Section IV: Other Accompanying Information

FY 2006 Performance and Accountability Report

Section IV: Other Accompanying Information

This section contains the HHS Inspector General's summary of the most significant management and performance challenges facing the Department, the Department's response to the Inspector General's assessment, HHS' detailed Improper Payments Information Act of 2002 Report, and Other Financial Information.

FY 2006 Top Management and Performance Challenges Identified by the Office of Inspector General

Challenge 1: Oversight of Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) established the new Medicare prescription drug benefit, known as Medicare Part D, which took effect on January 1, 2006. This voluntary benefit is available to all 43 million Medicare beneficiaries and, according to Congressional Budget Office estimates, will cost more than $30 billion in 2006 and approximately $746 billion over the next 10 years. The magnitude of expenditures and impact of this benefit on beneficiaries, from both health and financial perspectives, make it critical that Medicare Part D operates efficiently and effectively and is protected from fraud and abuse.

The structure and operation of the Part D benefit contains features that present significant management challenges. Within the Department, the Centers for Medicare & Medicaid Services (CMS) bear primary responsibility for implementing and administering Part D. However, administration of the Medicare Part D benefit depends upon extensive coordination and information sharing among a number of diverse entities, including Federal and state government agencies, private drug plan sponsors, contractors, and healthcare providers. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the transfer of more than 6 million dual eligibles (beneficiaries of both Medicare and Medicaid) from Medicaid to Medicare Part D drug coverage on the first day that the program became effective. Also, payments to drug plan sponsors based on bids, risk-adjustments, and reconciliations add to the complexities of the benefit. In addition, the relative financial responsibilities of Medicare, drug plan sponsors, and beneficiaries vary through three distinct phases (the initial coverage period, coverage gap, and catastrophic coverage) depending on the beneficiary's total drug costs at a given time. Finally, the complexities of this benefit also create challenges for educating beneficiaries in selecting a Part D plan as beneficiaries face a wide variety of drug plans with varying costs, formularies, and pharmacy networks.

The Office of Inspector General (OIG) plans a wide array of activities to identify and prevent fraud, waste, and abuse in the Medicare Part D program and to protect the health and welfare of beneficiaries enrolled in Part D. OIG's completed, ongoing, and planned work on Medicare Part D addresses the following areas: enforcement and compliance, payment accuracy and controls, beneficiary protections, informa-

tion technology and systems, drug pricing and reimbursement, and oversight. OIG is executing this plan through a combination of audits, evaluations, investigations, and legal guidance and assistance.

Prior to the implementation of Medicare Part D, OIG worked to identify potential vulnerabilities in the new benefit; train OIG staff, Federal law enforcement partners, CMS staff, and contractors; provide guidance to CMS and to industry; and build the infrastructure for Part D enforcement. In addition, OIG evaluated beneficiary enrollment and educational resources and assessed sponsors' materials associated with the temporary Prescription Drug Discount Card program to identify potential vulnerabilities that might impact individuals enrolling in Medicare Part D. OIG also assessed drug plan formularies' coverage of drugs commonly used by dual eligibles under Medicaid and found that drug plan formularies varied in their inclusion of commonly used drugs.

OIG is conducting a number of investigations of possible fraud and abuse related to Medicare Part D. Several OIG audits and evaluations of Part D are also underway. Some examples include assessing reimbursement to states for drug coverage and assistance provided to dual eligibles during the transition, reviewing the operations of prescription drug plans and retiree drug subsidy payments to employers, tracking beneficiaries' true out-of-pocket costs, and evaluating payments and access to contracted pharmacies in rural areas. This work will provide further insight into potential vulnerabilities and management challenges for Medicare Part D, as well as offer recommendations to help address such challenges.

OIG Assessment of Progress in Addressing the Challenge:

As of June 11, 2006, CMS reported that more than 22 million Medicare beneficiaries were enrolled in either a Part D standalone prescription drug plan or a Medicare Advantage drug plan. Additionally, almost 7 million beneficiaries have coverage through retiree drug subsidy plans.

CMS met the short timeframe for implementing the Part D program and has taken actions to respond to issues that arose during the enrollment and transition period. For example, CMS issued multiple letters to drug plan sponsors regarding their responsibilities for enrollment, appropriate drug access, and communication. Additionally, CMS reported that it reviewed prescription drug plan formularies and benefit structures to verify that plans comply with Part D formulary requirements. CMS has also developed a Part D oversight strategy. This strategy outlines activities in the areas of contractor management, auditing, compliance and enforcement, and program integrity. Most of the program integrity activities are designated as responsibilities of the four Medicare Drug Integrity Contractors (MEDIC). OIG is currently reviewing CMS' implementation of Medicare Part D program safeguards, including, but not limited to, the activities outlined in CMS' strategic plan.

Challenge 2: Integrity of Medicare Payments

The size and complexity of the Medicare program place it at high risk for payment errors. In FY 2005, Medicare benefit payments totaled about $330 billion for services provided to approximately 42 million beneficiaries. Ensuring that beneficiaries have continued access to appropriate and high-quality Medicare services and protecting the financial integrity of the program and the solvency of the Trust Fund require that correct and appropriate payments be made for properly rendered services. From FY 1996 through FY 2002, OIG developed and reported on the annual Medicare fee-for-service paid claims error rate. In FY 2003, CMS assumed responsibility for developing the error rate. In its 2005 financial report, CMS reported a gross paid claims error rate (overpayments plus underpayments) of 5.2 percent ($12.1 billion) for the fiscal year.

Targeted audits and evaluations by OIG and CMS continue to identify improper payments and problems in specific parts of the program. These reviews have revealed payments for unallowable services, improper coding, and other types of improper payments. For example, OIG identified $1.1 billion in improper payments for services billed as consultations, an estimated $402 million in improper payments for ambulance transports, and $285 million allowed for chiropractic services that did not meet Medicare coverage criteria or were miscoded and undocumented. OIG also found $72.4 million in improper payments to hospitals that incorrectly coded claims as discharges to home rather than transfers to postacute care facilities. In another example, OIG identified $71.5 million in improper payments to independent diagnostic testing facilities for services that were not reasonable and necessary, not sufficiently documented, or were performed without the knowledge of treating physicians. Finally, OIG

identified $16.8 million in improper payments to hospitals that inappropriately included dental residents in their position counts when computing Medicare graduate medical education payments.

The OIG's FY 2005 financial statement audit reported internal control weaknesses in managed care and the lack of an integrated general ledger accounting system. OIG audits continue to show that Medicare has serious internal control weaknesses in its financial systems and processes for producing financial statements. For example, the reporting mechanism that Medicare contractors use to reconcile and report funds expended depends heavily on inefficient, labor-intensive, manual processes that increase the risk of submitting inconsistent, incomplete, or inaccurate information to CMS.

OIG Assessment of Progress in Addressing the Challenge:

The FY 2005 gross paid claims error rate of 5.2 percent reported by CMS is 4.9 percentage points lower than the 10.1 percent error rate reported last year. CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. For example, CMS has worked with the provider community to clarify reimbursement rules and to impress upon providers the importance of fully documented services. CMS also has taken a number of steps to improve compliance with Medicare coverage and reimbursement requirements to curb inappropriate payments. These steps include increasing and refining one-on-one educational contacts with providers and working with contractors to assist providers in submitting sufficient documentation to support billed services.

CMS received an unqualified opinion on its 2005 financial statements. However, the lack of a fully integrated financial management system and insufficient oversight of Medicare contractors continued to impair CMS's reporting of accurate financial information. Although CMS has made improvements, the audit identified weaknesses in general and in application controls at Medicare contractors, at data centers where Medicare claims are processed, at sites that maintain the "shared" application system software used in claims processing, and at the CMS central office. In addition, although CMS had improved its oversight of Medicare contractors, continuing weaknesses affected its ability to analyze and accurately report financial information on a timely basis.

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

Challenge 3: Medicaid Administration

Medicaid is a joint Federal and state program that provides medical assistance to an estimated 52 million low-income and disabled Americans. The Federal share of Medicaid outlays in FY 2005 exceeded $182 billion and is estimated to exceed $200 billion in FY 2007. The Federal share, known as the Federal Medicaid Assistance Percentage, is determined annually by a statutory formula based on state average per capita income and generally ranges from 50 to 83 percent in the various state programs. Over the past 6 years, OIG's body of work has identified significant problems in state Medicaid financing arrangements involving the use of intergovernmental transfers. Specifically, OIG found that six states inappropriately inflated the Federal share of Medicaid by more than $3 billion by requiring public providers to return Medicaid payments to state governments through intergovernmental transfers. Once the payments are returned, funds cannot be tracked, and they may be used by the states for purposes unrelated to Medicaid. This practice shifts the cost of Medicaid to the Federal Government, contrary to Federal and state cost-sharing principles. Although this practice can occur with any type of Medicaid payment to public facilities, OIG identified serious problems in Medicaid supplemental payments available upper payment limits, disproportionate share hospital payments, and payments for school-based services.

OIG Assessment of Progress in Addressing the Challenge:

To curb abuses in state Medicaid financing arrangements, CMS promulgated final regulations (effective March 13 and November 5, 2001, and May 14, 2002) that modified upper payment limits regulations pursuant to the Benefits Improvement and Protection

Act of 2000. The rules created three aggregate upper payment limits: one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. CMS projects that these revisions will save a total of $79.3 billion in Federal Medicaid funds over the 10-year period from 2002–2011. However, when fully implemented, these regulatory changes will limit, but not eliminate, the risks of Medicaid monies being returned by public providers to the state and then used for non-Medicaid purposes because the regulations do not require the provider to keep and use the enhanced funds to provide medical services to Medicaid beneficiaries.

CMS also has been working with states to stop the inappropriate use of intergovernmental transfers. CMS identified 33 states that were using inappropriate intergovernmental transfers.

CMS should continue to work to ensure that all states eliminate the use of inappropriate intergovernmental transfers involving supplemental payments made pursuant to upper payment limits regulations, disproportionate share hospital payments, payments for school-based services, or any other type of Medicaid payment to a public provider.

In addition, CMS is drafting a "Notice of Proposed Rulemaking" that establishes a new regulatory provision explicitly requiring that providers retain the total computable amount of their Medicaid payments. OIG concurs with CMS' issuance of a regulation that requires that providers retain the total Medicaid payments received and considers this regulation to be a positive step in eliminating the inappropriate use of financing mechanisms. This change, in addition to the upper payment limits regulatory changes, will help ensure that Medicaid funds are used to provide necessary services to Medicaid beneficiaries.

