clearance process for government-wide grant forms, enabling a more expeditious transition from agency specific to government-wide grant application data sets and forms. In addition, Federal agencies began using the government-wide research grant application data set, which was published in the Federal Register. The mandatory grants application/plan was also published in the Federal Register and has been deployed for government-wide use. Going forward, Grants.gov will deploy version 2 of the core grant application data set, as well as other cross-agency (industry-specific) grant application data sets. At this time, 88 percent (23 of 26) agencies are using these Government-wide grant application forms. Having developed 27 Government-wide forms (as well as 45 agency-specific forms) Grants.gov drives the streamlining of forms for all agencies. As of September 2005, 85 percent of forms used in electronic applications on Grants.gov are Government-wide, accounting for over 11,000 uses of these forms in 1,455 application packages.

HHS has adopted the use of government-wide forms to assist the grant community in responding to grant opportunities. Use of government-wide forms allows the grants community to more easily apply, because they are familiar with the forms and can re-use application materials for similar grant opportunities. HHS has used 12 different government-wide forms over 4,600 times in preparing 548 application packages. In addition, Grants.gov has developed three PureEdge forms and has used them 377 times in their application packages. HHS uses government-wide forms 93 percent of the time for their application packages.

HHS, in collaboration with OIG, continues to work to improve Agency use of the HHS Alert List as a grants management tool. HHS maintains its Alert List in order to notify all HHS awarding offices of entities considered "high risk/special award conditions" by one or more awarding office and/or those for which the OIG has issued an alert. This allows other HHS Agencies to decide whether they should include special terms and conditions in awards they make to the same grantee. If an award contains special award conditions, the HHS Agencies must ensure that the grantee is aware of those conditions and understands the action necessary to satisfy them. Furthermore, HHS Agencies develop a corrective action plan with the affected grantee, monitor improvement, and assess, at the conclusion of the corrective action period, whether the special award conditions may be removed. To alleviate perceived confusion and/or further misuse of the HHS Alert List, OG is planning, in FY 2006, one-on-one training sessions with each HHS awarding agency to discuss proper use of the HHS Alert List, awarding agency issues, prevalent misconceptions and best practices. OG will consider a reevaluation/restructuring of the HHS Alert List based upon awarding agency comments.

As one of several initiatives designed to ensure that the Department meets the President's Management Agenda goal for improving the management and performance of the Federal Government, OG was authorized by the Secretary to conduct a Departmental review of grants management activities involving the pre-award process. Special interest was given to the development of funding opportunity announcements to afford greater efficiencies and increased accountability, and ensure that announcements are consistent with regulations and Departmental policies. The Departmental review has identified various recommendations for improvements in announcement preparation and presentation, which subsequently have been promulgated through a directed action transmittal to the awarding components. Beginning in FY 2004, the reviews had an additional focus to ensure that Agencies' funding opportunity announcements were compliant with OMB's new policy directive requiring the use of a government-wide standard program announcement format. All HHS Agencies are implementing the standard format and, as a result, funding opportunity announcements have greater consistency across the Department. In FY 2005, steps were taken to begin integrating "Topic Area" comparisons between Agencies into the reviews, having 100 percent compliance with OMB requirements including use of Grants.gov and the OMB standard announcement format, and any additional requirements directed by OMB as the result of ongoing P.L. 106-107 initiatives. In addition, FY 2005 reviews identified more specific program areas in which the OPDIVs need to pay closer attention during the development phases of the announcements prior to submitting them to the review process. In FY 2006, the process will be re-evaluated and updated to continue to streamline the topic areas and other identified redundancies.

OG encourages grants management offices to perform grants management financial/business process site visits to the grantees in order to identify any financial/business process internal control weaknesses. If weaknesses are found, grantees are required to submit corrective action plans which, if necessary, can be placed in the terms and conditions of the grant award. Ineffective compliance to the correction of a "weakness" as identified in the terms and conditions can result in a suspension or termination of the grant.

All of the initiatives referenced above require grant officials throughout the Department to examine their current business processes. The Department anticipates that through the implementation of the aforementioned initiatives, grant officials will not only focus on streamlining the various HHS grant processes but, also ensure that: (1) appropriate methods are put in place to achieve programmatic goals

and objectives, (2) collection and distribution of meaningful evaluation data will be enhanced, and (3) effective stewardship of all Federal funds will be achieved.

ACF:

In response to the OIG assessment of the methods used by states to monitor foster care subgrantees, ACF revised the terms and conditions for its Foster Care awards and includes them in new grant award packages to the states. To encourage states to strengthen their monitoring efforts under the program, the new conditions reiterate the regulatory requirement for the monitoring of grant, sub-grantee/sub-recipient and contract supported activities (45 CFR 92.40). An additional condition requires states to advise sub-grantees/subrecipients of requirements imposed on them by Federal laws, regulations and provisions of the Foster Care grant agreement.

ACF just recently received the draft reports on the studies the OIG is conducting related to worker contact, and has not yet developed an official response. However, ACF appreciates the OIG's willingness to look in greater detail into issues that ACF has raised to their attention. Based on the OIG's findings that result from the studies on training and administrative costs, and maintenance claims, ACF will disallow funds accordingly and engage states in corrective action, as appropriate.

With regard to ACF's Improper Payments Initiatives concerning Foster Care, Head Start and Child Care—three of the four ACF A-11 programs OMB identified as at risk of significant improper payments—ACF has been working with the Department and OMB to prepare and implement annual plans with deliverables aimed toward achieving error rates in these programs. Head Start was able to report an error rate of 3.9 percent in the FY 2004 PAR and will report an error rate of 1.6 percent in the HHS FY 2005 PAR. Similarly, in the FY 2005 PAR, Foster Care will be reporting a preliminary national error rate of 10.02%, Child Care will report error rates for four states that participated in its IPIA pilot, and TANF will report an error rate for the state that participated in its expanded A-133 audit pilot. . While the OIG has expressed concern that ACF's methodologies for developing these error rates will not result in a statistically valid estimate and rate, OMB is aware of the limitations in which ACF is actively pursuing these initiatives. ACF, HHS, and OMB officials jointly consider strategies that are most reasonable and cost-beneficial in light of statutory and regulatory limitations.

CDC:

HIV/AIDS Grants Management

OIG recommended that "…CDC continue to monitor its grants management operations to ensure full compliance with relevant laws, regulations, and departmental policies." Their findings stated that CDC failed to: "…perform required cost analyses of applications…to ensure that proposed costs were allowable and reasonable for the work to be performed"; "…[establish] clear, specific objectives providing a basis for assessing grantees' accomplishments"; require documented accomplishments before awarding a continuation to grants.

In order to resolve these deficiencies, CDC has:

- Rescinded the CDC Assistance Management Manual which was found to provide insufficient guidance in grant management and required all grants management staff to adhere to all provisions of the HHS Awarding Agency Grants Administration Manual.
- Established a comprehensive checklist to better facilitate grant administration.
- Developed and included a cost analysis instrument to be used by grants staff on its grants Web page.

Alert List

OIG recommended that "…CDC needs to ensure that grants officers follow policies for placing grantees on the Alert List, checking the Alert List, consulting with agencies that place grantees on the Alert List,

monitoring grantees with special award conditions, removing grantees from the Alert List when appropriate, and ensure that grants officers justify retaining a grantee whose name appears on the Alert List more than 2 years.

In order to resolve these deficiencies, CDC has:

- Assigned the responsibility for the Alert List to the Oversight & Evaluation Branch.
- Begun regular reviews of the list to ensure appropriateness of content.
- Removed 11 out of 25 grants from the Alert List.
- Sought guidance and clarification from the Department.
- Developing a written agency policy.

Required all Grants Management Officers to review grants to determine the need for inclusion on the list due to special condition.

It is CDC's desire to ensure compliance with all grant requirements. CDC appreciates the input and guidance provided by the recent OIG reviews. The current challenges have been fully embraced by CDC and measurable results have evolved. Development and implementation of additional improvement measures are forthcoming.

Management Issue 7: Ensuring the Integrity of Critical Support Systems and Infrastructure

Management Challenge:

IT Infrastructure and Data Integrity

HHS continues to make progress in securing its most critical assets, both cyber-based and physical, such as computer systems, data communication networks, and Department laboratories. However, the vastly distributed and complex network of systems, applications, and facilities makes this a daunting task. Recent legislation, such as the MMA, significantly increases the programmatic and systems demands on the Department, creating new or expanding existing relationships with business partners. These new relationships will create new systems exposures that have to be evaluated and, if need be, corrected to ensure the confidentiality, integrity, and availability of critical assets.

Recent OIG assessments found that many identified security weaknesses are attributed to either an absence of a process to protect resources or a failure to comply with an established process. The latter presents a major challenge to the Department. While the human factor is critical for the establishment of an effective security program, it is typically overlooked in the development of technical solutions to address weaknesses in entity-wide security, access controls, service continuity, application controls and development, and segregation of duties. As the Department focuses more on data integrity and application controls, the need to ensure adherence to general controls becomes paramount. For example, OIG's body of work indicates that the Medicare payment error is more often a function of the input of incorrect information than data processing. For the 7 years that OIG produced the Medicare fee-for-service error rate, the overwhelming majority (over 95 percent) of the improper payments identified were detected through medical reviews.

Through planned and scheduled work, OIG will place new emphasis on controls that are designed to ensure the integrity of data for numerous vital programs on which critical systems depend.

Human Resources

Critical to the integrity, management, efficiency and effectiveness of the Department's hundreds of programs serving the public is its valuable work force. Maintaining high ethical requirements for employees and grantees contributes to the delivery of programs through high standards and fosters public confidence in the integrity of the services provided as well as research conducted.

OIG has a special interest in controls related to ethical considerations. It is imperative that program administrators and grantees adhere to ethical standards that preclude conflicts of interest that could negatively affect program outcomes. HHS employees, including those engaged in intramural research and those who administer grants and contracts, as well as HHS grantees, must remain ever vigilant to ensure that conflicts of interest are prevented in all HHS programs, including HHS-funded research.

OIG examined NIH policies and procedures for reviewing and approving outside activities requests for its employees. Several vulnerabilities were identified that inhibit NIH's ability to effectively review outside activities. OIG found that sometimes employees submitted incomplete information regarding their outside activities. Also, several problems were identified with the review process itself, such as approvals after the start date, limited use of written recusals, and inadequate followup for ongoing outside activities of Federal employees. OIG recommended that NIH improve the quality and extent of information it receives for outside activities and address inadequacies in the review process for outside activities. NIH concurred with OIG's findings and recommendations and has undertaken initiatives to improve its process for outside activities. A similar review is being conducted at FDA that will identify and assess the conflict of interest policies and practices at the agency.

The importance of safeguarding the integrity of HHS research dollars is illustrated by a recent audit of a HRSA cooperative agreement implementing an HIV/AIDS peer treatment education program at a major university. OIG found that the university had not resolved a conflict of interest situation in which the program's co-principal investigator was at the same time a university employee hired specifically for the program and also the chief executive officer of the subcontractor. At a minimum, this "one person wearing two hats" situation gives the appearance that Federal funds were not adequately safeguarded. The school agreed to strengthen its procedures for identifying, reviewing, and resolving potential and actual conflicts of interest.

To further examine conflict of interest matters, OIG will examine how NIH monitors extramural grantees for potential conflicts of interest. The focus will be on the effectiveness of NIH's oversight, whether conflicts of interest have affected Federal and public interests, and whether the definition of "significant financial interest" effectively protects researchers from perceived or actual conflicts of interest.

As OIG continues to investigate conflicts of interest at the grantee level, it recognizes a corresponding need to ensure that departmental systems are also effective in preventing and detecting internal conflicts of interest and is encouraging maximum compliance by HHS employees. OIG will continue to issue the results of its assessments at both the grantee and Departmental levels.

Assessment of Progress in Addressing the Challenge:

IT Infrastructure and Data Integrity

HHS has made progress in securing the most critical and essential assets, both physical and cyber-based, such as Department laboratories, computer systems, and data communication networks. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, the collective assessment of recently identified weaknesses resulted in the reporting of a material weakness and significant deficiency for major Departmental Operating Divisions in the FY 2004 HHS financial statement audit and Federal Information Security Management Act evaluation. While no evidence of exploitation has been discovered, these weaknesses leave the Department vulnerable to unauthorized access to and disclosure of sensitive information; malicious

changes that could lead to fraud, error, or destruction of critical data; improper payments; or disruptions of operation.

Human Resources

Under the leadership of the Department's Designated Agency Ethics Official (DAEO), great strides have been made recently to enhance the Department's ethics program. One important step was the release on February 3, 2005, of an Interim Final Rule implementing more stringent HHS Supplemental Standards of Ethical Conduct that include policies for the review and approval of employee requests to participate in outside activities. All HHS employees continue to be required to seek prior approval before engaging in professional and consultative activities, service on a board of directors or other advisory body, and for teaching, speaking, writing and editing that are related to the employee's official duties. In addition, NIH employees, like FDA employees, are now required to seek prior approval of all outside employment or self-employed business activities. Moreover, the revised Departmental Supplemental Standards introduce a stricter standard of review for management officials who decide whether or not to approve an employee's outside activity request. Whereas the prior version, which was in place when OIG conducted recent work at NIH and FDA, required approval unless the proposed outside activity would violate a Federal law or regulation, the revised version mandates that "Approval shall be granted only upon a determination that the outside employment or other outside activity is not expected to involve conduct prohibited by statute or Federal regulation…" 5 CFR § 5501(d)(4).

In April 2005, the DAEO launched a revised and expanded outside activity approval form (Form HHS 520) and introduced a required annual report on outside activities (HHS Form 521), which requires more detailed information about the proposed outside activity and how it might relate to the employee's official duties. The new Supplemental Standards and outside activity forms, along with a tripling of the staff of the Office of General Counsel's Ethics Division, are indicative of the Department's efforts to guard against employee conflicts of interest and to help ensure the integrity of all of the Department's programs.

HHS Management Response:

IT Infrastructure and Data Integrity

HHS has made significant progress in mitigating the risks that are presented in the course of daily mission business processes, but realizes that there are always opportunities to increase Departmental diligence. A comprehensive HHS Security program is in place that has membership and participation from across the Department. HHS has taken a multi-faceted approach in striving to mitigate risk and eliminate any weaknesses in the Departmental security posture.

The HHS infrastructure consolidation efforts in the areas of network infrastructure, web access and e-mail services have limited Departmental exposure to cyber attacks by limiting the number of access points that must be protected.

The HHS Enterprise Architecture program has worked closely with the HHS Secure One HHS program to develop a security architecture that addresses management, technical, and operational controls at all levels of HHS activity. This architecture is built upon National Institutes of Standards and Technology (NIST) guidance and Federal Information Processing Standards (FIPS). This approach allows HHS to address necessary controls in business process areas, such as separation of duties, as well as those involved in the technical areas of automated assurance.

HHS has also begun the development and implementation of a role based learning management system that targets the required competencies for security professionals that have been identified in NIST guidance. This will not only provide technical competency but will help to address behavioral issues that may threaten ongoing data integrity.

Automated tools are being put in place to ensure that all aspects of the Federal Information Security Management Act (FISMA) compliance are addressed in a structured and consistent manner, and that the associated documents that provide evidence of that rigor are developed.

An HHS-wide network and security monitoring framework is being implemented that allows the Department to define network and operational policies for acceptable and secure network traffic, and monitor that traffic against those policies in an automated fashion, thus only allowing acceptable network traffic and appropriate access to digital resources. Network traffic that falls outside of the bounds of established policy is flagged for inspection, generates an alert to the security team, or is completely blocked, depending on the criticality of the offence and the risk that such an offence may expose. Plans are in place to provide this network and security monitoring service twenty-four hours a day, seven days a week to facilitate a more expedited response to potential security threats.

This list of actions and efforts confirms the HHS commitment to a strong security posture and a constant diligence in all areas that might help to eliminate any weakness in that posture.

NIH:

As a participant in the Secure One HHS IT security program, NIH has implemented several agency initiatives to support its research mission and operating environment. Examples are provided below:

- Required Certifications and Accreditations (C&A) including risk assessments, security plans, and contingency plans for all new systems before they are fully implemented. All security controls are reviewed prior to accreditation of a new NIH system. This includes new systems hosted by the NIH CIT Data Center, i.e. the System for Enterprise Records and Correspondence Handling (SERCH), put into production in FY05.
- Completed C&A for 100% of identified critical cyber-based infrastructure systems and datacenter and data communication networks, ensuring that safeguards are commensurate with risks and cost-effective. The NIH CIT Data Center was certified and accredited December 2004.
- Led the development and implementation of policies, procedures, and guidelines in the areas of security incident handling, network security, remote access security, security planning, wireless security, vulnerability scanning, antivirus updating, passwords, separation of duties, and instant messaging. These policies all apply to the NIH CIT Data Center.
- Maintained NIH Network Interconnection Security Agreement (ISA) with non-NIH organizations connected to critical NIH network resources. The ISA requires external organizations to have IT security standards that meet or exceed HHS and NIH requirements. Some of the external organizations that have ISAs signed with NIH have IT resources hosted by the NIH CIT Data Center.
- Implemented NIH network disaster recovery site, helping ensure NIH's ability to continue operations in the event of a major security breach or wide scale disaster. The NIH network disaster recovery site is designed for network continuity, rather than for the NIH CIT Data Center. However, the Data Center has its own disaster recovery program.
- Implemented the NIH Online Security Awareness Training course, completed by more than 98% of NIH employees. This includes employees whose responsibilities include security for the NIH CIT Data Center.
- Deployed autoblocking feature to block signature attacks in real time to prevent massive port scans of NIH critical and non-critical infrastructure. This feature helps protect the NIH CIT Data Center from electronic attacks.
- Conducted vulnerability assessments of all NIH systems, performed corrective actions, and directed resources to the areas in most need of improved security. The NIH CIT Data Center is periodically scanned for vulnerabilities, and corrective actions are implemented.

- Initiated Penetration Testing program for most critical/sensitive systems at NIH. The NIH CIT Data Center.
- The FY 2005 Federal Information Security Management Act (FISMA) audit by HHS' Inspector General resulted in zero Significant Deficiencies and zero reportable conditions. The scope of the FISMA audit included the NIH CIT Data Center.

The February 2005 interim final rule focused primarily on changes that affected employees of the National Institutes of Health. However, as a result of significant concerns and objections to the February interim rule, the Department carefully considered and made significant revisions to the final rule. Of most importance to FDA, is the fact that the Department removed entirely the requirement that FDA employees obtain prior approval for all outside activities. Activities that never posed a conflict of interest, such as coaching a sport team, teaching a crafts class, providing electrical or plumbing work have been eliminated from requiring prior approval.

By tailoring the prior approval requirement, FDA is now able to focus more closely on those activities that are most likely to pose a conflict or raise an appearance concern. Furthermore, by developing written procedures and policies, FDA will ensure consistency in the process to ensure compliance with the Departments Supplemental Standards of Conduct regulations.

Human Resources

- Under the leadership of the Department's DAEO, the Department's ethics program has been greatly enhanced to ensure that high ethical standards are maintained by HHS employees. The following are examples of program improvements and oversight efforts undertaken in FY 2005. The Final Rule revising the HHS Supplemental Standards of Ethical Conduct was promulgated on August 31, 2005. These regulations continue prior approval requirements and certain restrictions on outside activities for HHS employees and impose more stringent restrictions for NIH and FDA employees. The final rule also limits the ownership by certain NIH and FDA employees of financial interests in companies affected by the programs and operations of their respective agencies. In addition, NIH employees who exercise decision-making authority and clinical researchers in intramural trials involving human subjects must file a supplemental report of financial interests in pharmaceutical, biotechnology, and medical device companies that discloses the exact valuation of their holdings. Under the final rule, additional approval and review requirements for awards offered to NIH employees by outside entities have been implemented. . The final regulations adopted the standard for approval of outside activities contained in the interim rule which requires an affirmative determination that the outside employment or other outside activity is not expected to involve conduct prohibited by statute or federal regulation.
- Revised HHS Form 520 and the new HHS Form 521 were issued. Reporting and review procedures for these forms have been implemented, resulting in the Department's collection of detailed information about proposed and conducted outside activities. With this additional information, the Department and its component agencies are better able to evaluate the potential for any conflict between the activity and the employee's official duties. In addition, the final rule expressly limited the duration of an outside activity approval to one year, after which the employee must reapply in order to continue. This change ensures that decisions regarding outside activities reflect consideration of current employee duties and agency needs.
- New HHS Forms 716 and 717 have been developed to elicit from NIH and FDA employees detailed information concerning their financial interests in pharmaceutical, biotechnology, and medical device companies, and, for FDA employees, other types of companies regulated by the agency. This supplemental financial disclosure system will assist the Department in monitoring employee compliance with applicable restrictions and in performing case-by-case analyses under conflict of interest rules to ensure the integrity of agency programs.

