covered entities that it might investigate. As a result, CMS had no effective mechanism to ensure that covered entities were complying with the HIPAA Security Rule or that electronic personal health information was being adequately protected. Currently, OIG is assessing the control environment at major hospitals to determine if personally identifiable information and electronic protected health information data are adequately protected.

OIG continues its efforts to monitor HHS oversight of its vital IT systems to ensure that all necessary technical and policy measures are being taken to protect sensitive information, the systems storing the information, and the physical or electronic transport of the information. Through planned work, OIG will place new emphasis on controls designed to ensure the protection of personal data. OIG will also continue to review the controls that are designed to ensure the integrity of data on which critical systems depend for the accurate payment of billions of dollars through the numerous vital programs administered by the Department. For example, in FY 2009, OIG will review CMS oversight of data security requirements that require State-produced Medicaid information to be adequately stored and processed to protect it against unauthorized disclosure.

Health Information Technology

In 2001, the President announced the development and implementation of an "interoperable health information technology infrastructure" as a key initiative for ensuring that health care programs administered or sponsored by the Federal Government continue to promote health care quality and efficiency. HIT is the electronic technology used to collect, store, retrieve, and transfer data related to the clinical, administrative, and financial information of patients receiving health care services. In April 2004, the President issued Executive Order 13335 to facilitate reaching this goal and, in doing so, he directed the Secretary of HHS to establish the position of National Health Information Technology Coordinator (National Coordinator). According to the Executive Order, under the direction of the Secretary of HHS, "[t]he National Coordinator shall, to the extent permitted by law, develop, maintain, and direct the implementation of a strategic plan to guide the nationwide implementation of interoperable HIT in both the public and private health care sectors that will reduce medical errors, improve quality, and produce greater value for health care expenditures." A target date for the majority of Americans to have access to electronic health records by 2014 has also been set.

After being established in 2005, the Office of the National Coordinator for Health Information Technology (ONC) began addressing many of the considerations involved in developing and implementing a nationwide system of interoperable HIT. In particular, ONC participated in the establishment and facilitation of a Federal Advisory Committee, the American Health Information Community (AHIC), to assist in the development of specific recommendations on such topics as consumer empowerment, chronic care, bio-surveillance, and electronic health records. Additionally, AHIC is tasked with addressing issues of privacy and security, HIT systems certification, quality of care, and personalized care, among others. Much of this work will be transitioned to the AHIC successor organization when it is established in CY 2008.

In 2007, OIG conducted a survey of the implementation status of HIT and health information exchange (HIE) efforts in State Medicaid agencies. OIG found that almost a quarter of State Medicaid agencies have implemented HIT initiatives and that more than three quarters of States are developing similar HIT initiatives. Additionally, OIG reported that a number of Medicaid agencies were involved in the planning of statewide HIE networks, including incorporating the Medicaid Information Technology Architecture (MITA) into their HIT and HIE planning. Based on the survey findings, OIG recommended that CMS continue to support the goals of MITA to help facilitate future State Medicaid HIT and HIE initiatives, work in collaboration with other Federal agencies and offices to assist State Medicaid agencies in developing privacy and security policies, and continue to work with ONC to ensure that State Medicaid initiatives remain consistent with national goals.

In future HIT related work, OIG plans to examine the experiences of Part D plan sponsors related to e-prescribing, a prescription delivery practice that enables providers and pharmacists to electronically

transmit prescription orders and other prescription-related information for Part D beneficiaries. CMS rules require that Part D plans support an "electronic prescription program" for any providers and pharmacies that voluntarily choose to use e-prescribing, and OIG will examine how Part D sponsors have implemented e-prescribing programs and standards. Additionally, OIG will continue monitoring proposed changes to the Health Insurance Portability and Accountability Act of 1996 related to HIT and the impact that such changes would have on the permissible secondary uses of health information data for such activities as quality of care investigations and oversight.

To enable us to adapt to changing practices in health care and to continually update our oversight capabilities in this area, OIG is developing a specialized computer lab to train staff in new IT auditing technologies, tools, and approaches. This lab will enable OIG to improve the skills of its staff related to conducting assessments of HIT systems that contain clinical, administrative, and financial health information.

ASSESSMENT OF PROGRESS IN ADDRESSING THE CHALLENGE:

HHS has made progress in the security of the Department's most critical and essential assets, both physical and cyber-based, such as laboratories, computer systems, and data communication networks. The Secure One HHS project, begun in FY 2003 and supported through a multiyear contract, was initiated by the Department to improve IT security from the top down by providing security policy, procedures, and guidance to HHS agencies. The goals of this project are to improve the overall security of the Department's IT operations, ensure adequate departmentwide security standards, support integration of IT security practices into all phases of HHS operations, and promote an environment in which employee actions reflect the importance of IT security.

Since our review, CMS has made some progress in its oversight of covered entities implementation of the HIPAA Security Rule. After we completed our fieldwork in 2007, CMS executed a contract to conduct compliance reviews at covered entities. A list of potential policies, procedures and documents that could be included in these reviews was posted to the CMS Web site in late 2007. In its response to our draft report, CMS also described outreach and education efforts it has undertaken to heighten the industry's understanding of HIPAA security requirements and promote compliance.

In response to our review of HIT and HIE efforts in State Medicaid agencies, CMS stated that it is working with the Agency for Healthcare Research and Quality on selecting a vendor to work with State Medicaid and SCHIP agencies to expand their involvement with HIT and HIE in the areas of privacy and security. CMS also stated its intent to work closely with ONC to ensure that MITA and the State initiatives that CMS supports are consistent with national HIT goals and objectives.

As part of its efforts to encourage the development and use of HIT, on August 8, 2006, the Department issued final regulations that establish new exceptions (42 CFR 411.385 (v) and (w)) under the physician self-referral law and new safe harbors under the anti-kickback statute (42 CFR 1001.952(x) and (y)) involving the donation of certain HIT equipment and services. The final rules seek to lower perceived barriers to the adoption of HIT through exceptions and safe harbors that promote the adoption of e-prescribing technology and interoperable electronic health record systems while safeguarding the Federal programs and beneficiaries against undue risks of fraud and abuse. As required by the MMA, the first exception and safe harbor establish the conditions under which hospitals and certain other health care entities may donate to physicians and certain other recipients' hardware, software, or IT and training services necessary and used solely for e-prescribing. The second exception and safe harbor establish conditions under which certain entities may donate to physicians and certain other recipients interoperable electronic health record (EHR) software, IT, and training services necessary and used predominantly for EHRs.

In June 2008, ONC issued the ONC-Coordinated Federal HIT Strategic Plan to meet the requirements of Executive Order 13335. The plan outlines two goals covering "patient-focused health care" and "population health," and each goal shares four objectives focusing on privacy and security,

interoperability, adoption, and collaborative governance. Among the initiatives, programs and projects cited in the strategic plan as advancements that contribute to the President's vision, ONC highlights hosting or participating in numerous partnerships for developing interoperability, privacy, and security standards and definitions; creating frameworks for pilot testing select standards for future use; and launching HIT "use cases" through the Healthcare Information Technology Standards Panel.

ONC has also continued to lead the Interagency Health Information Technology Policy Council, which involves representation from across the Federal Government. Through this group, more than 20 Federal departments and agencies regularly interact and exchange information about Federal HIT activities and examine collaborative approaches to implementing HIT policy priorities, including those of privacy and security. Additionally, HHS plans to release by the end of 2008 a privacy and security framework to increase trust among consumers and users of electronic individual health information and to govern all privacy and security efforts related to electronic health information exchange.

Management Issue 9: Ethics Program Oversight and Enforcement

MANAGEMENT CHALLENGE:

OIG has historically been involved in oversight of the Department's ethics program. OIG's activities have ranged from evaluating agency ethics programs at selected Operating Divisions (OPDIV) to determine whether they comply with regulations issued by the Office of Government Ethics (OGE) and HHS, to investigating allegations of criminal ethics violations by current and former HHS employees. OIG's activities related to ethics issues have steadily increased as a result of congressional hearings, GAO reviews, press reports, and casework. Since 2005, ethics program oversight has been recognized as one of the Department's top management challenges in the context of both grants management and research and regulatory oversight management challenges.

OGE was established in 1978 to assist the executive branch in preventing and resolving conflicts of interest by Government employees. In partnership with executive branch agencies, OGE fosters adherence to high ethical standards to strengthen the public's confidence that the Government's business is conducted with impartiality and integrity. The Secretary of HHS has delegated responsibility for the day-to-day administration of the ethics program to the Designated Agency Ethics Official (DAEO). The DAEO appoints Deputy Ethics Counselors (DEC) to serve as ethics advisers in the OPDIVs and Staff Divisions (STAFFDIV). In addition, Congress has imposed prohibitions to help ensure that Federal employees are not compromised by conflicts of interest when performing their official duties. For example, the criminal conflict-of-interest statute, 18 U.S.C. § 208, prohibits employees from participating in official matters in which they and certain others (such as spouses) have a financial interest.

Although the DAEO is responsible for administering the Department's ethics program, OIG and DOJ are responsible for enforcement of the criminal ethics statutes. Within OIG, the Special Investigations Branch provides a central point for the DAEO and DECs to refer potential criminal violations and to discuss matters to determine whether referral is appropriate. Federal regulations and the Department's "General Administration Manual" require HHS employees and supervisors to report nonfrivolous allegations of "criminal offenses" (including conflicts of interest) to OIG. Allegations of improper conduct that do not implicate criminal laws may be handled by agency management through administrative remedies.

Although OIG continues to focus on the HHS ethics program covering the employees of the Department, we also are broadening our work to include conflict-of-interest issues related to non-Federal entities and non-Federal participants that play a role in HHS programs. As discussed below, we are looking at how NIH oversees financial conflicts of interest of grantees and how FDA oversees financial conflicts of interest of clinical investigators. Additionally, new emphasis is being placed on the role of Government contractors. A recent revision under the Federal Acquisition Regulation requires contractors to have a

written code of ethical conduct and to post information on how to report fraud. In response, we created and posted on our Web site an OIG Hotline poster for use by HHS contractors. And, as OGE released guidance on conflict-of-interest considerations of contractor employees in the workplace in 2007, OIG developed internal training on this topic for all OIG employees as part of their required annual ethics training (released on October 21, 2008). In addition, training is in progress for OIG contractors to inform them of emerging issues.

Oversight

OIG's prior work on ethics issues within HHS has focused on the oversight of employees' potential conflicts of interest. In a July 2005 report, OIG studied NIH's outside activities processes. OIG identified several vulnerabilities that inhibited NIH's ability to effectively review outside activities, such as a lack of supervisory signatures confirming approval of the requests. There were also several problems with the review process itself, such as approvals after the start dates, limited use of written recusals, and inadequate followup regarding ongoing outside activities. To address these vulnerabilities, OIG recommended that NIH improve the quality and increase the extent of information it receives for outside activity requests and address inadequacies in the outside activity review process.

In February 2006, OIG issued a report on conflicts of interest at FDA in which we identified a variety of vulnerabilities in the FDA process for review and approval of requests to engage in outside activities. OIG found that FDA employees submitted limited information regarding outside activities and found several problems in the review process itself, such as approvals after the start date, multiple activities listed on a single activity request, and inadequate followup for ongoing outside activities. To address these vulnerabilities, OIG recommended that FDA improve the quality and increase the extent of information it receives in outside activity requests and address inadequacies in the review process for outside activities.

OIG work will continue to focus on the oversight of ethics issues involving departmental employees. For example, in a review similar to the NIH and FDA outside activity reviews, OIG will assess whether CDC identifies and resolves conflicts of interests among Federal Advisory Committee Special Government Employees (SGEs) in a timely and complete manner. Compliance with the ethics statutes and standards of ethical conduct is of particular importance for these CDC employees because their research results and regulatory decisions affect the Nation's public health security.

OIG has also reviewed specific allegations that NIH received about employee activities that might be criminal or improper. The evaluation determined the number and nature of the allegations that NIH received and examined how NIH handled and resolved these allegations. OIG found that the majority of the Institutes do not have Institute-specific policies or procedures for reviewing allegations, do not handle allegations uniformly, and do not uniformly confer with the appropriate outside parties when handling allegations. To address these vulnerabilities, OIG recommended that NIH develop a formal, written policy outlining how allegations of conflicts of interest and ethics violations are to be handled among the Institutes' ethics offices, the NIH Ethics Office, the OGC Ethics Division, and the Office of Management Assessment and to maintain documentation detailing how allegations are ultimately resolved.

Although it is vital that intramural research undertaken within the Department be free from potential biases stemming from employee conflicts of interest, 80 percent of NIH's research funding goes to extramural grantees, primarily to research universities that undertake work pursuant to contracts and grants. As a result, OIG work has also focused on potential conflicts of interest relating to extramural grantees and researchers.

In January 2008, OIG released a report on the conflict-of-interest reports external grantees submitted to NIH in FYs 2004 through 2006. OIG found that NIH's Institutes and the Office of Extramural Research (OER) were unable to provide all of the actual conflict-of-interest reports they received from grantee institutions and did not follow up with grantee institutions regarding reported conflicts of interest. OIG recommended that NIH (1) increase oversight of grantee institutions to ensure their compliance with Federal financial conflict-of-interest regulations; (2) require grantee institutions to provide details

regarding the nature of financial conflicts of interest and how they are managed, reduced, or eliminated; and (3) require Institutes to forward to OER all financial conflict-of-interest reports that they receive from grantee institutions and ensure that OER's conflict-of-interest database contains information on all conflict-of-interest reports provided by grantee institutions.

OIG is continuing its efforts in this area. For example, OIG is conducting a study to determine the nature of financial conflicts of interest reported by grantee institutions to NIH. More specifically, OIG will examine how grantee institutions managed, reduced, or eliminated these conflicts. OIG will also review the conflict-of-interest policies established by these institutions.

Similarly, OIG is conducting a study on FDA's oversight of clinical investigators' financial interests. Clinical investigators lead clinical trials, recruit subjects, supervise, analyze, and report clinical trial results. The study will describe the extent and nature of clinical investigators' financial interest information submitted to FDA with all the marketing applications approved by FDA in 2007. It will also assess FDA's process for reviewing the information about clinical investigators' financial interests submitted with the marketing applications.

Enforcement

In addition to performing systemic reviews identifying vulnerabilities in the administration of the Department's ethics program, on the enforcement side, OIG has managed a significant caseload of conflict-of-interest matters. OIG has emphasized outreach within the Department, which has resulted in an increased number of conflict-of-interest referrals from across the various OPDIVs and STAFFDIVs. Additionally, OIG has partnered with Federal agencies outside HHS, such as the U.S. Securities and Exchange Commission, to investigate potential conflict-of-interest allegations.