Challenge 4: Integrity of Medicaid Payments

The Federal share of Medicaid outlays in FY 2005 exceeded $182 billion and is estimated to exceed $200 billion in FY 2007. Because Medicaid is a matching program, improper payments by states always cause corresponding improper Federal payments. However, because the Federal Government does not routinely examine individual provider claims, inappropriate state claims for a Federal share are not always easily identified.

Payment Error Rates

Payment accuracy in the Medicaid program helps to ensure the efficient use of Federal and state healthcare dollars. Until recently, little was known about payment error rates in the Medicaid program. This lack of information represented a substantial vulnerability in preventing fraud, waste, and abuse. Identifying errors and their causes is particularly difficult because of the diversity of state programs and their varying administrative and control systems.

To assist CMS with its development of Payment Error Rate Measurement, and at the request of the Office of Management and Budget, OIG conducted audits of Medicaid and the state Children's Health Insurance Program (SCHIP) eligibility in three of the four states with the largest Medicaid programs: New York, Florida, and California. Results of the three reviews indicated that Medicaid and SCHIP payments were made on behalf of beneficiaries who did not meet Federal and state eligibility requirements. The majority of the Medicaid and SCHIP improper payments were due to household incomes exceeding the threshold on the dates of service, citizenship requirements not being met, lack of Social Security numbers, beneficiaries improperly enrolled in SCHIP but eligible for Medicaid, and spend-down requirements not being met.

In addition to the eligibility issues discussed above, OIG has identified improper payments involving school-based health services, disproportionate share hospital payments, and targeted case management services. For example, OIG has consistently noted problems with schools adequately supporting the claims submitted to states for these services. Particularly in New York, OIG identified significant overpayments involving speech therapy and transportation claims. To date, OIG has issued four reports to the New York state Medicaid agency questioning unallowable Federal funds totaling $721 million. Major findings included payments for services that were not sufficiently documented, services not authorized, and services rendered by providers who did not have required qualifications. In another example, OIG identified states that made disproportionate share hospital payments that exceeded the hospital specific limits by approximately $1.6 billion ($902 million Federal share). Of the $902 million, $679 million resulted from using historical costs rather than actual costs, and $223 million resulted from including unal-

lowable costs in the calculations. OIG has also identified a state Medicaid agency that claimed Federal funding totaling $86 million for unallowable targeted case management services. Contrary to Federal regulations, the targeted case management claims included social workers' salary costs related to direct social services, such as child protection and welfare services. Signed into law February 8, 2006, the Deficit Reduction Act of 2005 provides additional funds to OIG to increase Medicaid program integrity efforts. OIG will receive $25 million for each of the fiscal years 2006 through 2010. With these additional resources, OIG has enhanced its efforts in addressing fraud, waste, and abuse. The Deficit Reduction Act mandated some activities for OIG, such as a report on issues to consider in developing the average manufacturers' prices used in the Medicaid reimbursement for prescription drugs.

OIG is planning reviews to oversee the Medicaid and SCHIP error rate process. In addition, ongoing and planned work includes various reviews to identify payment error vulnerabilities in the Medicaid managed care program, pediatric dental services, and durable medical equipment.

OIG Assessment of Progress in Addressing the Challenge:

Payment Error Rates

In July 2001, CMS invited states to participate in a demonstration project to develop a Payment Accuracy Measurement methodology for Medicaid, i.e., a single methodology that can produce both state-specific and national-level payment error estimates. The Payment Accuracy Measurement model was later modified to comply with the requirements of the Improper Payments Information Act of 2002.

The Improper Payments Information Act requires heads of Federal agencies to make estimates of improper payments for the programs they oversee, report to Congress annually, and submit a report on actions the agency is taking to reduce such payments.

FY 2004 was the final year for reporting the results of the Payment Accuracy Measurement pilots. The project has since been renamed the Payment Error Rate Measurement program and was published in late August 2006 as an interim final rule with comment. The Payment Error Rate Measurement includes the error rate processes for Medicaid and SCHIP—fee-for-service, managed care, and eligibility. CMS is using a national contracting strategy to produce Medicaid and SCHIP managed care and fee-for-service error rates. The Payment Error Rate Measurement also sets forth the state requirements for conducting reviews and estimating payment error rates due to errors in eligibility determinations. The FY 2006 Performance and Accountability Report will include the results of the Payment Error Rate Measurement pilot. The FY 2007 report will include a national Medicaid fee-for-service error rate for FY 2006 based on a statistically valid sample of states and claims within those states. CMS expects to be fully compliant with the Improper Payments Information Act requirements by FY 2008.

The Deficit Reduction Act provides additional funds to CMS to increase its Medicaid program integrity activities. The Act requires CMS to create a new Medicaid Integrity Program. In Section 6035 (d) of the Act, Congress mandated CMS to enter into contracts with "eligible entities" to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments, and educate providers and others on program integrity and quality of care. The Deficit Reduction Act also mandates that the agency devote at least 100 additional positions to support the Medicaid program integrity activities; to meet this mandate, in FY 2006, CMS created a new Medicaid Integrity Group. The hiring process is currently underway and CMS expects to complete the hiring of all 100 positions by September 2008. Additionally, the Act seeks to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures through the Medicare-Medicaid match programs.

CMS was required by Deficit Reduction Act section 6035 to consult with OIG in the development of its Medicaid Integrity Program. In July 2006, CMS issued a 5-year comprehensive Medicaid Integrity Plan for implementing the program. CMS has created a new organization, the Medicaid Integrity Group, which will have three main divisions: the Division of Medicaid Integrity Contracting, the Division of Field Operations, and the Division of Fraud Research and Detection. CMS worked on designing the

infrastructure for the Medicaid Integrity Program in FY 2006 and plans to begin implementation and procurement of staff and other resources in FY 2007.

Challenge 5: Payment for Medicaid Prescription Drugs

OIG and the Government Accountability Office have consistently found that the Medicaid program pays too much for prescription drugs compared to prices available in the marketplace, impacting both Federal and state expenditures.

CMS estimates that Medicaid expenditures for prescription drugs in 2005 totaled more than $40 billion, a substantial increase over the $9 billion spent in 1994. While drug expenditures slowed significantly in 2005 due to states' efforts to contain drug costs, drug spending continued to represent significant Medicaid expenditures. Overall, Medicaid drug spending rose from 11.2 percent of all Medicaid spending in 2000 to 14 percent in 2005.

As of January 1, 2006, the new Medicare prescription drug benefit provides drug coverage for 6.5 million "dual eligibles" formerly covered by Medicaid. This shift is significant given the high drug utilization of the dual eligibles. Despite the transfer of dual eligibles, Medicaid will continue to provide prescription drugs to approximately 45 million Medicaid beneficiaries.

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

While states must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries, they often lack access to pharmacies' actual purchase prices. Due to this lack of pricing data, states rely on estimates to determine Medicaid reimbursement. Most states base their calculations of estimated acquisition costs on average wholesale prices, which are published prices that states obtain through national drug pricing compendia. Average wholesale prices are not defined by law or regulation and are not necessarily based on actual sales transactions.

OIG has produced a body of work and consistently recommended that Medicaid programs reimburse pharmacies for drugs based on prices that more accurately reflect pharmacies' acquisition costs. OIG reports demonstrate that the published average wholesale prices used to determine Medicaid drug reimbursement amounts generally do not reflect the prices incurred by retail pharmacies. Most recently, OIG released two reports comparing the published prices that most states use to set Medicaid reimbursement, i.e., average wholesale prices and wholesale acquisition costs, to statutorily defined prices based on actual sales transactions, i.e., the average manufacturer price and average sales price. OIG found that average manufacturer prices and average sales prices were significantly lower than the published prices states use to set reimbursement, and these discrepancies were largest for generic drugs. Another report showed that Federal upper limit amounts were five times higher than the average manufacturer prices for generic drug products and that CMS could save from $650 million to $1.2 billion per year by basing Federal upper limit amounts on reported average manufacturer prices.

OIG is continuing to address pricing of Medicaid drugs. In its oversight role, OIG is comparing Federal upper limit amounts based on the new formula to the prices at which drugs are available from wholesalers, manufacturers, and other suppliers. OIG is also reviewing state reimbursement methodologies to determine whether states are planning to use reported average manufacturer prices as the basis for their reimbursements.

In addition to reimbursing pharmacies at prices that exceed drug acquisition costs, state Medicaid programs may not be receiving the proper amount of drug rebates they are entitled to receive from drug manufacturers. The statutory drug rebate program, which became effective in January 1991, requires drug manufacturers to pay rebates to state Medicaid programs. Medicaid rebates are partially based on the reported average manufacturer prices. OIG has found that manufacturers may not always report reported average manufacturer prices in a timely manner, or in some cases, may not report them at all. Further, both OIG and Government Accountability Office reviews have shown that manufacturers make inconsistent interpretations regarding how

to calculate the reported average manufacturer prices. OIG has recommended that CMS work to ensure that manufacturers provide accurate and timely reported average manufacturer price data and provide additional clarification on how to determine reported average manufacturer prices.

Most recently, as required by the Deficit Reduction Act, section 6001, OIG was required to "review the requirements for and manner in which average manufacturer prices are determined under section 1927 of the Social Security Act as amended," and provide recommendations to the Department for changes in the way the average manufacturer price is currently determined. OIG issued its recommendations to CMS on May 30, 2006.

OIG Assessment of Progress in Addressing the Challenge:

The Deficit Reduction Act impacts both Medicaid prescription drug reimbursement and rebates. It changes the basis for establishing the Federal upper limit amounts from the average wholesale price to the average manufacturer price. The Act also requires CMS to make average manufacturer prices available to state Medicaid programs on a monthly basis, as well as to post average manufacturer price data on its website quarterly. CMS has been directed to conduct a monthly survey of retail prices for prescription drugs. This information is to be provided to the states monthly and compared to state payment rates on an annual basis. With respect to Medicaid rebates, the Deficit Reduction Act clarifies issues related to rebates on physician-administered drugs and authorized generics. Finally, the statute made some changes to the way the average manufacturer price is calculated and requires CMS to promulgate a regulation no later than July 1, 2007, clarifying the manner in which the average manufacturer price is determined.