- Program reviews have been conducted by the DAEO's program review staff of the OPDIV ethics programs at CDC, HRSA, and CMS, and are currently underway at selected STAFFDIVS, such as OGC, OIG, ASBTF, ASAM, and ASPE.
- Single issue reviews to assess ethics practices involving advisory committees, to study and establish benchmarks for OGE Form 450 distribution, collection, tracking, and certification, and to evaluate the accuracy and effectiveness of ethics training are either scheduled or underway.
- Mandatory pre-screening for conflicting financial interests, prohibited outside activities and other potential government ethics issues has been implemented for all prospective employees entering positions for which public financial disclosure filing will be required, either by virtue of their appointment mechanism or pursuant to a determination by the Office of Government Ethics that a position is SES-equivalent based upon the nature of the duties. An ethics clearance must be obtained for these employees prior to their entrance on duty.
- Financial disclosure requirements have been further centralized within the OGC's Ethics Division ensuring an additional level of review after certification of public financial disclosure forms by OPDIVS and STAFFDIVS.
- Education and training efforts have been greatly expanded. Initial ethics orientation is now conducted in-person by an ethics attorney as part of the bi-weekly new employee intake process in OS Annual ethics training for covered employees has been augmented, and additional education sessions for Department ethics officials have been introduced. Numerous training sessions for a variety of HHS components have been developed and presented. The Ethics Division website has been expanded and updated to ensure information on the standards of ethical conduct are readily available to all HHS employees.

In addition to these measures implemented under the DAEO's leadership, the leadership of the NIH has undertaken a series of initiatives designed to improve the effectiveness of its ethics program.

- The NIH Director established the NIH Ethics Advisory Committee to ensure that the ethics matters of senior officials in the NIH and each of the Institutes and Centers, and other matters having a higher risk of perception or conflict problems, receive the appropriate level of management, scientific and ethics consideration.
- NIH is developing the NIH Ethics Enterprise System in which ethics records for all NIH employees will be maintained, and through which ethics and management officials will be able to access information from all relevant resources during their review of financial disclosure reports, outside activity requests, award approvals, and other ethics actions, including information on contracts, grants, research and development agreements, materials transfers, personnel, and more. Using technology to link separate systems together to ensure the consideration of all relevant agency information will significantly increase the amount of information available to deciding officials and improve the quality of the review process and the decisions.
- In addition, NIH has undertaken a program organization and staffing needs assessment and is in the process of reorganizing the NIH Ethics Office. This reorganization will include the selection of a full-time Chief NIH Ethics Program Officer who will oversee advice, administration and policy, and internal program review functions at NIH. Working closely with the DAEO and his OGC Ethics Division staff, and the ethics officials within each of the NIH Institutes and Centers, this expanded NIH Ethics Program Office will be well-equipped to both administer the ethics program at NIH and to evaluate the changing needs of the agency and the public over time.

FDA:

During the 4th quarter of 2004 and the 1st quarter of 2005, the OIG conducted a study on the Food and Drug Administration's (FDA) Outside Activity Program. The purpose of the study was to assess the nature and extent to which employees received approval and the Agency's process for reviewing outside

activity requests. OIG was interested in reviewing outside activity forms filed by FDA employees between 2000 and 2003.

Prior to commencement of the study , in June 2004, FDA's Acting Commissioner directed a review be conducted of all ongoing outside activities. The purpose was to assess compliance with the Agency's strict ethical standards as well as with the standards established by the Office of Government Ethics and the DHHS Supplemental Standards of Ethical Conduct to ensure that the outside activities undertaken by FDA employees were in the public interest. In the end, no outside activities were identified as posing a concern (with the exception of one previously identified and promptly remedied).

As a result of the internal review, FDA began to take steps to bolster its process to monitor outside activities. Steps included: 1) developing an automated process for the submission of all outside activity requests; 2) conducting annual reviews of all outside activities; 3) receiving approval to create form HHS-520-1 "Request for Approval of Outside Activity for FDA employees"; and 4) developing a guide on outside activities. While FDA was implementing internal changes to its outside activity process, on February 3, 2005, DHHS issued interim final regulations on the HHS Supplemental Standards of Ethical Conduct. As a result of the interim regulations, FDA had to again change its course of action. FDA learned yet again that the Department was in the process of making additional changes to the interim final regulations for NIH employees as it relates to outside activities and invited the FDA to participate.

Management Issue 8: Public Health Readiness

Management Challenge:

The tragedy of September 11, 2001, and events since then, such as the 2005 Gulf Coast hurricanes, underscore the importance of having a well functioning national public health infrastructure and the health care resources necessary to respond to threatened and actual acts of terrorism, bioterrorism, and other public health emergencies. Because HHS manages most of the nation's Federal health resources through surveillance, coordination, research, and delivery of health care service programs, OIG work has focused on vulnerabilities in those numerous programs. OIG assesses how well HHS programs and their grantees plan for, recognize, and respond to outside health threats, the security of HHS and grantee laboratory facilities, the management of these grant programs and funds by the Department and grantees, and the readiness and capacity of responders at all levels of government to protect the public's health.

Since 2001, OIG has completed numerous audits and evaluations of the Department's programs for bioterrorism preparedness and response. In 2002, OIG evaluated the effectiveness of the CDC bioterrorism preparedness efforts and assessed the ability of 12 state and 36 local health departments to detect and respond to bioterrorist events. Additionally, OIG conducted a review in 11 states and 21 localities to evaluate their ability to receive and deploy the National Pharmaceutical Stockpile (now the Strategic National Stockpile). The stockpile is designed to supplement state and local public health agency pharmaceutical supplies in the event of a biological or chemical incident. In both studies, OIG found that these states and localities were underprepared to detect and respond to bioterrorist events in general and that their planning documents tended to overstate preparedness.

Since that time, the Department has provided to states $1.9 billion to strengthen public health preparedness for bioterrorism. At CDC's request in 2003, OIG conducted follow-up reviews of progress made by the same states and localities OIG had previously reviewed both for general preparedness efforts and their ability to receive and deploy the Strategic National Stockpile. In both studies, OIG again found that while some progress had been made since 2002, the states and localities were still underprepared to detect and respond to bioterrorist events in general and that their planning documents tended to overstate preparedness. OIG found that the 35 selected local health departments report that they are still not fully prepared for bioterrorism and that these local health departments have made

moderate progress in completing general preparedness activities since 2002. Similarly, we found that the 21 localities in the 11 states examined were still not fully prepared to receive and deploy Strategic National Stockpile assets. Overall, the 21 localities met 57 percent of preparedness criteria for receipt and deployment of Strategic National Stockpile assets. In both of these studies, OIG noted that while some progress had been made, CDC needs to continue working with states and localities to ensure that priority planning systems are in place.

OIG performed reviews in 14 states and four major metropolitan areas assessing grantees' efforts to comply with the financial accounting and reporting requirements of the CDC and HRSA bioterrorism grant programs. OIG found that grantees did not always follow program regulations with respect to recording, summarizing, and reporting bioterrorism grant expenditures; monitoring subrecipient expenditures; and timely obligation of grant funds. In 2004, OIG also reviewed states' progress in developing and implementing jurisdiction-wide laboratory response programs for bioterrorism, which included Level A laboratories. These Level A laboratories are clinical labs that may be involved in the early detection of a bioterrorism event and can conduct initial testing to rule out critical agents of bioterrorism (such as Anthrax) and refer suspected specimens to higher level laboratories. They are generally hospital-based, freestanding, or local public health laboratories. OIG found that virtually all states had begun creating their programs by drafting plans and identifying, contacting, educating, and assessing the capabilities of at least some Level A laboratories. However, OIG noted key vulnerabilities, including insufficient training, a lack of critical emergency communication systems, and states' use of inconsistent standards to identify Level A laboratories.

In the period following the terrorist attacks, OIG assessed security at laboratories operated by CDC, NIH, FDA, and several colleges and universities, as well as CDC's role in regulating select agents. In FY 2004, OIG followed up on its original assessment of security controls at departmental laboratories and found that the agencies had implemented, or developed plans to implement, most of its prior recommendations. Because legal requirements for the possession of select agents have become more stringent and detailed in the last several years, OIG initiated additional audits of entities with select agents to assess their compliance with select agent regulations and plans in the near future to reassess CDC's management of the select agent program. In a related effort, OIG will also evaluate physical security and environmental controls over the Strategic National Stockpile.

In 2004, OIG conducted reviews of selected state health departments' 24/7 urgent disease reporting systems. These systems enable health care providers to report to or consult with states or local health department staff at any time regarding public health emergencies, such as bioterrorism events and other suspected or confirmed diseases that require urgent reporting. Only18 states reported to CDC that they had completed the establishment of their 24/7 systems. However, based on OIG assessment, these 18 states still need to make improvements in systems development, coordination, and management. OIG recommended that CDC require and ensure that states annually test their 24/7 systems, require states to develop backup systems that function independently of telephone lines, continue efforts in developing performance indicators that could be incorporated into their Cooperative Agreement on Public Health Preparedness and Response for Bioterrorism, and facilitate information sharing among all states.

In 2005, OIG examined hospital surge capacity, an important indicator of preparedness to respond to mass casualties incurred in a terrorist attack. OIG used the specific requirements in the HRSA Bioterrorism Cooperative Grant funding for state and local entities as the criteria for examining states' and localities' abilities to ensure attainment of this critical benchmark, which provides a tangible measurement of bioterrorism preparedness. OIG found that states reported shortcomings in meeting these critical benchmarks, which could undermine a hospital's ability to achieve overall surge capacity. HRSA's response to these findings includes standardizing data collection through a national survey tool and sentinel indicator project.

Additionally, as part of an interagency review in collaboration with the Inspectors General at the Environmental Protection Agency and the Department of Homeland Security, the HHS OIG is reviewing

CDC's role in the BioWatch program, which conducts surveillance for environmental indicators of bioterror agents.

In addition to our significant investment examining the Department's activities related to bioterrorism and public health preparedness, OIG has made it a priority to examine HHS's response to the public health challenges resulting from Hurricanes Katrina and Rita. We anticipate new work that will address the immediate response of the Department, with a focus on all types of procurements, deployment and recovery activities, as well as an in-depth assessment of the effectiveness of the Department's programmatic response.

Assessment of Progress in Addressing the Challenge:

HHS agencies continue to seek additional resources and work on corrective action plans that respond to OIG-reported concerns. Federal, state, and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. CDC has taken steps to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. States and localities are currently strengthening their bioterrorism preparedness programs, and recent increases in HHS funding address some of the OIG's concerns. However, OIG continues to believe that the general readiness of state and local governments to detect and respond to bioterrorist attacks is below acceptable levels.

HHS Management Response:

CDC:

To address the challenges associated with public health emergencies and terrorist threats, CDC continues to intensify its efforts to increase the preparedness and response capacity of the Nation's public health system. CDC has taken steps to implement the changes recommended in the FY 2004 PAR. CDC's major contributions to this effort include:

- Investments in strengthening early detection and containment of biological public health threats including:
  - BioSense: CDC is connecting multiple disparate data sources into a fully functioning, real-time surveillance system to allow Federal, state, and local health officials access to real-time data that will help identify and characterize the nature of a bioterrorist attack or public health emergency.
    - Since its creation, BioSense has received daily data feeds from an initial set of data providers, and to date has received and processed over 850 million records from the Departments of Defense and Veterans Administration.
    - The BioSense application has been made available to 34 city jurisdictions and all 50 states through the enrollment of BioSense administrators and standard users and currently supports over 400 users in states and major metropolitan areas
  - Quarantine: Increasing the number of quarantine stations and upgrading current facilities to handle modern day threats.
    - The new quarantine stations will be staffed with Medical Officers and Public Health Advisors and will allow greater coverage of the ports of entry to the United States, particularly in major international airports.
  - Electronic Lab Reporting: Standardized systems in place to send lab results to CDC from the BioWatch laboratories.
  - Rapid Toxic Screen: A series of analyses that can rapidly screen human blood and urine samples for 150 chemical agents.

- Laboratory Response Network (LRN): Number of labs has risen to 152, up from 90 in 2001. These labs are now located in all 50 states and the LRN even boasts several installations abroad.
  - 91 percent of these labs can confirm the presence of *B. anthracis*, 85 percent can confirm *F. tularensis*, and 34 percent can perform Variola rule out testing while 17 percent can perform Variola specific screen for Variola virus.
  - More than 8,800 clinical laboratorians have been trained to play a role in the detection, diagnostics, and reporting of public health emergencies.

- Investments in the ability to communicate with public health and health care partners:
  - A secure web-accessible database has been expanded to reach 180,000 clinical and public health laboratories.
  - Epi-X, the Epidemic Information Exchange, enables CDC to provide secure, moderated communications and notification services. Currently there are an estimated 3,000 users, up from 200 in 2001, with that number expected to increase to over 5,000.
  - Public Health Information Network (PHIN) is focusing its efforts on integrating several systems into a unifying framework to better monitor applicable data streams for early detection.
    - PHIN will enable consistent, secure exchange of response, health, and disease tracking data between public health partners.
    - PHIN is composed of five key components: (1) detection and monitoring, (2) data analysis, (3) knowledge management, (4) alerting, and (5) response.
    - Established the Emergency Communications System for information creation and distribution during an event.

- Invested in response capabilities:
  - The Cities Readiness initiative began in late FY 2004 with the goal of increasing the ability of densely populated metropolitan areas to rapidly and effectively distribute the contents of the Strategic National Stockpile in the event of a terrorist or hazardous event. This program is being expanded beyond the initial 21 pilot cities to include up to 18 additional large cities.
  - Funds and provides technical assistance to 62 grantees building preparedness and emergency response functions at state and local health departments.
  - Established the Director's Emergency Operations Center as CDC's "headquarters" for managing a public health event or emergency, exercised during hurricane response of 2004 and 2005.
  - Established a new BioSafety Level (BSL)-4 laboratory that triples CDC's capacity to conduct research and response involving highly pathogenic and infectious viruses that could be used as bioterrorism agents.
  - Expanded scientific collaborations with multinational organizations such as the World Health Organization to enhance global disease detection and response as the principle partner in the Global Outbreak Alert and Response Network (GOARN).

- Investments with state and local agencies to improve priority planning:
  - Developed performance measures to help track state and local agency efforts to comply with HSPD-8 specific criteria, e.g., ensure that first responders are prepared; and ensure that that preparedness measures are in appropriate balance to the potential threat and magnitude of terrorist attacks, major disasters, and other emergencies with the resources required to prevent, respond to, and recover from them.

- Investments to increase state's abilities to systems development, coordination, and management:
  - Established a common set of program goals, outcomes, and performance measures that were integrated into the FY 2005 Public Health Emergency Preparedness Cooperative Agreement guidance to serve as the framework from which state and local awardees will align their efforts and funding.
  - Established the Career Epidemiology Field Officers Program to create a national cadre of EIS-trained CEFOs who work directly with states and large local health departments to build epidemiologic and emergency response capacity. Twelve CDC CEFOs are currently assigned to various locales across the country.

HRSA:

Health Resources and Services Administration (HRSA) continues to address the preparedness of the nation's healthcare system by strengthening strategies at the state and local levels that will meet the needs of the general population, with consideration of the needs of special populations.

In July 2005 HRSA convened a panel of pediatric experts to identify and suggest strategies to meet the needs of the pediatric population in the event of a terrorist act or public health emergency. Results of the meeting have not been finalized but will be made available soon. HRSA and its partners planned a Pediatric Consensus Conference for September 2005. Although highly anticipated by professionals across the country, it was postponed due to the Hurricane Katrina and Rita responses. The consensus meeting is now scheduled for December 2005.

HRSA understands that additional personnel will be needed during a health emergency. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program continues to build a network of state-based registries that enables states to identify and pre-credential professionals that can then be called upon for immediate support if an event occurs. The program completed phase I (10 jurisdictions) and entered into phase II (adding 20 jurisdictions), with phase III (the remaining 32) planned to begin in January 2006. As an early indicator of progress, 1019 healthcare professionals were deployed from seven states in the Katrina response as a result of the ESAR-VHP registries.

Community health centers, poison control centers and emergency medical services organizations are eligible for funding under the program. HRSA encourages states to include these organizations in their surge capacity plans.

HRSA has implemented two strategies to enhance data collection. In collaboration with the Agency for Healthcare Research and Quality, HRSA has surveyed over 3,000 HRSA funded hospitals to better gauge the nation's hospital preparedness level. Results of the survey are expected to be released by the end of 2005. To measure program progress HRSA requires states to report sentinel indicators twice a year. The first set of data has been collected and is now being analyzed. The second set of data is expected in March 2006.

Finally, HRSA has closed the 18 OIG audits which assessed grantee's efforts to comply with the financial accounting and reporting requirements of the bioterrorism grant programs. All of the 18 grantees have either implemented or are in the process of implementing procedures to ensure that program regulations are followed with respect to recording, summarizing and reporting bioterrorism grant expenditures; monitoring sub recipient expenditures; and timely obligation of funds.

APPENDIX B – NET COSTS OF KEY HHS PROGRAMS FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 2005 AND 2004

(in millions)

The following table presents the Net Costs of HHS' 50 largest programs (based on their FY 2005 net cost) for FY 2005 and FY 2004. This listing includes programs aggregated from the several hundred total HHS programs. The net cost information is extracted from draft and final HHS component Consolidated Statements of Net Cost for FY 2005 and FY 2004, and supplements the programs identified in the Department's Consolidated Statement of Net Cost. The shaded programs below correspond or relate to the programs discussed in the Performance Overview section of the MD&A and in the HHS Performance section of this report.