OIG continues to investigate complaints involving potential conflicts of interest. For instance, an OIG investigation of a former FDA Commissioner's false reporting that he had sold stock in companies regulated by FDA, when in fact he continued to hold shares in those firms, resulted in guilty pleas to two criminal charges for false writings and conflict of interest, a fine of approximately $90,000, 3 years of supervised probation, and 50 hours of community service. In 2008, the former FDA Commissioner was debarred from being involved in contracting, subcontracting, or any covered transaction with any agency of the U.S. Government for 2 years. In another example, OIG handled a case involving an NIH senior scientist. The Chief of the Geriatric Psychiatry Branch at NIH pled guilty in December 2006 to conflict-of-interest charges relating to his alleged acceptance of $285,000 in consulting fees and additional travel expenses from a drug company without the required approval of and disclosure to NIH officials.

OIG's overall approach to conflict-of-interest enforcement has also emphasized outreach as a tool for improving the referral of conflict-of-interest matters within the Department. In 2006, in an effort to improve the efficiency of the referral process, OIG created a comprehensive form for the DAEO and DECs to use when referring conflict-of-interest cases to OIG. At a quarterly DEC meeting in 2007, representatives from OIG and the OGC Ethics Division gave a joint presentation regarding OIG's involvement with the enforcement of conflict of interest matters. This presentation outlined the use of the OIG referral form and increased the OIG's visibility with the DECs. Additionally, OIG's ongoing relationship with OGC, as well as regular OPDIV and STAFFDIV interaction by OIG staff, has yielded positive results with regard to conflict of interest matters. Specifically, OIG has noted an increase in the quality of the referrals, an increase in the number of referrals from various departmental divisions, and an increase in departmental contacts seeking input and guidance on conflict of interest matters.

ASSESSMENT OF PROGRESS IN ADDRESSING THE CHALLENGE:

Actions have been taken to address ethics issues identified by OIG. In response to recommendations in OIG studies of outside activities, both NIH and FDA have strengthened their process for reviewing outside activities by posting new guidance on the completion and evaluation of HHS form 520, "Request for

Approval of Outside Activity." In June 2008, NIH released new policy guidance on managing conflicts of interest and possible biases, including detailed procedures for ensuring that employees are appropriately recused from participating in official matters that might create an actual or apparent conflict of interest.

In response to recommendations pertaining to the conflicts of interest in extramural research, NIH has developed a Web-based financial conflict-of-interest tracking and monitoring system for its internal use. This system enables grantee institutes' grants management and program staff to enter their own records and view financial conflict-of-interest reports across NIH. The database also reminds grants management personnel to send acknowledgments to institutions and to forward copies of conflict-of-interest reports to OER. Moreover, NIH updated its OER Web site to better address grantee institutions' frequently asked questions on financial conflict requirements, and also launched a pilot Federal FCOI compliance program. This pilot program, which began in February 2008, will assess institutional implementation of and compliance with the regulatory requirements of the FCOI in research pertaining to NIH grants and cooperative agreements.

For its part, FDA is revising its conflict-of-interest procedures regarding advisory committee members to make the waiver of conflict-of-interest process more transparent and compliant with the Food and Drug Administration Amendments Act of 2007. In 2007, FDA posted on its Web site draft guidance for the public on procedures for identifying conflicts of interest and eligibility for participation in FDA Advisory Committees and on public availability of advisory committee members' financial interest information and waivers.

The OGC Ethics Division, led by the DAEO, continues to expand its ethics program oversight, guidance, and training activities. The ethics program of each OPDIV and STAFFDIV in HHS has been reviewed (except for FDA, which was scheduled for review in July 2008) and the review staff has begun the next phase by revisiting components with newly appointed ethics officials or where specific issues have surfaced. The Ethics Division sponsors half-day quarterly meetings for DECs and an annual full-day DEC workshop and also issues a quarterly "Ethics Update" newsletter, which is distributed to all HHS ethics program officials and posted on the Division's Intranet page.

The DAEO is also taking steps to tighten up the waiver process, issuing guidance to all DECs reminding them of their responsibility to (1) send to the DAEO copies of all waivers granted to Department employees along with data regarding the number of waivers issued; (2) establish a reliable tracking system for waivers; and (3) consult with an Ethics Division attorney prior to granting any 18 U.S.C. § 208 (b)(1) waiver (certifying that the individual's financial interest is not so substantial as to be deemed likely to affect the integrity of his or her services) and when granting 18 U.S.C. § 208 (b)(3) waivers (certifying that the need for an SGE's services on a Federal advisory committee outweigh the potential conflict of interest from the individual's financial interest) if there are unique fact patterns, special circumstances, or unusual situations. The DAEO is planning to issue a package with waiver guidance and information regarding which Department officials have the delegated authority to issue waivers. In addition, the DAEO's office is reaching out on a monthly basis to ethics coordinators for each OPDIV and STAFFDIV to inquire about the operation of the divisions' ethics programs, including the review of waivers.

DEPARTMENT'S RESPONSE TO THE OIG TOP MANAGEMENT AND PERFORMANCE CHALLENGES

Date: November 17, 2008

To: Daniel R. Levinson, Inspector General

From: Charles E. Johnson, Chief Financial Officer

Subject: FY 2008 Top Management and Performance Challenges Identified by the Office of the Inspector General

This memorandum is in response to OIG's *FY 2008 Top Management and Performance Challenges*. The *OIG's Top Management and Performance Challenges* report summarized the top management and performance challenges that the Department has faced over recent years. Additionally, OIG provided an assessment of our progress in addressing those challenges. This assessment is primarily based on cost to taxpayer, visibility, management, and other pertinent factors.

We concur with OIG's findings concerning the HHS top management and performance challenges. In response to OIG's report, we are providing the attached table which includes a brief summary of the top management challenges, management's response, and future plans to address these challenges during FY 2009.

Our management is committed to working toward resolving these challenges, and looks forward to continued collaboration with OIG to improve the health and well-being of the American people through our efforts.

FY 2008 TOP MANAGEMENT AND PERFORMANCE CHALLENGES SUMMARY

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
1. Oversight of Medicare Part D	CMS has demonstrated progress in: payment accuracy and internal controls; program safeguards; beneficiary protections.	CMS has made progress in its use of bid audits. MEDICs have not conducted data analysis to identify potential fraud. CMS has issued 9/18 chapters of the Prescription Drug Benefit Manual.	CMS will develop a centralized data repository to warehouse data on Medicare Parts A, B, D and Medicaid to provide a single source of information for CMS fraud, waste, and abuse activities.
2. Integrity of Medicare Payments	CMS has demonstrated vigilance in monitoring the gross paid claims error rate and is developing appropriate corrective action plans.	The CMS FY 2007 gross paid claims error rate of 3.9 percent is 6.2 percent lower than the FY 2004 error rate. CMS has made progress in its general and applicable controls and has begun implementing the Healthcare Integrated General Ledger Accounting System.	HHS will continue to address potential improper payment exposure for durable medical equipment under a 2-year effort aimed at stopping fraudulent billing to protect beneficiaries and taxpayers.
3. Appropriateness of Medicaid and SCHIP Payments	CMS has annually updated its 5-year Comprehensive Medicaid Integrity Plan to promote the proper expenditure of Medicaid fund, improve integrity performance, and foster collaboration with internal and external stakeholders.	The final Medicaid payment error rate is reported in the IPIA Report, included in the *FY 2008 Agency Financial Report*, Section III.	CMS plans to start educating providers on payment and billing integrity as well as quality-of-care issues related to personal care services beginning in FY 2009. CMS is working to address data limitations by creating a new database to store Medicaid data from all States.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
4. Quality of Care	Progress continues to strengthen oversight of the quality of care paid for by the Medicare and Medicaid programs. CMS has promoted quality by collecting and publishing quality-related data on nursing homes and hospitals.	Progress continues to strengthen oversight of the quality of care paid for by the Medicare and Medicaid programs.	CMS plans to improve hospice oversight by improving the survey process and proposes to amend the hospice section of the State Operations Manual to enable State surveyors to make more consistent decisions regarding compliance with Medicare regulations.
5. Public Health and Medical Emergency Preparedness	States and localities are making progress in strengthening their bioterrorism preparedness programs. Federal, State and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. The Commissioned Corps are equipping designated response teams.	HHS issued an updated Purchase Card Guide and a 2-page Quick Reference Guide that highlights key information about emergency situations related to HHS purchase card policies and procedures.	CDC implemented stronger performance measures, which will continue to expand in future years, for the Public Health Emergency Preparedness cooperative agreement. Additionally, clearer guidance was developed for grantees to report on these measures.
6. Oversight of Food, Drug, and Medical Device Safety	HHS has implemented many changes to protect human research subjects and to strengthen FDA and NIH oversight of scientific research. During FY 2008, FDA established offices in China to facilitate inspections of Chinese food and drugs before they are imported to the United States.	As a major milestone in the globalization of efforts to enhance the safety of imported food and medical products, FDA announced plans to establish overseas offices in China, India, Europe and Latin American before the end of 2008, with a fifth office in the Middle East to follow in 2009.	FDA is developing an internal listing of all ongoing clinical trials as part of a broader effort to manage FDA's regulated product information electronically. FDA is also developing recommendations for improving the quality of its post-marketing study commitment processes for human drugs and biologics.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
7. Grants Management	HHS has worked to develop more consistent policies and practices, and has undertaken a leadership role in implementation of key legislation, along with the availability of grants funding opportunities via grants.gov.	AHRQ has established practices to ensure the integrity of grant data, timeliness of grantee reporting, and closeout procedures.	Emphasis is being placed on timely financial closeout of ended projects.
8. Integrity of Information Technology Systems and the Implementation of Health Information Technology	HHS has made progress in the security of its most critical and essential assets, such as laboratories, computer systems, and data communication networks. CMS has made progress in oversight of the HIPAA Security rules. ONC issued the ONC-coordinated Federal Health IT Strategic Plan, outlining two goals covering patient-focused health care and population health.	ONC is actively involved in several activities including the drafting of a privacy and security framework for electronic health information exchange and other supplemental materials. Significant progress also continues with collaborative initiatives involving state leadership and other stakeholders to address issues that have direct benefit to U.S. citizens, and cannot be resolved at the Federal level alone. ONC awarded a contract in May 2008, to engage experts and the public to develop a knowledgebase and a roadmap for health IT and health information exchange actions to help prevent, detect, and remedy medical identity theft in the U.S.	HHS plans to release by the end of 2008, a privacy and security framework to increase trust among consumers and users of electronic individual health information and to govern all privacy and security efforts related to electronic health information exchange. In FY 2009, plans are to build on the momentum achieved in FY 2008, and continue to develop more detailed best practices, tools, training and outreach mechanisms that could be built into existing health information technology initiatives.

Management Challenge Identified by the OIG	OIG Progress Assessment	Management Response	Future Plans to Address the Challenge
9. Ethics Program Oversight and Enforcement	Both NIH and FDA have strengthened processes for reviewing outside activities. Additionally, the OGC Ethics Division continues to expand its ethics program oversight, guidance and training activities.	HHS continued program reviews at NIH and other components. The Program Review Section, uncovered significant vulnerabilities in a number of component ethics programs and has issued formal reports this year containing recommendations for improvement, including monitoring by OPDIVs and STAFFDIVs to achieve full compliance with applicable laws and regulations. The Program Review Section also devoted significant efforts in monitoring certification. The Ethics Division provided many ethics presentations for a variety of HHS personnel.	The OGC Ethics Division is planning to issue a package with waiver guidance and information regarding delegation of authority to issue waivers. In addition, the Ethics Division oversees component ethics program operations, including the review of waivers.

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

Table 1.

Summary of Financial Statement Audit

Audit Opinion			Unqualified		
Restatement			No		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
Financial Reporting, Systems, Analyses & Oversight	☑			☑	☑
Budgetary Accounting	☑			☑	
Financial Management Information Systems	☑			☑	☑
Medicare Claims Processing	☑			☑	
Total Material Weaknesses	***4***	***0***	***0***	***4***	***2***

Definition of Terms – Tables 1 and 2

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

Resolved: The total number of material weaknesses that have dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a material weakness does not meet the criteria for materiality or is redefined as more correctly classified under another heading (e.g., Section 2 to a Section 4 and vice versa).

Ending: The agency's year-end balance.

Table 2.

Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)

Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Financial Reporting Systems & Processes	☑					☑
Total Material Weaknesses	***1***	***0***	***0***	***0***	***0***	***1***

Effectiveness of Internal Control over Operations (FMFIA #2)

Statement of Assurance	Qualified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	☑					☑
Total Material Weaknesses	***1***	***0***	***0***	***0***	***0***	***1***

Conformance with financial management system requirements (FMFIA #4)

Statement of Assurance	Nonconformance					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Financial Reporting Systems & Processes	☑					☑
Information System Controls and Security	☑					☑
Total Non-Conformances	***2***	***0***	***0***	***0***	***0***	***2***

Compliance with Federal Financial Management Improvement Act (FFMIA)

	Agency	Auditor
Overall Substantial Compliance	No	No
1. System Requirements	No	
2. Accounting Standards	Yes	
2. USSGL at Transaction Level	No	

IMPROPER PAYMENTS INFORMATION ACT REPORT

1.0 Overview

Our FY 2008 *Improper Payments Information Act* (IPIA) Report includes a discussion of the following information, as required by the Improper Payments Information Act of 2002, OMB Circular A-136 and OMB Circular A-123, Appendix C.

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
- Corrective Action Plans (Section 4.0)
- Recovery Auditing Reporting (Section 5.0)
- Accountability in Reducing and Recovering Improper Payments (Section 6.0)
- Information Systems and Other Infrastructure (Section 7.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 8.0)
- Progress and Achievements (Section 9.0)
- Improper Payment Reduction Outlook (Section 10.0)
- Program Specific Reporting Information (Section 11.0)
    - Medicare Fee-for-Service Program (Section 11.10)
    - Medicare Advantage (Section 11.20)
    - Medicare Prescription Drug Benefit (Section 11.30)
    - Medicaid (Section 11.40)
    - State Children's Health Insurance Program (Section 11.50)
    - Temporary Assistance for Needy Families (Section 11.60)
    - Foster Care (Section 11.70)
    - Head Start (Section 11.80)
    - Child Care (Section 11.90)

1.10 Program Descriptions

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

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

2) Medicare Advantage (Medicare Part C)- A Medicare health insurance program that allows beneficiaries to receive their Medicare benefits through a private heath plan.