Although changes mandated by the Deficit Reduction Act are positive steps toward improving Medicaid reimbursement for prescription drugs and the collection of rebates, the remaining challenge is to ensure that the cost-saving provisions in the law are implemented in ways that assist Medicaid in appropriately paying for prescription drugs. For example, section 6001(b) of the Act requires CMS to make average manufacturer prices available to state Medicaid programs monthly and to the public quarterly on its website beginning July 1, 2006. While CMS has sent average manufacturer price data to state Medicaid agencies as mandated by the Act, CMS has stated that it would not publicly release the current average manufacturer price figures on its website because changes in the confidentiality provisions are not effective until January 1, 2007. CMS indicated that, instead, it would focus on developing a revised definition of average manufacturer price as well as data based on the new definition, for public disclosure.

Given the high Federal and state expenditures and the potential for significant savings, CMS should continue to be attentive in its oversight of Medicaid reimbursement for prescription drugs and the Medicaid drug rebate program. In particular, CMS should work to ensure that the cost-saving provisions in the Deficit Reduction Act are effectively implemented. States need accurate data that reliably reflect the actual costs of drugs paid by pharmacies and are based on pricing data that can be validated. Given that the Act allows states access to average manufacturer prices to assist in estimating prescription drug costs, it is also essential that all manufacturers report timely and accurate data. Currently, this is important for the rebate process to work as intended. If states begin to use the average manufacturer prices as the basis for Medicaid reimbursement, the timeliness and validity of the average manufacturer price will be crucial to ensuring accurate reimbursements as well.

Challenge 6: Quality of Care in Long-Term Care Services

With the expected growth in the long-term care population, ensuring quality of care provided to long- term care beneficiaries warrants significant attention to ensure that Federal dollars are spent on appropriate and quality long-term care. While there will always be a need for nursing home services, care will likely continue to shift to more community-based services. This shift may increase utilization of alternatives to institutional-based care such as home health, hospice care, and other community-based services. Thus, it is imperative that HHS continue to monitor quality of care provided to beneficiaries in all long-term care settings.

Through a body of work, OIG identified concerns regarding payment and quality issues in nursing facilities. Prior OIG work found an increase in the number of deficiencies and that a large number of nursing homes had been cited for substandard care. OIG continues to be concerned that enforcement mechanisms may neither be effectively bringing nursing homes with serious deficiencies back to compliance nor preventing nursing homes with egregious practices from continuing to provide substandard care to Medicare beneficiaries.

In three recent studies, OIG reported a number of concerns regarding enforcement of quality of care standards. In one study, OIG found that states appropriately referred most nursing home cases that warranted enforcement; but 8 percent of the cases were either not referred or were referred but the referral was not recognized as such by the CMS regional office. In another recent report, OIG found that for the majority of cases requiring mandatory termination, CMS did not apply the remedy due to both late case referrals by states and CMS' staff reluctance to impose this severe remedy. Finally, in a third report, OIG found that CMS did not investigate some of the most serious nursing home complaints within the required timeframe and that CMS oversight of nursing home complaint investigations is limited.

OIG is also concerned about whether payments to nursing homes are correct and whether the funds are being used for patient care-related activities. OIG examined the adequacy of Medicaid payments to nursing facilities in states that have enhanced payment programs for public nursing facilities. As part of these studies, in 2004 and 2005, OIG found that nursing homes were required by their states or counties to return a majority of their enhanced funding. These nursing homes had received the most unfavorable survey ratings the states can issue. The homes might have provided higher quality services if they had been able to retain all the funding they initially received.

Some nursing home care problems are so serious that they constitute "failure of care" and thereby invoke the civil False Claims Act. These cases often involve allegations of widespread or systemic problems, such as excessive falls, medication errors, an undue number of residents with facility-acquired pressure ulcers, and chronic staff shortages. OIG continues to work with U.S. Attorneys and the Department of Justice on development and settlement of these egregious cases. OIG is also working on more joint cases with the Medicaid Fraud Control Units to help protect the health and safety of this especially vulnerable population. OIG has developed exclusion actions against individuals and entities whose conduct causes the furnishing of poor care, with particular emphasis on higher-level officials of nursing facilities and chains. OIG continues to negotiate quality-of-care Corporate Integrity Agreements as part of the settlement of such False Claims Act cases. All of these Corporate Integrity Agreements require an outside monitor and include effective enforcement remedies for breach of the Corporate Integrity Agreements, such as specific performance, stipulated penalties, and exclusion.

OIG is currently conducting a series of reviews to further address quality issues in long-term care. Examples of topics include the use of psychotherapy services in nursing homes, the impact of Medicare Part D on dual eligible residents in nursing homes, cyclical noncompliance with certification standards in home health agencies, oversight of quality of care in hospices, and appropriateness of payments and care for hospice beneficiaries residing in nursing homes.

OIG Assessment of Progress in Addressing the Challenge:

CMS has implemented several data systems to manage survey and enforcement actions and complaint and incident-related activities. For example, CMS indicated that its Automated Survey Processing Environment enforcement management system, which contains information on both enforcement and survey results, has improved its ability to manage enforcement cases and has resulted in more timely application of mandatory denial of payment remedies. Additionally, a specific field in the system allows regional office staff to identify cases that have been referred by states and anticipate their arrival. However, increased dependence on these systems to manage and track survey, enforcement, and complaint actions, as well as increased national reporting capabilities of the two systems, is dependent upon timely, complete, and accurate data entry. Further, the data need to be routinely monitored and utilized to lead to improvement.

CMS has also made changes to state performance standards and its Special Focus Facility program to strengthen its oversight of quality of care in nursing homes. Further, CMS plans to begin an internal triage review geared to assess cases at specific intervals to identify any additional actions that might help bring a facility back into compliance in a timely manner. Recently, CMS has worked to make improvements in the complaint investigation process, including stronger protocols for handling complaints and strengthened oversight of the requirement to investigate complaints alleging actual harm (high) within 10 days.

Challenge 7: Public Health Emergency Preparedness and Response

The events of September 11, 2001, the 2005 Gulf Coast hurricanes, and the potential for future public health emergencies, such as the threat of pandemic influenza, have underscored the importance of having a comprehensive national public health infrastructure that is prepared to rapidly respond to public health emergencies. Because HHS manages most of the Nation's Federal health resources through surveillance, coordination, research, and delivery of healthcare service programs, OIG work has focused on vulnerabilities in those numerous programs. OIG assesses how well HHS programs and their grantees plan for, recognize, and respond to outside health threats; the security of HHS and grantee laboratory facilities; the management of these grant programs and funds by the Department and grantees; and the readiness and capacity of responders at all levels of government to protect the public's health.

Since 2001, OIG has completed numerous audits and evaluations of the Department's programs for bioterrorism preparedness and response. In earlier work, OIG evaluated the effectiveness of the Centers for Disease Control and Prevention (CDC) bioterrorism preparedness efforts, assessing the ability of state and local health departments to detect and respond to bioterrorist events and their ability to receive and deploy the Strategic National Stockpile (previously the National Pharmaceutical Stockpile). OIG has since conducted follow-up evaluations and found that, while some progress had been made, the states and localities were still under-prepared in general and their planning documents continued to overstate preparedness. OIG will continue to assess the Centers for Disease Control and Prevention's preparedness assistance to state and local health departments, paying particular attention to levels of preparedness for impending public health threats such as pandemic flu.

Ensuring the security of internal HHS and Department-funded laboratories, including those where select agents are used, and security over assets and materials to be used in responding to an emergency remains an OIG concern. In the past, OIG reviewed Departmental and external (non-Federal) laboratories' compliance with laws and regulations relating to the use of select agents and found that many of them did not adequately safeguard against the theft or loss of select agents. As legal requirements for the possession of select agents have become more stringent and detailed in the last several years, OIG initiated additional audits of entities with select agents to assess their compliance with select agent regulations. OIG plans in the near future to reassess Centers for Disease Control and Prevention's management of the select agent program. In a related effort, OIG will also evaluate physical security and environmental controls over the Strategic National Stockpile.

OIG has followed up on work performed in 2004 assessing grantees' efforts to comply with the financial accounting and reporting requirements of CDC's and the Health Resources and Services Administration's bioterrorism grant programs. OIG is drafting reports that will be issued in Fall 2006 reporting specifically on the timeliness with which all grantees obligated grant funds. In 2005 and 2006, as part of an interagency review in collaboration with the Inspectors General at the U.S. Environmental Protection Agency and the Department of Homeland Security, OIG reviewed CDC's role in the BioWatch program, which conducts surveillance for environmental indicators of bioterror agents. OIG's recommendations addressed overall management concerns, including inaccuracies in data reporting; background investigation levels for laboratory staff that were inconsistent with the level of program sensitivity; a need for more information sharing among laboratories; and CDC's limited guidance to health departments about response to positive test results. At the same time, OIG examined CDC's CHEMPACK program, a program designed to pre-deploy packages of medical countermeasures in anticipation of a chemical disaster. Similarly, OIG recommended that the CHEMPACK program should assist in deployment by providing testing guidelines and test containers to program participants, and utilize existing Centers for Disease Control and Prevention's medical expertise to answer participants' medical questions.

In addition to the significant investment in examining the Department's activities related to bioterrorism and public health preparedness, OIG has made it a priority to examine HHS' response to the public health challenges resulting from Hurricanes Katrina and Rita. In response to the 2005 Gulf Coast hurricanes, OIG continues to work with the President's Council on Integrity and Efficiency to assess the overall effectiveness of the Department's deployment and recovery activities, including Departmental procurements and associated management controls, beneficiary protections, and the delivery of critical healthcare services. OIG reviewed the emergency preparedness and response of nursing homes during recent hurricanes among a selection of nursing homes in five Gulf states and found that all experienced problems during the 2004 and 2005 hurricanes, whether evacuating or sheltering in place. OIG recommended that CMS consider strengthening Federal certification standards for nursing home emergency plans.

OIG recently issued several reports on its review of the procurement process for pharmaceuticals and other relief-related products and services associated with HHS' response to the Gulf Coast Hurricanes. OIG found that procurement officials complied with Federal Acquisition Regulation in awarding the contracts. A number of evaluations and audits are currently underway to examine the Department's overall response and recovery efforts, beneficiary protections, and Departmental procurements. OIG anticipates issuing a final report to be published before the end of 2006 that reviews the U.S. Public Health Service Commissioned Corps response to the hurricanes. For 2007, OIG plans to continue to evaluate the Department's approach to all-hazards disaster response and mitigation, including examining food facility security concerns, pandemic influenza preparedness, and early event detection efforts.