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2005	FY 2004	FY 2005	FY 2004		
Medicare	295,713	269,748	1	1	Medicare	Centers for Medicare and Medicaid Services
Medicaid	182,226	177,060	2	2	Health	Centers for Medicare and Medicaid Services
Research	27,348	25,748	3	3	Health	National Institutes of Health
Temporary Assistance for Needy Families	17,289	17,798	4	4	Education, Training & Social Services / Income Security	Administration for Children and Families
Child Welfare	7,378	7,193	5	5	Education, Training & Social Services / Income Security	Administration for Children and Families
Head Start	7,034	6,750	6	6	Education, Training & Social Services / Income Security	Administration for Children and Families
SCHIP	5,135	4,611	7	8	Health	Centers for Medicare and Medicaid Services
Child Care	5,001	4,863	8	7	Education, Training & Social Services / Income Security	Administration for Children and Families
Child Support Enforcement	4,204	3,971	9	9	Education, Training & Social Services / Income Security	Administration for Children and Families
Infectious Diseases (Note 1)	3,145	3,276	10	10	Health	Centers for Disease Control & Prevention
Low-Income Home Energy Assistance	2,127	1,895	11	13	Education, Training & Social Services / Income Security	Administration for Children and Families
HIV/AIDS Programs	2,077	2,130	12	11	Health	Health Resources and Services Administration
Public Health and Social Services	1,970	1,662	13	16	Health	Office of the Secretary
Primary Care	1,837	2,115	14	12	Health	Health Resources and Services Administration
Social Services Block Grant	1,824	1,753	15	14	Education, Training & Social Services / Income Security	Administration for Children and Families
Substance Abuse Prevention & Treatment Block Grant	1,750	1,662	16	17	Health	Substance Abuse and Mental Health Services Administration
Clinical Services	1,619	1,681	17	15	Health	Indian Health Service
Community Based Services	1,279	1,239	18	18	Education, Training & Social Services	Administration on Aging
Maternal and Child Health	1,044	1,025	19	19	Health	Health Resources and Services Administration
Health Professions	870	906	20	21	Health	Health Resources and Services Administration
Health Promotion	829	981	21	20	Health	Centers for Disease Control & Prevention
Community Services	773	761	22	22	Education, Training & Social Services / Income Security	Administration for Children and Families
Foods and Cosmetics	546	566	23	24	Health	Food and Drug Administration
Refugee Resettlement	530	508	24	25	Education, Training & Social Services / Income Security	Administration for Children and Families

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2005	FY 2004	FY 2005	FY 2004		
Contract Health Care	480	485	25	26	Health	Indian Health Service
Business Services Support	476	0	26	0	Health / Natural Resources & Environ	Centers for Disease Control & Prevention
Healthcare Systems (Note 2)	471	323	27	33	Health	Health Resources and Services Administration
Program of Regional National Significances/Targeted Capacity Expansion	471	423	28	29	Health	Substance Abuse and Mental Health Services Administration
Community Mental Health Services Block Grant	426	451	29	27	Health	Substance Abuse and Mental Health Services Administration
Program of Regional National Significances-Best Practices (new)	404	367	30	31	Health	Substance Abuse and Mental Health Services Administration
PHS Commissioned Corps	346	627	31	23	Health	Program Support Center
Environmental Health and Injury (Note 1)	343	437	32	28	Health / Natural Resources & Environ	Centers for Disease Control & Prevention
Ticket to Work	325	34	33	62	Health	Centers for Medicare and Medicaid Services
Human Drugs	313	352	34	32	Health	Food and Drug Administration
General Departmental Management	302	402	35	30	Health	Office of the Secretary
Family Planning	275	283	36	34	Health	Health Resources and Services Administration
Tribal Activities: Contract Support	273	282	37	35	Health	Indian Health Service
Medical Devices & Radiological Health	240	253	38	36	Health	Food and Drug Administration
Occupational Safety and Health (Note 1)	220	248	39	37	Health / Natural Resources & Environ	Centers for Disease Control & Prevention
Hospitals-Facilities Support	211	219	40	38	Health	Indian Health Service
Public Health Improvement and Leadership (Note 1)	194	80	41	53	Health	Centers for Disease Control & Prevention
Developmental Disabilities	165	154	42	40	Education, Training & Social Services / Income Security	Administration for Children and Families
Youth	165	119	43	47	Education, Training & Social Services / Income Security / Admin of Justice	Administration for Children and Families
Diabetes Initiative	139	78	44	54	Health	Indian Health Service
Health Information and Service	135	149	45	41	Health	Centers for Disease Control & Prevention
Domestic Violence	131	120	46	44	Education, Training & Social Services / Income Security	Administration for Children and Families
Preventive Health and Health Services Block Grant	125	120	47	45	Health	Centers for Disease Control & Prevention
Biologics	117	131	48	43	Health	Food and Drug Administration
Animal Drugs and Feeds	116	120	49	46	Health	Food and Drug Administration
Preventative Health	112	109	50	49	Health	Indian Health Service
All Other HHS Programs	980	1,282			Various Components	Various Components
Total Net Costs (Note 3)	$ 581,503	$ 547,550				

Note 1. CDC has revised/combined several of their programs resulting in net cost revisions to four of their programs. The rank by $ in the FY 2004 column was revised resulting (generally) in a shift of one position from the FY 2004 Appendix B report.

Note 2. Name of the program changed in FY 2005; was "Office of Special Programs".

Note 3. Total Net Costs agrees with OPDIV combined Totals in the Consolidating Statement o f Net Cost by Budget Function located in Other Accompanying Information.

The shaded programs above relate to the programs discussed in the Performance Overview section of the MD&A and in the HHS Performance section of this report.

Highlighted Programs (#)	18	18
Highlighted Programs ($)	$ 538,024	$ 506,066
Highlighted Programs (%)	92.52%	92.42%

APPENDIX C – IMPROPER PAYMENTS INFORMATION ACT OF 2002

Narrative Summary of Implementation Efforts for FY 2005 and Agency Plans for FY 2006 – FY 2008

The Improper Payments Information Act of 2002 (IPIA) requires that Federal agencies annually review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For high-risk programs, the IPIA requires that various information related to its improper payment activities be reported on annually. The Office of Management and Budget (OMB) issues guidance for reporting on improper payment activities in the Performance and Accountability Report (PAR). In accordance with the IPIA and OMB guidance, the following information is being provided.

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.

HHS developed a risk assessment model in FY 2003 to be used Department-wide in conducting program risk assessments of its programs as required under the IPIA. During FY 2004 and FY 2005, HHS worked with the OMB, a contractor with expertise in risk analysis, and the HHS Office of Inspector General (OIG) to address any potential deficiencies in the model and/or identify where the model might be strengthened.

Program risk assessments were completed for FY 2005. While HHS did not identify any high-risk programs in its FY 2005 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. The sections below contain information on HHS activities related to estimating and reducing improper payments in these programs.

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

A. <u>Medicare</u> - The Medicare fee-for-service (FFS) improper payment estimate is derived from two programs: the Comprehensive Error Rate Testing (CERT) Program and the Hospital Payment Monitoring Program (HPMP). Each component represents about 50 percent of the total FFS Medicare payments. The CERT Program calculates the error rate for Carriers, Durable Medical Equipment Regional Carriers, and non-Prospective Payment System (PPS) inpatient Part A claims submitted to Fiscal Intermediaries (FIsFish). The HPMP calculates the error rate for PPS inpatient hospital claims submitted to the FIsFish. The methodology includes:

- Randomly selecting about 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. <u>Medicaid</u> – Twenty-four states determined Medicaid payment accuracy rates in year three of the Payment Accuracy Measurement (PAM) Pilot. All 24 states determined payment accuracy rates for the FFS component and 12 states also determined payment accuracy rates for the Managed Care (MC) component. In the FFS component, the states conducted three types of reviews—medical, data processing, and eligibility—and categorized improper payments found through the reviews using the same error codes. In the MC component, processing and eligibility reviews were performed, but no medical reviews were conducted.

States drew a proportional, stratified random sample of Medicaid claims across the major service categories. All states used a standard methodology and the same formula to compute the payment accuracy rates. Samples were drawn from a universe of all Medicaid FFS claims and MC capitation payments paid by the states from October 1 through December 31, 2003 (the first quarter of FY 2004).

C. State Children's Health Insurance Program (SCHIP) – Fifteen states determined SCHIP payment accuracy rates in year three of the PAM Pilot. Of the 15 states that measured SCHIP payment accuracy rates in FY 2004, ten states reviewed FFS components, seven states reviewed MC components; one state only reviewed eligibility; and three states reviewed both FFS and MC components. In the FFS component, states conducted three types of reviews—medical, data processing, and eligibility—and categorized improper payments found through the reviews using the same error codes. In the MC component - processing and eligibility reviews were performed, but no medical reviews were conducted.

Samples were drawn from a universe of all SCHIP FFS claims and MC capitation payments paid by the states from October 1 through December 31, 2003. Each state had the option of designing the sample to achieve 3 percent precision at the 95 percent confidence level or 4 percent precision at the 90 percent confidence level for the FFS and MC components. All states used a standard methodology and the same formula to compute the accuracy rate.

D. Temporary Assistance for Needy Families (TANF) – The extensive flexibility of state TANF Program operations and the prohibitions on data collection in the TANF legislation have continued to present challenges to identifying an effective and cost efficient methodology for measuring improper payments in the TANF Program. However, during FY 2005 HHS continued to engage in various activities to identify and reduce improper payments in the TANF Program. These activities include:

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 are being asked to voluntarily provide information on how they define improper payments, the process (es) used to identify such payments, and what actions are taken to reduce or eliminate improper payments. A repository for this information will be posted on an HHS/ACF website and will be available for viewing by all states.

Public Assistance Reporting Information System (PARIS) – The PARIS 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). HHS engaged in a number of activities to improve data match capability and usefulness and increase state utilization of PARIS. These activities included engaging in outreach activities to encourage states to participate in the PARIS match process; making a conference contract award to enable all PARIS participating states to meet in Washington, DC for HHS training in utilizing the PARIS to its fullest capability; and making an award to a contractor to evaluate the PARIS, formulate recommendations for improving and enhancing its usefulness, and develop a uniform reporting format.

TANF A-133 Audit Pilot – During FY 2005, HHS obtained agreement from one state to engage in a pilot to undergo a more in-depth review of TANF expenditures as part of its audit required under OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The objective of the pilot is to explore the viability of estimating improper payments in the A-133 audit process. In the expanded A-133 audit, the auditors used a statistical sample of a fixed size for a test of controls (attribute sampling method). The auditors reviewed 208 TANF cases to achieve a 95 percent confidence level with an expected deviation rate of 2.25 percent.

E. Foster Care – Title IV-E Foster Care eligibility reviews, promulgated in regulations at 45 CFR 1356.71(c), are conducted to ensure that Federal title IV-E funds are used only for eligible children who are placed with eligible providers. Since FY 2000, HHS has systematically conducted more than 70 title IV-E reviews 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 FY 2001 to FY 2004.

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 eligible homes and institutions. Each review specifies the number of error cases and amount of payment errors determined from the review of a sample drawn from the state's overall title IV-E caseload for its six-month Period Under Review (PUR). An error case is defined as a case in which a payment is made on behalf of an ineligible child during the 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 PUR, and "unallowable" payments for services not covered by title IV-E (e.g. therapy).

F. Head Start – HHS is legislatively required to perform reviews of each Head Start Program every three years. In the conduct of these reviews in FY 2004 and FY 2005, various data was collected to determine an estimate of improper payments for these years. A payment error 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).

Fifty programs were selected from the population of programs scheduled for review in FY 2005. An appropriate sampling strategy was utilized to determine the number of children's records to be pulled for each of the 50 selected programs to result in an estimate at plus or minus 2.5 percent precision at a 90 percent confidence interval.

G. Child Care – The complexity of the Child Care and Development Fund (CCDF) and the broad flexibility that the states have in the design and administration of the Program have presented challenges in identifying a methodology for estimating improper payments in the Program. However, during FY 2004, HHS initiated an improper payment pilot project to assess the efforts of several states to prevent and reduce improper payments in their Child Care Programs. Eleven states worked with HHS in assessing the adequacy of state systems, databases, policy, and administrative structures to detect, prevent, and identify payment errors in the Child Care Program. In FY 2005, HHS expanded state participation from 11 to 18.

As part of the pilot project, site visits were conducted in four states during FY 2005. These visits studied client eligibility, specifically, the states' ability to verify information received from clients during the initial eligibility process or otherwise to establish eligibility correctly. For this four-state error rate study, a research team used a random sampling approach to select a sample of 150 children per state for review, which provided a statistical basis for a 90 percent confidence interval of +/- 6 percent.. In addition, interviews were conducted with five other states to gather information about improper payment activities in those states.

During FY 2006, HHS will be continuing to work with the states to identify an appropriate strategy for determining estimates of payment errors in the Child Care Program.

III. A. Explain the corrective actions your agency plans to implement to reduce the estimated rate of improper payments. Include in this discussion what is seen as the cause(s) of errors and the corresponding steps necessary to prevent future occurrences. 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.

B. For grant-making agencies with risk susceptible grant programs, discuss what your agency has accomplished in the area of funds stewardship past the primary recipient. Include the status on projects and results of any reviews.

A. Medicare - A significant problem among the FY 2004 findings was a high insufficient-documentation rate by providers. To address the insufficient-documentation problem, HHS took the following steps during FY 2005:

- Revising letters requesting medical records to include the components of the medical record needed for review;
- Hiring an error rate documentation contractor whose primary focus will be lowering non-response and insufficient documentation rates;
- Allowing for faxing of medical records;
- Requesting medical records in Spanish;
- Performing more initial and follow-up providers contacts;
- Extending the time that providers have to respond to documentation requests from 55 days to 90 days;
- Conducting an insufficient documentation special study to better understand the causes of insufficient documentation;
- Allowing all providers a second chance to submit documentation;
- Developing a website to track sampled claims status; and
- Encouraging the use of Electronic Medical Record submission pilots to facilitate process of submitting medical records.

Based on the FY 2004 findings, HHS has identified and initiated the following corrective actions during FY 2005:

- Releasing a List of Over-utilized Codes that show error rates and improper payments by contractor/by service;
- Opening a Los Angeles satellite office focused on identifying and preventing improper payments to providers in the Los Angeles area;
- Developing new data analysis procedures to help identify payment aberrancies and using that information in order to stop improper payments before they occur;
- Conducting 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;
- Working with the American Medical Association to clarify evaluation and management code documentation guidelines;
- Considering contractor-specific error rates in the evaluation of contractors beginning in 2005;
- Increasing and refining one-on-one educational contacts with providers who are billing in error; and
- Working on developing and installing new correct coding edits.

As a result of these actions, the Medicare paid claims error rate decreased from 10.1 percent ($21.7 billion in gross payments), to 5.2 percent ($12.1 billion in gross payments) from FY 2004 to FY 2005.

The FY 2005 paid claims error rate of 5.2 percent exceeded HHS' Medicare Fee for Service Contractor Error Rate GPRA goal of 7.9percent. Because of this dramatic improvement, HHS has revised its GPRA goals for 2006 and beyond as follows:

- FY 2006: 5.1percent
- FY 2007: 4.9percent
- FY 2008: 4.7percent

(Part B of this section is not relevant to the Medicare Program.)

B. Medicaid – HHS has worked closely with each state participating in the PAM pilot to develop and implement a methodology for estimating payment error rates in the Medicaid Program for all states. HHS will provide recommendations for state corrective action plans based on the results of the PAM year three pilot. The emphasis of the pilot was for each state to individually measure the payment accuracy of its program since the Medicaid Program is unique to each state. HHS expects that each state will continue to identify and implement corrective action measures based on the results of the pilot projects and the states own experiences with its Medicaid Program.

HHS has also engaged in other activities. The Health Care Fraud and Abuse Control (HCFAC) account includes at least two projects (the hiring of 100 staff positions to do prospective reviews of state Medicaid operations, and the Medicare/Medicaid data match program) designed to identify improper payments and areas in need of improved payment accuracy. The HHS OIG also continues to receive money from the account to conduct audits on the Medicaid Program.

(Part B of this section is not relevant to the Medicaid Program.)

C. State Children's Health Insurance Program (SCHIP) – HHS has worked closely with each state participating in the PAM pilot to develop and implement a methodology for estimating payment error rates in the SCHIP Program for all states. HHS will provide recommendations for state corrective action plans based on the results of the PAM year three pilot. The emphasis of the PAM pilots was for each state to individually measure the payment accuracy of its program since the SCHIP Program is unique to each state. HHS expects that each state will continue to identify and implement corrective action measures based on the results of the pilot projects and the states own experiences with its SCHIP Program.

(Part B of this section is not relevant to the SCHIP Program.)

D. Temporary Assistance for Needy Families (TANF) – HHS has not yet identified or developed a methodology for determining an estimate of payment errors. However, as noted in Section II.D, HHS is engaging in various activities to identify and reduce improper payments in the TANF Program.

HHS policies and procedures for subrecipient monitoring and oversight are consistent with what is allowed by the TANF legislation and related program and grant regulations and provided for in OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.*

E. Foster Care - In an analysis of the improper payments that were identified, HHS determined that six types of eligibility errors were found more than 50 times across these samples and accounted for 84 percent of all errors found in the title IV-E reviews. The frequency of the remaining types of eligibility errors ranged from 1 to 36, with most of the error types occurring 12 or fewer times across all samples. The most frequently occurring errors are:

- Permanency finalization not timely (286 errors);
- Provider not licensed or approved (173 errors);
- No reasonable efforts to prevent removal (114 errors);
- Not AFDC eligible at time of removal (81 errors);
- Criminal records check not completed (71 errors); and
- No contrary to welfare determination (65 errors).

Since nearly 70 percent of states were found to have at least one provider licensing/approval error, ensuring that title IV-E Foster Care children are placed with licensed approved providers appears to be the most common challenge across states receiving title IV-E funds.

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 CFR 1356.71(c). Related activities include:

1. HHS conducts onsite and post-site review activities to effectively validate the accuracy of a state's claim for reimbursement of payments made on behalf of children and their foster care providers. Specific feedback is provided onsite to the state agency to directly impact the proper and efficient administration and implementation of the state's title IV-E Foster Care maintenance payments programs. Further, a comprehensive report is issued to the state agency to confirm the final findings of the onsite review. The final report serves as the basis for the development of a Program Improvement Plan (PIP).

2. States are required to develop and execute state specific PIPs 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.

   The PIP must be developed by state staff in consultation with Federal staff and must include the following components:

   - Specific goals or outcomes for program improvement;
   - Measurable action steps required to correct each identified weakness or deficiency;
   - Date for completing each action step;
   - Description of how progress will be evaluated by the state and reported to the ACF regional office, including the frequency and format of the evaluation procedures; and
   - Description of how the HHS regional office will know that an action step has been achieved.

3. HHS provides onsite training and technical assistance to states to develop and implement program improvement strategies. The assistance is coordinated through HHS regional offices.

4. HHS works toward heightening judicial awareness of and investment in the Child and Family Services Reviews (CSFR). Three of the six most frequently occurring errors involve the judiciary. Specifically, those errors which depend on the judiciary include (1) judicial determination regarding reasonable efforts to finalize permanency plan not timely; (2) no reasonable efforts to prevent removal; (3) no contrary to welfare determination; and (4) no judicial determination regarding child's best interest within 180 days of voluntary placement agreement. Judicial organizations with which HHS works on CFSR issues have already acknowledged that the same type of education and support needs to be provided regarding the title IV-E eligibility reviews. HHS will share the results of the Foster Care reviews and its analysis of the findings data with these organizations and seek to obtain their support in providing training for judges with regard to title IV-E eligibility requirements. Through the National Resource Center network, HHS offers training and technical assistance to educate and inform the judiciary in areas pertaining to their role directly impacting the state agency's performance on the eligibility factors.

5. HHS works closely with the Court Improvement Program (CIP) in states where judges require training and court orders warrant modification to reduce the error rate for this finding. The CIP is funded under title IV-B and is administered by state courts. Further, recommendations to improve the court system will be developed and assistance will be provided to implement the recommended reforms.

6. HHS conducts secondary reviews (as applicable) and takes appropriate disallowances consistent with the review findings. The development and implementation of the PIP in conjunction with a second review of a substantially larger number of cases may result in a much larger disallowance for the state than was taken as a result of the first review. That is because the larger number of cases being examined allows HHS to extrapolate the results to the universe of foster care cases in the state, thereby increasing the resulting disallowance. HHS' expectation is that these disallowances will serve as strong encouragement to the states to improve their programs to the extent that when a secondary review is conducted they will be determined to be in substantial compliance.

HHS 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 OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

F. Head Start - During FY 2005, HHS undertook various actions to address the causes attributed to the improper payments identified and reported on in the FY 2004 PAR. To improve recruiting and enrollment practices, an Information Memorandum was sent to all programs reiterating the need to adhere to 45 CFR 1305, "Eligibility, Recruitment, Selection, Enrollment and Attendance in Head Start." Further, HHS added to the FY 2005 Program Review Instrument for Systems Monitoring Guide a requirement that the teams review a sample of children's files using the same data collection form which is used in the reviews conducted for the purpose of estimating payment errors. As a result of these actions, the Head Start payment error rate decreased from 3.9 percent in FY 2004 to 1.6 percent in FY 2005.

In FY 2006, HHS will continue to require examination of a sample of files to obtain information regarding the Program's compliance with income eligibility program requirements as part of all reviews conducted under 45 CFR 1305.