3) Medicare Prescription Drug Benefit (Medicare Part D)- A Federal prescription drug benefit program for Medicare beneficiaries.

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

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

6) Temporary Assistance for Needy Families (TANF)- A joint Federal/State program, administered by the States that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency.

7) Foster Care- A joint Federal/State program, administered by the States for children who need placement outside their homes in a foster family home or a child care facility.

8) Head Start- A Federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families. Head Start provides diverse services consistent with its goals for success in education, health, parent involvement and social services.

9) The Child Care Development Fund (CCDF)- A Joint Federal/State program, administered by the States that provides child care financial assistance to low-income working families.

2.0 Risk Assessments

In addition to the nine programs that HHS measures, we conduct risk assessments on 23 additional high dollar programs. OMB Circular A-123, Appendix C requires HHS to perform risk assessments once every three years on these programs. HHS did not perform any risk assessments in FY 2007, performed 14 risk assessments in FY 2008, and will perform the remaining 9 risk assessments in FY 2009. Of the 14 programs assessed in FY 2008, 13 were deemed low-risk and one was deemed medium-risk.

3.0 Statistical Sampling Process

The statistical sampling process conducted to estimate the improper payment rate for each program identified in our program description section is discussed in the Program Specific Reporting section. Eight of our programs that report error rates use a statistical contractor and one uses the HHS Office of Inspector General to ensure that all statistical methodologies, sampling, calculations, and validation are performed according to accepted statistical practices. Unless otherwise stated in the Program Specific Reporting section, all programs also comply with IPIA guidance that requires that all estimates shall be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments.

4.0 Corrective Action Plans

Corrective Action Plans for reducing the estimated rate of improper payments for each program are included in the respective Program Specific Reporting section. There are two important aspects to the corrective action plans: (1) setting aggressive, but realistic, goals and targets and (2) achieving the targets according to the timetable in the plan. Corrective action plans are reviewed each year to ensure that they are focused on the root causes of the errors and that the targets are being met. If targets are not being met, remediation will take place which can include employing new strategies, adjusting staffing and other resources, and possibility revising targets.

5.0 Recovery Auditing Reporting

In July 2004, HHS awarded a contingency fee contract to a recovery auditing firm to review FY 2002 and FY 2003 contract payments. During FY 2006, HHS exercised an option under the contract for review of FY 2004 and FY 2005 contract payments. As reported in the FY 2007 Agency Financial Report (AFR), our recovery auditors have found the HHS payment systems to be without major program integrity issues. HHS has recovered $74,401 out of more than $24 billion of contracts reviewed. We have not sought a contractor to attempt to recover funds beyond FY 2005 since our efforts to date have produced such small recoveries. HHS is currently assessing whether the costs in HHS resources to assist our contractor outweighs the small amount of recoveries that have been achieved over the past four years.

Full results for FY 2002-FY 2005 are displayed in the table below.

AGENCY COMPONENT	HHS
Amount Subject to Review for CY + PY Reporting	$24.2 billion
Actual Amount Reviewed and Reported CY + PY	$24.2 billion
Amounts Identified for Recovery CY	0
Amounts Recovered CY	0
Amounts Identified for Recovery PYs	$1,586,643
Amounts Recovered PYs	$74,401
Cumulative Amounts Identified for Recovery (CY + PYs)	$1,586,643
Cumulative Amounts Recovered (CY + PYs)	$74,401

NOTE: PY= Prior Year, CY= Current Year

6.0 Accountability in Reducing and Recovering Improper Payments

HHS has initiated a number of measures to ensure that agency managers and appropriate officers are held accountable for reducing and recovering improper payments. HHS' commitment to this initiative is illustrated through HHS' Strategic Plan. One of our stated objectives is "Responsible Stewardship and Effective Management," which includes the improper payment initiative.

HHS has shown tremendous leadership in this area, as we have been publishing an error rate for Medicare fee-for-service since FY 1996 and have successfully reduced that error rate over time. HHS has also been reporting Foster Care and Head Start error rates since FY 2004. All of our other programs will be reporting at least a componentrate in FY 2008. We will be working with those programs to reduce their error rates in the future.

The improper payment initiative is tracked quarterly by OMB at the Department level using the President's Management Agenda scorecard. The Department's score reflects HHS' progress in achieving its improper payment goals. HHS has maintained a "Yellow" status and "Green" progress score throughout FY 2008.

In addition, HHS issues interim scorecard ratings to each of its operating divisions each quarter. These interim ratings help facilitate HHS leadership discussion and accountability as well as to help ensure that HHS will meet its quarterly goals. Affected HHS operating divisions have all maintained a "Green" progress score throughout FY 2008.

Further, HHS management performance plan objectives hold agency managers, beginning at the top of the leadership and cascading down through HHS Senior Executives (including component heads) and below, accountable for achieving progress in this initiative. As part of the semi-annual and annual performance

evaluation, HHS Senior Executives are evaluated on the progress the agency achieves toward its stated goals.

7.0 Information Systems and Other Infrastructure

Reporting requirements related to information systems and other infrastructure is discussed by program within the Program Specific Reporting section.

8.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Reporting requirements related to whether there are any statutory or regulatory barriers to reducing improper payments are discussed by program within the Program Specific Reporting section.

9.0 Progress and Achievement

9.10 FY 2008 Progress

HHS currently has nine programs that have been deemed risk susceptible: Medicare Fee-for Service, Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Head Start, Child Care, and Foster Care. For the first time, in FY 2008, we are reporting at least one component of an error rate for each of these programs.

HHS has maintained a "Yellow" status and "Green" progress rating for the Eliminating Improper Payments initiative under the President's Management Agenda (PMA) throughout FY 2008. This is a result of having an OMB-approved measurement plan in place for all risk susceptible programs and a corrective action plan in place with OMB-approved targets for all programs that have been measured.

Once baselines have been established for all programs, reduction targets and corrective action plans can be developed for those programs that do not currently have them. Meeting and maintaining the reduction targets is the next milestone towards achieving a "Green" status rating under the PMA.

9.20 Achievements

9.21 Improving Program Integrity in Medicare

Beginning in 2005, HHS engaged in a three year Demonstration Project for Improving Program Integrity in Medicare. Under section 306 of the *Medicare Prescription Drug Improvement Modernization Act of 2003* (MMA), HHS was given the authority to conduct a demonstration project to demonstrate the use of recovery audit contractors (RACs) in identifying and correcting improper payments under the Medicare Fee-for-Service program.

This demonstration project was so successful that under Section 302 of the *Tax Relief and Health Care Act of 2006*, Congress made the RAC Program permanent. Under this Act, HHS is required to implement the program in all 50 states no later than January 1, 2010. This fall HHS awarded four recovery auditing contracts through full and open competition. Each of the four RACs will be responsible for identifying and correcting improper payments in approximately one-quarter of the country. Nationwide implementation of these contractors will be gradual. HHS and the RACs will provide extensive outreach to the provider community during implementation.

9.22 Contracting Actions

HHS for the first time included a "pilot" Comprehensive Error Rate Testing Program award fee metric into the award fee plan for the Jurisdiction 3 (J3) Medicare Administrative Contractor. The purpose of this pilot is to utilize contract actions, specifically award fee plans, to create incentives for Medicare Administrative Contractors to further reduce improper payments. Under this award fee "pilot," the J3 contractor can earn some, all or none of the award fee pool for the Comprehensive Error Rate Testing program metric based on its FY 2008 error rate. HHS will be evaluating this metric for the first time after the November 2008 Medicare Fee-For-Service Improper Payments Report is published.

9.23 Head Start Signed Statement Template Form

HHS has developed a standard signed statement template form for Head Start, which will be available to all grantees in FY 2009. Grantees will be encouraged to use the template until OMB clearance for the form can be obtained, at which point the use of the form will be mandatory. The standard signed statement form will help educate grantees on the type of information they need to collect from prospective families during the enrollment process and provide them with a structure for recording this information.

9.24 Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is a voluntary Federal-State partnership which provides the forty-five participating State Public-Assistance Agencies detailed information and data to assist them in maintaining program integrity and detecting/deterring improper payments. On October 10, 2008, the QI Program Supplemental Funding Act of 2008 was signed by the President. The Act stated that in order to receive Medicaid federal matching funds for reimbursement of state costs for automated data systems used for the administration of the Medicaid state plan, the provision would require states to have in operation a Medicaid eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) (or any successor system), including matching with medical assistance programs operated by other States. As a result of passage of this Act, HHS will have to commence rulemaking to incorporate this revision into regulation.

In FY 2008, HHS allowed PARIS Member States to explore the two newest programmatic matches, Child Care and Workers' Compensation. These new matches are in addition to the Federal, State, and Veteran program matches already available to States. Numerous jurisdictions are testing these new matches to determine the viability of utilizing them. The August 2008 data match was the largest to date, both in terms of number of Agencies (40) participating and number of Social Security Numbers submitted. In August of 2008, California became the 43rd State to join PARIS, which brings the total number of States involved to 43, or 45 total jurisdictions including the District of Columbia and Puerto Rico.

10.0 Improper Payment Reduction Outlook FY 2007 – 2011

The chart on the next page shows our IPIA results for the current year (CY) 2008, the prior year (PY) 2007, along with targets for the years 2009-2011. For each year we show, for each program, outlays for that fiscal year, an error rate or target (IP%), and the dollars paid improperly (IP $).

IMPROPER PAYMENT REDUCTION OUTLOOK FY 2007 – FY 2011

Program	PY Outlays	PY %	PY$	CY Outlays	CY IP%	CY IP$	CY+1 Est Outlays	CY+1 IP%	CY+1 IP$	CY+2 Est Outlays	CY+2 IP%	CY+2 IP$	CY+3 Est Outlays	CY+3 IP%	CY+3 IP$
Medicare FFS	$276,200 Note (a)	3.9	$10,800 ($9.8B over, $1.0B under)	$288,200 Note (b)	3.6 Note (1)	$10,400 ($9.5B over, $0.9B under)	$321,127 Note (c)	3.5	$11,239	$335,185	3.4	$11,396	$349,613	3.3	$11,537
Medicare MC	77,096 Note (d)	N/A	N/A	64,600 Note (e)	10.6 Notes (2,3)	6,848	111,323	N/A Note (4)	N/A	122,293	N/A	N/A	144,438	N/A	N/A
Medicare Drug	49,103 Note (f)	N/A	N/A	46,127	N/A Note(5)	N/A	56,239	N/A	N/A	62,156	N/A	N/A	72,898	N/A	N/A
Medicaid	139,896 Note (g)	4.7 Note (6)	6,575	177,547 Note (h)	10.5 Note (7)	18,642	216,477 Note (i)	N/A Note (8)	N/A	231,497	N/A	N/A	249,336	N/A	N/A
SCHIP	5,999 Note (j)	N/A	N/A	5,676 Note (k)	14.7 Note (9)	834.4	5,868	N/A Note (10)	N/A	5,701	N/A	N/A	5,596	N/A	N/A
TANF	16,988	N/A	N/A	17,880	9.3 Note (11)	1,663	17,446	N/A Note (12)	N/A	17,386	N/A	N/A	17,382	N/A	N/A
Head Start	6,889	1.3	89.5	6,878	3.0	206.3	7,027	2.0	140.5	7,027 Note (l)	1.9	133.5	7,027	1.8	126.5
FosterCare	1,593 Note (m)	3.30	52.6	1,551	6.42 Note (13)	99.6	1,523	6.0	91.4	1,512	5.5	83.2	1,487	5.0	74.3
Child Care	5,129	N/A	N/A	4,983	11.5 Note (14)	573	5,028	11.0	553.1	4,985	10.5	523.4	4,979	10.0	497.9

(a) PY Outlays for Medicare FFS are from the November 2007 Improper Medicare FFS Payments Report (based on CY 2006 claims).

(b) CY Outlays for Medicare FFS are from the November 2008 Improper Medicare FFS Payments Report (based on CY 2007 claims).

(c) Medicare FFS CY+1, CY+2, CY+3 - CY outlay numbers based on FY 2009 Mid-session Review (Medicare Outlays current law (CL)).

(d) Medicare Advantage PY, CY+1, CY+2, CY+3 outlay numbers based on FY 2009 Mid-session Review (Medicare Outlays (CL)).

(e) Medicare Advantage CY Outlays are from the Medicare Part C Payment Error Final Report 2008 (based on CY 2006 data).

(f) Medicare Prescription Drug Benefit PY, CY, CY+1, CY+2, CY+3 outlay numbers based on FY 2009 Mid-session Review (Medicare Outlays (CL)).

(g) PY Outlays for Medicaid FFS are from the 2007 Medicaid FFS Component Final Annual Error Rate Report (based on FY 2006 claims).

(h) CY Outlays for Medicaid are from the 2008 Medicaid Annual Error Rate Report (based on FY 2007 data).

(i) Medicaid CY+1, CY+2, CY+3 outlay numbers based on FY 2009 Mid-session Review (Medicaid Net Outlays (CL), excluding CDC Program Vaccine for Children obligations).

(j) SCHIP PY, CY+1, CY+2, CY+3 outlay numbers based on FY 2009 Mid-session Review (SCHIP Total Outlays (CL)).

(k) SCHIP CY outlays are from the 2008 SCHIP Annual Error Rate Report (based on FY 2007 data).

(l) For IPIA reporting purposes Head Start, a discretionary program, is assumed to be flat funded in the out years.

(m) PY Outlays revised to reflect final FY 2007 outlays.

Improper Payment Reduction Outlook Notes:

1) To strengthen our confidence in review findings and assure the accuracy of reported error rates, HHS began an effort to independently perform blind, random reviews of its CERT review contractor's payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete.

2) For FY 2008 IPIA reporting for Medicare Advantage, HHS calculated a composite error rate, based on (1) the Medicare Advantage and Prescription Drug System (MARx) Payment Error (MPE) for CY 2006; and (2) the CY 2006 Risk Adjustment Error (RAE), as described in section 11.21.

3) HHS has taken initial steps and continues to evaluate the benefits of including a dual eligible (a term used to describe beneficiaries eligible for benefits under both Medicare and Medicaid) component in future Medicare Part C error measurements. Of the total Medicare Part C payment of $64.6 billion for Calendar Year 2006, approximately 3 percent of payments are attributable to dual eligible beneficiaries. While the actual error rate for dual eligibles has not been determined, the impact of dual eligibles on the overall Medicare Part C error rate would range from as little as approximately $25 million (based on the eligibility errors in five states) up to approximately $50 million (assuming that dual eligibles have the same level of Medicaid eligibility error as the entire Medicaid population).