OIG Assessment of Progress in Addressing the Challenge:

HHS agencies continue to seek additional resources and work on corrective action plans that respond to OIG-reported concerns. Federal, state, and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. The Centers for Disease Control and Prevention has taken steps to improve its capacity to detect and respond to harmful agents, and to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. Both the CDC and the Health Resources and Services Administration have updated their Public Health and Hospital Preparedness Cooperative Agreements to incorporate stronger performance measures and clearer guidance for grantees. In response to an OIG recommendation, the Centers for Disease Control and Prevention also now require states to address mental health needs in their Cooperative Agreement guidance. The Assistant Secretary for Public Health and Emergency Preparedness utilized earlier OIG reports to work with both components to standardize performance measures and required reporting for grantees.

Recent guidance for the CDC's Cooperative Agreement on Public Health Preparedness and Response now requires states to establish electronic systems that can effectively detect and report disease outbreaks and other public health emergencies. OIG will examine the extent to which states have made use of early event detection technology in fulfilling this requirement. In response to OIG's review of the Biowatch program, the Centers for Disease Control and Prevention stated that it has already begun addressing some of OIG's concerns and plans to implement automated data entry in laboratories and a forum for information sharing, as well as identify additional technical resources to increase state and local capacity to respond to a potential terrorist threat.

States and localities are currently strengthening their bioterrorism preparedness programs, and recent increases in HHS funding address some of OIG's concerns. However, based on OIG findings, significant improvements are still needed for local health departments to be fully prepared to detect and respond to bioterrorism and, by extension, naturally occurring disasters. The 2005 hurricanes underscored the need for a comprehensive Federal plan to respond quickly and effectively to a mass public health emergency event that also requires a seamless integration with responses at the state and local levels. CMS concurred with the findings in the nursing home emergency response and preparedness report. It is exploring ways to strengthen Federal certification standards for nursing home emergency preparedness and to promote better coordination among Federal, state, and local emergency management entities. As a result of a briefing on an early draft of the report reviewing the Commissioned Corps' response to the hurricanes, along with findings of the White House Katrina After-Action Report, the Office of the Surgeon

General, Office of Public Health and Science, is implementing many of the recommendations OIG identified, including the pre-identification, rostering, training, and equipping of designated response teams of Commissioned officers.

Challenge 8: Research and Regulatory Oversight

Through the work of the National Institutes of Health, the Department is responsible for acquiring knowledge that can help prevent, diagnose, and treat disease and disability. Additionally, through the work of the Food and Drug Administration, the Department is responsible for assuring the safety, efficacy, and security of human and veterinary drugs, medical devices, the Nation's food supply, cosmetics, and products that emit radiation. Given these critical public health mandates, it is necessary that NIH and FDA have in place policies and programs that ensure the integrity of medical research endeavors, including the protection of human research subjects and accountability over grant funds; pre-and post-approval of regulated medical products and treatments; ensuring the safety of the Nation's food supply; and the professional ethics of agency employees, members of advisory panels, and grantees.

Over the past decade, OIG has conducted numerous evaluations and audits that have consistently documented weaknesses in the oversight system for protecting human research subjects in clinical trials associated with NIH grants, those conducted by manufacturers seeking FDA approval for regulated products, and HHS oversight of clinical trials generally. FDA's bioresearch monitoring program conducts inspections of clinical investigators involved in clinical research to ensure the quality and integrity of data submitted to the agency and to protect the rights and welfare of human subjects. HHS agencies and grantees must effectively use appropriate tools to ensure both the safety of clinical trial participants and the validity and integrity of scientific data.

Research on approved drugs and devices often continues after products are approved for marketing. This research can help manufacturers and FDA identify important information about additional risks and benefits facing patients using these products. In 2006, OIG examined FDA's monitoring of these postmarketing study commitments and the timeliness with which these studies are being completed. This work identified several vulnerabilities that limit FDA's ability to readily identify whether or how timely these commitments are progressing toward completion. As a result, OIG made several recommendations to improve FDA's ability to oversee and monitor these commitments.

Vigilance in the area of medical research is especially crucial because when researchers fail to disclose and mitigate their financial conflicts of interest, their research findings may be or appear to be compromised. These concerns are magnified when Federal dollars are funding medical research. Federal concerns about conflict of interest extend to both intramural research performed by Federal employees in the Federal laboratories and extramural research, for which Federal research grants are provided to non-Federal research institutions. To address issues of conflicts of interest among HHS employees, in 2005, OIG evaluated the outside activity approval process for employees of both NIH and FDA. OIG identified several problems with the agencies' overall review process itself and recommended that both agencies improve the quality and extent of information they receive and address inadequacies in their review processes.

While intramural research undertaken within the Department is vital, the bulk of HHS' research funding goes to the private sector, primarily to research universities that undertake work pursuant to contracts and grants. HHS regulations require grantee institutions to utilize procedures to identify and deal with potential conflicts of interests of their researchers who are funded by the Department. In 2007, OIG will review NIH's oversight of these requirements. Furthermore, on November 29, 2005, OIG issued draft compliance program guidance for recipients of extramural research awards from NIH and other U.S. Public Health Service agencies. While focused on grant compliance and administration, the proposed compliance elements were intended to be helpful in connection with other areas, including conflicts of interest. On June 7, 2006, with the OIG's concurrence and support, the National Science and Technology Council's Committee on Science decided to expand the OIG draft guidance and establish an interagency initiative to develop voluntary compliance guidance for recipients of Federal research funding from all agencies across the Federal Government. These efforts will provide assistance to research institutions on guarding against conflicts of interest in Federally funded research.

OIG Assessment of Progress in Addressing the Challenge:

HHS has implemented many changes examining protections for human research subjects and NIH and FDA oversight of activities to protect the integrity and validity of scientific research. Notably, in June 2000, HHS created the Office for Human Research Protections within the Office of the Secretary, which is charged with oversight of all research involving human subjects that is conducted or funded by HHS. The Office for Human Research Protections closely coordinates with both NIH and FDA. However, recent reports of incidents concerning clinical drug trials have raised serious questions about potential vulnerabilities surrounding the protection of human research subjects and validity and integrity of scientific data from clinical trials. For example, in November 2005, a series of news articles highlighted problems with clinical trials at a for-profit Institutional Review Board. These articles raised concerns consistent with issues OIG had raised between 1998-2000[1] in reviewing oversight activities of Institutional Review Boards. The news series blamed lax oversight by FDA and Institutional Review Boards for deaths and injuries of several participants in clinical trials. The series identified specific problems with the oversight systems, including insufficient informed consent procedures, inadequate training and certification requirements for Institutional Review Boards, limited Federal regulations, and FDA's lack of enforcement of existing regulations.[2] To follow up on this previous work, in FY 2007 OIG will evaluate the oversight of clinical trials and human subject protections.

Federal law required HHS to issue regulations for the protection of human research subjects and to implement and update its programs of instruction and guidance in ethical issues associated with such research. The first harmonized regulations pertaining to informed consent and human subject protection were issued jointly by FDA and HHS in 1981. These regulations were revised and further harmonized in 1991 as the Federal Policy for the Protection of Human Subjects or the "Common Rule (45 Code of Federal Regulations Part 46)." The 16 Federal agencies that conduct, support, or otherwise regulate Federal human subject research agreed to abide by the requirements of the Common Rule. FDA adopted certain of the Common Rule's provisions. Revised regulations were issued on June 23, 2005, and amend the 1991 regulations. Pursuant to these regulations, all institutions that receive funds or seek approval of new drugs, devices, biologics, or other regulated products from HHS to conduct or support research with human subjects are subject to specific requirements and, as appropriate, to oversight by the Office for Human Research Protections and either NIH or FDA.

With respect to the vulnerabilities in oversight of postmarketing study commitments, FDA is currently undertaking a review of the decision-making process behind requests for postmarketing commitments for human drugs and biologics. The study is intended to assist FDA in determining if improved guidance is needed for industry. At the same time, FDA has undertaken activities to improve the response on postmarketing and postapproval studies for human drugs, biologics, and devices.

In the intramural arena, the Department has, in recent years, focused on devising new approaches and mechanisms for helping to ensure that HHS employees, particularly those involved in research and regulatory oversight at NIH and FDA, conduct their work free of conflicts of interest, so that the public can be assured that the Department's programs and responsibilities are not affected by financial concerns on the part of the Federal employees involved in this work. The Department's Designated Agency Ethics Official led an effort to strengthen the HHS Supplemental Standards of Ethical Conduct, culminating in the promulgation of a new final regulation on July 31, 2005. The new, expanded Supplemental Standards focus on the financial holdings and outside activities of FDA and NIH employees. A more thorough system of examining the outside activities of all HHS employees was also instituted, whereby the HHS Form 520, "Request for Approval of Outside Activities," was expanded from a 4-page to a 16-page detailed questionnaire and the requirement to annually report on outside activities was instituted.

Management Challenge 9: Grants Management

HHS' public health and human service agencies rely on grants and cooperative agreements to meet mission objectives, such as providing health and social services safety nets, preventing the spread of communicable diseases, and researching causes and treatments of diseases. In FY 2006, the Department expects to issue grants totaling $240 billion ($37 billion discretionary and $203 billion mandatory). Medicaid, which constitutes the largest portion of mandatory grants ($193 billion), is discussed under Issues three, four, and five, where program vulnerabilities are identified.

[1] OEI-01-97-00197: Protecting Human Research Subjects: Status of Recommendations; final report signed April 2000; report summarizes Department, NIH, and FDA responses to recommendations contained in OEI-01-97-00190-00196.

[2] Bloomberg.com, November 2, 2005.

Grants management remains a challenge because of the very nature of a grant. A grant is financial assistance for an approved activity with performance responsibility resting primarily on the grantee, with little or no government involvement in the funded activity. This expectation of minimal government involvement is compounded by the fact that many HHS grantees have limited experience managing Federal funds. New, inexperienced grantees are particularly likely to receive funding when new grant programs are created or existing programs are expanded. In addition, even experienced grantees sometimes allegedly use grant funds for nonapproved purposes, as evidenced by recent grant fraud related settlements between the Department of Justice and several major universities.

To ensure the integrity of HHS' grant programs, OIG will continue to examine grants management, including the agencies' grant selection and oversight processes, program performance and results, implementation of information technology efforts to increase program access and operational efficiency, and accountability for Federal funds. OIG plans to pay particular attention to vulnerabilities associated with expanded grant programs, newly funded initiatives, and first-time Federal grantees.