HHS policies and procedures for subrecipient monitoring and oversight are consistent with what is allowed by the Head Start legislation, related program and grant regulations, and provided for in OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

G. Child Care - HHS identified potential sources of payment error in the states participating in the Child Care pilot (discussed in Section II.G.). HHS and the states are working together to address potential errors identified during pilot activities.

HHS policies and procedures for subrecipient monitoring and oversight in the Child Care and Development Fund (CCDF) are consistent with what is allowed by the Child Care legislation, related program and grant regulations, and provided for in OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

Primary recipients of CCDF funds are lead agencies from states, territories, and Tribes, usually the Department of Human Services, Human Resources, Social Services or Workforce Development. Subrecipients include, but are not limited to, Child Care Resource and Referral Agencies, Community Action Agencies, contracted providers, and agencies responsible for administering quality dollars or other earmarked funds.

HHS receives biennial CCDF plans and regular reports from states, territories, and Tribes that detail how they implement the CCDF Program, how they spend their allotment of CCDF funds, and the nature of services provided (i.e., 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 CCDF regulations.

IV. The table below is required for each reporting agency. Please note the following changes from prior year reporting: (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.

Improper Payment Reduction Outlook FY 2004 – FY 2008
($ in millions)

Program	PY Outlays	PY %	PY $	CY Outlays	CY IP %	CY IP $	CY+1Est Outlays	CY+1 IP %	CY+1 IP $	CY+2Est Outlays	CY+2 IP %	CY+2 IP $	CY+3Est Outlays	CY+3 IP %	CY+3 IP $
Medicare	213,500*	10.1%	$21,700 ($20.8B over, $0.9B under)	234,100**	5.2%	12,100 ($11.2B over, $0.9B under)	282,533	5.1%	14,409	286,684	4.9%	14,407	295,232	4.7%	13,875
Medicaid	176,231	Note (1)	Note (1)	181,719	N/A	N/A	191,593	N/A	N/A	204,096	N/A	N/A	222,231	N/A	N/A
SCHIP	4,607	Note (2)	Note (2)	5,129	N/A	N/A	5,326	N/A	N/A	5,247	N/A	N/A	5,287	N/A	N/A
TANF	17,725	Note (3)	Note (3)	17,401	N/A	N/A	17,918	N/A	N/A	17,828	N/A	N/A	17,404	N/A	N/A
Foster Care	1,800***	10.33% Note (4)	186	1,816	10.02% Note (4)	182 Note (4)	1,821	9.41%	171	1,841	8.49%	156	1,856	7.57%	140
Head Start	6,555	3.9%	255	6,865	1.6%	110	6,866	1.5%	103	6,886	1.4%	96	6,888	1.4%	96
Child Care	4,832	Note (5)	Note (5)	4,901	N/A	N/A	4,801	N/A	N/A	4,767	N/A	N/A	4,756	N/A	N/A

* PY Outlays for Medicare FFS are from the November 2004 Improper Medicare FFS Payments Report (which were based on CY 2003 claims)

** CY Outlays for Medicare FFS are from the November 2005 Improper Medicare FFS Payments Report (which were based on FY 2005 claims)

*** FY 04 Outlays of $4,404 reported in the FY 2004 PAR for the Foster Care Program included administrative costs. Since the payments reviewed in determining the estimated FY 2004 and FY 2005 estimated error rates did not include administrative costs, the PY outlay amount was revised to reflect maintenance payments only.

NOTE:

1. Payment accuracy rates were determined by the states participating in the PAM pilot. Twenty-four states determined Medicaid FFS payment accuracy rates ranging from 46 percent to 99 percent, with 50 percent of the states having a payment accuracy rate over 95 percent. Twelve states determined Medicaid MC payment accuracy rates which ranged from 93 percent to 100 percent, with 11 of the 12 states having a payment accuracy rate above 99 percent.
2. Payment accuracy rates were determined by the states participating in the PAM pilot. Eleven states determined SCHIP FFS payment accuracy rates ranging from 75 to 99 percent, with 36 percent of the states having a payment accuracy rate over 95 percent. Seven states determined SCHIP MC payment accuracy rates which ranged from 80 percent to 100 percent, with six of the seven states having a payment accuracy rate greater than 97 percent.
3. HHS has not yet identified or developed a methodology for determining an estimate of payment errors for the TANF Program. As noted in Section II.D, HHS is engaging in various activities to identify and reduce improper payments in the TANF Program. In an expanded audit of TANF cases/expenditures conducted as part of HHS' A-133 pilot, the pilot state's A-133 auditors reported an overall case error rate of 20 percent and a payment error rate of 3.9 percent based on their review of 208 cases.
4. The FY 2004 Foster Care error rate was not finalized prior to FY 2004 PAR completion and therefore is being reported for the first time in FY 2005. For FY 2005, a preliminary Foster Care error rate is being reported. It is expected that the FY 2005 final rate will be available on or before November 30, 2005.
5. HHS has not yet identified or developed a methodology for determining an estimate of payment errors for the Child Care Program. However, payment error rates were determined in four states in the Child Care pilot project (see section II.G.) based on the sample of 150 children. The payment error rate estimates are at a 90 percent confidence interval of +/-6 percent. The four rates determined were 4 percent, 8 percent, 14 percent and 20 percent.

V. Discuss your agency's recovery auditing effort, if applicable, including any contract types excluded from review and the justification for doing so; actions taken to recoup improper payments, and the business process changes and internal controls instituted and/or strengthened to prevent further occurrences. In addition, complete the table below.

During FY 2004, HHS implemented a Department-wide recovery auditing program as required by Section 831 of the Defense Authorization Act of 2002. This includes awarding a contingency fee contract to a recovery auditing firm in June 2004. During FY 2005, the recovery auditing firm completed its review of a substantial portion of the $11.1 billion of FY 2002 and FY 2003 contract payment transactions subject to review. Although the auditors identified $2.1M of potential improper payments, $1.3M was determined to be related to payment that were voided and/or for which credits had already been applied. HHS is working on recovering $0.8 of payments determined to be improper.

Also, HHS is required under the Medicare Prescription Drug Improvement Modernization Act of 2003 (MMA) to conduct a demonstration project to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare Program for services for which payment is made under Part A or B of title XVIII of the Social Security Act. One of the outcomes of this demonstration is to see if the 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.

HHS is conducting the demonstration in the three states with the highest Medicare utilization rates and has committed administrative dollars to creating a database to facilitate communication and to track the progress of the demonstration. The recovery audit contractors have been given almost one billion claims that Medicare paid between FY 2002 and 2004 and the recovery auditors are tasked with reviewing these claims to determine improper payments. Each fiscal year the recovery auditor will receive the prior fiscal years' paid claims. The recovery auditors will use complex medical review and proprietary software to complete their analysis. HHS is committed to tracking the progress of the demonstration and to using the information to improve the claim payment accuracy rate. At the end of FY 2005, the demonstration was still in the start-up phase and recovery information was not yet available.

Agency Component (if applicable)	Amount subject to Review for FY05 Reporting	Actual Amount Reviewed and Reported	Amounts Identified for Recovery	Amounts Identified/Actual Amount Reviewed	Amounts Recovered CY	Amounts Recovered PY(s)
HHS	$12.6B	$11.1B	$2.1M	$0.8M	$14,430	$0

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

HHS is issuing interim scorecard ratings for the HHS Operating and Staff Divisions, which have helped facilitate HHS leadership discussion and accountability on the improper payment initiatives. Further, in FY 2004, HHS performance plan objectives were established which require that managers "identify and address weaknesses in grant systems(s), procurement systems(s) and finance offices to ensure recovery of improper payments and to reduce the number of improper payments by the Department." Similar performance plan objectives were included in FY 2005 and 2006 performance plans.

VII. A. Describe whether the agency has the information systems and other infrastructure it needs to reduce improper payments to the levels the agency has targeted.

B. If the agency does not have such systems and infrastructure, describe the resources the agency requested in its FY 2006 budget submission to Congress to obtain the necessary information systems and infrastructure.

A. Medicare - 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. Medicaid – HHS will be implementing the Payment Error Rate Measurement (PERM) Program in FY 2006 using a national contractor to determine state Medicaid FFS payment error rates. The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until implementation is near or at completion and actual results become available.

C. State Children's Health Insurance Program (SCHIP) – HHS expects to begin measuring SCHIP error rates in FFS, MC, and eligibility components in FY 2007. The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until implementation of the measurement plan is near or at completion and actual results become available

D. Temporary Assistance for Needy Families (TANF) – HHS has not yet developed a methodology for estimating payment errors in the TANF Program and therefore has not established reduction targets.

E. Foster Care – 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. No other systems or infrastructure are needed at this time.

F. Head Start - HHS has the information systems and infrastructure needed to reduce improper payments to the levels that HHS has targeted for the Head Start Program.

G. Child Care – HHS has not yet developed a methodology for estimating payment error in the Child Care Program and therefore has not established reduction targets.

VIII. Describe any statutory or regulatory barriers which may limit the agencies' corrective actions in reducing improper payments and actions taken by the agency to mitigate the barriers' effects.

A. Medicare - No statutory or regulatory barriers have been identified.

B. Medicaid – During the pilot projects, states administered on a voluntary basis the Medicaid payment error measurement for each participating state, which was the basis for calculating the Medicaid improper payment estimates. HHS adopted a national contracting strategy with expected implementation beginning in FY 2006. Because states administer the Medicaid and SCHIP Programs, the ability of HHS to obtain state compliance is limited in the absence of statutory authority to hold states accountable for meeting targets for the reduction and recovery of improper payments.

C. State Children's Health Insurance Program (SCHIP) – During the pilot projects, states administered on a voluntary basis the SCHIP payment error measurement for each participating state, which was the basis for calculating the SCHIP improper payment estimates. HHS adopted a national contracting strategy with expected implementation beginning in FY 2006. In FY 2007, CMS expects to begin measuring SCHIP error rates in FFS, MC, and eligibility components. Because states administer the Medicaid and SCHIP Programs, the ability of HHS to obtain state compliance is limited in the absence of

statutory authority to hold states accountable for meeting targets for the reduction and recovery of improper payments.

D. Temporary Assistance for Needy Families (TANF) - HHS has not yet developed a methodology for estimating payment errors in the TANF Program which would lend itself to the identification of appropriate corrective action measures for the Program as a whole. In the activities it is undertaking to develop a methodology, HHS is addressing corrective action on a case-by-case basis.

E. Foster Care – Current program regulations define the sample size, the extrapolation of a disallowance following the primary review, and the current corrective action process. Any proposed changes in the compliance framework or current methodology for estimating improper payments would need to be made available for public comment through the rulemaking process and a final rule published prior to implementation.

F. Head Start – No statutory or regulatory barriers have been identified.

G. Child Care – HHS has not yet developed a methodology for estimating payment errors in the Child Care Program which would lend itself to the identification of appropriate corrective action measures for the Program as a whole. In the activities it is undertaking to develop a methodology, HHS is addressing corrective action on a case-by-case basis.

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 OIG 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 CERT HPMP, 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. In FY 2005, HHS reduced the Medicare paid claims error rate from 10.1 percent ($21.7B in gross payments), to 5.2 percent ($12.1B in gross payments) from FY 2004 to FY 2005. This rate reduction exceeds the HHS FY 2005 targeted reduction rate of 7.9 percent.

HHS also experienced successes in addressing improper payments in other programs. In the Head Start Program, HHS also experienced a significant decline in the payment error rate; from 3.9 percent to 1.6 percent from FY 2004 to FY 2005. Again, HHS exceeded the established reduction target (3.5 percent).

In the Foster Care Program, HHS developed a methodology for estimating improper payments and is reporting a payment error rate for the first time. Both the FY 2004 actual rate and preliminary FY 2005 rate are being reported on.

HHS will be implementing the Payment Error Rate Measurement (PERM) Program in FY 2006 using a national contractor to determine date Medicaid FFS payment error rates for medical error and data processing error. Further, work toward developing and implementing methodologies for other SCHIP and other components of Medicaid will be continuing throughout FY 2006.

In the TANF and Child Care Programs, HHS engaged in numerous activities to identify and reduce improper payments. Since these are block grant programs where program legislation allows states maximum flexibility in operating its programs, it has been difficult to define error in a way that has meaning across the states. Further, there are barriers to requesting information and/or requiring participation in improper payment activities. Although it has been most challenging in identifying effective and cost efficient approaches for estimating payment errors in these programs, HHS is engaging in numerous activities working toward identification of appropriate strategies for estimating improper payments in these programs.

While the successes that HHS has been able to achieve in its improper payment initiatives are due to a

number of reasons, 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 of what the HHS OIG and the OMB can contribute to the HHS initiatives as it develops and implements strategies and has ensured that they 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.

In FY 2006, HHS hopes to overcome the challenges it faces in estimating payment errors in the TANF and Child Care Programs. Further, HHS will be working toward reducing payment errors for not only those programs where it is undertaking PMA improper payment activities, but also where it identifies any opportunity in the course of financial and program operations.

APPENDIX D – FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT ON SYSTEMS AND CONTROLS

The Federal Managers' Financial Integrity Act (FMFIA) requires agencies to provide an annual statement of assurance on the effectiveness of their management, administrative, and accounting controls (Section 2 of the Act), and financial management systems (Section 4 of the Act). Significant deficiencies in internal controls are considered material weaknesses; significant deficiencies in financial management systems are considered material nonconformances. The full text of the Secretary's assurance statement for FY 2005 can be found in the Secretary's Letter at the beginning of this report; the Sections 2 and 4 results are discussed in the following pages.

FMFIA Section 2 Material Weaknesses and Section 4 Nonconformances Outstanding					
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Section 2 Material Weaknesses Outstanding					
From Prior Year	5	2	1	0	3
New	0	0	0	3	1
Corrected/Reclassified	3*	1	1**	0	3
Outstanding as of 9/30/2005					**1**
Section 4 Material Nonconformances Outstanding					
From Prior Year	0	1	1	1	1
New	1*	0	0	0	0
Corrected/Reclassified	0	0	0	0	0
Outstanding as of 9/30/2005					**1**

* Financial Systems and Processes (HHS-00-01). This single Section 4 finding reflects HHS' action during FY 2001which formerly combined the following three Section 2 material weakness findings into a single finding, and reclassified the combined finding as a Section 4 non-conformance Details and status in chart below):

- Financial Systems and Processes (HHS-00-01) (1a below)
- Financial Systems Analysis and Oversight (CMS-01-01) including Managed Care (1b below) Note: Per the auditors, the components of this sub-finding have been corrected to a reportable condition in 2005, (except for the lack of an integrated accounting system (HIGLAS) and Managed Care. Managed Care is being reported as a separate Section 2 material weakness.
- Medicare EDP Controls (CMS-01-02) (1c below) Per the auditors, this subcomponent was corrected to a reportable condition in 2005. See appendix E.

** "Deficiency in the Enforcement Program for Imported Foods" (FDA-89-02). Due to substantial FDA efforts, HHS no longer considers FDA-89-02 to be material at the Department-wide level FDA reported that, consistent with its target to correct this material weakness in FY 2005, FDA has taken sufficient corrective action to warrant removal from the material weakness list at FDA although FDA will continue to monitor this area closely and report any major findings or initiatives in future FMFIA reports.

Status of Outstanding FMFIA Material Weaknesses or Nonconformances			
#	Title and Identification Code	First FY Reported	Target Correction Date
Section 2			
1	Managed Care Benefit Expense Cycle ID: HHS-05-01	FY 2005	FY 2006
Section 4			
1a	Financial Systems & Processes ID: HHS-00-01	FY 2001	UFMS FFMIA compliance (FY 2006) UFMS full implementation (FY 2007)
1b	CMS Financial Systems ID: CMS-01-02 (formerly HCFA 97-02)	FY 2001	HIGLAS FFMIA compliance (FY 2008) HIGLAS full implementation (FY 2011)

HHS reports one new Section 2 material weakness in FY 2005, Managed Care Benefit Expense Cycle. Two Section 2 material weaknesses from the FY 2004 report, Federal Information Security Management Act (FISMA) Significant Deficiency and Departmental Financial Reporting, have been corrected as planned. For the Departmental Payroll System material weakness, the auditors found that substantial progress was made and it is no longer material.

FY 2004 Section 2 Material Weaknesses Corrected

The following three material weaknesses were corrected in FY 2005.

Federal Information Systems Management Act (FISMA) Significant Deficiency (HHS-04-01)

The HHS FISMA report for FY 2005 will reflect that this significant deficiency involving contingency planning and disaster recovery for some of HHS systems has been corrected. Based on the level of attention to the contingency plan development and subsequent testing for high impact systems, coupled with the overall attention that has been placed on contingency plans and testing across all HHS FISMA systems, the Inspector General opinion (in the FISMA Report) was that this issue no longer rose to the level of a significant deficiency.

Due to FISMA confidentiality requirements, the FISMA report findings are not published and therefore a detailed report on corrective actions taken is not included in this published FMFIA report. However, the HHS Chief Information Office (CIO) has reported that the following actions were taken in FY 2005 at the Departmental level (HHS CIO):

- Completion and testing of contingency plans are monitored by the HHS Security Program, Secure One HHS, on an ongoing basis and resulted in an increased completion percentage from 80 percent to 95 percent for contingency plans and from 29 percent to 81 percent for contingency plan testing of systems overall. Contingency plan and testing completion has been accomplished for 100 percent of high risk impact level systems.
- During FY 2005 each of the OPDIVs was required twice to complete a corrective action plan that documented how and when the deficiencies noted in their individual FISMA reports would be resolved**.**
- The HHS Security Program, Secure One HHS, is currently reviewing the HHS OPDIV security Programs to ensure that all issues have been addressed and that the security programs themselves have processes in place that allow for security issues to be addressed effectively.
- HHS executive commitment to resolving this issue was articulated and responsibility for that resolution was documented in executive performance plans across HHS.

Departmental Payroll System (HHS-04-02)

The auditors found that substantial progress was made regarding the finding from last year's audit and is no longer considered by the auditors to be material. The most significant development in 2005 was the conversion of the central payroll system to DFAS in April 2005.

Following are some of the corrective actions taken in FY 2005:

- As stated above, the transition of payroll services to the Defense Finance and Accounting Service (DFAS) was completed in April 2005. Additionally, migration of the Electronic Official Personnel Folders (eOPF) project was completed August 14, 2005.
- Quarterly reviews are being performed on a random sample basis between the Enterprise Human Resources and Payroll System (EHRP) and central payroll to ensure deductions and withholdings in the personnel system coincide with the central payroll system.
- New documentation was posted regarding standard operating procedures based on DFAS.

Future actions to be taken include:

- Continue quarterly reviews of EHRP and central payroll.
- Expand internal review with the HR centers to include documentation such as eOPF/OPF for supporting documentation.
- Document and finalize additional standard operating procedures for DFAS.

The Department is committed to putting any necessary remedial or preventive mechanisms in place to improve its audit standing. HHS fully embraces having solid oversight responsibilities for payroll and personnel and has already implemented procedures and processes that address many of the concerns discovered during its massive data cleanup efforts. HHS believes that its efforts in the HR consolidation, implementation of Department-wide automated HR systems, and the transition to DFAS will enhance the Department's ability to have a solid payroll system.

Departmental Financial Reporting (HHS-04-03)

This material weakness was corrected in FY 2005 as planned. In FY 2004, the auditors found that the Department lacked a coordinated process among cross-functional teams of finance, operations, and legal personnel to monitor business activities to identify situations where accounting evaluation or decision making may be necessary. The issue that gave rise to this problem was that HHS had a significant policy issue at the end of FY 2004 that had a material impact on its financial statements. This issue was below the materiality threshold in prior years.