4) The baseline measurement for Medicare Part C will be established in the FY 2009 Agency Financial Report and outyear targets will be set at that time. HHS considers the FY 2008 measurement year (based on CY 2006 payments) to be a pilot year because a statutorily-mandated change in the payment methodology for the health plans occurred in CY 2007 (the data year for next year's measurement). Per Section 1853(a)(3)(C)(ii) of the Social Security Act, risk adjustment of Part C payments was phased-in from 2000 through 2007, replacing an earlier methodology where Medicare payments to private health plans were adjusted only with demographic factors (such as age, sex, and Medicaid status). Therefore, as required by the statute for CY 2006, 75 percent of the Medicare Part C monthly prospective payment for each beneficiary enrolled in a private health plan was calculated under the risk adjustment methodology, and the remaining 25 percent was calculated under the demographic-only methodology. Beginning in CY 2007 100 percent of the Medicare Part C monthly prospective payments for each beneficiary enrolled in a private health plan was risk adjusted. As a result, any targets being set based on our CY 2006 results would not be comparable to next year's rate.

5) For FY 2008 IPIA reporting for the Medicare Prescription Drug Benefit, HHS calculated two components of payment error , based on (1) the Medicare Advantage and Prescription Drug System (MARx) Payment Error for CY 2007 (MPE); and (2) a Low Income Subsidy (LIS) payment error estimate for CY 2007, as described in section 11.31. HHS calculated a Part D MPE rate of .59 percent for prospective payments made from January 1, 2007 through December 31, 2007, and estimated a gross amount of payment error totaling $ 250,093,758. Estimated Part D MPE underpayments were $ 233,038,295, and estimated overpayments were $ 17,055,463. HHS calculated a Part D LIS error rate for prospective payments made from January 1, 2007 through December 31, 2007 of 0.25 percent, and estimated a gross amount of payment error totaling $ 106,535,176 (all errors are underpayments). The Part D LIS error rate is the sum of error rates for Low Income Cost Sharing Subsidy, Low Income Premium Subsidy, and the Direct Subsidy error estimates.

6) In the *FY 2007 Agency Financial Report*, HHS reported a preliminary Medicaid fee-for-service component error rate of 18.45 percent based on a review of 17 States for quarters 1 and 2 of FY 2006. In FY 2008, HHS completed the FY 2006 Medicaid fee-for-service component measurement and is reporting the annual FY 2006 Medicaid fee-for-service component error rate of 4.7 percent.

7) The Medicaid error rate is composed of three components: fee-for-service, managed care, and eligibility. The component error rates are 8.9 percent, 3.1 percent, and 2.9 percent, respectively. The States were asked to report the eligibility data in three categories: eligible, ineligible and undetermined. The eligibility component noted above counts the ineligibles and the undetermined cases as errors. The undetermined portion of the eligibility component error rate was .5 percent. When the undetermined cases are not included, the eligibility component error was 2.4 percent. HHS also calculated a national case error rate. The active case error rate for Medicaid is 3.2 percent and the negative case error rate is 6.2 percent. In FY 2007, 94.7 percent of sampled active cases were determined eligible; 2.5 percent of sampled active cases were determined ineligible; and 2.8 percent of sampled active cases could not be determined. For sampled negative cases, 96.7 percent of cases were correctly denied or terminated and 3.3 percent were improperly denied or terminated. The FY 2007 breakout of specific eligibility findings are based on actual findings from States' samples, and unlike the case error rates, are not national projections.

8) The baseline measurement for Medicaid, based on the measurement of 50 States and the District of Columbia over a three year period (FY 2007 – FY 2009) will be published in the *FY 2010 Agency Financial Report.* Therefore, setting targets is not applicable at this time.

9) The SCHIP error rate is composed of three components fee-for-service, managed care, and eligibility. The component error rates are 11.0 percent, 0.1 percent, and 11.0 percent, respectively. The States were asked to report the eligibility data in three categories: eligible, ineligible and undetermined. The eligibility component noted above counts the ineligibles and the undetermined cases as errors. The undetermined portion of the eligibility component error rate was 8.3 percent. When the undetermined cases are not included, the eligibility component error was 2.7 percent. HHS also calculated a national case error rate.

The active case error rate for SCHIP is 11.5 percent and the negative case error rate is 1.6 percent. In FY 2007 91.1 percent of sampled active cases were determined eligible; 5.7 percent of sampled active cases were determined ineligible; and, 3.2 percent of sampled active cases could not be determined. For the sampled negative cases, 97.9 percent of cases were correctly denied or terminated and 2.1 percent were improperly denied or terminated. The FY 2007 breakout of specific eligibility findings are based on actual findings from States' samples, and unlike the case error rates, are not national projections.

10) The baseline measurement for SCHIP, based on the measurement of 50 states and the District of Columbia over a three-year period (FY2007 – FY 2009) will be published in the *FY 2010 Agency Financial Report.* Therefore, setting targets is not applicable at that time.

11) The FY 2008 TANF error rate reported above is a national estimate based on seven States reviewed in FY 2008, using data from April 1, 2006 through March 31, 2007 and based on one State reviewed in FY 2007, using a timeframe of July 1, 2005 through December 31, 2005. The review of the eighth State will take place in FY 2009, and will be added to the previous FY 2008 State data to produce the statistically valid national FY 2008 error rate. This statistically valid FY 2008 error rate will be reported in the *FY 2009 Agency Financial Report.*

12) The statistically valid baseline measurement for TANF will be published in the *FY 2009 Agency Financial Report.* Therefore, setting targets is not applicable at this time.

13) The FY 2008 (current year) error rate is not comparable to the FY 2007 (previous year) error rate due to a methodological change in the error rate calculation. The change allows for the calculation to be more precise. Had HHS continued to calculate the error rate using the FY 2007 methodology, the error rate would have been 4.62 percent.

14) Eighteen Child Care States were randomly selected to report in Cycle Year One. For FY 2008 reporting, one State in Cycle Year One failed to comply with the methodology for implementing the CCDF Error Rate Reporting at Subpart K – 45 CFR Part 98 of CCDF regulations and thus is omitted from the national baseline payment authorization error rate. States that fail to substantially comply with the methodology are subject to corrective action by HHS. Another State, which was included in the calculation of the national payment authorization error rate, used an incorrect sampling method when selecting the sample for the case record review. However, the sample used did not differ systematically from the universe of child care cases served in the States, nor did it result in a bias selection of cases to be included in the case record review.

11.0 Program-Specific Reporting Information

Within this section we discuss each program's methodology for complying with IPIA, the results and future plans. For each program we discuss:

- How they performed their sampling, including sample sizes and methodology;
- Plans for corrective action, including a breakdown of most common error types;
- Actions taken as a result of potential overpayments; and
- Whether there are statutory, regulatory, or information systems barriers that limit potential corrective actions.

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

11.11 Medicare Fee-For-Service Statistical Sampling Process.

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). The CERT program reviews claims that account for approximately 60 percent of the total Medicare FFS payments. HPMP reviews claims that comprise the remaining 40 percent. The CERT Program calculates the error rate for Medicare Administrative Contractors (MAC), Carriers, and non-Prospective Payment System inpatient Hospital claims submitted to Fiscal Intermediaries (FIs). The HPMP calculates the error rate for Prospective Payment System (PPS) inpatient hospital claims submitted to the FIs and MACs. For FY 2008, the fee-for-service error rate in Medicare was 3.6 percent. To strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate, HHS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete.

The Medicare FFS improper payment methodology begins with a random sample of approximately 170,000 claims. For each sampled claim, HHS obtains medical records from providers and additional claim detail from its shared systems. This information is reviewed for compliance with Medicare coverage, coding and billing rules. When a provider does not provide the requested medical record documentation or the information submitted does not meet the Medicare requirements, the claim is counted as an error.

11.12 Corrective Action Plans.

The primary causes of improper payments, as identified in the FY 2008 Medicare FFS Improper Payments report were medically unnecessary services and incorrect coding errors. No documentation and insufficient documentation errors have been significantly reduced since the inception of the measurement program. HHS developed an Error Rate Reduction Plan that outlines actions the agency will implement in an effort to prevent/reduce improper payments for all categories of error.

Medically Unnecessary Services:

- HHS developed state-specific hospital billing reports to help Quality Improvement Organizations and hospitals analyze administrative claims data.
- HHS worked to address possible issues with observation versus inpatient admission that could be contributing to inappropriate inpatient admissions. A multi-state case-control study to determine the usefulness of a case management protocol was conducted.
- HHS completed and distributed an extensive workbook designed to be a resource for hospitals in their compliance efforts and activities.
- HHS tasked each Carrier, FI, and MAC with developing an Error Rate Reduction Plan (ERRP) that targets medical necessity errors in their jurisdiction.
- HHS requires the Carriers, FIs, and MACs to review and validate the CERT results for their jurisdiction to determine the education needed to reduce insufficient medical necessity errors.

Incorrect Coding Errors:

- Increase and refine educational contacts with providers who are billing in error.
- Develop and install new correct coding edits.

No Documentation and Insufficient Documentation Errors:

- HHS is implementing a Durable Medical Equipment Accreditation program to ensure the legitimacy of the DME suppliers that bill Medicare and to ensure those suppliers meet all the requirements for participation in the Medicare program.
- HHS will conduct a pilot that uses claim attachment records to allow providers to submit electronic medical records (EMR).
- HHS issued regulations that clarify and strengthen provider enrollment requirements and standards and increased efforts to deactivate or, when necessary, revoke billing privileges for providers and suppliers that are inactive or do not meet program requirements.
- HHS has implemented safeguards to better ensure that only legitimate providers and suppliers receive Medicare payments:
  - HHS is in the process of executing a strategy to realign the Program Safeguard Contractors (PSC) with the Medicare Administrative Contractors (MACs). Seven zones will be developed to address fraud "hot spots" in the United States, thereby concentrating on areas of high fraud occurrence. The name for this entity is being changed from PSCs to Zone Program Integrity Contractor (ZPIC).
  - The new ZPICs will look at billing trends and patterns across all Medicare claim types within a zone and will be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), and eventually Part C (Medicare Advantage health plans) and Part D (prescription drug plans).
  - HHS will take additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics in Florida, California, Texas, Illinois, Michigan, North Carolina, and New York. These efforts include more stringent reviews of new suppliers' applications; unannounced site visits; extensive pre- and post-payment review of claims; interviews with high volume ordering/referring physicians; and visits to high risk beneficiaries to ensure they are appropriately receiving items and services for which Medicare is being billed.
- HHS published two final regulations in Calendar Year 2008 that clarify and strengthen provider and supplier enrollment requirements and establish provider and supplier enrollment appeal rights. These two regulations are the "CY 2009 Physician Fee Schedule" and "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges."
- The CERT program implemented a process to distribute an insufficient documentation report to all contractors 60 days prior to the due date of an improper payment report.
- The CERT Documentation Contractor contacted third party providers to request documentation when the billing provider indicated that a portion of the medical record was possessed by a third party.

11.13 Medicare FFS Improper Payment Recovery.

The actual overpayments identified in the FY 2008 Medicare FFS Improper Payments Report were $15,128,414. The identified improper payments are to be recovered by the Medicare contractors via the standard payment recovery methods. As of the report publication date, Medicare contractors reported collecting $667,966 of the $966,014 of actual overpayments identified by the CERT program. The HPMP identified $14,162,399 in actual overpayments; and, as of the report publication date collected $12,326,700.

11.14 Medicare FFS Information Systems and Other Infrastructure.

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the levels that we have targeted. HHS' systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with State and national rates. The systems at both the Medicare contractor level and the central office level are tied

together by a high-speed secure network that allows rapid transmission of large data sets between systems. No other systems or infrastructure are needed at this time.

11.15 Statutory or Regulatory Barriers.

No statutory or regulatory barriers for limiting corrective actions have been identified.

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

11.21 Medicare Advantage Statistical Sampling Process.

In FY 2008, HHS developed a methodology to estimate improper payments in the Medicare Advantage Program (MA) (Part C). The Part C Composite Payment Error Rate presents the combined impact of two component payment error measures on total Part C payments to produce a CY 2006 error rate, the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) and the Risk Adjustment Error (RAE). For the MPE, HHS is using CY 2007 data trended back to CY 2006, because production of the payment validation data used to estimate the MPE was introduced in mid-2006, so there are not 12 months of this CY 2006 validation data. Trending back of MPE data should not be necessary in future years.

Use of a CY 2006 MPE estimate instead of a CY 2007 MPE estimate for FY 2008 reporting is driven by the fact that the Part C composite error rate is a combination of the MPE and RAE estimates. The RAE estimate will always be on a two-year lag for purposes of IPIA reporting because medical record reviews (MRRs) cannot begin until after the final Part C risk score reconciliation for a payment year has been completed, reconciliation occurs six months after the close of a payment year.

The first component error rate is the MPE estimate, which captures errors in prospective Part C payments caused by errors in transfer of data, interpretation of data, and payment calculations in the MARx system. The methodology includes:

- A random 3% sample of beneficiary payments to plans for each month of 2007.
- Computation of the prospective payment error amount for sampled beneficiaries.
- Extrapolating the sample to the monthly population and annualizing the payment error amount.
- Trending to annualize CY 2007 payments back to CY 2006.
- Dividing the CY 2006 payment error amount by total CY 2006 prospective payments.

The second component of the error rate is the RAE estimate, which captures payment errors due to the application of incorrect beneficiary risk scores. The primary component of a beneficiary risk score is based on clinical diagnoses submitted by plans. If incorrect diagnoses are submitted, the risk scores will be incorrect and there will be errors in payments. Calculation of this error rate is based on medical record reviews (MRRs). The MRRs identify erroneous risk scores for a national random sample of beneficiaries. The CY 2006 methodology includes:

- A random sample of 537 beneficiaries for whom a risk adjusted payment was made in CY 2006.
- Medical record review of the diagnoses submitted by plans for the 537 sampled beneficiaries.
- Calculation of beneficiary-level payment error amounts.
- Extrapolating the total sample payment error to the entire Part C population subject to risk adjustment.
- Dividing the population-level payment error amount by the total CY 2006 Part C final risk payments.

The CY 2006 Part C composite payment error rate is the total of the component payment error amounts divided by the CY 2006 total final Part C payments. The steps to calculate the Part C composite payment error rate are:

- Add the MPE error amount to the RAE error amount to compute the total Part C payment error amount.
- Divide this total Part C payment error amount by the CY 2006 total final Part C payments to compute the composite payment error rate.

The Part C composite error rate for CY 2006 is 10.6 percent.