Discretionary Grants

The risk of inefficient use or misuse of grant funds is high when the grant-making or oversight process is flawed. In a September 2005 review of the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) prevention grant-making process operated by CDC, OIG identified numerous deficiencies throughout the preaward, award, and postaward phases of the agency's grant management operations. OIG concluded that CDC could not be assured that its grant management operations provided appropriate direction and oversight for the activities of grantees under the HIV/AIDS prevention program.

HHS agencies have several grants management tools at their disposal, including the Department Alert List. Failure to use these tools increases the risk that grant funds will be used for purposes other than those intended. In September 2005 and May 2006, OIG completed two related reviews examining the Health Resources and Services Administration's (HRSA) and CDC's adherence to Departmental policies governing placement on and use of the Alert List. The Alert List contains the names of high-risk grantees and is used by the Department to ensure that such grantees are known to the HHS grant-making agencies and to safeguard Department funds. OIG found that HRSA and CDC did not consistently follow Alert List policies for placing grantees on the list and monitoring their status. OIG also found that HRSA grants officers did not use the information on the list to make grant decisions. OIG recommended that both HRSA and CDC develop methods to ensure that grants officers follow Alert List policies.

Even when grantees are providing the intended service, they often do not observe all of the programmatic or financial requirements to which such grantees are subject. A series of reviews of HRSA's Ryan White HIV/AIDS service providers completed in 2004 and 2005 indicated that the intended services were generally being provided, but certain aspects of grantee or sub-recipient operations, such as service delivery and fiscal management, could be improved. For example, a provider of emergency housing served some clients beyond the time period established in agency guidelines, while other potential clients were on waiting lists. OIG also identified a number of grantees that claimed costs at budgeted levels, rather than actual costs as required by Federal cost principles.

Grant oversight and monitoring continues to be a concern of OIG. In June 2006, OIG completed a review of the Agency for Healthcare Research and Quality's (AHRQ) monitoring of its Patient Safety Grants, which totaled $128 million in FYs 2001 through 2003. OIG found that although grantee performance reports generally complied with Federal requirements, most financial reports were not received or were late, and Federal requirements for closeout were not met. OIG recommended that AHRQ require submission of interim financial information, establish a tracking system for Financial Status Reports, require grantees with no-cost extensions to submit Financial Status Reports in compliance with Federal requirements, and ensure that grants awaiting closeout are closed promptly.

At NIH and university grantee sites, OIG has several initiatives aimed at evaluating the allowability of costs charged to NIH grants. Ongoing work is focused primarily on costs transferred to NIH grants and administrative and clerical costs charged to

NIH grants. OIG is also conducting a congressionally requested review of graduate student researcher compensation charged to NIH grants.

Mandatory Grants

OIG has reviewed the Administration for Children and Families' (ACF) monitoring and oversight of the Title IV-E Foster Care Programs, because these programs serve children who comprise a vulnerable population. OIG has examined states' standards and capacities to track frequency and content of caseworker visits with children in the Foster Care program. OIG found that although most states surveyed had written standards calling for a minimum of monthly caseworker visits, fewer than half demonstrated the ability to produce statewide visitation reports, and several states indicated that, on average, caseworkers visited fewer than half of foster children monthly. OIG recommended that ACF promote the use of automated systems for recording and reporting caseworker visitation data and work with states to ensure that these data are recorded in their systems. OIG also assessed states' methods of monitoring foster care sub-grantees and found that some states' systems were inadequate, according to study criteria that OIG developed based on Federal grants management requirements; some states did not communicate required information to sub-grantees; and ACF paid minimal attention to oversight of states' sub-grantee monitoring systems. OIG recommended that ACF hold states accountable for adhering to grant management requirements relating to sub-grantees.

Since 2002, OIG has performed reviews in 10 states that have focused on the appropriateness of Federal reimbursement related to Foster Care and Adoption Assistance training and administrative costs and maintenance claims. OIG has monitored ACF's plan to identify erroneous payments for Foster Care, Head Start, and Child Care as mandated by the Improper Payments Information Act and Office of Management and Budget Memorandum M-03-13. In addition, during FY 2007 OIG will perform reviews in three states to identify erroneous payments in its Temporary Assistance for Needy Families program, which has a FY 2006 funding level of $17.2 billion.

OIG Assessment of Progress in Addressing the Challenge:

Through the government-wide Federal Grant Streamlining Program, the HHS grants management environment is continually undergoing significant changes. The program is intended to implement the Federal Financial Assistance Management Improvement Act of 1999 (Public Law 106-107), which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. The initiative requires grant officials to examine the way they do business, focusing not only on streamlining the grant process, but also on ensuring that results are achieved and that Federal funds are used appropriately for the maximum benefit of program recipients. It is crucial that HHS agencies adequately manage and monitor their grantees' and, to the extent possible, their sub-grantees' program performance and require fiscal accountability through the life of the grant. A critical part of this streamlining process involves the consistent use of Department-wide grants management policies. Over the next fiscal year, OIG will continue to address Department-wide efforts to improve the streamlining of Federal assistance programs, grants management, and program oversight and monitoring.

In response to OIG's report on the Alert List, CDC has begun regular reviews of the list to ensure appropriateness of content and requires all grants management officers to review grants to determine the need for placement on the list due to special conditions and facilitate timely removal. It has also worked closely with the HHS Office of Grants for guidance and training and developed a written policy on Alert List procedures to complete its planned corrective actions. In its response to OIG's report, HRSA indicated that it expects that the recently concluded consolidation of its grants management operations into a single operating unit, with standardized operating procedures and uniform guidance, will prevent a recurrence of the types of adverse findings identified by OIG. Additionally, the HHS Office of Grants has conducted Department-wide training on Alert List policies and procedures.

AHRQ has committed to improving its grant monitoring overall and agreed in general to the recommendations in OIG's review of patient safety grants. In response to OIG's report, AHRQ intends to initiate several actions that are intended to improve the

availability of needed financial information for use in making funding decisions, developing an electronic tracking system for Financial Status Reports, and closing out grants timely.

ACF concurred with OIG recommendations concerning the frequency and content of state foster care caseworker visits and in response to the OIG report said that it plans to use the findings and recommendations from OIG's review to provide technical assistance to the state grantees.

Management Challenge 10: Integrity of IT Systems and Infrastructure

Over the past several years, the importance of protecting personal data has become much more visible, as illustrated by media attention to personal data lost by accounting firms, credit bureaus, universities, insurance companies and, most recently, the serious loss of data by Federal agencies. The Office of Management and Budget has recently reemphasized Federal agency responsibilities under the law and policies to appropriately safeguard sensitive, personally identifiable information and train employees regarding their responsibilities in this area. HHS has personal information in its internal systems and the systems that serve Medicare and Medicaid and other programs. HHS needs to ensure that all necessary technical and policy measures are being taken to protect sensitive information, the systems that store that information, and the physical or electronic transport of that information.

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

The human factor is a critical component of an effective security program. It is typically overlooked in the development of technical solutions to address weaknesses in entity-wide security, access controls, service continuity, application controls and development, and segregation of duties. As the Department focuses more on data integrity and application controls, the need to ensure adherence to general controls becomes paramount. For example, OIG's body of work indicates that the Medicare payment error rate is more often a function of the input of incorrect information than data processing. For the 7 years during which OIG produced the Medicare fee-for-service error rate, the overwhelming majority (more than 95 percent) of the improper payments identified were detected through medical reviews. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. The OIG Federal Information Security Management Act assessments also found that many identified security weaknesses are attributed to either an absence of a process to protect resources or a failure to comply with an established process.

Through planned work, OIG will place new emphasis on controls designed to ensure the protection of personal data and will continue to place emphasis on controls that are designed to guarantee the integrity of data for numerous vital programs on which critical systems depend for the accurate payment of billions of dollars through the Department's many programs.

Health Information Technology

In 2001, the President identified the development and implementation of an "interoperable health information technology infrastructure" as a key initiative. To facilitate this, in April 2004, the President issued Executive Order 13335, which established the position of the National Health Information Technology Coordinator and outlined incentives for the use of health information technology (IT). According to the President's executive order, "The 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 health information technology in both the public and private healthcare sectors that will reduce medical errors, improve quality, and produce greater value for healthcare expenditures."

Because the majority of key health IT initiatives are in their formative stages, OIG will assess HHS' progress in implementing key health IT initiatives in the public health agencies and at CMS and identify barriers to their implementation. OIG's work related to the health IT initiative will focus on use of electronic health records, e-prescribing, state initiatives to utilize health IT, and the use of health IT to respond to public health emergencies.

OIG 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. Core requirements for security controls have been established and distributed, and system architecture documents are being developed.

The "Secure One HHS" project, which is supported through a multiyear contract, is the Department's effort to improve IT security from the top down by providing security policy, procedures, and guidance. The project began in earnest in March 2003. Its goal is to improve the Department's overall IT security posture, ensure adequate enterprise-wide security standards, support integration of IT security into lines of business, and promote an environment in which employee actions reflect the importance of IT security. However, insufficient resources have been allocated for the day-to-day oversight function for this project. Despite resource deficiencies, during FY 2005 the Department made significant progress in addressing deficiencies noted in prior Federal Information Security Management Act reviews.

Although the adoption of health IT is in its early stages throughout the Department, there are several areas where health IT is currently in use or development is being funded. AHRQ awards $166 million in grants and contracts to programs across the country to support and stimulate investment in health IT, especially in rural and underserved areas. For three decades, the Indian Health Service has used its Resource and Patient Management System to capture clinical and public health data and manages patient care and followup using electronic health records NIH, through the National Library of Medicine, hosts an online medical database that provides up-to-date information to consumers and healthcare professionals. Called Medline Plus, the database is free to use; provides extensive information about drugs; and offers an illustrated medical encyclopedia, interactive patient tutorials, and the latest health news.

On August 8, 2006, the Department issued final regulations that establish new exceptions under the physician self-referral law and new safe harbors under the anti-kickback statute involving the donation of certain electronic health IT and services. The final rules seek to lower perceived barriers to the adoption of health IT 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 Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the first exception and safe harbor establish the conditions under which hospitals and certain other 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 records software, IT, and training services.