In December 2004, at the direction of the Acting HHS Chief Financial Officer (CFO) by memorandum, the Department implemented the following actions to address this material weakness:

- Developed policies and procedures to promptly identify and communicate significant policy issues such as potential loss contingencies in accordance with Statement of Financial Accounting Standards No. 5, *Accounting for Contingencies*.
- Developed a systematic accountability process to ensure timely resolution of policy, legal, and accounting questions involving loss contingencies. These procedures will include consulting and coordinating with the Assistant Secretary for Budget, Technology, and Finance, Office of the General Counsel, and the Office of Inspector General.
- Strengthened the existing CFO quarterly meetings at the Department level to ensure ongoing coordination among cross-functional teams of operations, legal, and finance personnel to identify significant programmatic activities that may affect the quarterly and annual financial statements.
- In May 2005, a memorandum from the Acting CFO required mandatory Statement of Auditing Standards (SAS) No. 99, *Consideration of Fraud in a Financial Statement Audit*, training for all management officials who sign the management representation letter. SAS documents are internationally recognized auditing standards developed by the American Institute of Certified Public Accountants. SAS 99 defines fraud as an intentional act that results in a material misstatement in financial statements and requires additional scrutiny from the auditor, who must consider two types of fraud: misstatements arising from fraudulent financial reporting (e.g., falsification of accounting records) and misstatements arising from misappropriation of assets (e.g., theft of assets or fraudulent expenditures). Since then, HHS has been conducting extensive SAS 99 training including interviews for all HHS management officials who sign the management representation letter in coordination with the auditors. The training was completed as scheduled during the fourth quarter FY 2005. Among those interviewed were the Secretary, Deputy Secretary, Chief of Staff, HHS CFO, OPDIV CFOs, and other senior managers at the Department.

With regard to the Special Disability Workload (SDW) issue that gave rise to the finding, CMS reported the following status:

- There have been no changes to the underlying assumptions or methodology developed at September 30, 2004 related to estimation of the contingent liability for the SDW issue.
- For the June 30, 2005 interim financial statements, the September 2004 white paper was updated to include an estimated change of $96 million over the $1.867 billion estimate reported as of September 30, 2005.
- The Social Security Administration's Office of the Chief Actuary provided updated information in September 2005. The CMS revised the SDW estimate as of September 30, 2005, resulting in a new estimate of $1.638 billion.

HHS will continue to engage the active participation of OMB officials in the resolution of any significant policy issues that could affect future audits.

Following is a discussion of the new Managed Care Benefit Expense Cycle material weakness (HHS-05-01).

FY 2005 Section 2 Material Weakness Corrective Action Plan
HHS-05-01 Managed Care Benefit Expense Cycle

The internal controls over the Medicare Managed Care Program need to be improved. Inadequate internal controls over audit and payment activities for the Medicare Managed Care Program resulted in the following CFO-audit related findings: (1) CMS does not maintain sufficient documentation to support the on-going monitoring of Managed Care organizations by the regional offices in accordance with CMS policies and procedures; (2) inadequate policies, documentation and supervisory controls exist related to the authorization and payment process for the Medicare Managed Care Program; (3) during 2005, CMS underwent a major systems conversion and implemented the Medicare Managed Care System (MMCS) payment system that resulted in erroneous payments for Medicare Managed Care contractors. Inaccurate payments were made throughout the year due to the use of inaccurate information. The CMS failed to establish a systematic method for identifying, documenting, and correcting errors found in the MMCS system; and (4) CMS has not established proper segregation of duties related to authorization and controls around payments made to Medicare Managed Care contractors.

Summary of Corrective Action Approach

Managed Care (Monitoring) - With regard to the oversight of the Managed Care Program, the CMS Central Office (CO) staff will follow up with all Regional Offices (ROs) to ensure that the ROs follow the Medicare Advantage organization, cost organization, demonstration, and health care pre-payment plans audit protocols and document retention standard protocols.

Managed Care (Payment) – The CMS will continue to work with the Division of Enrollment and Payment Operations (DEPO) external contractor to develop standard operating procedures, policies, procedures, and internal controls around payment system functions. The CBC will work to develop systems for better identifying system errors and related payment errors. The CBC will work to strengthen the Agency's segregation of duties around Managed Care payments.

Key Milestones for Corrective Action

FY 2005 Actions:

Managed Care (Monitoring) – The CMS has accomplished the following initiatives in FY 2005 to improve the maintenance of documentation to support the ongoing monitoring of Managed Care organizations by the regional offices in accordance with the CMS policies and procedures.

- Created new Health Plan Management System (HPMS) Monitoring Module functionalities in order assist with proper reporting and maintenance of documentation. The new functionalities included: (1) the removal of the automatic schedule functionality (this will eliminate the problem of creating estimated site visits not being utilized), (2) the creation of a new requirement to create nine and five day e-mail reminders, (3) the creation of a new requirement to remove certain demonstration types from the contracts available for selection in the HPMS Monitoring Module, (4) the creation of a requirement to create a new report, Visit Schedule/History Report, and (5) the creation of a new requirement to remove all plans that are terminated from the selection criteria in the HPMS Monitoring Module.

- Completed CO/RO led internal audits also called Continuous Quality Improvement Visits (CQI) of all but one regional office. The CQI visits assessed whether or not regional offices were conducting Medicare Managed Care audits timely, accurately and in accordance with established procedures and guidelines. The visits also established continuously improving oversight of CMS Medicare Managed Care contractors.

Managed Care (Payment) – The CMS has obtained an external contractor to audit DEPO's payment systems. Currently the external contractors are preparing a report of audit findings and based on the audit findings, the contractors will develop new and revised policies, procedures and internal controls pertaining to authorization and payment processes.

Target Correction Date: FY 2006

FY 2006 Planned Actions:

- External contractor to audit DEPO payment systems and develop internal control policies and procedures. *March 2006*
- Conduct CO internal reviews of applications, standard operating procedures, and monitoring documentation. *April 2006*
- Conduct RO monitoring documentation reviews. *May 2006*

Section 4 Material Nonconformance Outstanding Financial Systems and Processes (HHS-00-01)

Summary

At the end of FY 2005, HHS reported one repeat Section 4 nonconformance, Financial Systems and Processes (HHS-00-01). The Managed Care Program, formerly reported as part of the Department-wide Financial Systems and Processes material nonconformance, is being reported as a separate material weakness under Section 2 of the FMFIA. (See HHS-05-01 as reported above.) For one of the two subcomponents of this material nonconformance, Financial Systems Analysis and Oversight, CMS made progress which resulted in the findings in both the Medicare and Health Programs being reduced to a reportable condition or incorporated into the Managed Care Benefit Expense Cycle material weakness. Both CDC and FDA continued to record thousands of nonstandard accounting entries both prior and subsequent to the UFMS conversion. FDA recorded 14 thousand non-standard accounting entries totaling an absolute value of approximately $9.4 billion to create the September 30, 2005 financial statements. FDA noted this was primarily due to the productivity dip and lack of familiarity with the system. To prepare the September 30, 2005 financial statements, CDC indicated it was required to do the following:

- Accounting entries totaling an absolute value of $11.3 billion either to adjust its statements or to another HHS operating division.
- Adjustments totaling an absolute value of $24.4 billion with the Automated Desktop Integrator Program. Generally these adjustments related to conversion, data clean up, corrections, account reclassifications, and other adjustments to conform to UFMS processing.
- A $19.1 billion absolute value adjustment to the database to generate financial statements as a result of conversion adjustments made in the UFMS which could not be extracted into the database.

For the second subcomponent, Medicare Electronic Data Processing Controls, much of that finding was corrected and the auditors also classified it as a reportable condition.

HHS auditors have cited the Department's lack of an integrated accounting system as a material weakness and a specific impediment in preparing timely financial reports and statements.

As part of the "One HHS" approach to managing the Department, HHS is developing and implementing an integrated UFMS to provide for Department-wide financial reporting. UFMS will generate interim

and annual financial statements, as well as other required external and internal financial reports. UFMS consists of two primary components: the Health Care Integrated General Ledger System (HIGLAS), dedicated to CMS, and the second dedicated to the rest of HHS.

FY 2005 has seen a significant achievement for the UFMS effort. In April, the system was deployed at the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). The National Institutes of Health (NIH) Business and Research Support System (NBRSS) has already been "stood up." By the end of the year, HIGLAS will have been deployed at four of the largest CMS Medicare contractors. While CMS was unable to implement HIGLAS at Empire (Part A) in June, it achieved an end of July implementation.

This level of deployment will not comply with the requirements of the Federal Financial Management Improvement Act (FFMIA). The Department advised OMB that it would not meet this level of materiality of financial operations until the end of FY 2008 as a result of implementing Medicare Contractor Reform, which resulted in the HIGLAS roll-out schedule to contractors being extended to be consistent with the procurement schedule and to minimize roll-out costs However, while implementing HIGLAS is the biggest hurdle to achieving FFMIA compliance, HHS plans to resolve all other non-HIGLAS-related FFMIA noncompliance and the material weaknesses by the end of FY 2006, before completion of HIGLAS. Correction of the overall material weakness is pending full UFMS implementation by FY 2007, even though HIGLAS is not expected to achieve full FFMIA compliance until FY 2008 as stated above.

In the short term, account analysis and reconciliations are helping to mitigate systems weaknesses. The OPDIVs have continued to make substantial progress in addressing account analysis and reconciliation problems that contribute to the Department's FMFIA Section 4 nonconformance. Relative to the subfinding of Financial Statement Preparation, HHS continued during FY 2005 to improve the financial reconciliation and financial reporting improvement processes necessary for preparation of accurate and timely financial statements. UFMS experienced some reconciliation problems at FDA and CDC relative to the go-live in April that are being resolved. PSC also made significant manual efforts in FY 2005 by quarter relative to reconciliations, flux analyses, and quarterly statements.

NIH initiated a review to address and resolve the material weakness cited in the audit of the HHS FY 2004 financial statements. The review included NIH and contract audit staff and focused on the methodology and discipline applied to the fiscal year end closing process. As a result of these efforts NIH has implemented numerous additional analyses and reconciliations; a new, more disciplined and controlled process to prepare the trial balances from which financial statements are prepared; and identified additional areas of potential improvement. NIH also plans to validate or change certain internal processes and provide significant training to staff. This effort will result in benefits to accounting operations and to the administrative operations of ICs. In addition, the NIH Center for Information Technology has implemented a new web-based tool that allows staff to analyze online all general ledger accounts individually and by transaction code. This has allowed NIH to correct and compensate for some of the deficiencies noted by auditors. The information is more reliable and available in a timely manner for review and reporting.

- CDC conducts periodic reviews, as well as monthly and quarterly reconciliations. CDC completed reconciliation of the Strategic National Stockpile (SNS) purchase orders and invoices to verify current inventory valuation. CDC has acknowledged a need to comprehensively evaluate the management and financial controls in this area, and plans to perform a comprehensive evaluation of the Stockpile Program to make recommendations for system changes that will improve management and financial controls.
- PSC is working on improving estimation techniques and correcting CORE transaction to reduce the number of adjustments and evaluating the posting of estimates and accruals to CORE. In addition, the Division of Financial Operations (DFO) will continues to analyze and review data to post corrections and estimates into CORE and will establish as many transactions and journal vouchers

(JV) in the CORE Accounting System prior to closeout to reduce the quantity of journal vouchers necessary to prepare statements. This process will be ongoing throughout the year. Finally, DFO will continue to reconcile Federal Agencies' Centralized Trial-Balance System II to the financial statements through in depth analysis on a quarterly basis. In addition, DFO, with additional contractor staff, will: (1) address the unreconciled differences in the Fund Balance with Treasury; (2) address the outdated accounts payable and undelivered orders on an ongoing basis in an effort to prepare for the conversion to UFMS; and (3) provide copies of quarterly financial statements to the OPDIVs for review and analysis.

- The new UFMS will eliminate this material weakness by generating financial statements without the manually-intensive process.
- Auditors reported in the FY 2004 CMS audit report that, overall, the Medicare contractors continue to significantly improve the maintenance of supporting records for financial activities and year-end balances. However, the lack of an integrated financial management system continues to impair CMS and its Medicare contractors' abilities to efficiently and effectively support and analyze accounts receivable and other reported financial balances on a timely basis. The CMS long-range plan to address this material weakness is to implement HIGLAS at the Medicare contractor locations.

Medicare Electronic Data Processing (EDP) Controls

The CMS revised its strategy to address CFO EDP audit issues in FY 2005. This strategy was successfully implemented as the prior material weakness has been downgraded to a reportable condition. See Appendix E.

The subsequent pages discuss HHS' corrective action plans for the Section 4 material nonconformance, Financial Systems and Processes

- Department-wide (HHS-00-01),
- CMS Financial Systems (HIGLAS)

Section 4 Material Nonconformance Outstanding Corrective Action Plan Department-wide Financial Systems and Processes (HHS-00-01)

Background

This Department-wide material nonconformance was first identified in FY 2000.
The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. The finding was reclassified in FY 2001 under Section 4 of the FMFIA as Financial Systems and Processes (HHS-00-01).

Target Correction Date: FY 2008

FFMIA/FMFIA compliance for UFMS and HIGLAS (the largest Medicare contractors will be using HIGLAS): For FFMIA compliance, HHS advised OMB that it will not meet this level of materiality of financial operations until the end of FY 2008 as a result of implementing Medicare Contractor Reform, which resulted in the HIGLAS roll-out schedule to contractors being extended to be consistent with the procurement schedule and to minimize roll-out costs. However, while implementing HIGLAS is the biggest hurdle to achieving FFMIA compliance, HHS expects to resolve all other non-HIGLAS related noncompliance and the material weaknesses under FMFIA by end of FY 2006, before completion of HIGLAS. Correction of the overall material weakness is pending full UFMS implementation by FY 2007. HIGLAS will achieve FFMIA compliance by FY 2008, and full implementation of HIGLAS by FY 2011.

Key Milestones for Corrective Action

FY 2005 Milestones:

- CDC and FDA implemented UFMS general ledger and payroll accounting activities. *October 2004*

- CDC implemented grant accounting. *First quarter*
- FDA and CDC implemented the full scope of UFMS. *April 2005*
- CMS/HIGLAS -- Completed implementation of an approved Joint Financial Management Improvement Program commercial-off-the-shelf product for the two pilot contractors and two non-pilot contractors.
- *CMS/HIGLAS* - Initiated transition and conversion activities for two additional non-pilot contractors who are on schedule for implementation in the second and third quarters of FY 2006.
- Established the Application Service Provider and technical infrastructure, and running 11 non-production instances of the Oracle software in a test environment.

Long-Term UFMS Milestones:

- NIH Business and Research Support System (NBRSS) – complete deployment. *FY 2007*
- UFMS: Department-wide full implementation. *FY 2007*

HIGLAS Rollout to Medicare Contractors:

- CMS implemented HIGLAS at Empire Part B (Pilot contractor), Empire Part A, and First Coast Service Options. With the implementation at Palmetto in FY 2005 third quarter, this will bring the total to four HIGLAS contractors implemented in FY 2005.
- By the end of the second quarter of FY 2006, implement HIGLAS at Trailblazer Health Enterprises.
- By the end of the third quarter of FY 2006, implement HIGLAS at Mutual of Omaha Insurance Co.
- By September 30, 2006, CMS expects to implement HIGLAS at CMS' central office for Medicaid and SCHIP payments as well as for Medicare contractors' administrative cost payments.

HIGLAS FFMIA Compliance:

- Starting with FY 2007, HIGLAS will leverage the contractor reform strategy that includes transitioning to one new Medicare Administrative Contractor (MAC) for Part A & B (A/B MAC) in FY 2007, seven A/B MACs in FY 2008, and seven A/B MACs in FY 2009. Each A/B MAC consolidates workload from two to six states.
- HIGLAS: Full implementation. *FY 2011.*

Material Nonconformance Subcomponent
CMS-01-01 CMS Financial Systems Corrective Action Plan
This finding is a subset of the Section 4 Department-wide Material Nonconformance HHS-00-01

Background

First Year Identified: FY 1997

The financial statement auditors reported that CMS relies on a decentralized organization, complex and antiquated systems, and ad hoc reports to accumulate data for financial reporting, due to the lack of an integrated accounting system at the Medicare contractor level. An integrated financial system and a strong oversight strategy are needed to ensure that periodic analyses and reconciliation are completed to detect errors in a timely manner. Also, improvement is called for in the oversight of the Managed Care Program and the Health Programs.

Target Correction Date: FY 2008 for FFMIA Compliance

As part of implementing Medicare Contractor Reform, the HIGLAS roll-out schedule to contractors was extended to be consistent with the procurement schedule and to minimize roll-out costs. However, while implementing HIGLAS is the biggest hurdle to achieving FFMIA compliance, HHS plans to resolve all other non-HIGLAS related FFMIA noncompliance and the material weaknesses by end of FY 2006, before completion of HIGLAS. A subcomponent of Financial Systems and Processes, Financial Statement Preparation has been reduced to a reportable condition. Correction of the overall material weakness is

pending full UFMS implementation by FY 2007. HIGLAS will achieve FFMIA compliance by FY 2008, and full implementation of HIGLAS by FY 2011.

Brief Description of Corrective Action Plan

Financial Systems (Medicare/Health Programs**) –** The CMS' long-term solution to this material weakness is HIGLAS. Until this system is implemented, CMS will continue projects and activities aimed at compensating for the lack of the modernized system. Until HIGLAS can be fully implemented, CMS will continue to implement short-term corrective actions to address this material weakness. For example, CMS: (1) prepares a quarterly trending analysis of Medicare contractor reported accounts receivable balances; and (2) conducts Medicare contractor oversight by using SAS 70 audits and accounts receivable agreed upon procedures reviews.

Medicaid:

- Enhance policies and procedures related to access controls and the MBES. *September 2005*
- Continue to implement the pilot project to estimate improper payments. *September 2005*
- If feasible, develop a methodology to collect the necessary data to estimate the Medicaid entitlement benefits due and payable amount. *November 2005*

Implementation of OMB Circular A-123 Appendix A

In January 2005, OMB revised Circular A-123, *Management Accountability and Control*, to strengthen the internal control requirements over financial reporting in Federal agencies. The new circular, entitled *Management's Responsibility for Internal Control*, is effective in FY 2006. A major enhancement of the revised circular is Appendix A, which prescribes a separate assurance statement on the effectiveness of the internal controls over financial reporting. OMB required agencies to submit implementation plans for this new requirement.

Approach

HHS began its efforts by conducting preliminary benchmarking with other Federal agencies and private sector accounting firms in January 2005. The benchmarking yielded general information on approaches planned by the agencies.

HHS is taking a centralized approach to planning for implementing OMB Circular A-123, Appendix A. A guidance manual containing standardized templates is being developed for issuance to the OPDIVs this fall that will expand on an already circulated assessment scope and summary approach that identifies financial reports and selected accounts to be assessed. The document will articulate HHS-specific instructions on implementing Appendix A, to include the topics of materiality, assessment approach, and testing. The document will also provide standard reporting templates. The HHS guidance is being designed to complement internal controls efforts already underway by the OPDIVs. Standard reporting templates will be used Department-wide with OPDIVs conducting the individual assessments. Training to support implementation for A-123 Appendix A will be standardized for delivery throughout the Department.

Timeline

- HHS submitted it's A-123 Implementation Plan to OMB on August 31st that HHS believes conforms to the final CFO guidance on implementing Appendix A of OMB Circular A-123 issued in July 2005. The plan included a timeline for implementing A-123, Appendix A. HHS' goal is to complete the risk assessments by the end of the second quarter and required testing in the third quarter to support the Appendix A assurances as of June 30 and September 30, 2006.
- HHS also created a governance structure and charters for a department-level Risk Management and Financial-Oversight Board and HHS-Department/OPDIV-level Senior Assessment Team. These governance bodies will guide and direct implementation of A-123 within HHS.

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APPENDIX E – FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT REPORT ON COMPLIANCE

Auditors of Executive Agencies' financial statements are required to report if the agencies' financial management systems are in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996. Such audits are to be conducted in accordance with OMB's revised FFMIA *Implementation Guidance*, dated January 4, 2001.

Under FFMIA, agencies also are required to report whether their financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal Accounting Standards, and the United States Government Standard General Ledger (USSGL) at the transaction level.

Instances of Noncompliance

The Department's FY 2005 financial statement audit revealed one instance of noncompliance – Financial Systems and Processes, in which HHS financial management systems did not substantially comply with federal financial management systems requirements. The one noncompliance includes four sub-components; 1a) CMS' financial systems analysis and oversight, 1b) the Department's Payroll System, 1c) the CORE accounting system, and 1d) NIH's Center for Information Technology (CIT). HHS concurs with the auditor's findings.