11.22 Medicare Advantage Corrective Action Plans.

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

For the RAE, HHS is developing and has begun implementing a corrective action plan to reduce the RAE. In CY 2008, HHS conducted national training sessions for Part C Medicare Advantage plans that provided comprehensive information on the processes for submitting accurate risk adjustment data. This training also reviewed risk adjustment data validation procedures based on medical record review and payment error associated with inaccurate risk adjustment data.

11.23 Medicare Advantage Program Improper Payment Recovery.

The MARx payment system error rate is based on analysis of prospective payments. MARx payment system errors are fixed on a flow basis throughout the payment year. The resulting payment adjustments are also implemented on a flow basis in the MARx system, including the round of payment adjustments due to the final Part C risk score reconciliation. Therefore, recovery of MPE errors occurs on a flow basis as part of the routine operation of the MARx payment system.

Regarding the risk adjustment error, the CY 2006 Medical Record Review was based on a national random sample, and no payment recovery has been conducted at this point.

11.24 Medicare Advantage Information Systems and Other Infrastructure.

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

11.25 Medicare Advantage Statutory or Regulatory Barriers.

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

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

11.31 Medicare Prescription Drug Benefit Statistical Sampling Process.

In FY 2008, HHS developed a methodology to estimate improper payments for two components of the Medicare Prescription Drug Benefit (MPDB) (Part D) error rate: the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) and the Low Income Subsidy (LIS) component.

The MPE component estimate captures errors in prospective Part D payments caused by errors in transfer of data, interpretation of data, and payment calculations in the MARx system. The methodology includes:

- A random 3% sample of beneficiary payments to plans for each month of 2007.
- Computation of the prospective payment error amount for sampled beneficiaries.
- Extrapolating the sample to the monthly population and annualizing the payment error amount.
- Dividing the CY 2007 payment error amount by total CY 2007 prospective payments.

The Low Income Subsidy component estimate captures three types of Medicare payments to Part D plan sponsors that are affected by beneficiary LIS status: the Low Income Cost Sharing Subsidy (LICS) amount; the Low Income Premium Subsidy (LIPS) amount; and the Direct Subsidy, due to the low-income multiplier applied to the beneficiary risk score. The methodology includes:

- 100% of Part D beneficiaries are analyzed for the specified calendar year of the payment error estimation.
- An LIS-related payment error is estimated for beneficiaries where the Part D sponsor records have a more favorable LIS status for the beneficiary than HHS records. This can occur for two reasons: (1) there are time lags in transfer of LIS status data from the Social Security Administration and the States to HHS; and (2) plans work directly with the beneficiary to establish low income status on a real-time, immediate basis.
- If the LIS status for a beneficiary is incorrect as defined above, payment errors associated with LICS, LIPS and the Direct Subsidy may result.

11.32 Corrective Action Plans.

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

For the LIS component, HHS will continue to resolve LICS, LIPS, and Direct Subsidy payment-related errors through Part D payment reconciliation process.

11.33 Medicare Prescription Drug Benefit Improper Payment Recovery.

The MARx payment system error rate is based on analysis of prospective payments. MARx payment system errors are fixed on a flow basis throughout the payment year. The resulting payment adjustments are also implemented on a flow basis in the MARx system, including the round of payment adjustments due to the final Part D risk score reconciliation. Therefore, recovery of MPE errors occur on a flow basis as part of the routine operation of the MARx payment system.

The LIS payment errors are addressed in separate reconciliation processes. Specifically, Low-Income Cost Sharing payments are reconciled through a cost settlement process. Low Income Premium Subsidy payments are reconciled during the Part D reconciliation process. Errors in the LIS multiplier are reconciled in the Part D Risk Adjustment reconciliation process. Payment adjustments are conducted as a result of these reconciliations.

11.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure.

The information systems and other infrastructure that would be valuable to HHS in reducing improper payments will not be known until this measurement is fully implemented. However, for the two components that we have measured, HHS has the information systems and other infrastructure needed to reduce improper Medicare Prescription Drug Benefit payments. HHS uses the following internal Medicare systems to make and validate the Part D payments: the Medicare Beneficiary Database, the URisk

Adjustment System, the UHealth Plan Management System, and the MARx payment system. HHS also uses an internal Medicare database for the Low-Income Subsidy payment error estimates and the LIS Match Rate Analysis data. No other systems or infrastructure are needed at this time.

11.35 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers.

No statutory or regulatory barriers that could limit corrective actions have been identified at this time. Statutory or regulatory barriers for limiting corrective actions will not be known until full implementation is complete and results are available.

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

11.41 Medicaid Statistical Sampling Process.

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

Table 1: Number of States to be Selected from Each Stratum in Each Year

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

Medicaid improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care claims are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care claims are subject only to a data processing review. Each State's sample size is determined based on annual expenditures. For FY 2006, the average FFS sample size was 1,000 claims. For FY 2007, the average FFS sample size was 500 claims and the average managed care

sample size was 250 claims per State. Since FY 2007 was the first year of the composite measurement, measuring three components, HHS reduced the sample size to ensure timely completion.

A challenge to the FY 2007 measurement was that one State's managed care payment system was not able to provide Medicaid managed care claims at the beneficiary level, as required for universe data. To accommodate this system limitation, the State utilized its eligibility enrollment files and constructed a universe of "pseudo-claims", which included beneficiaries who were highly likely to be receiving managed care benefits. The sample was drawn from the universe of "pseudo-claims".

Eligibility Component

For FY 2007, States conducted an eligibility review on a randomly selected sample of 504 active and 204 negative Medicaid cases over a nine month period.

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

Each State calculated two error rates for active cases, a payment error rate and a case error rate.

- The payment error rate is calculated using the dollar value of payments made for services provided to beneficiaries who were ineligible divided by the dollar value of claims for the sample of beneficiaries, i.e., dollars in error over total dollars in the sample. HHS combines the State reported eligibility component payment error rates to develop a national eligibility error rate for Medicaid.
- The case error rate is calculated by dividing the number of ineligible beneficiaries into the total number of beneficiaries in the sample. States calculate only a case error rate for negative cases because no payments were made. For the active and negative case error rates, the errors are not dollar weighted.

Since there was no historical eligibility error rate data, the initial sample size was calculated under the assumption that the error rate is five percent. This means that the desired precision requirements will be achieved with a high probability if the actual error rate is five percent or less. For this reason, an annual sample of 504 active cases should meet the desired State-level precision with a high probability. In subsequent years, if the State's actual error rate is lower, the State may demonstrate that a smaller sample size based on the documented lower error rate is sufficient. Conversely, if a State's actual error rate is higher, the State may need to select a larger sample.

Detailed eligibility review guidelines for the FY 2007 measurement were released to States in October 2006 along with a request for states to submit eligibility sampling plans. Given the timing, the first quarter of the eligibility measurement was used as an implementation period for States to acquire funding, staffing, and to create sampling programs. States began the eligibility measurement in the second quarter of the fiscal year. Despite the delayed implementation, the full-year sample size of 504 active cases and 204 negative cases was still implemented, but was selected from the three remaining quarters of the fiscal year. Since HHS has no empirical evidence or reason to believe that the eligibility error rate would differ between the first quarter and the other three quarters, HHS assumes that the active case payment error rate in the first quarter of FY 2007 does not differ systematically from the error rate over the last nine months of the year. This assumption allows HHS to project a national annual Medicaid error rate using nine months of eligibility data.

Calculations and Findings

All payment error rate calculations for the Medicaid program (the FFS component, managed care component, eligibility component, and national Medicaid error rate) are based on the ratio of estimated

dollars of improper payments to the estimated dollars of total payments. Individual State error rate components are combined to calculate the national component error rates and individual State Medicaid program error rates are combined to calculate the national Medicaid program error rate. National component error rates and the Medicaid program error rate are weighted by State size, so that a State with a ten billion dollar program "counts" ten times more toward the national rate than a State with a one billion dollar program. The national program error rate represents the combination of Medicaid fee-for-service, Medicaid managed care, and Medicaid eligibility error rates. A small correction factor ensures that Medicaid eligibility errors do not get "double-counted."

For FY 2006, HHS measured Medicaid fee-for-service (FFS) improper payments only. A preliminary FY 2006 error rate was reported in the FY 2007 Agency Financial Report (AFR). HHS has completed this measurement and is reporting a final FY 2006 Medicaid FFS error rate of 4.7 percent in the FY 2008 AFR.

The FY 2007 annual national Medicaid error rate is 10.5 percent. The FY 2007 annual component error rate for Medicaid fee-for-service is 8.9 percent. The FY 2007 annual component error rate for Medicaid managed care is 3.1 percent. The FY 2007 annual component error rate for Medicaid eligibility is 2.9 percent. HHS also calculated a national case error rate. The active case error rate for Medicaid is 3.2 percent and the negative case error rate is 6.2 percent. The Medicaid eligibility component error rate did not affect the precision of the Medicaid program error rate as much as the FFS component, which had substantial variation in error rates across sampled States.

11.42 Medicaid Corrective Action Plans.

For the FY 2006 FFS measurement, the most common causes of improper payments were:

Medical review:

- no documentation,
- insufficient documentation, and
- policy violation

Data processing review:

- pricing errors,
- logic edits, and
- third party liability

For FY 2007, the most common causes of improper payments were:

Medical review:

- no documentation, and
- insufficient documentation

Data processing review:

- pricing errors, and
- non-covered services

Eligibility review:

Specific causes of eligibility errors are not reported because States conducted the eligibility reviews. HHS conducted an informal survey of large, medium, and small states to ascertain the causes of eligibility errors. The reasons provided by the surveyed States were: caseworker errors and lack of internal controls.

The majority of the FY 2007 errors (90%) were a result of non-response or insufficient documentation, which is a similar trend witnessed in the early years of the Medicare FFS error rate measurement program.

For the FY 2006 and FY 2007 measurements, each State is expected to take corrective actions to reduce the most common causes of improper payments within the State. States will submit and implement corrective action plans that include the following:

- Data analysis - an analysis of the findings to identify where and why errors are occurring.
- Program analysis - an analysis of the findings to determine the causes of errors in program operations.
- Corrective action planning - steps taken to determine cost-effective actions that can be implemented to correct error causes.
- Implementation - plans to operationalize the corrective actions, including milestones and a timeframe for achieving error reduction.
- Monitoring and evaluation – assessment of whether the corrective actions are in place and are effective at reducing or eliminating error causes.

HHS will monitor States' implemented corrective actions to determine whether the actions are effective and whether milestones are being reached. HHS is also developing an error rate reduction plan at the Federal level based on its analysis of the FY 2006 and FY 2007 measurement.

11.43 Medicaid Program Improper Payment Recovery.

For FY 2006, the actual Medicaid FFS improper payments identified in the sample were $ 693,319.

For FY 2007, the actual improper payments identified for the Medicaid program in the sample were $1,258,525.

The recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the *Social Security Act* and related regulations at Part 433, Subpart F under which States must return the Federal share of overpayments. States reimburse the Federal share on the CMS-64 form for Medicaid which contains a line item for program collections. No results are available at this time on actual recoveries.

11.44 Medicaid Information Systems and Other Infrastructure.

Since Medicaid payments occur at the State level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems based only on paper and aggregate claims; changes in information systems at the State level during the course of the measurement cycle; and a wide variation of systems designs and capabilities from State to State. HHS has been active in encouraging and supporting States in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS). Such improvements would produce greater efficiencies in the PERM measurement and strengthen program integrity. HHS is currently investigating possible collaborations with States and providers with regard to shared databases, data repositories, and other technology innovations that may benefit the PERM measurement.

11.45 Medicaid Statutory or Regulatory Barriers.

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

11.50 SCHIP- A joint Federal/State program, administered by the States that provides health insurance for qualifying children.

11.51 SCHIP Statistical Sampling Process.

Medicaid and SCHIP employed the same State sampling process. For detailed information on the State sampling process, please see section 10.41. We determined that SCHIP can be measured in the same States selected for Medicaid review each fiscal year with a high probability that the SCHIP error rate will meet the requirements for confidence and precision levels. Since SCHIP and Medicaid will be measured in the selected States at the same time, each State will be measured for SCHIP once and only once every three years.

In FY 2007, improper payments in SCHIP were measured in 16 States for reporting in the FY 2008 AFR. The State of Tennessee was randomly selected to be measured under SCHIP in FY 2007. However, PERM did not measure SCHIP in the State of Tennessee in FY 2007 because Tennessee did not implement a SCHIP program until mid-year. Tennessee's SCHIP program will be included in the FY 2010 measurement cycle.

SCHIP improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

FFS and Managed Care Component

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care claims are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care claims are subject only to a data processing review. Each State's sample size is determined based on annual expenditures. For FY 2007, the average FFS sample size was 500 claims and the average managed care sample size was 250 claims per State.

A challenge to the FY 2007 measurement was that one State's managed care payment system was not able to provide SCHIP managed care claims at the beneficiary level, as required for universe data. To accommodate this system limitation, the State utilized its eligibility enrollment files and constructed a universe of "pseudo-claims", which included beneficiaries who were highly likely to be receiving managed care benefits. The sample was drawn from the universe of "pseudo-claims".

Eligibility Component

For FY 2007, States conducted an eligibility review on a randomly selected sample of 504 active and 204 negative SCHIP cases over a nine month period.

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

Each State calculated two error rates for active cases, a payment error rate and a case error rate.

- The payment error rate is calculated using the dollar value of payments made for services provided to beneficiaries who were ineligible divided by the dollar value of claims for the sample of beneficiaries, i.e., dollars in error over total dollars in the sample. HHS combines the State

reported eligibility component payment error rates to develop a national eligibility error rate for SCHIP.

- The case error rate is calculated by dividing the number of ineligible beneficiaries into the total number of beneficiaries in the sample. States calculate only a case error rate for negative cases because no payments were made. For the active and negative case error rates, the errors are not dollar weighted.

Since there was no historical eligibility error rate data, the initial sample size was calculated under the assumption that the error rate is five percent. This means that the desired precision requirements will be achieved with a high probability if the actual error rate is five percent or less. For this reason, an annual sample of 504 active cases should meet the desired State-level precision with a high probability. In subsequent years, if the State's actual error rate is below five percent, the State may demonstrate that a smaller sample size based on the documented lower error rate is sufficient. Conversely, if a State's actual error rate is above five percent, the State may need to select a larger sample.