Improper Payments Information Act Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improper Payment Reduction Outlook FY 2005 – FY 2009

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

($ in millions)

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

NOTE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Financial Information

U. S. Department of Health and Human Services
Appendix B - Net Cost of HHS Top 50 Programs
For the Year Ended September 30, 2006 and 2005
(in millions)

The following table presents the Net Costs of HHS' 50 largest programs (based on their FY 2006 net cost) for FY 2006 and FY 2005. This listing includes programs aggregated from the several hundred total HHS programs. The net cost information is extracted from draft and final HHS component Consolidated Statements of Net Cost for FY 2006 and FY 2005, and supplements the programs identified in the Department's Consolidated Statement of Net Cost.

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2006	FY 2005	FY 2006	FY 2005		
Medicare	$ 336,969	$ 295,713	1	1	Medicare	Centers for Medicare and Medicaid Services
Medicaid	179,481	182,226	2	2	Health	Centers for Medicare and Medicaid Services
Research	27,852	27,348	3	3	Health	National Institutes of Health
Temporary Assistance to Needy Families	17,063	17,289	4	4	Education, Training & Social Services/ Income Security	Administration for Children and Families
Child Welfare	7,347	7,378	5	5	Education, Training & Social Services/ Income Security	Administration for Children and Families
Head Start	6,834	7,034	6	6	Education, Training & Social Services/ Income Security	Administration for Children and Families
SCHIP	5,739	5,135	7	7	Health	Centers for Medicare and Medicaid Services
Child Care	5,246	5,001	8	8	Education, Training & Social Services/ Income Security	Administration for Children and Families
Child Support Enforcement	4,290	4,204	9	9	Education, Training & Social Services/ Income Security	Administration for Children and Families
Infectious Diseases (Note 1)	3,471	3,145	10	10	Health	Centers for Disease Control & Prevention
Low-Income Home Energy Assistance	2,635	2,127	11	11	Education, Training & Social Services/ Income Security	Administration for Children and Families
HIV/AIDS Programs	2,123	2,077	12	12	Health	Health Resources and Services Administration
Public Health and Social Services	1,960	1,970	13	13	Health	Office of the Secretary
Ticket to Work	1,940	325	14	33	Health	Centers for Medicare and Medicaid Services
Social Services Block Grant	1,848	1,824	15	15	Education, Training & Social Services/ Income Security	Administration for Children and Families
Substance Abuse Prevention & Treatment Block Grant	1,685	1,750	16	16	Health	Substance Abuse and Mental Health Services Administration
Clinical Services	1,611	1,619	17	17	Health	Indian Health Service
Primary Care	1,382	1,837	18	14	Health	Health Resources and Services Administration
Community Based Services	1,273	1,279	19	18	Education, Training & Social Services	Administration on Aging
Health Promotion	971	829	20	21	Health	Centers for Disease Control & Prevention
Maternal and Child Health	880	1,044	21	19	Health	Health Resources and Services Administration
PHS Commissioned Corps	727	346	22	31	Health	Program Support Center
Community Services	714	773	23	22	Education, Training & Social Services/ Income Security	Administration for Children and Families
Health Professions	695	870	24	20	Health	Health Resources and Services Administration
Foods and Cosmetics	579	546	25	23	Health	Food and Drug Administration
Program of Regional National Significances/ Targeted Capacity Expansion	565	471	26	28	Health	Substance Abuse and Mental Health Services Administration
Refugee Resettlement	518	530	27	24	Education, Training & Social Services/ Income Security	Administration for Children and Families
Contract Health Care	485	480	28	25	Health	Indian Health Service
Healthcare Systems (Note 2)	478	471	29	27	Health	Health Resources and Services Administration
Community Mental Health Services Block Grant	423	426	30	29	Health	Substance Abuse and Mental Health Services Administration
Business Services Support	369	476	31	26	Health	Centers for Disease Control & Prevention
Environmental Health and Injury (Note 1)	352	343	32	32	Health	Centers for Disease Control & Prevention
General Departmental Management	347	302	33	35	Health	Office of the Secretary
Human Drugs	342	313	34	34	Health	Food and Drug Administration
Program of Regional National Significances - Best Practices (new)	332	404	35	30	Health	Substance Abuse and Mental Health Services Administration
Terrorism	320	(116)	36	0	Health	Centers for Disease Control & Prevention
Family Planning	300	275	37	36	Health	Health Resources and Services Administration
Hospitals-Facilities Support	277	211	38	40	Health	Indian Health Service
Medical Devices & Radiological Health	275	240	39	38	Health	Food and Drug Administration
Tribal Activities: Contract Support	251	273	40	37	Health	Indian Health Service
Youth	241	165	41	43	Education, Training & Social Services/ Income Security	Administration for Children and Families
Public Health Improvement and Leadership (Note 1)	219	194	42	41	Health	Centers for Disease Control & Prevention
Developmental Disabilities	177	165	43	42	Education, Training & Social Services/ Income Security	Administration for Children and Families
Occupational Safety and Health (Note 1)	175	220	44	39	Health	Centers for Disease Control & Prevention
Rural Health	168	110	45	51	Health	Health Resources and Services Administration
Diabetes Initiative	162	139	46	44	Health	Indian Health Service
Global Health	154	104	47	52	Health	Centers for Disease Control & Prevention
Biologics	153	117	48	48	Health	Food and Drug Administration
Animal Drugs and Feeds	136	116	49	49	Health	Food and Drug Administration
Domestic Violence	122	131	50	46	Education, Training & Social Services/ Income Security	Administration for Children and Families
All Other HHS Programs	1,285	1,254			Various Components	Various Components
Total Net Costs (Note 3)	**$ 623,941**	**$ 581,503**				

Note 1. CDC has revised/combined several of their programs resulting in net cost revisions to four of their programs.
Note 2. Name of the program changed in FY 2005; was "Office of Special Programs".
Note 3. Total Net Costs agrees with OPDIV combined Totals in the Consolidating Statement of Net Cost by Budget Function located in Other Accompanying Information.

U.S. Department of Health and Human Services
Consolidating Balance Sheet by Budget Function
As of September 30, 2006
(In Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Natural Resources & Environment	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)								
Intragovernmental								
Fund Balance with Treasury (Note 3)	$ 6,874	$ 108,607	$ 28,726	$ 15,699	$ 15	$ 159,921	$ -	$ 159,921
Investments, Net (Note 5)	-	2,431	339,545	-	-	341,976	-	341,976
Accounts Receivable, Net (Note 6)	13	633	42,998	1	-	43,645	(42,919)	726
Anticipated Congressional Appropriation (Note 7)	-	-	-	-	-	-	-	-
Other (Note 10)	1	499	-	-	-	500	(368)	132
Total Intragovernmental	$ 6,888	$ 112,170	$ 411,269	$ 15,700	$ 15	$ 546,042	$ (43,287)	$ 502,755
Accounts Receivable, Net (Note 6)	-	342	2,865	-	-	3,207	-	3,207
Cash and Other Monetary Assets (Note 4)	-	-	145	-	-	145	-	145
Inventory and Related Property, Net (Note 8)	-	2,322	-	-	-	2,322	-	2,322
General Property, Plant & Equipment, Net (Note 9)	2	4,564	405	-	-	4,971	-	4,971
Other (Note 10)	-	438	71	-	-	509	-	509
Total Assets	**$ 6,890**	**$ 119,836**	**$ 414,755**	**$ 15,700**	**$ 15**	**$ 557,196**	**$ (43,287)**	**$ 513,909**
Stewardship PP&E (Note 32)								
Liabilities (Note 11)								
Intragovernmental								
Accounts Payable	$ 19	$ 191	$ 43,174	$ -	$ -	$ 43,384	$ (42,764)	$ 620
Accrued Payroll and Benefits	2	83	4	-	-	89	(1)	88
Other (Note 15)	-	1,141	336	-	-	1,477	(522)	955
Total Intragovernmental	$ 21	$ 1,415	$ 43,514	$ -	$ -	$ 44,950	$ (43,287)	$ 1,663
Accounts Payable	14	538	3	7	-	562	-	562
Entitlement Benefits Due and Payable (Note 12)	-	20,340	40,824	-	-	61,164	-	61,164
Accrued Grant Liability (Note 14)	440	2,307	-	1,084	2	3,833	-	3,833
Federal Employee and Veterans Benefits (Note 13)	4	7,518	10	-	-	7,532	-	7,532
Accrued Payroll and Benefits	15	735	52	2	-	804	-	804
Other (Note 15)	4	2,009	841	14	(1)	2.867	-	2,867
Total Liabilities	**$ 498**	**$ 34,862**	**$ 85,244**	**$ 1,107**	**$ 1**	**$ 121,712**	**$ (43,287)**	**$ 78,425**
Net Position								
Unexpended Appropriations - earmarked funds	-	7	27,658	-	-	27,665	-	27,665
Unexpended Appropriations - other funds	6,407	81,829	-	14,596	-	102,832	-	102,832
Unexpended Appropriations, Total	6,407	81,836	27,658	14,596	-	130,497	-	130,497
Cumulative Results of Operations - earmarked funds	-	2,598	301,853	-	14	304,465		304,465
Cumulative Results of Operations - other funds	(15)	540	-	(3)	-	522		522
		3,138						
Cumulative Results of Operations, Total	(15)		301,853	(3)	14	304,987	-	304,987
Total Net Position	$ 6,392	$ 84,974	$ 329,511	$ 14,593	$ 14	$ 435,484	$ -	$ 435,484
Total Liabilities and Net Position	**$ 6,890**	**$ 119,836**	**$ 414,755**	**$ 15,700**	**$ 15**	**$ 557,196**	**$ (43,287)**	**$ 513,909**