In last year's report (FY 2004 PAR), the auditors reported 3 FFMIA non-compliances: 1) Financial Systems and Processes, 2) CMS Financial Systems and Analysis, and 3) Departmental Payroll System. These three non-compliances have now been consolidated into one noncompliance with 2 sub-components. In addition, the auditors identified 2 new non-compliances -- the core accounting system and the NIH Center for Information Technology (CIT) which they are reporting as additional sub-components of the one non-compliance, Financial Systems and Processes.

Instances of Noncompliance

Noncompliance Number 1: Financial Management Systems and Processes

- The financial management systems and processes used by HHS and its agencies made it difficult to prepare reliable and timely financial statements. The processes required extensive, time-consuming manual spreadsheets and adjustments to report accurate financial information;
- At most HHS Agencies, suitable systems were not in place to adequately support sufficient reconciliation and analyses of significant fluctuations in account balances; and
- CMS did not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the financial reporting system did not conform to the requirements specified by the Joint Financial Management Improvement Program. CMS needed extensive consultant support to establish reliable accounts receivable balances.

Noncompliance Number 1a: General and Application Controls

General and application controls over the Medicare contractors' financial management systems, as well as systems of certain other HHS Agencies, were significant departures from requirements specified in OMB Circular A-127, *Financial Management Systems*, and OMB Circular A-130, *Management of Federal Information Resources*.

Noncompliance Number 1b: Payroll System

The Independent Auditor's Report for the Human Resources Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development and change controls for the Commissioned Corps Personnel/Payroll System (COPPS) that were not operating effectively.

Following are three of the seven findings from the SAS-70 audit report (four items not included for security concerns):

- Inspected the service level agreement between PSC and ITSC and determined that the security responsibilities between HRS and ITSC were not documented in sufficient detail.
- Inspected a selection of four background investigations for CCSB new hires and determined that background investigations were performed commensurate with job responsibilities, for three of the four new hires selected.
- Inspected a list of individuals awaiting access to the Silver Spring data center and inquired of HRS management and were informed that their individuals on the list were not approved by HRS for access.

Noncompliance Number 1c: Core Accounting Systems

The Independent Service Auditors' Report for the Division of Financial Operations related to the general information technology and application control environment over the CORE Accounting Systems and feeder systems identified certain controls related to the application software development and change controls, computer resources' protection against unauthorized modification, disclosure, loss, or impairment and changes to existing systems software and implementation of new system software were not operating effectively.

Noncompliance Number 1d: NIH Center for Information Technology

CIT has procedures for systems software implementation and maintenance for the Windows and Mainframe environment. However, documentation and logging of change requests, authorizations, testing, and approval for the Mainframe and Windows environment are inconsistent and incomplete. This resulted in controls not being suitably designed for the control objective-" Controls provide reasonable assurance that all changes to hardware and operating systems software in the Windows and Mainframe environment are authorized, properly tested, reviewed, approved, documented, and implemented"-as they relate to the Mainframe and Windows environment.

Several federal financial management applications are hosted on the mainframe, including the NIH CIT Central Accounting System.

To make the HHS general ledger USSGL- compliant, the Department has created an extension, based on the Common Accounting Number (CAN)-Budget Accounting Classification Structure (BACS) crosswalk, which will select the correct Treasury transaction codes. This extension will enforce rules and populate the correct values to make the Unified Financial Management System (UFMS) USSGL-compliant.

The FY 2005 audit recognized the significant steps taken by the Department to resolve material weaknesses found in previous years.

The following is a summary of some of the corrective actions taken and the current status for each of the areas of noncompliance.

Corrective Actions

FFMIA Systems and Processes

The Department's long-term strategic plan to resolve this material weakness is to replace the existing accounting systems and certain other financial systems within the Department with the UFMS. The short-term focus has been on improving the quality of the data in the accounting systems by increasing periodic reconciliation and analyses, and implementing a web-based automated financial system for collecting and consolidating financial statements Department-wide. Over the last several years HHS has continued to make progress in strengthening its financial management and has a plan to bring its FFMIA systems into compliance by replacing antiquated financial systems with the UFMS.

A major subcomponent of UFMS is the CMS Healthcare Integrated General Ledger Accounting System (HIGLAS). The lack of an integrated financial management system continues to impair CMS' and the Medicare contractors' abilities to adequately support and analyze accounts receivable and other financial balances reported.

The CMS is implementing a comprehensive plan to bring its financial systems into compliance. Specifically, CMS has initiated steps to implement an integrated standard general ledger system, known as HIGLAS, for the Medicare contractors and regional and central offices. HIGLAS will initially integrate the CMS' financial systems with two of the Medicare contractors' existing shared claims processing systems. The CMS' current mainframe-based financial system will also be replaced by HIGLAS, the foundation of which is a web-based, commercial-off-the-shelf system. The HIGLAS has been deployed at four of the largest CMS Medicare contractors. Two pilot Medicare contractors, Palmetto GBA (Fiscal Intermediary, May 2005) and Empire Medicare Services (Carrier, July 2005), and two non-pilot Medicare contractors, Empire Medicare Services (Fiscal Intermediary August 2005) and First Coast Service Options (Fiscal Intermediary, September 2005). This level of deployment makes progress towards compliance with the requirements of the FFMIA. The CMS will meet its original goal for materiality of financial operations by the end of FY 2006. HIGLAS will be FFMIA compliant in FY 2008, and fully implemented by FY 2011.

FY 2005 Unified Financial Management System (UFMS) Accomplishments

- Began implementation at the Program Support Center (PSC).
- The Food and Drug Administration conducted successful conference room pilot.
- The Centers for Disease Control and Prevention (CDC) conducted mock conversions 1-4.
- CDC began end-user training.
- CDC conducted integration testing.
- PSC conducted conference room pilot.
- Travel module deployed at the National Institutes of Health (NIH) for HHS travelers.
- Implemented Oracle General Ledger and Federal Administrator at NIH.
- Completed full implementation of core financial modules at CDC and FDA.

Medicare General and Application Controls

The CMS recognizes the significance of security measures regarding Medicare EDP issues as they relate to the integrity, confidentiality, and availability of sensitive Medicare data. The CMS continues to accept risk, primarily due to the large size and complexity of the Medicare fee-for-service claims processing system and number of data centers. The sheer magnitude of the Medicare claims processing system, encompassing 14 data centers and 32 entities that process claims, coupled with the level of aggressive oversight guarantees that there will always be findings. The major focus needs to be on limiting the number of findings including critical or high-risk vulnerabilities.

FY 2005 HIGLAS Accomplishments

- Established a CMS HIGLAS program office with a staff of 20 full-time equivalents. An FY 2002 action, the HIGLAS program office continues to exist.
- Completed implementation of an approved JFMIP commercial-off-the-shelf product for the two pilot contractors and two non-pilot contractors.
- Initiated transition and conversion activities for two additional non-pilot contractors who are on schedule for implementation in the second and third quarters of FY 2006.
- Established the Application Service Provider and technical infrastructure, and running 11 non-production instances of the Oracle software in a test environment.
- Created a HIGLAS website at www.cms.hhs.govto provide program status for project stakeholders.

The CMS revised its strategy to address CFO EDP audit issues in FY 2005. This strategy was successfully implemented as the prior material weakness has been downgraded to reportable conditions in the areas of logical access controls; and application security, development and program change control. The report of the independent contractors noted improvements in the areas of entity-wide security program, systems software and service continuity planning and testing. The CMS has now refined the strategy further to eliminate the two reportable conditions. This refinement extends through FY 2007 after which CMS plans for the CFO EDP reportable conditions to be eliminated from its financial statements. The CMS' objectives are to eliminate by September 30, 2006 all findings within each of the reportable conditions as reported as part of the CFO EDP audit that are attributable to inadequate management oversight. By September 30, 2007, CMS' objective is to put into place the appropriate processes and controls to eliminate both the reportable conditions and the root causes for the reportable conditions.

The CMS strategy to accomplish the objectives involves a short-, mid- and long-term approach to correct all technical and management vulnerabilities and emplace a strong management oversight program to eliminate the root causes of the problems. The short-term strategy is simply to correct all vulnerabilities attributable to inadequate management oversight from whatever source in FY 2006. Whatever source includes SAS 70 audits, CFO EDP findings, and the results of other evaluations, tests or assessments at both central office and the Medicare contractors. The mid-term strategy is to address the system or root causes for the vulnerabilities. The long-term strategy is to sustain the improvements implemented in the short and mid-term. The CMS' progress in addressing individual findings is measured by its Plan of Actions and Milestones Report, which is submitted to HHS and OMB.

The long-term strategy in eliminating the reportable conditions also includes the CMS' revitalization initiative that will further improve its security posture. A more secure system environment is a key component of the revitalization plan. The CMS is building security into the agency's modernized infrastructure through capital investments targeted to reduce its security perimeter. The CMS will limit its exposure to risk through preemptive measures such as data center consolidation and Medicare contractor reform. This simplification of CMS' contractor environment will leave less opportunity for exploitation than is the case in the current highly complex systems environment. The CMS plans for its security perimeter to be considerably smaller than is the situation today.

Payroll System

The independent Service Auditor's Report for the Human Resources Service Personnel and Payroll Systems' General Information Technology and Application Controls identified certain controls related to the application software development and change controls for the Commissioned Corps Personnel/Payroll System (COPPS) were not operating effectively.

Centers of Excellence

HHS currently meets the following goals of the Financial Management Line of Business (FMLoB)

Goal: Select a Center of Excellence (COE) which will host the Department's core financial management systems and to which the Department may migrate its financial management services.
Status: Commercial centers of excellence are currently hosting HHS' core accounting systems. Additional milestones related to the selection of a different hosting facility are not appropriate for consideration until the HHS Unified Financial Management System (UFMS) implementation has been completed.

Goal: Migrate financial management hosting (and potentially services) to the selected COE.
Status: Commercial facilities are currently being utilized for the hosting of HHS' core accounting systems (CMS HIGLAS: IBM facilities; UFMS: AT&T facility via the CDC Mid-Tier Data Center). Additional milestones related to the migration to different hosting facility are not appropriate for consideration until the HHS Unified Financial Management System (UFMS) implementation has been completed.

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APPENDIX F – MANAGEMENT REPORT ON FINAL ACTION

October 1, 2004 - September 30, 2005

Background

The Inspector General Act Amendments of 1988 (Public Law 100-504) require Departments and Agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to the Office of Inspector General's (OIG) audit recommendations. This annual management report provides the status of OIG reports in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period.

Departmental Findings

For the fiscal year covered by this report, the Department accomplished the following:

- Initiated action to recover $1.260 billion through collection, offset, or other means (see Table I);
- Completed action to recover $1.148 billion through collection, offset, or other means (see Table I);
- Initiated action to put to better use $7 billion (see Table II); and
- Completed action that over time will put to better use $56 billion (see Table II).

At the end of this period there are 268 reports over 1 year old with uncollected balances or unimplemented monetary findings. The reasons these reports are still pending are found in the notes to the tables.

Departmental Conflict Resolution

In the event that the HHS agencies and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2005, there were no disagreements requiring the convening of the Conflict Resolution Council.

The HHS Process

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

- The HHS Agencies have a lead responsibility for implementation and followup on most OIG and independent auditor recommendations;
- The Assistant Secretary for Budget, Technology, and Finance establishes policy and monitors HHS Agencies' compliance with audit follow-up requirements;
- The audit resolution process includes the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the HHS Departmental Board of Appeal regulations in 45 C.F.R. Part 16; and
- If necessary, the Assistant Secretary for Budget, Technology, and Finance or the Deputy Secretary resolves conflicts between the HHS Agencies and the OIG.

Status of Audits in the Department

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

Report on Final Action Tables

The following tables summarize the Department's actions in collecting disallowed costs and implementing recommendations to put funds to better use. Disallowed costs are those costs that are challenged because of a violation of law, regulation, grant term or condition, etc. Funds to be put to better use relate to those costs associated with cost avoidances, budget savings, etc. The tables are set up according to the requirements of Section 106(b) of P.L. 100-504.

TABLE I Management Action on Costs Disallowed in OIG Reports
As of September 30, 2005
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	456	$1,062,499
B. Reports on which management decisions were made during the reporting period. See Note 2.	399	$1,259,794
Subtotal (A+B)	855	$2,322,293
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of disallowed costs that were recovered through collection, offset, property in lieu of cash, or otherwise.	475	$1,148,072
ii. The dollar value of disallowed costs that were written off by management.	21	$3,043
Subtotal (i+ii)	496	$1,151,115
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	359	$1,171,178

Notes:
1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents the two organizations having different cut-off dates.
3. Includes the list of audits over 1 year old with outstanding balances to be collected. Includes audits under administrative or judicial appeal, under current collection schedule, and legislatively uncollectible.

TABLE II Management Action on OIG Reports
with Recommendations That Funds Be Put to Better Use
As of September 30, 2005
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	13	$56,430,860
B. Reports on which management decisions were made during the reporting period.	28	$6,880,755
Subtotal (A+B)	41	$63,311,615
C. Reports for which final action was taken during the reporting period:		
i. The dollar value of recommendations that were actually completed based on management action or legislative action.	14	$56,501,260
ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	26	$6,794,688
Subtotal (i+ii)	40	$63,295,948
D. Reports for which no final action has been taken by the end of the reporting period.	1	$15,667

Notes:
1. Includes adjustments of amended disallowances and disallowances excluded from the previous reporting period.

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected
As of September 30, 2005

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	01-04-76290	State of ME	Jul-04	$49,534	5
ACF	02-00-64555	Utica-HS	Oct-01	$166,880	6
ACF	02-01-02002	Puerto Rico	Jul-03	$144,837	4
ACF	02-03-74816	State of NY	Dec-03	$90,825	5
ACF	02-04-77127	NJ Dept of Health Services	Apr-04	$68,579	5
ACF	02-91-14405	Bedford Stuyvesanto/OCS	Mar-02	$34,593	3
ACF	02-95-33649	Puerto Rico	Mar-99	$1,433	5
ACF	02-97-47637	Puerto Rico IV-B	Sep-97	$9,703	25
ACF	02-99-02005	Puerto Rico	Oct-02	$1,214,299	25
ACF	03-01-00510	Council Southern MT	Nov-01	$9,863	4
ACF	03-02-72227	State of VA	Jan-01	$1,100,000	1
ACF	03-03-73256	Lawrence Cty HS, Inc	Jun-03	$148,663	6
ACF	03-03-73829	Preschool Dev Prog	Jul-03	$961,497	2
ACF	03-03-74937	Preschool Dev Prog	Sep-03	$448,772	2
ACF	03-95-33212	Commonwealth of PA	Sept-95	$22,662	25
ACF	03-97-43787	VA/CCDBG	Jun-97	$937,769	5
ACF	03-97-47731	State of DE	Sep-97	$11,880	25
ACF	03-99-03305	Research Assessment State of MD	Jul-00	$4,453,336	2
ACF	04-00-66032	State of FL	Jan-01	$41,989	5
ACF	04-01-00002	State of NC	Dec-03	$27,951	4
ACF	04-01-00006	State of NC	Dec-03	$2,742,231	4
ACF	04-02-00010	East Winston Comm Dev	Apr-04	$250,000	6
ACF	04-96-00105	Delta Foundation	Apr-99	$1,225,291	2
ACF	04-96-00107	Harambee Child Level	Aug-99	$124,811	2
ACF	04-97-47475	Wash Cty Opport Inc.	Nov-97	$173,151	4
ACF	04-98-00123	State of NC	Dec-03	$2,132,771	4
ACF	04-99-56945	Quitman Cty Dev Org Inc	Jun-02	$6,375	6
ACF	05-01-67360	MI Family Independence Agency	Jul-01	$150,000	25
ACF	05-03-73766	Family Dev Service	Sep-03	$20,679	5
ACF	05-03-74102	Ohio Dept of Job & Family	Apr-04	$212,374	5
ACF	05-04-78796	Dunmar Center Inc	Aug-04	$1,075	4
ACF	05-97-48402	Montgomery Co CAA	Nov-97	$79,374	7
ACF	06-00-62531	NA Five Sandoval Indian Pueblos Inc.	Oct-00	$13,958	2
ACF	06-02-70441	Five Sandoval Indian Tribe	Apr-03	$67,998	2
ACF	06-03-75545	LA Dept of Social Services	Oct-03	$213,171	5
ACF	06-04-77155	State of AK	Jul-04	$142,270	5
ACF	06-90-00052	Mexican Amer/Discret	Apr-92	$107,659	3
ACF	06-97-47657	Five Sandoval	Nov-99	$46,660	2
ACF	07-02-00138	State of NE	Sep-03	$11,681,442	1
ACF	07-02-72037	State of KS	Oct-01	$57,236	1
ACF	08-03-74249	Three Affiliated Tribes	Apr-04	$4,211	6
ACF	08-99-59826	Crow Creek Sioux Tribe	Jan-00	$9,845	2
ACF	08-99-59907	Crow Creek Sioux Tribe	Aug-00	$344,504	2
ACF	09-00-63951	Tohono O Odham Nation	May-01	$57,298	4
ACF	09-01-00096	State of VT	Mar-04	$89,581	25
ACF	09-90-56270	Rinco San Luiseno Band	Apr-01	$3,220	6

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected
As of September 30, 2005

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	09-98-00065	Latino Resource Org	Mar-04	$95,102	25
ACF	10-01-66783	Native Village of Mekoryuk	Apr-01	$15,883	4
ACF	10-03-72484	Maniilaq Manpower, Incak	Jul-03	$44,498	6
ACF	10-98-00008	Siletz River Co.	Apr-00	$27,316	6
		Total for ACF		**$30,085,052**	
CDC	01-00-62266	State of ME	Feb-00	$138,782	5
CDC	01-00-66460	State of ME	Jan-03	$363,364	5
CDC	01-02-70271	State of ME	Apr-03	$561,697	5
CDC	01-02-71527	State of MA	Apr-02	$29,260	5
CDC	01-02-73084	State of ME	Sep-02	$188,524	5
CDC	01-94-27881	State of ME	Aug-95	$5,235	5
CDC	01-96-37165	Haitian American Public Health Initiative	Mar-97	$20,209	5
CDC	03-01-66421	American Assoc. of Community Colleges	Nov-00	$7,474	5
CDC	03-02-72715	DC Dept. of Health	Jul-03	$7,851	5
CDC	03-03-72847	DC Dept. of Health	Oct-02	$12,850	5
CDC	03-98-50835	Nat'l Organ. of Black County Officials	Jan-99	$19,385	5
CDC	03-98-50836	Nat'l Organ. of Black County Officials	Jan-99	$27,140	5
CDC	03-98-50837	Nat'l Organ. of Black County Officials	Mar-99	$1,078	5
CDC	03-98-51634	City of Philadelphia, PA.	Jun-98	$93,690	5
CDC	03-99-56842	Nat'l Assoc. for Equal Opport. in Higher Ed.	Feb-01	$33,585	5
CDC	04-00-65030	State of SC	Jul-00	$688,633	1
CDC	04-98-51239	State of AL Child Care & Dev. Fund Mand.	Sep-98	$227,200	5
CDC	06-02-70732	US-Mexico Border Health Association	Jan-02	$23,483	5
CDC	10-98-53017	Self Enhancement Inc	Apr-98	$6,868	5
CDC	10-98-53018	Self Enhancement, Inc.	May-00	$3,452	5
CDC	10-98-53162	People of Color Against AIDS Network	Sep-00	$8,289	5
		Total for CDC		**$2,468,049**	
CMS	01-00-00506	Hospital for Nonphysician Outpatient Services	Jul-01	$5,042,207	5
CMS	01-00-00509	Medicare Part B Payments for DME	Jul-01	$35,000,000	5
CMS	01-00-00538	Medicare Part B Services	Jun-01	$47,633,686	5
CMS	01-01-00502	Ambulance & Radiology Serv	Oct-02	$39,084	5
CMS	01-01-00542	Associated Hospital Serv	Dec-02	$518,981	5
CMS	01-89-00518	Blue Shield of MA	Oct-90	$216,053	11
CMS	01-90-00500	Blue Cross of MA	Sep-90	$7,048,076	4
CMS	01-91-00508	Aetna Life-Parts A&B Adm.	Jan-92	$223,655	12
CMS	01-92-00517	Blue Cross of M.	Apr-93	$160,122	5
CMS	01-92-00523	BC/BS of MA -Part B Lab Tests	Jan-94	$2,250,000	26
CMS	01-93-00512	BC/BS of MA-Lab Test	Jul-94	$426,817	26
CMS	01-94-00510	BC/BS of MS - ADM costs	Apr-95	$130,299	5
CMS	01-95-00503	G/A & Capital McLean Ho- Adm Costs	Aug-95	$186,190	5
CMS	01-96-00513	Separately Billable ESRDL Lab Tests	Dec-96	$6,300,000	5
CMS	01-96-00519	Nat'l Medical Care ESRD	Sep-97	$4,319,361	7
CMS	01-96-00527	Clinical Lab Tests- Hosp. Outpatient Labs	Dec-00	$43,632,767	5
CMS	01-98-00512	CT BC/BS Noncompliance	Jun-98	$3,264	5
CMS	01-99-00501	Waterbury Hospital	Oct-99	$103,588	5
CMS	01-99-00507	Outpatient Psychiatric Services	Mar-00	$94,716	5
CMS	01-99-00518	Danbury Hospital	May-00	$62,104	5