Detailed eligibility review guidelines for the FY 2007 measurement were released to States in October 2006 along with a request for states to submit eligibility sampling plans. Given the timing, the first quarter of the eligibility measurement was used as an implementation period for States to acquire funding, staffing, and to create sampling programs. States began the eligibility measurement in the second quarter of the fiscal year. Despite the delayed implementation, the full-year sample size of 504 active cases and 204 negative cases was still implemented, but was selected from the three remaining quarters of the fiscal year. Since HHS has no empirical evidence or reason to believe that the eligibility error rate would differ between the first quarter and the other three quarters, HHS assumes that the active case payment error rate in the first quarter of FY 2007 does not differ systematically from the error rate over the last nine months of the year. This assumption allows HHS to project a national annual SCHIP error rate using nine months of eligibility data.

Calculations and Findings

All payment error rate calculations for the SCHIP program (the FFS component, managed care component, eligibility component, and national SCHIP error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual State error rate components are combined to calculate the national component error rates and individual State SCHIP program error rates are combined to calculate the national SCHIP program error rate. National component error rates and the SCHIP program error rate are weighted by State size, so that a State with a ten billion dollar program "counts" ten times more toward the national rate than a State with a one billion dollar program. The national program error rate represents the combination of SCHIP fee-for-service, SCHIP managed care, and SCHIP eligibility error rates. A small correction factor ensures that SCHIP eligibility errors do not get "double-counted."

The FY 2007 annual national SCHIP error rate is 14.7 percent. The FY 2007 annual component error rate for SCHIP fee-for-service is 11.0 percent. The FY 2007 annual component error rate for SCHIP managed care is 0.1 percent. The FY 2007 annual component error rate for SCHIP eligibility is 11.0 percent. HHS also calculated a national case error rate. The active case error rate for SCHIP is 11.5 percent and the negative case error rate is 1.6 percent. The SCHIP eligibility component rate affected the precision of the SCHIP program error rate due to a large variation in eligibility error rates across sampled States.

11.52 SCHIP Corrective Action Plans.

For FY 2007, the most common causes of improper payments for SCHIP were:

Medical review:

- no documentation, and
- insufficient documentation

Data processing review:

- pricing errors, and
- non-covered services

Eligibility review:

Specific causes of eligibility errors are not reported because States conducted the eligibility reviews. HHS conducted an informal survey of large, medium, and small States to ascertain the causes of eligibility errors. The reasons provided by the surveyed States were: caseworker errors and lack of internal controls.

For the FY 2007 measurement, each State is expected to take corrective actions to reduce the most common causes of improper payments within the State. States will submit and implement corrective action plans that include the following:

- Data analysis - an analysis of the findings to identify where and why errors are occurring.
- Program analysis - an analysis of the findings to determine the causes of errors in program operations.
- Corrective action planning - steps taken to determine cost-effective actions that can be implemented to correct error causes.
- Implementation - plans to operationalize the corrective actions, including milestones and a timeframe for achieving error reduction.
- Monitoring and evaluation – assessment of whether the corrective actions are in place and are effective at reducing or eliminating error causes.

HHS will monitor States' implemented corrective actions to determine whether the actions are effective and whether milestones are being reached. HHS is also developing an error rate reduction plan at the Federal level based on its analysis of the FY 2007 measurement.

11.53 SCHIP Program Improper Payment Recovery.

For FY 2007, the actual SCHIP improper payments identified in the sample were $539,436.

The recoveries of SCHIP improper payments are governed by Section 2105 of the *Social Security Act* and related regulations at Part 457 under which States must return the Federal share of overpayments. States reimburse the Federal share on the CMS-21 form for SCHIP which contains a line item for program collections. No results are available at this time on actual recoveries.

11.54 SCHIP Information Systems and Other Infrastructure.

Since SCHIP payments occur at the State level, information systems and other infrastructure needed to reduce SCHIP improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems based only on paper and aggregate claims; changes in information systems at the state level during the course of the measurement cycle; and wide variation of systems designs and capabilities from state to state. HHS has been active in encouraging and supporting states in efforts to modernize and improve state MMIS systems. Such improvements would produce more efficiencies in the PERM measurement and strengthen program integrity. HHS is currently investigating possible collaborations with States and providers with regard to shared databases, data repositories, and other technology innovations that may benefit the PERM measurement.

11.55 SCHIP Statutory or Regulatory Barriers.

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

11.60 TANF- A joint Federal/State program, administered by the States that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency.

11.61 TANF Statistical Sampling Process.

HHS' Office of Inspector General (OIG) conducts the review of the TANF program. The objective is to determine whether the State agency made TANF basic assistance payments to recipient families in accordance with Federal and State requirements, as demonstrated by adequate documentation of eligibility and payment determinations.

The sampling universe for each State consists of all TANF basic assistance payments made for a 12-month audit period. The sampling time period for this review was from April 1, 2006, through March 31, 2007. Using the standard methodology that OIG piloted in FY 2007, the OIG is conducting an improper payment measurement in the TANF program in eight States for FY 2008. The eight States were randomly selected from all states (50 states plus the District of Columbia), using a probability proportional to size sampling model, where the States with larger expenditures have a higher probability of being selected in the sample.

The sample unit is a monthly TANF basic assistance payment to a recipient family for the audit period. The payment includes all basic assistance payments made to the family for the month. OIG used a simple random sample and sequentially numbered the payments in the sampling frame and selected the sequential numbers that correlated to the random numbers generated.

The OIG determined whether each sampled payment was improper based on Federal and State laws, regulations, and other requirements. Specifically, if at least one of the following characteristics was met, OIG considers the payment under review improper:

- The recipient family did not meet one or more eligibility requirements.
- The recipient family was eligible for assistance but received an improper payment amount (overpayment or underpayment).
- The case file did not contain sufficient documentation to support eligibility and payment determinations as required by Federal and State regulations.

OIG used its statistical software, RAT-STATS, to calculate improper payment estimates for each State. For each State and nationally, the OIG estimated: (1) the total Federal dollar value of TANF basic assistance payments with eligibility or payment calculation errors and with documentation errors; and (2) the total number of these improper payments.

HHS will report an estimate of the national TANF error rate for FY 2008 in this AFR and will report a final, statistically valid, error rate for FY 2008 in the FY 2009 AFR because work in one of the eight States remains outstanding.

11.62 TANF Corrective Action Plans.

HHS annually submits a letter to all TANF States with recommendations for potential corrective actions based on the reviews done by OIG. The reviews show that the primary causes of error are ineligible recipients, incorrect payment amounts and insufficient documentation. State may employ these recommendations in their corrective action efforts to reduce future improper payments.

11.63 TANF Improper Payment Recovery.

Due to legislative restrictions, HHS is not able to recover improper payments in the TANF program.

11.64 TANF Information Systems and Other Infrastructure.

Since TANF payments occur at the State level, information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the State level. States utilize the Public Assistance Reporting Information System (PARIS), the National Directory of New Hires (NDNH) matching program, and the Income Eligibility Verification System (IEVS), to help ensure that improper payments are minimized. No other systems or infrastructure are needed at this time.

11.65 TANF Statutory or Regulatory Barriers.

Corrective actions that could help reduce improper payments would have to be implemented at the State level. The TANF statute prohibits HHS from requiring State TANF agencies to implement the measurement program and implement and report on corrective actions.

11.70 Foster Care- A joint Federal/state program, administered by the States for children who need placement outside their homes in a foster family home or a child care facility.

11.71 Foster Care Statistical Sampling Process.

Under the regulatory review promulgated at 45 CFR 1356.71, Foster Care Eligibility Reviews are conducted systematically in each State (the 50 States, the District of Columbia and Puerto Rico) every three years. During these reviews, a team comprised of Federal and state staff review 80 cases selected from the State's title IV-E foster care population to determine a State's level of compliance in meeting the Federal eligibility requirements for the foster care program and to validate the accuracy of a State's claim for Federal reimbursement of foster care payments. Each regulatory review identifies 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 or its regulatory provisions (e.g. therapy).

HHS employs a 10 percent error threshold to determine the level of State compliance in meeting the Federal requirements in the foster care program. If during a primary review a State exceeds the error threshold, Foster Care takes a disallowance and the State is required to develop and implement a Program Improvement Plan (PIP). Following PIP implementation (which generally is completed within a year) the State is subjected to a secondary review, where 150 cases are selected for review. If a State again exceeds the error threshold in a secondary review, the State is assessed an additional extrapolated disallowance, which is equal to the lower limit of a 90 percent confidence interval for the State foster care population's total dollars in error during the six-month PUR. The extrapolation increases geometrically the resulting disallowance. Since FY 2000, HHS has systematically conducted more than 130 regulatory foster care reviews, with over 12,000 foster care cases reviewed.

The Foster Care error rate and national estimates of improper payments are calculated each year using data collected in the most recent eligibility review for each of 50 States, the District of Columbia, and Puerto Rico. Since, each State is reviewed every three years, each year's "composite sample" of data from 52 State reviews incorporates new review data for about one-third of the States. While each State sample represents a distinct six-month PUR, the national "composite" sample reflects a composite PUR. Consequently, the resulting error rate is referred to as a "rolling" estimate, since about one-third of the review data are replaced with new data each year. To arrive at the national estimates of improper payments and payment error rate, data from each State review sample are used to develop an estimate of State improper payments for the PUR. This estimate considers both under- and overpayments in accordance with the IPIA. State estimates are then aggregated to estimate national improper payments for the composite PUR. The national estimate is divided by the sum of payments received during respective PURs to determine the

national payment error rate for the program. This year marks an important benchmark in the Foster Care error rate reporting as this year's update reflects the transition from case-based estimation to a refined dollar-based methodology for estimating State improper payments. While the previous methodology extrapolated the average improper payments per case for the sample to the number of cases in the State, the refined methodology extrapolates the dollar error rate of the sample (i.e., sample PUR improper payments divided by sample PUR total payments) to the total PUR payments for the State. Using this new methodology, for FY 2008, the Foster Care estimated national payment error rate is 6.42 percent. This represents an increase over the FY 2007 error rate due in part to the revised methodology and in part to an increase in eligibility errors for several large States reviewed in FY 2008. While higher than the FY 2007 error rate, the FY 2008 error rate remains lower than rates reported in FY 2004 – FY 2006 under the previous methodology.

11.72 Foster Care Corrective Action Plans.

Corrective action plans instituted by HHS to address improper payments in the foster care program have been designed to address those eligibility errors and other payment errors (e.g., underpayments) that have contributed most to improper payments. In FY 2008, the major contributors to payment errors for the foster care program included the following:

- Underpayments (26 percent of payment errors),
- Provider not licensed or approved (13 percent of payment errors),
- Ineligible payment (e.g., therapy) (9 percent of payment errors),
- Not AFDC eligible at time of removal (9 percent of payment errors),
- Judicial determination regarding reasonable efforts to finalize permanency plan not timely (8 percent of payment errors),
- Criminal records check not completed (6 percent of payment errors), and
- No judicial determination of reasonable efforts to prevent removal (6 percent of payment errors)

Together these seven items account for over 75 percent of payment errors for foster care. Progress in addressing these errors has leveled off slightly between FY 2007 and FY 2008. The overall frequency of all types of payment errors in the composite foster care sample (i.e., across all States) increased by about 12 percent from 528 in FY 2007 to 593 in FY 2008. However, total payment errors for the program for FY 2008 remain far below the initial level of 1,034 eligibility errors reported in the program's FY 2005 Corrective Action Plan. The FY 2008 figure is just 57 percent of the initial figure, and if we exclude underpayments which were not included in the initial figure, the FY 2008 count of eligibility errors is 441, or just 43 percent of eligibility errors since the start of this effort. Thus, since the inception of these improper payment reduction efforts solid progress has been made in reducing payment errors across the program. In FY 2008, the most frequently identified payment error across foster care reviews is underpayments (152 errors, or 26 percent of errors).

While the overall frequency of the types of errors has decreased since improper payments reduction efforts began, the increase over the past year highlights the importance of maintaining diligence in corrective action efforts. Key features of HHS' corrective action strategies include the following:

- HHS conducts on-site 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 on-site 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 on-site review. The final report serves as the basis for the development of a Program Improvement Plan (PIP).

- States are required to develop and execute State-specific PIPs that target corrective action to the root cause of payment errors in the State. The PIP is developed by State staff in consultation with Federal staff and are required to include the following components:
  - Specific goals or outcomes for program improvement;
  - Measurable action steps required to correct each identified weakness or deficiency;
  - Target date for completing each action step;
  - Description of how progress will be evaluated by the State and reported to HHS, including the frequency and format of the evaluation procedures; and
  - Description of how the State will report to HHS when an action step has been achieved.
- The PIP is designed to lead to measurable changes in State program operations and is required to identify the specific action steps developed to attain the desired outcomes and correct program deficiencies. Each action strategy has a projected completion date that will not extend more than one year from the date the PIP is approved by HHS. This assures that proper attention is given to correcting deficiencies in a timely manner. HHS believes that the development and implementation of the PIP is the key to identifying the reasons why cases are in error and motivating States to correct the identified problems. Requiring States to implement PIPs has proven to be an effective solution in reducing eligibility errors as reflected in the decrease in the national error rate since FY 2004.
- HHS provides onsite training and technical assistance to States to develop and implement program improvement strategies.
- HHS works toward heightening judicial awareness of and investment in the monitoring reviews. In past years, three of the six most frequently occurring errors have involved 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 judicial determination of reasonable efforts to prevent removal; and (3) no contrary to welfare determination. HHS continues to share the results of the Foster Care reviews with judicial organizations and offers training and technical assistance to educate and inform the judiciary in areas pertaining to their role directly impacting the State agency's performance on the eligibility factors. Following these efforts, only two errors related to the judiciary (judicial determination regarding reasonable efforts to finalize permanency plan not timely and no judicial determination of reasonable efforts to prevent removal) remain in the top seven most frequently occurring errors and together account for only 14 percent of errors.
- HHS works closely with the Court Improvement Program in States where judges require training and court orders warrant modification to reduce the error rate for this finding.
- HHS conducts secondary reviews (as applicable) and takes appropriate disallowances consistent with the review findings. HHS' expectation is that these disallowances, in conjunction with the development and implementation of the PIP, will serve as strong encouragement to the States to improve their programs to the extent that when a secondary review is conducted they will be determined to be in substantial compliance.
- As noted in last year's AFR, the number of underpayments increased in FY 2007. This was partially due to the fact that some states were being reviewed for underpayments for the first time. However, to address the increase in this payment error, during FY 2008 HHS instituted the following practices:
  - Included a discussion of any underpayments identified during a title IV-E eligibility review at the exit conference with State agency senior management;
  - Identified underpayments in the final reports issued to States following a title IV-E eligibility review; and

- Added language to the Title IV-E Foster Care Eligibility Review Guide clarifying what constitutes an "underpayment" to ensure that Federal and State agency staff accurately identify underpayments.