U.S. Department of Health and Human Services
Consolidating Balance Sheet by Operating Division
As of September 30, 2006
(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)	$ 22,029	$ 544	$ 65	$ 6,222	$ 82,806	$ 847	$ 5,642	$ 1,431	$ 30,406	$ 7,109	$ 174	$ 2,646	$ 159,921	$ -	$ 159,921
Investments, Net (Note 5)	-	-	-	-	339,545	-	2,402	-	29	-	-	-	341,976	-	341,976
Accounts Receivable, Net (Note 6)	14	-	5	113	473	85	-	26	-	98	160	4	978	(252)	726
Anticipated Congressional Appropriation (Note 7)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other (Note 10)	1	-	-	66	-	-	1	1	-	66	-	-	135	(3)	132
Total Intragovernmental	22,044	544	70	6,401	422,824	932	8,045	1,458	30,435	7,273	334	2,650	503,010	(255)	502,755
Accounts Receivable, Net (Note 6)	-	-	-	13	3,009	40	1	116	17	1	7	3	3,207	-	3,207
Cash and Other Monetary Assets (Note 4)	-	-	-	-	145	-	-	-	-	-	-	-	145	-	145
Inventory and Related Property, Net (Note 8)	-	-	-	352	-	-	-	6	10	1,945	9	-	2,322	-	2,322
General Property, Plant & Equipment, Net (Note 9)	2	-	-	1,012	440	335	-	904	2,155	116	7	-	4,971	-	4,971
Other (Note 10)	-	-	-	-	124	1	373	2	8	1	-	-	509	-	509
Total Assets	**$ 22,046**	**$ 544**	**$ 70**	**$ 7,778**	**$ 426,542**	**$ 1,308**	**$ 8,419**	**$ 2,486**	**$ 32,625**	**$ 9,336**	**$ 357**	**$ 2,653**	**$ 514,164**	**$ (255)**	**$ 513,909**
Liabilities (Note 11)															
Intragovernmental															
Accounts Payable	$ 18	$ 1	$ 1	$ -	$ 540	$ 4	$ 19	$ 7	$ 10	$ 112	$ -	$ 5	$ 717	$ (97)	$ 620
Accrued Payroll and Benefits	2	-	1	13	4	5	5	15	27	7	6	4	89	(1)	88
Other (Note 15)	-	-	39	84	434	77	29	203	107	-	-	139	1,112	(157)	955
Total Intragovernmental	$ 20	$ 1	$ 41	$ 97	$ 978	$ 86	$ 53	$ 225	$ 144	$ 119	$ 6	$ 148	$ 1,918	$ (255)	$ 1,663
Accounts Payable	21	-	8	33	3	(4)	14	9	402	29	27	20	562	-	562
Entitlement Benefits Due and Payable (Note 12)	-	-	-	-	61,164	-	-	-	-	-	-	-	61,164	-	61,164
Accrued Grant Liability (Note 14)	1,438	86	13	331	-	(5)	401	12	1,547	(31)	-	41	3,833	-	3,833
Federal Employee and Veterans Benefits (Note 13)	4	-	2	34	11	22	25	77	60	14	7,266	17	7,532	-	7,532
Accrued Payroll and Benefits	16	1	4	88	55	86	26	134	309	46	32	7	804	-	804
Other (Note 15)	16	2	(1)	59	1,986	348	237	122	99	(1)	-	-	2,867	-	2,867
Total Liabilities	**$ 1,515**	**$ 90**	**$ 67**	**$ 642**	**$ 64,197**	**$ 533**	**$ 756**	**$ 579**	**$ 2,561**	**$ 176**	**$ 7,331**	**$ 233**	**$ 78,680**	**$ (255)**	**$ 78,425**
Net Position															
Unexpended Appropriations - earmarked funds	-	-	-	-	27,658	(1)	4	4	-	-	-	-	27,665	-	27,665
Unexpended Appropriations - other funds	20,548	455	1	5,921	32,521	(261)	4,815	1,402	27,809	7,141	34	2,446	102,832	-	102,832
Unexpended Appropriations, Total	20,548	455	1	5,921	60,179	(262)	4,819	1,406	27,809	7,141	34	2,446	130,497	-	130,497
Cumulative Results of Operations - earmarked funds	-	-	1	32	301,853	142	2,193	(6)	250	-	-	-	304,465		304,465
Cumulative Results of Operations - other funds	(17)	(1)	1	1,183	313	895	651	507	2,005	2,019	(7,008)	(26)	522		522
Cumulative Results of Operations, Total	(17)	(1)	2	1,215	302,166	1,037	2,844	501	2,255	2,019	(7,008)	(26)	304,987	-	304,987
Total Net Position	$ 20,531	$ 454	$ 3	$ 7,136	$ 362,345	$ 775	$ 7,663	$ 1,907	$ 30,064	$ 9,160	$ (6,974)	$ 2,420	$ 435,484	$ -	$ 435,484
Total Liabilities and Net Position	**$ 22,046**	**$ 544**	**$ 70**	**$ 7,778**	**$ 426,542**	**$ 1,308**	**$ 8,419**	**$ 2,486**	**$ 32,625**	**$ 9,336**	**$ 357**	**$ 2,653**	**$ 514,164**	**$ (255)**	**$ 513,909**

U. S. Department of Health and Human Services
Supplemental Statement of Net Cost
For the Years Ending September 30, 2006 and 2005
(In Millions)

	2006			
	Agency Consolidated	Inter-Agency Eliminations		HHS Consolidated
Responsibility Segments	Totals	Costs (-)	Earned/Exchange Revenues (+) [1]	Totals
ACF	$ 47,114	$ (13)	$ 64	$ 47,165
AoA	1,386	(4)	4	1,386
AHRQ	7	(308)	21	(280)
CDC	6,330	(305)	127	6,152
CMS	524,156	(6)	248	524,398
FDA	1,527	(30)	102	1,599
HRSA	6,041	(23)	162	6,180
IHS	3,259	(43)	59	3,275
NIH	27,852	(112)	710	28,450
OS	2,431	(397)	149	2,183
PSC	629	(388)	20	261
SAMHSA	3,209	(84)	43	3,168
Net Cost of Operations	$ 623,941	$ (1,713)	$ 1,709	$ 623,937

	2005			
	Agency Consolidated	Inter-Agency Eliminations		HHS Consolidated
Responsibility Segments	Totals	Costs (-)	Earned/Exchange Revenues (+) [1]	Totals
ACF	$ 46,680	$ (12)	$ 54	$ 46,722
AoA	1,400	(4)	4	1,400
AHRQ	9	(321)	15	(297)
CDC	5,510	(391)	123	5,242
CMS	483,402	(8)	251	483,645
FDA	1,378	(20)	91	1,449
HRSA	6,700	(65)	152	6,787
IHS	3,140	(34)	51	3,157
NIH	27,348	(146)	673	27,875
OS	2,308	(357)	208	2,159
PSC	362	(407)	27	(18)
SAMHSA	3,266	(110)	43	3,199
Net Cost of Operations	$ 581,503	$ (1,875)	$ 1,692	$ 581,320

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

U.S. Department of Health and Human Services
Consolidating Statement of Net Cost By Budget Function
For the Year Ending September 30, 2006
(In Millions)

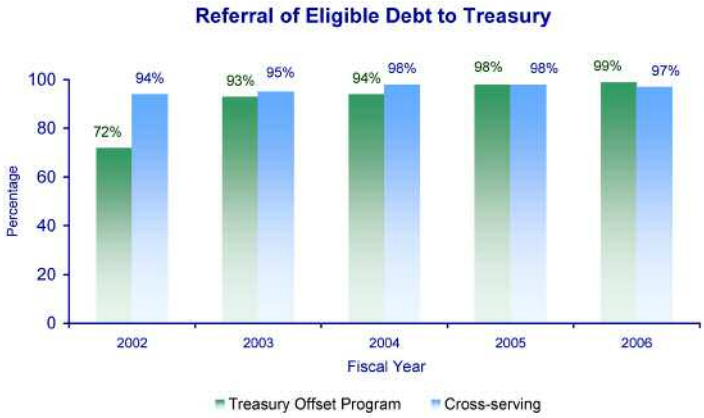
Responsibility Segments:	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations		HHS Consolidated Totals
						Cost (-)	Revenue	
ACF	$ 10,827	$ -	$ -	$ 36,287	$ 47,114	$ (13)	$ 64	$ 47,165
AoA	1,386	-	-	-	1,386	(4)	4	1,386
AHRQ	-	7	-	-	7	(308)	21	(280)
CDC	-	6,330	-	-	6,330	(305)	127	6,152
CMS	-	187,187	336,969	-	524,156	(6)	248	524,398
FDA	-	1,527	-	-	1,527	(30)	102	1,599
HRSA	-	6,041	-	-	6,041	(23)	162	6,180
IHS	-	3,259	-	-	3,259	(43)	59	3,275
NIH	-	27,852	-	-	27,852	(112)	710	28,450
OS	-	2,431	-	-	2,431	(397)	149	2,183
PSC	-	629	-	-	629	(388)	20	261
SAMHSA	-	3,209	-	-	3,209	(84)	43	3,168
Net Cost of Operations	**$ 12,213**	**$ 238,472**	**$ 336,969**	**$ 36,287**	**$ 623,941**	**$ (1,713)**	**$ 1,709**	**$ 623,937**

U.S. Department of Health and Human Services
Gross Cost and Exchange Revenue
For the Year Ending September 30, 2006
(In Millions)

	Intragovernmental						With the Public		
	Gross Cost			Less: Exchange Revenue					
Responsibility Segments	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated	Gross Cost	Less: Exchange Revenue	HHS Consolidated Net Cost of Operations
ACF	$ 186	$ (22)	$ 164	$ 31	$ (73)	$ (42)	$ 46,959	$ -	$ 47,165
AoA	14	(4)	10	6	(4)	2	1,378	-	1,386
AHRQ	43	(308)	(265)	316	(21)	295	280	-	(280)
CDC	739	(328)	411	541	(150)	391	6,144	12	6,152
CMS	755	(6)	749	16	(248)	(232)	573,496	50,079	524,398
FDA	572	(30)	542	41	(102)	(61)	1,364	368	1,599
HRSA	334	(30)	304	114	(169)	(55)	5,901	80	6,180
IHS	321	(43)	278	69	(59)	10	3,815	808	3,275
NIH	3,682	(2,299)	1,383	2,499	(2,897)	(398)	26,764	95	28,450
OS	401	(445)	(44)	616	(197)	419	2,642	(4)	2,183
PSC	124	(404)	(280)	636	(36)	600	1,152	11	261
SAMHSA	152	(84)	68	215	(43)	172	3,275	3	3,168
Totals	**$ 7,323**	**$ (4,003)**	**$ 3,320**	**$ 5,100**	**$ (3,999)**	**$ 1,101**	**$673,170**	**$ 51,452**	**$ 623,937**

Debt Collection Improvement Act

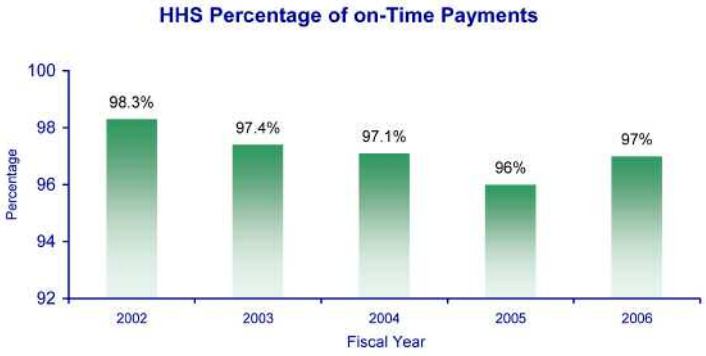
HHS manages its delinquent debt pursuant to the Debt Collection Improvement Act of 1996. HHS refers delinquent debt to the Department of the Treasury (Treasury) for cross-servicing and offset. The debt referral process is centralized through the Department's delinquent debt collection center. Treasury has granted a cross-servicing exemption for several types of program debts (e.g., Medicare Secondary Payer and various health professional loans). The Program Support Center cross-services these debts and also refers them to the Treasury Offset Program.