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected
As of September 30, 2005

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	01-99-00521	Hematology Indices	Sep-00	$14,000,000	5
CMS	01-99-00522	Medicare Clinical Lab Tests	Oct-00	$31,200,000	5
CMS	01-99-00523	United HealthCare Ins.	Aug-00	$19,282	5
CMS	02-00-01023	N. Shore Long Island Jewish Hlth System	Jul-02	$319,130	5
CMS	02-00-01032	St. Barnabas Hosp	Jul-02	$205,100	5
CMS	02-00-01048	Triple S Inc.	Dec-01	$298,693	5
CMS	02-86-62015	Empire BC/BS	Mar-88	$1,277,575	9
CMS	02-91-01022	Prudential Ins.-ADM	Mar-92	$6,837,167	14
CMS	02-96-01034	Staff Blders. Home Health Inc. Buffalo-ORT	Jan-98	$2,046,576	5
CMS	02-97-01034	Dr. Pila Foundation Home Care Program	Sep-99	$857,208	5
CMS	02-99-01026	South Jersey Rehab Associates, Inc.	Nov-00	$259,068	5
CMS	03-00-00007	Philadelphia RO efforts	Apr-01	$1,649,411	5
CMS	03-00-00214	Maryland Dept. of Health and Mental Hygiene	Mar-03	$2,093,729	14
CMS	03-01-00005	Veritus, Inc.	Oct-01	$131,071	5
CMS	03-92-00150	Elmira Jeffries MNH	Jan-94	$164,188	22
CMS	03-92-00201	Commonwealth of VA	Jan-93	$205,177	14
CMS	03-92-00602	PA DPW - Upper limit	Sep-94	$230,520	5
CMS	03-93-00013	Omega Med. Lab.	Nov-93	$1,102	5
CMS	03-93-00025	PBS - Lab Fee Schedules	Sep-95	$953,377	5
CMS	03-95-38380	Commonwealth of VA	Mar-96	$68,333	5
CMS	03-99-00012	John Hopkins Bayview Medical Ctr	Jun-02	$957,458	5
CMS	04-00-01210	BC and BS of GA	Dec-00	$891,000	5
CMS	04-00-02162	First coast Service Options	Feb-01	$2,042,060	5
CMS	04-00-61620	State of NC	Nov-01	$57,097	5
CMS	04-00-61627	State of TN	Mar-00	$359,907	24
CMS	04-02-07005	Medicare Postacute Care Transfer Policy	Apr-03	$60,860,570	5
CMS	04-03-00018	Palmetto GBA	Feb-04	$57,861	5
CMS	04-03-75509	State of NC	May-03	$5,045	5
CMS	04-94-01096	Humana Medical Plans, Inc.	Apr-95	$624,048	5
CMS	04-95-01104	American Health Care-ORT	Jan-97	$1,200,000	5
CMS	04-95-02110	SC BC (Hospice of Lake and Sumter, Inc.) ORT	Apr-97	$4,000,000	5
CMS	04-95-02111	B/C of SC (Hospice of FL Suncoast, Inc.)	Mar-97	$14,800,000	5
CMS	04-96-01125	Aetna- Rosemont Health Care Ctr	Jan-02	$55,306	5
CMS	04-96-01129	CA BC - ORT SNF of Washington Manor	Jan-02	$284,378	5
CMS	04-96-01131	Aetna (Health Svcs. Of Green Briar)-ORT	Nov-97	$202,780	5
CMS	04-96-01134	Aetna Colonnade Med. Ctr - ORT	Jan-02	$385,338	5
CMS	04-96-01135	Aetna Washington Manor ORT	Jan-02	$220,483	5
CMS	04-96-01136	Aetna Savanna Cay Manor -ORT	Jan-02	$354,537	5
CMS	04-96-01148	Aetna Life Insur. Co.	Nov-97	$148,955	5
CMS	04-96-02122	Blue Cross of GA	Oct-98	$791,327	6
CMS	04-97-01164	1996 ACR Proposal for FL MCP	Jan-00	$9,660,000	5
CMS	04-97-01166	Staff Builders Home Health Care	Apr-99	$2,300,000	5
CMS	04-97-01168	FL Agency for Health Care Administration	Dec-99	$8,885,855	14
CMS	04-97-01169	Med Tech Home Health Services Inc	Apr-99	$1,900,000	5
CMS	04-97-02130	Mutual of Omaha	Apr-99	$1,709,245	5
CMS	04-97-02138	Mutual of Omaha	Apr-99	$2,382,527	5

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2005					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	04-98-01184	Homebound Medical Care, Inc.	Jun-00	$1,860,760	5
CMS	04-98-01185	Commonwealth of KY	Sep-99	$1,579,988	5
CMS	04-99-01193	Six State Review of O/P Rehab. Facilities	Jun-00	$74,067,804	5
CMS	04-99-01195	Medicare Home Health Services in FL	Mar-01	$57,022	5
CMS	04-99-55388	State of NC (OGM)	Jun-99	$103,275	5
CMS	04-99-55653	State of TN (OGM)	Nov-99	$309,448	5
CMS	05-02-72686	State's Home Care Program	Aug-02	$20,572	5
CMS	05-03-74058	Bellefaire Jewish Children's Bureau	Nov-02	$11,410	5
CMS	05-03-74769	Ohio youth Advocate Program Inc	Mar-03	$1,395	5
CMS	05-90-00013	BC/BS of MI - Admin	Dec-90	$2,413,388	10
CMS	05-97-00029	Office of Medicaid Policy and Planning - IN	Mar-99	$2,000,000	5
CMS	06-00-00041	Medicare Inpatient Hospital PPS Transfers	Nov-01	$163,900,000	5
CMS	06-00-00056	Medicaid Drug Rebates	Mar-01	$108,000,000	5
CMS	06-01-00027	Palmetto Govt. Benefit Admin	Sep-01	$44,558	5
CMS	06-01-68876	State of LA -OGM	Jun-02	$48,414	5
CMS	06-02-00026	TX Health and Human Serv Comm	Jan-03	$555,341	5
CMS	06-02-00037	Houston Independent School district	Jan-04	$1,792,575	5
CMS	06-02-00038	NM Human Serv Dept	Mar-03	$1,392,725	5
CMS	06-02-72136	State of LA	Jun-02	$64,870	5
CMS	06-03-00009	TX Health and Human Serv Comm	Sep-03	$1,290,047	5
CMS	06-03-00015	NM Human Serv Dept	Jan-04	$518,492	24
CMS	06-92-00043	BC/BS of TX - GME Costs	Mar-94	$4,252,743	23
CMS	06-95-00095	Palmetto Gov. (Fam Hospice/Dallas)	Apr-97	$871,306	22
CMS	06-96-00027	Palmetto Gov. (VNA of TX Hospice)	Apr-97	$1,156,341	22
CMS	06-97-00034	Risk Base Health Maint.	Jun-99	$55,895	5
CMS	06-99-00058	State of LA (OGM)	Jun-00	$5,290,000	5
CMS	06-99-56489	State of LA (OGM)	Aug-99	$291,803	5
CMS	07-01-02616	Mutual of Omaha	Aug-01	$11,336,867	5
CMS	07-02-04006	MO Provider	May-04	$8,373,044	5
CMS	07-03-02654	Ambulatory Surgical Centers	Dec-02	$15,266	5
CMS	07-03-02655	Ambulatory Surgical Centers	Dec-02	$92,393	5
CMS	07-03-02657	Ambulatory Surgical Centers	Dec-02	$2,617	5
CMS	07-03-02658	Empire Medicare Serv	Jan-03	$2,340	14
CMS	07-03-02659	Ambulatory Surgical Centers	Nov-02	$2,655	5
CMS	07-03-02663	Ambulatory Surgical Centers	Jan-03	$9,338	5
CMS	07-03-02665	WI Physicians Serv	Jan-03	$106,363	5
CMS	07-91-00471	BC/BS of MI - Pension Seg.	Dec-92	$5,021,873	10
CMS	07-91-00473	BC/BS of FL, Inc.-Pension Seg.	Aug-93	$4,755,565	13
CMS	07-92-00525	BC/BS of MI -Pension Costs	Dec-92	$2,135,884	10
CMS	07-92-00578	BC/BS of TX - Unfunded Pension Costs	Oct-92	$6,244,637	13
CMS	07-92-00585	BS of CA - Pension Costs	Feb-94	$2,973,504	5
CMS	07-92-00604	WVA BC/BS Term Pension	Jan-93	$617,644	17
CMS	07-92-00608	BC/BS of Missouri	Jun-93	$960,615	15
CMS	07-93-00634	Travelers - Pension Seg.	Oct-93	$1,026,460	18
CMS	07-93-00665	Travelers Ins.- Pension Costs	Oct-93	$1,218,963	5
CMS	07-93-00709	BC/BS of CT - Pension Seg.	Apr-94	$119,472	19
CMS	07-93-00710	BC/BS of CT - Pension Costs	Mar-93	$237,392	19

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected
As of September 30, 2005

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	07-93-00713	PA BS - Pension Costs	Jun-95	$5,490,995	5
CMS	07-94-00762	Health Care Svcs. Corp - Unfunded Pen.	Jul-94	$1,233,337	10
CMS	07-94-00763	Health Care Svcs. Corp.- Pension Seg.	Aug-94	$1,055,458	10
CMS	07-94-00768	BC/BS of SC - Pension Costs	Sep-94	$840,493	13
CMS	07-94-00769	BC/BS of SC - Pension Costs	Sep-94	$329,001	19
CMS	07-94-00770	BC/BS of SC- Unfunded Pension Costs	Sep-94	$793,508	13
CMS	07-94-00777	BC/BS of GA - Pension Costs	Oct-94	$90,736	13
CMS	07-94-00778	BC/BS of GA - Unfunded Pension Costs	Oct-94	$363,921	13
CMS	07-94-00779	BC/BS of GA - Pension Seg.	Oct-94	$113,256	13
CMS	07-94-00805	BC/BS of TN -Pension Seg.	Jan-95	$1,400,063	13
CMS	07-94-00816	BC/BS of TN. -Unfunded Pension Costs	Jan-95	$352,026	13
CMS	07-94-00817	BC/BS of AL - Pension Unfunded Costs	Jul-95	$912,730	13
CMS	07-94-00818	BC/BS of AL - Pension Seg.	Jul-95	$951,281	13
CMS	07-94-01107	BC/BS of FL - Pension Seg.	Apr-96	$813,122	13
CMS	07-95-01126	BC/BS of FL - Pension Unfunded Costs	Apr-96	$4,049,889	13
CMS	07-95-01149	BC/BS of TX - Pension Costs	Apr-96	$874,111	13
CMS	07-95-01150	BC/BS of Oregon - Pension Seg.	Aug-97	$191,312	5
CMS	07-95-01159	BC/BS of NE - Pension Seg.	Jan-96	$96,955	27
CMS	07-95-01166	BC/BS of NE - Pension Unfunded Costs	Jan-96	$73,509	27
CMS	07-96-01189	BC of WA & AK- Pension Seg.	Dec-97	$96,740	5
CMS	07-96-01194	Community Mutual Ins. Co. Pension Seg.	Jul-97	$1,866,026	5
CMS	07-97-01205	BC of WA & AK - Pension Seg.	Dec-97	$15,688	5
CMS	07-97-01206	BC of WA & AK - Pension Unfunded Costs	Dec-97	$106,843	5
CMS	07-97-01207	Community Mutual Ins. Co. Unfunded Pen	Sep-00	$571,413	5
CMS	07-97-01208	Community Mutual Ins Co Pension Costs	Sep-00	$991,972	5
CMS	07-97-01209	BC/BS of MS - Pension Seg.	Jan-98	$224,711	13
CMS	07-97-01210	BC/BS of MS - Unfunded Pension Costs	Jan-98	$482,549	13
CMS	07-97-01211	BC/BS of MS - Pension Costs	Jan-98	$134,312	13
CMS	07-97-01213	Travelers Pension Seg.	Jan-98	$5,624,747	5
CMS	07-97-01222	AdminaStar Federal of KY - Pension Seg.	Oct-98	$1,236,890	13
CMS	07-97-02500	Anthem BC/BS of CT	Mar-98	$122,548	5
CMS	07-98-01224	AdminaStar Federal - Unfunded Pension	Oct-98	$4,286,294	5
CMS	07-98-01225	AdminaStar Federal - Pension Costs	Oct-98	$736,134	5
CMS	07-98-02501	Anthem BC/BS of CT - Unfunded Pension	Mar-98	$292,152	5
CMS	07-98-02522	BS of CA - Pension Plan Terminated	Apr-99	$7,623,524	5
CMS	07-99-01278	Rebound Inc.	Apr-02	$1,042,522	5
CMS	07-99-01283	Medicare Managed Care Risk Plans	Feb-00	$1,350,000	5
CMS	07-99-01288	Wellmark, Inc.	Nov-01	$1,169	5
CMS	07-99-02540	General American Life Insurance Company	Jul-00	$6,205,564	27
CMS	08-03-75595	State of CO	Jul-03	$3,271,299	5
CMS	08-94-00739	BC/BS of ND - Pension Seg.	Jan-95	$730,875	13
CMS	08-94-00740	BC/BS of NC - Unfunded Pension Costs	Jan-95	$671,198	13
CMS	09-01-00083	National Heritage Insur Co	May-03	$593,177	1
CMS	09-04-76305	HI Dept of Human Serv	Dec-03	$6,810	5
CMS	09-89-00162	Nationwide Employer Project - MSP	Mar-95	$2,218,824	16
CMS	09-95-00072	CA DHS	Nov-96	$4,013,490	5

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected
As of September 30, 2005

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	09-96-00050	BC of CA	Nov-97	$13,924	5
CMS	09-96-00061	BS of CA	Jun-98	$1,006,192	18
CMS	09-96-00064	San Diego Hospice Corp. - ORT	Nov-98	$993,779	5
CMS	09-96-00094	BC of Ca - Dynasty Home Hlth Inc	Jan-02	$217,720	5
CMS	14-96-00202	Excluded Unlicensed Health Care Providers	Sep-97	$2,931	5
CMS	17-95-00096	HCFA Financial Statement Audit for FY 1996	May-98	$300,000	5
CMS	17-97-00097	HCFA Financial Statement Audit for FY 1997	Sep-98	$141,796	5
		Total for CMS		**$815,766,034**	
HRSA	04-04-75420	Mantachie Rural Health Care	Feb-04	$8,403	4
HRSA	08-02-70421	Aberdeen Area Tribal Chairmen's Hlth Board	Feb-03	$1,509	6
		Total for HRSA		**$9,912**	
IHS	08-00-56759	SD Urban Indian Health	Nov-99	$32,783	5
IHS	08-00-59899	SD Urban Indian Health	Nov-99	$6,818	5
IHS	08-00-60654	Spirit Lake	Jan-00	$22,031	5
IHS	08-99-56446	Sisseton-Wahpeton Sioux Tribe	May-99	$5,843	5
IHS	09-01-65664	Lovelock Paiute Tribe	Dec-00	$50,473	5
		Total for IHS		**$117,948**	
OPHS	01-04-77730	Health Awareness Services of Central MA	Nov-03	$78,425	29
OPHS	06-03-74833	Amigo Volunteers in Education & Services	Jan-03	$31,180	28
OPHS	08-03-74361	Porcupine Clinic	Nov-02	$12,611	29
OPHS	08-03-74833	Porcupine Clinic	Nov-02	$65,027	29
OPHS	08-04-77295	Southern UTE Indian Tribe	Mar-04	$12,337	28
OPHS	08-05-79580	Porcupine Clinic	Jun-04	$45,688	29
OPHS	09-01-69017	Southeast Asian Community Center	July-01	$3,111	28
OPHS	15-01-20002	Congress Heights	May-01	$11,300	28
		Total for OPHS		**$259,679**	
OS	01-01-00004	State of ME	Sep-01	$4,047	4
OS	03-00-63670	State of PA	Nov-00	$11,388,686	1
OS	06-00-61716	TX Dept. of Health	Sep-00	$32,230	6
OS	07-03-02008	Kansas Advocacy Service	Aug-04	$355,997	1
OS	08-99-59826	Crow Creek Sioux Tribe	Feb-00	$14,448	6
OS	09-02-70938	Pascua Yaqui Tribe of Arizona	Jun-02	$1,729	6
OS	09-97-48247	Karidat	Dec-97	$50,612	1
OS	09-97-48966	Karidat	Jan-98	$2,234	1
OS	09-98-52613	Marianas	Dec-98	$639,432	6
OS	10-02-71415	Nooksack Indian Tribe	Dec-02	$42,474	5
		Total for OS		**$12,531,889**	
PSC/DCA	03-90-00453	State of WV	Mar-91	$12,850,856	7
PSC/DCA	06-02-72136	State of LA	June-02	$8,735,851	1
PSC/DCA	06-99-59584	State of LA	Sep-00	$19,261,661	1
		Total for PSC		**$40,848,368**	
SAMHSA	02-99-02502	Southeast Queens Community Partnership, Inc.	May-00	$500,263	2
SAMHSA	04-04183	Columbus Co. Services Mgmt.	Jul-94	$35,167	4
SAMHSA	06-03-74833	Amigos Volunteers in Education and Service	Nov--03	$39,667	4
		Total for SAMHSA		**$575,097**	
		Total for HHS		**$902,662,025**	

Notes:
1. Appeal process.
2. Referred to Department of Justice (DOJ).
3. Referred to DOJ/payment plan.
4. Payment plan.
5. Pursuing collection.
6. Transferred to Treasury Offset Program.
7. In District Court.
8. Contractor has signed the closing agreement. An amended official clearance document is being prepared.
9. Contractor appealed and court ruled in contractor's favor. HHS Agency has appealed.
10. Pending resolution of contractor's termination audit, any related termination agreement, and pending lawsuit.
11. HHS Agency has instructed the carrier to calculate and recover partial overpayments. Recoupment is still on hold pending resolution of the company's appeal to an administrative law judge.
12. Additional documentation has been provided by the state or contractor. OIG and/or HHS Agency reviewing.
13. HHS Agency is working with all Medicare providers to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
14. HHS Agency is in process of negotiating or determining outstanding overpayment amount and/or payment options.
15. HHS Agency will verify that corrective action has been completed by the fiscal intermediary.
16. Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in HIAA vs. Shalala case will result in few recoveries of funds from EGHP's timely filing limits. HHS agency is attempting to "fix" the HIAA decision via new legislation.
17. Contractor was declared insolvent and placed in receivership. DOJ has filed a claim on HHS agency's behalf.
18. HHS Agency is negotiating a settlement with the state or the contractor.
19. HHS Agency is of developing a formula to settle all waivers regarding pension segmentation and/or unfunded pension costs.
20. HHS Agency is awaiting verification from the pension actuarial staff that an adjustment was made.
21. An on-site audit is in process. A global settlement will close pension and administrative costs.
22. The state or contractor is in the process of determining or collecting overpayment.
23. Collection activity has been suspended pending resolution of an objection lodged by two providers' legal counsel with the OIG and the Office of General Counsel.
24. HHS Agency is verifying collection of overpayment.
25. Awaiting confirmation that account receivable may be closed out.
26. Waiting for a decision and/or action by the Asst. U.S. Attorney.
27. HHS Agency is negotiating with the contractor on the related administrative costs audit.
28. HHS Agency to examine related claims.
29. Working with new Executive Director to resolve all issues.