Through implementation of its comprehensive corrective action plan, HHS has demonstrated steady progress in reducing the error rate in FY 2005, FY 2006, and in FY 2007. The error rate decreased from 10.33 percent in FY 2004 (baseline), to 8.60 percent in FY 2005, to 7.68 percent in FY 2006, to 3.30 percent in FY 2007. Although the rate increased in FY 2008 to 6.42 percent, this reflects a new methodology, in part, and yet still represents a reduction of the rate by over one-third since establishing the baseline in FY 2004.

11.73 Foster Care Improper Payment Recovery.

As a result of its conducting foster care eligibility reviews in 14 States during the 12-month period of August 1, 2007 through July 31, 2008, HHS has recovered $ 2,150,210 in title IV-E improper payments. The funds recovered are comprised of $ 1,420,550 disallowed maintenance payments and $ 729,660 disallowed administrative payments.

11.74 Foster Care Information Systems and Other Infrastructure.

Since Foster Care payments occur at the State level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the State level. No other systems or infrastructure are needed at this time.

11.75 Foster Care Statutory or Regulatory Barriers.

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

11.80 Head Start- A Federal program that provides comprehensive developmental services for America's low-income, preschool children ages three to five and their families. Head Start provides diverse services consistent with its goals for success in education, health, parent involvement and social services.

11.81 Head Start Statistical Sampling Process.

HHS is legislatively required to perform reviews of each Head Start program every three years. The design of the sample for the Erroneous Payments Study of Head Start programs is a three-stage element sample. Since each program is reviewed once every three years, the first stage of the sample is to identify the programs up for review. The second stage of the sample is to select the programs to be reviewed. As was done in the FY 2007 Erroneous Payments study, the FY 2008 study selected 50 programs and ten alternates. Programs were selected through a stratified random sample, where programs were divided into five stratum by enrollment. The number of programs sampled within each stratum is roughly proportional to the number of children represented in each stratum, based on the most recent Program Information Report funded enrollment data. The third stage of the sample is to select the records to be reviewed in each selected program, using a systematic sampling scheme.

In the FY 2008 Erroneous Payments Study, 50 Head Start programs from 29 states were reviewed. A total of 11,314 records were examined. The purpose of the reviews was to determine whether documentation demonstrated that a Head Start child was income eligible. A payment error in the Head Start program is defined as a payment for an enrolled child from a family whose income exceeds the allowable limit (in excess of the ten percent program allowance for families above the income limit). To make this determination, reviewers were required to look at each sample child's folder and determine if the child was

ineligible. A child was deemed ineligible if (1) there was not, as required by 45 CFR Part 1305.4(e), a signed statement by a Head Start employee stating the child was eligible to participate or (2) there was income documentation in the child's folder that, in the reviewer's judgment, suggested the child was not Head Start eligible. Reviewers are also asked to review income documentation regardless of whether there was a signed statement from the staff in the file.

The FY 2008 error rate is 3.0%, an increase from 1.3% in FY 2007. The increase in the error rate is due mainly to the number of files reviewed that contained no signed statement forms or a form with inadequate documentation. In FY 2007, 156 (2.4%) of the files reviewed contained inadequate documentation compared to 350 files (3.1%) in FY 2008. The majority of the national increase is due to a single grantee that had a flawed record keeping system for signed statements, which made it difficult to determine eligibility for a sizable number of children in the program. When this grantee is factored out of the sample, the error rate is approximately 1.8% for FY 2008. There was also a slight increase in the number of known ineligible children admitted into the programs.

11.82 Head Start Corrective Action Plans.

Categories of error and associated corrective actions for Head Start grantees:

- Absence of a complete and accurate signed income verification statement, meeting regulatory requirements, in grantee file.
    - Grantee is to develop corrective action plan based on its findings.

In addition, HHS has taken the following actions:

- Issued a memorandum reminding all grantees of documentation requirements.
- Developed a standard signed statement template form, which will be available to all grantees in FY 2009. Grantees will be encouraged to use the form until OMB clearance for the form can be obtained, at which point the use of the form will be mandatory.
- Increased oversight of documentation activities being performed by HHS regional offices.
- Increased grantee emphasis for on-going monitoring through training and development of a monitoring protocol to review management systems.

11.83 Head Start Improper Payment Recovery.

Given the recent legislative changes to Head Start that were enacted in December 2007, HHS is reviewing the potential for taking recoveries in Head Start. Currently there is no recovery activity for this program.

11.84 Head Start Information Systems and Other Infrastructure.

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

11.85 Head Start Statutory or Regulatory Barriers.

The Head Start Act does not require grantees to maintain documentation supporting eligibility in a case file. Grantees are only required to maintain a signed statement verifying eligibility. Monitoring of grantees' compliance with eligibility requirements is therefore limited to whether the case file contains a signed eligibility statement.

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

11.91 Child Care Statistical Sampling Process.

For FY 2007, reported in the FY 2008 Agency Financial Report (AFR), the Child Care and Development Fund (CCDF) program baseline payment error rate or percentage of improper authorizations for payment is 11.5 percent. The national over-authorization error rate, or the percentage of authorizations in excess of the amounts for which cases are eligible, is 11.1 percent. The percentage of under-authorizations is equal to .4 percent.

HHS uses a 3-year rotation for measuring CCDF improper authorizations for payments. A stratified random sampling method was used for selecting States. One third of the total of 52 States (50 States plus the District of Columbia and Puerto Rico) was selected to participate each year of a 3-year cycle in the error rate measurement methodology. The sample of States was stratified by region (10 total), with the regions randomly ordered. States were sorted within each region by caseload, from the most to the least number of cases. Every third State on the list was then selected, using a random start number the first and second years. The third year included those States not selected in year one or year two. Each year this sample yields a mix of county-administered and State-administered programs and States serving small and large numbers of children.

The CCDF error rate methodology employs a case record review process to determine whether child care subsidies were properly authorized to eligible families. The methodology focuses on administrative errors and improper authorizations for payment made during the client eligibility determination process. It is important to note that the CCDF methodology distinguishes between authorizations for payment and actual payments made to providers for child care services rendered. Because States were estimating improper *authorizations* for payment, the authorization amounts do not represent what was actually paid. In general, the amount of actual payments is lower, computed to be about 15 percent lower. Reporting the amount of improper authorizations for payment in the CCDF program is more stringent than the IPIA requirements.

CCDF improper authorizations for payment are estimated on a fiscal year basis. States select a random statewide sample of cases for each month of the fiscal year. States may choose to sample either 271 or 276 cases for the 12-month review period which provides a representative estimate of the annualized amount of improper authorizations for payments. This sample size is projected to allow the CCDF program at the national level to achieve a precision level of 5 percent at the 90 percent confidence interval. CCDF was granted an exception by OMB allowing CCDF to meet 5 percent precision rather than the required 2.5 percent. States generate a list of all cases authorized to receive a child care payment during the review month. The list is subsequently sorted by county and caseload size, listing counties with the largest caseload first to counties with the smallest caseload. States calculate a sampling interval based on the size of the sampling frame and the sample cases are selected. This process is repeated each month to allow States to select the sample cases and replacement cases.

States conduct reviews of sampled cases using the ACF-400 *Record Review Worksheet* template. As a block grant, CCDF devolves a great deal of flexibility to States to determine administrative rules and eligibility

requirements within broad Federal guidelines. Therefore, States are instructed to customize the *Record Review Worksheet* to incorporate State eligibility policies in effect at the time of the case record review. The template consists of four sections designed for review of the following areas:

- Section I: State Child Care Program Forms – Review the presence and completeness of application/re-determination forms.
- Section II: Priority Group Placement – Review if the child met the criteria of State-designated priority groups.
- Section III: General Program Requirements – Review if the client met the State's definition of parent, residency requirements, and if the client was working or attending a job training or educational program or other eligible activity. Review the child's eligibility for a subsidy, the number of hours of care authorized, and if child care provider regulatory requirements were met.
- Section IV: Income and Payments – Review if the household income met State requirements and if the computation of the amount authorized was accurate based on income and family size, the State's payment rate schedule, and the sliding fee schedule (parent co-pay requirement).

For FY 2007, Cycle Year One States conducted case record reviews and calculated State-specific error measures for reporting to HHS. The payment error rate, which is the improper authorizations for payment rate for purposes of CCDF, is estimated by applying the percentage of improper authorizations for payment derived from the sampled cases to the annual amount of authorizations for payment. HHS combines the State-reported payment authorization error rates to develop a weighted national improper authorizations for payment rate for the CCDF program.

11.92 Child Care Corrective Action Plans.

Fifty-two percent of the improper authorization for payment errors were due to missing or insufficient documentation. Major reasons for errors due to missing or insufficient documentation included: (1) inability to locate the case record, missing or incomplete application or recertification forms, missing pages or forms without signatures; and (2) insufficient documentation of relationship of family members, child's age, parent's work, school or training schedule, units of care and hours of service needed in the child care plan, provider registration for the review month, provider's rate, documentation of earned and unearned income and deductions, and absence of a TANF referral form.

Other reasons for improper authorization for payment errors included:

- Parents training schedule ended but services continued,
- Providers did not meet regulatory requirements because of an expired license exemption,
- Number of hours authorized for care did not match allowable hours,
- Category of care did not match age and/or status of child,
- Income calculation errors,
- Use of incorrect family size,
- Duplicate authorizations to different providers, and
- Miscalculation of parental co-pays.

Cycle Year One States described a range of corrective actions they had taken or planned to take based on the findings of the case record review to reduce the amount of improper authorizations for payment. Strategies included training, more frequent case record reviews, improved monitoring or audits, increased awareness through review of results, and targeted corrective actions to managers. States reported action steps to hold staff accountable at both the agency and staff level. Agency accountability steps included performance improvement plans, decisions whether or not to contract with local agencies based on payment accuracy performance, and annual management reviews with corrective action plans if case reviews fail to meet targets.

HHS corrective actions for payment errors associated with missing and insufficient documentation include:

- HHS will provide technical assistance to States to increase awareness of the problem and focus on staff training to improve knowledge of State policies, eligibility determination procedures, documentation requirements, and the quality of routine case reviews.
- HHS will work with States to explore technology enhancements that can help to reduce errors associated with missing and/or insufficient documentation.

HHS corrective actions for other types of payment errors include:

- HHS developed the *State Internal Control Self-Assessment Instrument* as a promising tool for State agencies. This tool provides a systematic method for reviewing and documenting the adequacy of a State's internal control system, identifying internal control weaknesses, and providing documentation of findings and possible corrective actions.
- HHS developed a voluntary survey in FY 2006 to obtain information from States about the design and scope of their CCDF systems used for administering the child care program and managing improper payments. Twenty-four States responded to this survey. These responses were summarized and made available on the HHS website www.acf.hhs.gov/programs/ccb. HHS has utilized responses to this survey to promote sharing of best practices among States.
- HHS revised the CCDF Plan Pre-Print to require States to submit information on strategies implemented to prevent, measure, identify, reduce and/or collect improper payments. This information is made publicly available and summarized in the CCDF biennial report of State Plans.
- HHS has been working with State Child Care Administrators to promote participation in the Public Assistance Reporting Information System (PARIS) program which is a data matching process that can help States identify duplicate receipt of benefits and reduce fraud and improper payments.

11.93 Child Care Program Improper Payment Recovery.

For FY 2007, the actual CCDF improper authorizations for payment identified in the sample review by Cycle Year One States in FY 2007 was $175,610. As stated earlier, the CCDF methodology distinguishes between authorizations for payment and actual payments made to providers. Therefore, the amount of improper authorizations for payment identified by Cycle Year One States during the review process does not represent actual improper payments. In general, the amount of payments is lower, computed to be on average about 15% lower. Any actual improper payments related to a specific case that was included in the sample during the case review process will be recovered from States by HHS through the disallowance process as set forth at 45 CFR 98.86 of CCDF regulations.

States also may take their own action to pursue recovery from the appropriate party (e.g., client or child care provider), however pursuant to CCDF regulations at 45 CFR 98.60(i), States are only required to recover child care payments that are the result of fraud. States have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error. Improperly spent funds are subject to disallowance by HHS regardless of whether the State pursues recovery. In the event that improper payments identified through the case review process are recovered, 45 CFR 98.60(g) provides that such payments shall 1) if received by the Lead Agency during the applicable obligation period be used for activities specified in the Lead Agency's approved plan and must be obligated by the end of the obligation period or 2) if received after the end of the applicable obligation period, be returned to the Treasury.

11.94 Child Care Program Information Systems and Other Infrastructure.

Since Child Care payments occur at the State level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the State level. State investments in information systems for administering the CCDF program varies widely and there are large disparities in the capacity and capabilities of State systems.

While the majority of Cycle Year One States have statewide automated systems and the necessary infrastructure to meet targets to reduce improper authorizations in their next reporting cycle, States reported a variety of areas in which improvements to information systems are still needed:

- Integrating systems to enhance the application for child care benefits and to build the child care authorization spreadsheet into the application system.
- Incorporating alerts into the child care application system to remind eligibility workers to check completeness and accuracy of case files.
- Enhancing child care information systems to include capacity for automated calculation of authorization amounts given family income, hours of care needed, provider payment rate and co-pay requirements.