HHS referral rates at the end of the third quarter FY 2006 were: 99 percent of debt eligible for referral was referred to the Treasury Offset Program (a significant increase; and 97 percent of debt eligible for referral was cross-serviced. HHS collections exceeded $16.6 billion at the end of the third quarter FY 2006.

Prompt Payment Act

The Prompt Pay Act requires Federal agencies to make timely vendor payments and to pay interest penalties when payments are late. HHS reached a Department-wide record in FY 2002 by making over 98 percent of payments on time. Since then, HHS' prompt pay rate has decreased slightly. HHS' prompt pay rate at the end of FY 2006 was 97.5 percent.



Federal Civil Penalties Inflation Adjustment Act

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

Other Financial Information

Financial Related Measures

Performance Goal	FY 2006 Results	FY 2005 Results	FY 2004 Results	FY 2003 Results	FY 2002 Results	Comments
Submit Performance and Accountability Report on Time	Met	Met	Dec 8	Met	Met	Target Date Nov. 15
Retain Unqualified Audit Opinion	Met	Met	Met	Met	Met	Eighth Consecutive Year
Implement Unified Financial Management System	Met	Met	Met	Met	Met	See Note 1
Maximize Use of Electronic Payments	Met-T Not Met-V	Met-T Not Met-V	Not Met-T Not Met-V	Not Met-T Not Met-V	Not Met-T Not Met-V	See Note 2
Pay Vendors on Time	Not Met	Not Met	Met	Met	Met	See Note 3
Collect Debts Owed	Available in December	Met	Not Met	Met	Met	See Note 4
Resolve Non-Federal Audits Within 6 Months	Met	Met	Met	Not Met	Not Met	See Note 5

Notes

1. Significant milestones:

   FYs 2002-2004—Mock conversion, integration testing, performance testing, and user acceptance testing.

   FY 2005—Deployment of full financial functionality for CDC and FDA user communities of 3,000.

   FY 2006—Prepared for the deployment of HHS agencies serviced by the Program Support Center by completing integration testing in July, performance testing in August, and the final mock conversion and user acceptance testing in September.

   FY 2007—Deployment planned for the Office of the Secretary, HRSA, ACF, AHRQ, Federal Occupational Health, SAMHSA, AoA, and the PSC, adding 1,347 new users to the Unified Financial Management System.

2. Vendor and travel payments are made electronically. The travel payments target for FYs 2002-2004 was set, unrealistically, at 100 percent. Actual results ranged from 96 percent to 95 percent. In FY 2005, the target was reset to 96 percent, which was met in FYs 2005 and 2006. For vendor payments, the target of 95 percent for FYs 2002-2004 was raised to 96 percent in 2005. Actual results haven fallen short each year a few percentage points.

3. In FY 2005, the target was raised from 97 percent to 98 percent. The rate of on-time payments in 2005 was 97.1 percent and 97.5 percent for FY 2006, slightly less than the new target.

4. The target to collect 10 percent above prior year's collections was reset to 5 percent for FY 2005 as a result of the reduction in the receivable pool. The FY 2004 collections fell short of the target by $1.6 billion.

5. The baseline of 94 percent was established in FY 2003, to be increased 0.5 percent each year until 96 percent is achieved. In FY 2003, results fell short 0.4 percent and in FY 2002 the target was missed by 13.5 days; however, the target has been met since FY 2004. The FY 2006 results exceeded the target by 2.6 percent.

FMFIA Information

Federal Managers' Financial Integrity Act Report on Systems and Controls

HHS's management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the Federal Managers' Financial Integrity Act (FMFIA) and OMB Circular A-123, *Management's Responsibility for Internal Control,* dated December 21, 2004. The FMFIA requires agencies to provide an annual statement of assurance on the effectiveness of their management, administrative, and accounting controls (Section 2 of FMFIA), and financial management systems (Section 4 of FMFIA). The annual assurance statement for the Department is contained in Section I of this Report.

For FY 2006, HHS has a qualified statement of assurance that its internal controls and financial systems meet the objectives of FMFIA, except for the following three material weaknesses, two of which also constitute nonconformances under Section 4 of FMFIA::

A. Medicare Advantage and Prescription Drug Benefit Payments;

B. Financial Systems and Processes (nonconformance); and

C. Medicare Electronic Data Processing Operations (nonconformance).

Significant deficiencies in internal controls are considered material weaknesses; significant deficiencies in financial management systems are considered material nonconformances. FMFIA exceptions identified in FY 2006 and prior years are described below.

FMFIA Section 2 Material Weaknesses and Section 4 Nonconformances Outstanding					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Section 2 Material Weaknesses Outstanding					
From Prior Year	2	1	0	3	1[2] A
New	0	0	3	1[2]	1 C
Corrected/Reclassified	-1[1]	-1	-0	-3	1 B
Outstanding as of 9/30/2006					3
Section 4 Nonconformances Outstanding					
From Prior Year	1[1]	1	1	1	1 B
New	0	0	0	0	1[3] C
Corrected/Reclassified	0	0	0	0	0
Outstanding as of 9/30/2006					2

[1] Financial Systems and Processes (HHS-00-01). This single Section 4 finding reflects HHS' action during FY 2001, which formerly combined the following Section 2 material weakness findings into a single finding and reclassified the combined finding as a Section 4 nonconformance for tracking purposes. Financial Systems and Processes (HHS-00-01) and CMS Financial Systems. (CMS-01-01) (see 1B below)

[2] Medicare Advantage and Prescription Drug Benefit Payments. This is a Section 2 material weakness. CMS is continuing to work on remediation of the weakness. (HHS-05-01) (see 1A below)

[3] Medicare Electronic Data Processing Operations. There is a weakness in internal controls over the effectiveness and efficiency of EDP operations for Medicare (Section 2). CMS also has EDP systems that do not conform to the requirements of FFMIA (Section 4). The finding was a reportable condition in FY 2005, and was identified as a material weakness and noncomformance in FY 2006. (CMS-06-01) (see 1C below)

Status of Outstanding FMFIA Material Weaknesses or Nonconformances			
	Title and Identification Code	First FY Reported	Target Correction Date
Section 2			
1A	Medicare Advantage and Prescription Drug Benefit: Payments(HHS-05-01)	FY 2005	FY 2007
1B	Financial Systems and Processes (HHS-00-01)	FY 2001	FY 2009
1C	Medicare Electronic Data Processing Operations (CMS-06-01)	FY 2006	FY 2008
Section 4			
1B	Financial Systems and Processes (nonconformance) (HHS-00-01)	FY 2001	FY 2009
1C	Medicare Electronic Data Processing Operations (nonconformance) (CMS-06-01)	FY 2006	FY 2008

Section 2 Material Weakness

1A Medicare Advantage and Prescription Drug Benefit Payments (formerly Managed Care Benefit Expense Cycle) (CMS-05-01)

In FY 2005, a material weakness related to Medicare Advantage and Prescription Drug Benefit payments was identified. In FY 2006, the material weakness had not been corrected. The lack of integration of accounting processes within operating procedures and a comprehensive methodology for implementation of new payment systems related to Medicare Advantage and prescription drug organizations creates an environment where the high internal control risk is not sufficiently mitigated.

Corrective action will include documenting procedures and controls to determine the eligibility of organizations; improving oversight of providers; implementing adequate policies; documenting supervisory controls covering the authorization and payment process for the programs; and testing the adequacy of the internal controls implemented.

Section 2 Material Weakness and Section 4 Nonconformance

1B Financial Systems and Processes (HHS-00-01)

In FY 2005, a material weakness related to the Department's financial systems and processes was identified. In FY 2006, the material weakness had not been corrected. The lack of an integrated financial management system makes it difficult for the Department to prepare timely and reliable financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside the general ledger system are needed to produce the financial statements.

HHS is implementing the Unified Financial Management System (UFMS) to integrate Department-wide financial management systems and operations by aligning HHS' businesses with modern technological capabilities. UFMS will generate interim and annual financial statements, as well as other required external and internal financial reports. (More information on the UFMS can be found at UFMS website at http://www.hhs.gov/ufms/.)

By the end of FY 2006, CMS had successfully implemented HIGLAS at several Medicare contractor sites. Additionally, CDC and FDA had migrated to UFMS. In October 2006, PSC was brought "on-line" adding numerous Departmental components to the system including ACF, AoA, AHRQ, HRSA, and SAMHSA. IHS will be going on-line during FY 2007. CMS will continue its phased integration of Medicare Contractors into CMS Health Care Integrated General Ledger System (HIGLAS) as part of UFMS. HHS continues to analyze and review data in order to establish processes and procedures to reduce the amount of posting corrections and estimates necessary to prepare the financial statements.

Section 2 Material Weakness and Section 4 Nonconformance

1C Medicare Electronic Data Processing Operations (HHS 06-01)

In FY 2006, a material weakness related to the Centers for Medicare and Medicaid Services central office and (CMS) contractor sites related to electronic data processing operations was identified. Weaknesses were identified in logical access controls; application security, development, and program change control; and systems software. In addition, it was determined that EDP operations systems do not conform to the FFMIA requirements. This control area had been previously reported as a reportable condition in the Department's FY 2005 internal control report.

During FY 2007, the Department will be implementing a comprehensive strategy focusing efforts on both short term and mid-term actions to address the material weakness in this area. This effort will be continuing throughout FY 2007 and FY2008.

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The report also is available electronically at
http://www.hhs.gov/of/reports/account/index.html