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APPENDIX G – CIVIL MONETARY PENALTIES

Civil monetary penalties (CMP) are non-criminal penalties for violation of federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMP maintain their deterrent value and that the imposed penalties are properly accounted for and collected. During FY 2005, only the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA) imposed CMP.

Civil Monetary Penalties

For the Fiscal Year Ended September 30, 2005

CMS & FDA Combined

Outstanding Receivables	Number	Amount (in Dollars)
Beginning Balances	518	$ 413,404,976
Assessments (+)	1,469	$ 628,104,195
Collections (-)	(1,000)	$ (428,345,175)
Adjustments	(168)	$ (14,416,678)
Amounts Written Off	0	$ -
Ending Balance	**819**	**$ 598,747,318**
Current Receivables	760	$ 595,597,038
Non-Current Receivables	59	$ 3,150,280
Allowance	0	$ (403,537,804)
Net Receivables	819	$ 195,209,514
Total Delinquent	**49**	**$ 2,707,175**
Total Non-Delinquent	**770**	**$ 596,040,143**

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APPENDIX H – FINANCIAL MANAGEMENT PERFORMANCE MEASURES

Measure	Baseline	Performance Trend					
		FY 2001	FY 2002	FY 2003	FY 2004	FY 2005 Target	FY 2005 Actual
Audited financial statements for HHS and CMS are submitted to OMB by submission due date.	FY 1996: No	Yes	Yes	Yes	No	Yes	Yes
Number of Department-level material weaknesses outstanding at end of fiscal year.	FY 1996: 5	2 Financial Systems and Processes and Medicare EDP Controls	2 Financial Systems and Processes and Medicare EDP Controls	2 Financial Systems and Processes and Medicare EDP Controls	2 Financial Systems and Processes and Medicare EDP Controls	2 Financial Systems and Processes and Managed Care	2 Financial Systems and Processes and Managed Care Benefits Payment Cycle
Number of Department-level reportable conditions outstanding at end of fiscal year.	FY 1997: 3	3 Medicaid Improper Payments; Departmental Information Systems Controls; and Management Systems Planning and Development	1 Departmental Information Systems Controls	1 Departmental Information Systems Controls	3 Departmental Information Systems Controls; Omission and Delays in Obtaining Documentation; and Departmental Payroll System	1 Departmental Information Systems Controls	2 Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control; and Departmental Information Systems Controls
Percentage of Medicare contractors that will be subject to a SAS 70 audit each fiscal year.	FY 2000: 26 of 50	32%	50%	48%	40%	33%	46%
Number of Department-level instances of FFMIA noncompliance.	FY 1997: 4	2	2	2	3	3	1*
Percent of vendor payments made on time.	FY 1998: 91%	97.7%	98.3%	97.4%	97.1%	98.0%	97.1%
Increase percent of debt collection over prior year.	FY 1998: $13.3 billion	$14.4 billion 5.8% decrease	$14.4 billion	$16.1 billion 11.8% increase	$ 15.1 billion 6.2% decrease	5% increase	$11.5 billion as of June 30, 2005
Percent of eligible non-waived delinquent debt referred for cross-servicing to the Treasury.	FY 1998: 0%	67.8%	93.5%	95.0%	97.6% as of June 30, 2004	100.0%	97% as of June 30, 2005
Number of Department-level FMFIA material weaknesses/ nonconformances pending at year-end. Sections 2 and 4.	FY 1997: Sec 2 - 7 Sec 4 – 0	Sec 2 - 2 Sec 4 - 1	Sec 2 - 1 Sec 4 – 1	Sec 2 - 0 Sec 4 – 1	Sec 2 - 3 Sec 4 – 1	Sec 2 - 2 Sec 4 - 1	Sec 2 - 1 Sec 4 - 1

*In last year's report (FY 2004 PAR), the auditors reported 3 FFMIA noncompliances: 1) Financial Systems and Processes, 2) CMS Financial Systems and Analysis, and 3) Departmental Payroll System. These 3 noncompliances have now been consolidated into one noncompliance with 2 sub-components. In addition, the auditors identified 2 new noncompliances – the core accounting system and the NIH Center for Information Technology (CIT) which they are reporting as additional sub-components of the one noncompliance, Financial Systems and Processes.

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APPENDIX I – ACRONYMS

A	ACF	Administration for Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ACS	Automated Commercial System
	ACYF	Administration on Children, Youth and Families
	AFCARS	Adoption and Foster Care Analysis and Reporting System
	AFS	Automated Financial Statement
	AFPS	Accounting for Pay System
	AHP	Advancing HIV Prevention
	AHRQ	Agency for Healthcare Research and Quality
	AI/AN	American Indian/Alaska Native
	AICPA	American Institute of Certified Public Accountants
	AIDS	Acquired Immunodeficiency Syndrome
	AMP	Average Manufacturer Price
	AoA	Administration on Aging
	AR/AP	Accounts Receivable/Accounts Payable
	ASP	Average Sale Price
	ASPE	Assistant Secretary for Planning and Evaluation
	ATSDR	Agency for Toxic Substances and Disease Registry
	AWP	Average Wholesale Price
	AZT	Zidovudine
B	BACS	Budget and Accounting Classification Structure
	BCCPTA	Breast and Cervical Cancer Prevention and Treatment Act of 2000
	BHCDANET	Bureau of Health Care and Delivery Network
	BPD	Bureau of Public Debt (Department of the Treasury)
	BSC	Balanced Scorecard
C	C&A	Certification and Accreditation
	CAHPS	Consumer Assessment Health Plans Surveys
	CAN	Common Accounting Number
	CAPTA	Child Abuse Prevention and Treatment Act
	CARE	Comprehensive AIDS Resources Emergency
	CAS	Central Accounting System
	CBCAP	Community-Based Child Abuse Prevention
	CBP	Customs and Border Patrol
	CDC	Centers for Disease Control and Prevention
	CDRH	Center for Device and Radiological Health
	CEBS	Chemical Effects in Biological Systems
	CEFO	Career Epidemiology Field Officer
	CERT	Comprehensive Error Rate Testing
	CFBCI	Center for Faith-Based and Community Initiatives
	CFO	Chief Financial Officer
	CFR	Code of Federal Regulations
	CIA	Corporate Integrity Agreement
	CIO	Chief Information Officer

	CJ	Congressional Justification
	CMP	Civil Monetary Penalties
	CMS	Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration/HCFA)
	COL	Cost of Living
	CORE	PSC Core Financial Management System
	COTS	Commercial Off-The-Shelf
	CPI	Consumer Price Index
	CPIC	Capital Planning and Investment Control
	CPIM	Consumer Price Index Medical
	CRADA	Cooperative Research and Development Agreement
	CRP	Conference Room Pilot
	CRS	Clinical Reporting Systems
	CSBG	Community Services Block Grant
	CSE	Child Support Enforcement
	CSRS	Civil Service Retirement System
	CY	Calendar Year
D	DAEO	Designated Agency Ethics Officer
	DASIS-TEDS	Drug Abuse Services Information System-Treatment Episode Data Set
	DC	District of Columbia
	DCIA	Debt Collection Improvement Act of 1996
	DDTP	Division of Diabetes Treatment and Prevention
	DFO	Division of Financial Operations
	DFAS	Defense Finance and Accounting Service (Department of Defense)
	DNA	Deoxyribose Nucleic Acid
	DOE	Department of Energy
	DOJ	Department of Justice
	DOL	Department of Labor
	DR	Disaster Recovery
	DTaP	Diphtheria Tetanus acellular Pertussis
	DUNS	Data Universal Number System
E	EBDP	Entitlement Benefits Due and Payable
	e-Gov	Electronic Government
	EDP	Electronic Data Processing
	EHRP	Enterprise Human Resources and Payroll System
	eOFP	Electronic Official Personnel Folder
	EPA	Environmental Protection Agency
	Epi-X	Epidemic Information Exchange
F	FACES	Family And Child Experiences Survey
	FACS	Financial Accounting Control System
	FACTS II	Federal Agencies' Centralized Trial-Balance System II
	FAIR	Federal Activities Inventory Reform
	FASAB	Federal Accounting Standards Advisory Board

	FBWT	Fund Balance with Treasury
	FCRA	Federal Credit Reform Act of 1990
	FDA	Food and Drug Administration
	FECA	Federal Employees' Compensation Act
	FERS	Federal Employees Retirement System
	FFMIA	Federal Financial Management Improvement Act of 1996
	FFS	Fee-for-Service
	FI	Fiscal Intermediary
	FICA	Federal Insurance Contribution Act
	FIFO	First In, First Out
	FISMA	Federal Information Security Management Act of 2002
	FMFIA	Federal Managers' Financial Integrity Act of 1982
	FRPC	Federal Real Property Council
	FTE	Full-Time Equivalent
	FUL	Federal Upper Limit
	FY	Fiscal Year
G	GA	Georgia
	GAAP	Generally Accepted Accounting Principles
	GAO	U.S. Government Accountability Office
	GATES	Grants Administration, Tracking, and Evaluation System
	GDP	Gross Domestic Product
	GISRA	Government Information Security Reform Act of 2000
	GLAS	General Ledger Accounting System
	GMRA	Government Management Reform Act
	GPO	Government Printing Office
	GPRA	Government Performance and Results Act of 1993
	GSA	General Services Administration
H	HapMap	Haplotype Map
	HbA1C	Hemoglobin (test for diabetes control)
	HCFA	Health Care Financing Administration (now the CMS)
	HCFAC	Health Care Fraud and Abuse Control
	HCGLP	Health Center Guarantee Loan Program
	HEAL	Health Education Assistance Loan
	HEW	Department of Health, Education and Welfare (now HHS)
	HHS	Department of Health and Human Services
	HI	Hospital Insurance
	Hib	Haemophilus Influenzae type B
	HIFA	Health Insurance Flexibility and Accountability
	HIGLAS	Healthcare Integrated General Ledger Accounting System
	HIPAA	Health Insurance Portability and Accountability Act of 1996
	HIV	Human Immunodeficiency Virus
	HPMP	Hospital Payment Monitoring Program
	HPMS	Health Plan Management System
	HR	Human Resources
	HRSA	Health Resources and Services Administration
	HSB	Head Start Bureau

I	IBNR	Incurred But Not Reported
	IDDA	Intra-Departmental Delegations of Authority
	IG	Inspector General
	IHS	Indian Health Service
	IMPAC	Information for Management, Planning, Analysis, and Coordination
	IP	Improper Payment
	IPA	Independent Public Accountant
	IPIA	Improper Payments Information Act
	ISA	Interconnection Security Agreement
	IT	Information Technology
	ITIRB	Information Technology Investment Review Board
	ITSC	Information Technology Service Center
J	JFMIP	Joint Financial Management Improvement Program
	JV	Journal Vouchers
K		
L	LAN	Local Area Network
	LLP	Limited Liability Partnership
	LRN	Laboratory Response Network
M	M&M	Mortality and Morbidity
	MACCS	Managing and Accounting Credit Card System
	MC	Managed Care
	MD	Maryland
	MedSun	Medical Product Surveillance and Radiological Health Network
	MIAME	Minimal Information about a Microarray Experiment
	MIP	Medical Integrity Program
	MK	Market-based
	MMA	Medicare Prescription Drug, Improvement and Modernization Act 0f 2003
	MMR	Measles, Mumps, and Rubella
	MOE	Maintenance of Effort
	MSIS	Medicaid Statistical Information System
N	N/A	Not Applicable
	NACHGR	National Advisory Council for Human Genome Research
	NBRSS	NIH Business and Research Support System
	NBS	NIH Business System
	NCEH	National Center for Environmental Health
	NCP	Non-Custodial Parent

	NHDR	National Health Disparities Report
	NHQR	National Health Quality Report
	NHSC	National Health Service Corps
	NHGRI	National Human Genome Research Institute
	NIAID	National Institute of Allergy and Infectious Diseases
	NIH	National Institutes of Health
	NIOSH	National Institute for Occupational Safety and Health
	NIS	National Immunization Survey
	NMEP	National Medicare & You Education Program
	NOM	National Outcome Measure
	NQMC	National Quality Measures Clearinghouse
	NREPP	National Registry of Evidence-Based Programs and Practices
	NRS	National Reporting System
O	OAA	Older Americans Act
	OACT	Office of the Actuary
	OASDI	Old-Age, Survivors, and Disability Insurance (Social Security)
	OASIS	Operational and Administrative System for Import Support
	OCSE	Office of Child Support Enforcement
	OGC	Office of General Counsel
	OGMP	Office of Grants Management and Policy
	OIG	Office of Inspector General
	OMB	Office of Management and Budget
	OPDIV	Operating Division
	OPHEP	Office of Public Health Emergency Preparedness
	OPM	Office of Personnel Management
	OS	Office of the Secretary
P	PAM	Payment Accuracy Measurement
	PAR	Performance and Accountability Report
	PARIS	Public Assistance Reporting Information System
	PART	Program Assessment Rating Tool
	PCV	Pneumococcal Conjugate Vaccine
	PDUFA	Prescription Drug User Fee Amendments of 2002
	PERM	Medicaid Payment Error Rate Measurement
	PHIN	Public Health Information Network
	PHS	Public Health Service
	PIP	Program Improvement Plan
	PIR	Program Information Report
	P.L.	Public Law
	PMA	President's Management Agenda
	PMO	Program Management Office
	PMPP	Performance Measurement Partnership Project
	PMS	Payment Management System
	PNC	Prior Notice Center
	PNSI	Prior Notice System Interface
	POA&M	Plan of Action and Milestones Report
	PP&E	Property, Plant and Equipment

	PPS	Prospective Payment System
	PRISM	Program Review Instrument for Systems Monitoring
	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
	PSC	Program Support Center
	PTF	Payments to the Health Care Trust Funds
	PwC	Pricewaterhouse-Coopers
Q	QIO	Quality Improvement Organization
R	R&D	Research and Development
	RAMP	Real Property Asset Management Plan
	REACH	Racial and Ethnic Approaches to Community Health
	RHY	Runaway and Homeless Youth
	RPMS	Resource and Patient Management System
	RSSI	Required Supplementary Stewardship Information
S	SACWIS	Statewide Automated Child Welfare Information System
	SAMHSA	Substance Abuse and Mental Health Services Administration
	SARS	Severe Acute Respiratory Syndrome
	SARTS	State Annual Report Template System
	SAS	Statement of Auditing Standards
	SBR	Statement of Budgetary Resources
	SCHIP	State Children's Health Insurance Program
	SCN	Sentinel Centers Network
	SDPI	Special Diabetes Program for Indians
	SDW	Special Disability Workload
	SECA	Self-Employment Contribution Act of 1954
	SEDS	Statistical Enrollment Data System
	SES	Senior Executive Service
	SFFAS	Statement of Federal Accounting Standards
	SMI	Supplementary Medical Insurance
	SNP	Single Nucleotide Polymorphisms
	SNS	Strategic National Stockpile
	SOF	Statement of Financing
	SOP	Standard Operating Procedures
	SSA	Social Security Administration
	STD	Sexually Transmitted Diseases
	SysBio-OM	System Biology Object Model
	SySTox-OM	System Biology Toxicology Model
T	TANF	Temporary Assistance for Needy Families
	TEDS	Treatment Episode Data Set
	TLP	Transitional Living Program

	TOP	Treasury Offset Program
	TOPS	Total On-Line Processing System
	TPR	Termination of Parental Rights
	Treasury	Department of the Treasury
	TROR	Treasury Report on Receivables
	TSP	Thrift Savings Plan
	TWWIA	Ticket to Work and Work Incentives Act of 1999
U	UDS	Uniform Data System
	UFMS	Unified Financial Management System
	US	United States
	USAMRIID	U.S. Army Medical Research Institute of Infectious Diseases
	USPSTF	United States Preventive Services Task Force
V	VFC	Vaccines For Children Program

W, X, Y, and Z

	WAC	Wholesale Acquisition Cost

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APPENDIX J – KEY HHS FINANCIAL MANAGEMENT AND PERFORMANCE OFFICIALS

Chief Financial Officer
Charles E. Johnson

Acting Deputy Chief Financial Officer
Terry Hurst

Administration for Children and Families (ACF)
Wade F. Horn, Assistant Secretary for Children and Families
Curtis Coy, Chief Financial Officer

Agency for Healthcare Research and Quality (AHRQ)
Carolyn M. Clancy, Director
Kathleen Kendrick, Acting Chief Financial Officer

Administration on Aging (AoA)
Josefina G. Carbonell, Assistant Secretary for Aging
John Wren, Chief Financial Officer

Centers for Disease Control and Prevention (CDC)
Julie Louise Gerberding, Director
Barbara Harris, Acting Chief Financial Officer

Centers for Medicare & Medicaid Services (CMS)
Mark B. McClellan, Administrator
Timothy B. Hill, Chief Financial Officer

Food and Drug Administration (FDA)
Andrew C. von Eschenbach, Acting Commissioner
Kathy Heuer, Chief Financial Officer

Health Resources Services Administration (HRSA)
Elizabeth M. Duke, Administrator
Steven Pelovitz, Chief Financial Officer

Indian Health Service (IHS)
Charles W. Grim, Director
Thomas Thompson, Chief Financial Officer

National Institutes of Health (NIH)
Elias A. Zerhouni, Director
Colleen Barros, Acting Chief Financial Officer

Program Support Center (PSC)
J. Philip VanLandingham, Director
Larry Bedker, Chief Financial Officer

Substance Abuse and Mental Health Administration (SAMHSA)
Charles G. Curie, Administrator
Daryl Kade, Chief Financial Officer

Performance and Accountability Management and Staff

Office of Finance

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Karen Cavanaugh	Director, Division of Financial Management Policy
Katherine Lee	Director, Division of Accounting and Fiscal Policy
Terry Hurst	Director, Office of Program Management and Systems Policy
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COMMENTS AND QUESTIONS

Thank you for your interest in the Department of Health and Human Services' FY 2005 Performance and Accountability Report. We welcome your comments and questions regarding the report's content and are interested in your feedback as to how we can improve this report for our readers.

Please direct any comments and questions to Scott Bell at Scott.Bell@hhs.gov, Laura Barnes Laura.Barnes@hhs.gov, or Rick Werner at Rick.Werner@hhs.gov, or write to:

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WHERE TO OBTAIN THIS REPORT

This report is available on a CD, which is included in the Department's FY 2005 Performance and Accountability Report Highlights publication. Copies may be requested by contacting Scott Bell at Scott.Bell@hhs.gov, Laura Barnes at Laura.Barnes@hhs.gov, or Rick Werner at Rick.Werner@hhs.gov, or by writing to the above mailing address.

This report is also available on the HHS website at http://www.hhs.gov/of/reports/account/index.html

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Agency for Healthcare Research and Quality	http://www.ahrq.gov
Agency for Toxic Substances and Disease Registry	http://www.atsdr.cdc.gov
Centers for Disease Control and Prevention	http://www.cdc.gov
Centers for Medicare & Medicaid Services	http://www.cms.gov
Food and Drug Administration	http://www.fda.gov
Health Resources and Services Administration	http://www.hrsa.gov
Indian Health Service	http://www.ihs.gov
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