11.95 Child Care Program Statutory or Regulatory Barriers.

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

Net Cost of HHS Top 20 Programs

For the Years Ended September 30, 2008 and 2007

(Dollars in Millions)

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2008	FY 2007	FY 2008	FY 2007		
Medicare	$395,055	$367,551	1	1	Medicare	CMS
Medicaid	201,094	187,940	2	2	Health	CMS
Research	29,477	28,250	3	3	Health	NIH
Temporary Assistance to Needy Families	18,147	17,044	4	4	Education, Training & Social Services / Income Security	ACF
Child Welfare	7,667	7,609	5	5	Education, Training & Social Services / Income Security	ACF
Head Start	6,968	6,922	6	6	Education, Training & Social Services / Income Security	ACF
SCHIP	6,978	6,010	7	7	Health	CMS
Child Care	5,045	5,145	8	8	Education, Training & Social Services / Income Security	ACF
Infectious Diseases	4,692	4,466	9	9	Health	CDC
Child Support Enforcement	4,204	4,262	10	10	Education, Training & Social Services / Income Security	ACF
Low-Income Home Energy Assistance	2,666	2,473	11	11	Education, Training & Social Services / Income Security	ACF
HIV/AIDS Programs	2,229	2,142	12	12	Health	HRSA
Primary Care	2,139	1,948	13	14	Health	HRSA
Clinical Services	1,828	1,676	14	15	Health	I H S
Social Services Block Grant	1,823	1,963	15	13	Education, Training & Social Services	ACF
Substance Abuse Prevention & Treatment Block Grant	1,718	1,654	16	16	Health	SAMHSA
Public Health and Social Services	1,484	1,297	17	17	Health	OS
Community Based Services	1,291	1,250	18	18	Education, Training & Social Services	AOA
Terrorism	1,150	849	19	22	Health	CDC
Health Promotion	947	1,007	20	20	Health	CDC
Total, Top 20 Programs	**$696,602**	**651,458**				
All Other HHS Programs	12,544	13,141			Various Functions	Various Components
Total Net Costs	**$709,146**	**$664,599**				

CONSOLIDATING BALANCE SHEET BY BUDGET FUNCTION

As of September 30, 2008

(In Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental							
Fund Balance with Treasury (Note 3)	$ 7,006	$ 90,993	$ 12,443	$ 13,838	$ 124,280	$ -	$ 124,280
Investments, Net (Note 5)	-	2,932	382,465	-	385,397	-	385,397
Accounts Receivable, Net (Note 6)	5	1,095	48,571	7	49,678	(48,798)	880
Other (Note 9)	-	379	17	-	396	(304)	92
Total Intragovernmental	$ 7,011	$ 95,399	$ 443,496	$ 13,845	$ 559,751	$ (49,102)	$ 510,649
Accounts Receivable, Net (Note 6)	2	2,526	4,891	-	7,419	-	7,419
Cash and Other Monetary Assets (Note 4)	-	-	354	-	354	-	354
Inventory and Related Property, Net (Note 7)	-	4,603	-	-	4,603	-	4,603
General Property, Plant & Equipment, Net (Note 8)	-	4,618	393	-	5,011	-	5,011
Other (Note 9)	-	515	720	-	1,235	-	1,235
Total Assets	**$ 7,013**	**$ 107,661**	**$ 449,854**	**$13,845**	**$ 578,373**	**$(49,102)**	**$529,271**
Stewardship PP&E (Note 1)							
Liabilities (Note 10)							
Intragovernmental							
Accounts Payable	$ 23	$ 135	$ 48,711	$ -	$ 48,869	$ (48,463)	$ 406
Accrued Payroll and Benefits	1	99	6	-	106	(1)	105
Other (Note 14)	19	1,069	593	14	1,695	(638)	1,057
Total Intragovernmental	$ 43	$ 1,303	$ 49,310	$ 14	$50,670	$ (49,102)	$1,568
Accounts Payable	19	614	-	-	633	-	633
Entitlement Benefits Due and Payable (Note 11)	-	20,909	44,942	-	65,851	-	65,851
Accrued Grant Liability (Note 13)	700	2,247	-	931	3,878	-	3,878
Federal Employee and Veterans Benefits (Note 12)	5	8,726	11	-	8,742	-	8,742
Contingencies (Note 19)	-	3,782	-	-	3,782	-	3,782
Accrued Payroll and Benefits	14	718	52	-	784	-	784
Other (Note 14)	12	688	632	24	1,356	-	1,356
Total Liabilities	**$ 793**	**$ 38,987**	**$ 94,947**	**$ 969**	**$ 135,696**	**$ (49,102)**	**$ 86,594**
Net Position							
Unexpended Appropriations - earmarked funds	-	(95)	12,267	-	12,172	-	12,172
Unexpended Appropriations - other funds	6,245	62,220	-	12,885	81,350	-	81,350
Unexpended Appropriations, Total	6,245	62,125	12,267	12,885	93,522	-	93,522
Cumulative Results of Operations - earmarked funds	-	3,647	342,640	-	346,287	-	346,287
Cumulative Results of Operations - other funds	(25)	2,902	-	(9)	2,868	-	2,868
Cumulative Results of Operations, Total	(25)	6,549	342,640	(9)	349,155	-	349,155
Total Net Position	$ 6,220	$ 68,674	$ 354,907	$ 12,876	$ 442,677	$ -	$ 442,677
Total Liabilities and Net Position	**$ 7,013**	**$ 107,661**	**$ 449,854**	**$ 13,845**	**$ 578,373**	**$ (49,102)**	**$ 529,271**

CONSOLIDATING BALANCE SHEET BY OPERATING DIVISION
As of September 30, 2008
(In Millions)

	ACF	AoA	AHRQ	CDC	CMS	FDA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Agency Consolidated Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)															
Intragovernmental															
Fund Balance with Treasury (Note 3)	$20,280	$ 564	$ 22	$ 6,438	$ 48,012	$ 1,450	$ 5,254	$ 1,832	$ 31,068	$ 6,559	$ 77	$ 2,724	$ 124,280	$ -	$ 124,280
Investments, Net (Note 5)	-	-	-	-	382,465	-	2,894	-	38	-	-	-	385,397	-	385,397
Accounts Receivable, Net (Note 6)	11	1	31	94	511	2	25	63	25	186	365	36	1,350	(470)	880
Other (Note 9)	-	-	-	2	17	-	-	-	-	1	1	72	93	(1)	92
Total Intragovernmental	20,291	565	53	6,534	431,005	1,452	8,173	1,895	31,131	6,746	443	2,832	511,120	(471)	510,649
Accounts Receivable, Net (Note 6)	-	2	1	19	7,191	64	16	105	7	9	5	-	7,419	-	7,419
Cash and Other Monetary Assets (Note 4)	-	-	-	-	354	-	-	-	-	-	-	-	354	-	354
Inventory and Related Property, Net (Note 7)	-	-	-	938	-	1	-	123	10	3,526	5	-	4,603	-	4,603
General Property, Plant & Equipment, Net (Note 8)	-	-	1	1,207	428	306	-	884	2,081	101	3	-	5,011	-	5,011
Other (Note 9)	-	-	-	2	840	(4)	394	2	1	-	-	-	1,235	-	1,235
Total Assets	**$ 20,291**	**$ 567**	**$ 55**	**$ 8,700**	**$439,818**	**$ 1,819**	**$ 8,583**	**$ 3,009**	**$ 33,230**	**$ 10,382**	**$ 456**	**$ 2,832**	**$ 529,742**	**$ (471)**	**$ 529,271**
Stewardship PP&E (Note 1)															
Liabilities (Note 10)															
Intragovernmental															
Accounts Payable	$ 23	$ -	$ -	$ 1	$ 438	$ 1	$ 13	$ 1	$ 7	$ 57	$ 0	$ -	$ 541	$ (135)	$ 406
Accrued Payroll and Benefits	1	-	-	16	6	15	5	22	30	7	1	3	106	(1)	105
Other (Note 14)	33	-	34	77	627	10	48	241	63	67	1	191	1,392	(335)	1,057
Total Intragovernmental	$ 57	$ -	$ 34	$ 94	$ 1,071	$ 26	$ 66	$ 264	$ 100	$ 131	$ 2	$ 194	$ 2,039	$ (471)	$ 1,568
Accounts Payable	19	-	4	1	-	-	(4)	7	578	5	17	6	633	-	633
Entitlement Benefits Due and Payable (Note 11)	-	-	-	-	65,851	-	-	-	-	-	-	-	65,851	-	65,851
Accrued Grant Liability (Note 13)	1,531	100	7	214	-	-	406	17	1,538	18	-	47	3,878	-	3,878
Federal Employee and Veterans Benefits (Note 12)	5	-	1	39	12	25	23	79	60	19	8,465	14	8,742	-	8,742
Contingent Liabilities (Note 19)	-	-	-	-	3,513	-	269	-	-	-	-	-	3,782		3,782
Accrued Payroll and Benefits	13	1	3	122	58	90	10	94	348	28	13	4	784	-	784
Other (Note 14)	35	1	8	57	647	9	90	317	42	86	50	14	1,356	-	1,356
Total Liabilities	**$ 1,660**	**$ 102**	**$ 57**	**$ 527**	**$ 71,152**	**$ 150**	**$ 860**	**$ 778**	**$ 2,666**	**$ 287**	**$ 8,547**	**$ 279**	**$ 87,065**	**$ (471)**	**$ 86,594**
Net Position															
Unexpended Appropriations - earmarked funds	-	-	-	-	12,267	(98)	-	3	-	-	-	-	12,172	-	12,172
Unexpended Appropriations - other funds	18,664	466	1	6,198	13,258	(559)	4,346	1,787	28,158	6,505	20	2,506	81,350	-	81,350
Unexpended Appropriations, Total	18,664	466	1	6,198	25,525	(657)	4,346	1,790	28,158	6,505	20	2,506	93,522	-	93,522
Cumulative Results of Operations - earmarked funds	-	-	2	25	342,640	696	2,642	2	280	-	-	-	346,287	-	346,287
Cumulative Results of Operations - other funds	(33)	(1)	(5)	1,950	501	1,630	735	439	2,126	3,590	(8,111)	47	2,868	-	2,868
Cumulative Results of Operations, Total	(33)	(1)	(3)	1,975	343,141	2,326	3,377	441	2,406	3,590	(8,111)	47	349,155	-	349,155
Total Net Position	$ 18,631	$ 465	$ (2)	$ 8,173	$ 368,666	$ 1,669	$ 7,723	$ 2,231	$ 30,564	$ 10,095	$(8,091)	$ 2,553	$ 442,677	$ -	$ 442,677
Total Liabilities and Net Position	**$ 20,291**	**$ 567**	**$ 55**	**$ 8,700**	**$ 439,818**	**$ 1,819**	**$ 8,583**	**$ 3,009**	**$ 33,230**	**$ 10,382**	**$ 456**	**$ 2,832**	**$ 529,742**	**$ (471)**	**$ 529,271**

SUPPLEMENTAL STATEMENT OF NET COST
For the Years Ended September 30, 2008 and 2007
(In Millions)

	2008			
	Agency	Inter-Agency Eliminations		HHS
Responsibility Segments	Consolidated Totals	Costs (-)	Earned/Exchange Revenues (+) [1]	Consolidated Totals
ACF	$ 48,544	$ (21)	51	$48,574
AoA	1,398	(6)	3	1,395
AHRQ	5	(394)	11	(378)
CDC	8,487	(342)	164	8,309
CMS	603,557	(2)	284	603,839
FDA	1,210	(35)	104	1,279
HRSA	7,003	(33)	174	7,144
IHS	3,532	(24)	54	3,562
NIH	29,477	(127)	892	30,242
OS	2,149	(401)	183	1,931
PSC	775	(471)	19	323
SAMHSA	3,102	(213)	37	2,926
Net Cost of Operations	$ 709,239	$ (2,069)	$ 1,976	$ 709,146
	2007			
ACF	$ 47,330	$ (10)	$ 45	$ 47,365
AoA	1,372	(4)	3	1,371
AHRQ	6	(204)	13	(185)
CDC	7,899	(305)	117	7,711
CMS	561,938	(7)	176	562,107
FDA	1,461	(33)	95	1,523
HRSA	6,823	(66)	129	6,886
IHS	3,303	(31)	62	3,334
NIH	28,250	(124)	681	28,807
OS	1,853	(260)	174	1,767
PSC	1,204	(389)	24	839
SAMHSA	3,156	(120)	38	3,074
Net Cost of Operations	$ 664,595	$ (1,553)	$ 1,557	$ 664,599

[1]Eliminations for non-exchange revenue are reported in the Statement of Changes in Net Position

GLOSSARY OF TERMS USED IN REPORT	
IHS	Indian Health Service
IP	Improper Payment
IPIA	Improper Payments Information Act
IT	Information Technology
J3	Jurisdiction 3
LLP	Limited Liability Partnership
LTC	Long Term Care
MA	Medicare Advantage
MACs	Medicare Administrative Contractors
MC	Managed Care
MEDIC	Medicare Drug Integrity Contractor
MFCUs	Medicare Fraud Control Units
MIG	Medicaid Integrity Group
MIPPA	Medicare Improvements for Patients and Providers Act
MITA	Medicaid Information Technology Architecture
MK	Non-Marketable Market Based
MMA	Medicare Prescription Drug, Improvement and Modernization Act 0f 2003
MPDB	Medicare Prescription Drug Benefit
MRI	Magnetic Resonance Imaging
MSIS	Medicaid Statistical Information Systems
N/A	Not Applicable
NCH	National Class History
NCI	National Cancer Institute
NDC	National Drug Code
NHIN	National Health Information Network
NIH	National Institutes of Health
NPI	National Provider Identifiers
NRS	National Reporting System
OACT	Office of the Actuary
OGD	Office of Genetic Drugs
OGE	Office of Government Ethics
OGM	Office of Grants Management

GLOSSARY OF TERMS USED IN REPORT	
OHRP	Office of Human Research Protection
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator (for Health Information Technology)
OnePI	One Program Integrity System Integrator
OPD	Orphan Products Development
OPDIV	Operating Division
OS	Office of the Secretary
PAHPA	Pandemic and All-Hazards Preparedness Act
PAM	Payment Accuracy Measurement
PAR	Performance and Accountability Report
PARIS	Public Assistance Reporting Information System
PART	Program Assessment Rating Tool
PDP	Prescription Drug Plan
PERM	Medicaid Payment Error Rate Measurement
PHIN	Public Health Information Network
PHS	Public Health Service
P.L.	Public Law
PMA	President's Management Agenda
PMCs	Postmarketing Study Commitments
PMS	Payment Management System
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PPS	Prospective Payment System
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PSCD	Payment System Calculation Discrepancies
PSOs	Patient Safety Organizations
PUR	Period Under Review
PY	Prior Year
QIO	Quality Improvement Organization
R&D	Research and Development

GLOSSARY OF TERMS USED IN REPORT	
RACs	Recovery Audit Contractors
RDS	Retiree Drug Subsidy
RRB	Railroad Retirement Board
RSI	Required Supplementary Information
RSSI	Required Supplementary Stewardship Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statement of Auditing Standards
SBR	Statement of Budgetary Resources
SCHIP	State Children's Health Insurance Program
SECA	Self-Employment Contribution Act of 1954
SFFAS	Statement of Federal Accounting Standards
SIU	Special Investigations Unit
SMI	Supplementary Medical Insurance
SOSI	Statement of Social Insurance
SSA	Social Security Administration
STAFFDIV	Staff Divisions
TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
Treasury	Department of the Treasury
TrOOP	True Out-of-Pocket (cost)
TROR	Treasury Report on Receivables
UFMS	Unified Financial Management System
UPL	Upper Payment Limit
US	United States
VICP	Vaccine Injury Compensation Program
WAC	Wholesale Acquisition Cost

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