

## **STRATEGIC GOAL 8:**

### **Achieve Excellence in Management Practices**

HHS is committed to improving the efficiency and effectiveness of the Department's programs by creating an organization that is citizen-based focus, results oriented, and market-driven, where practicable. The President's Management Agenda identifies key elements needed for HHS to achieve its commitment to effective management. In particular, HHS is dedicated to improving management of our financial resources; using competition to obtain the best price for services acquired; improving the management of our human capital and tying human capital goals to program performance goals; using technology wisely and in a cost effective manner; and achieving budget and performance integration.

This report highlights four programs that contribute to achieving this strategic goal including CMS Medicare Integrity Program (MIP), Medicaid, State Children's Health Insurance Program, and Office of Inspector General's (OIG) Health Care Fraud and Abuse Control Program. MIP ensures the right Medicare amounts are paid to a legitimate provider for an eligible beneficiary. Similarly, HCFAC conducts and supervises audits, inspections, and investigations of HHS programs and supplies guidance to the health care industry.

#### **Highlighted Programs**

- 8a: CMS Medicare Integrity Program
- 8b: CMS Medicaid and the State Children's Health Insurance Program
- 8c: OIG Health Care Fraud and Abuse Control Program

**8a Medicare Integrity Program**

*Centers for Medicare and Medicaid Services (CMS)*

**Significance**

One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. The significance of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program as reported in the CMS Financial Report.

The complexity of Medicare payment systems and policies, as well as the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented an Error Rate Reduction Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program	5.1 %	4.4%	Met
<b>Data Source:</b> Comprehensive Error Rate Testing Program and the Hospital Payment Monitoring Program			

**Result Analysis**

CMS began producing paid claims error rates in FY 2003 using the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The Office of Inspector General produced error rate information for years before those included in the FY 2003 report. In FY 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. In FY 2005, CMS exceeded its target of 7.9 percent with an error rate of 5.2 percent. Therefore, CMS adjusted its error rate targets downward for future years. In FY 2006, Medicare also exceeded its target of 5.1%, with an error rate of 4.4 percent.

Trends Performance Measure	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program	6.3 %	5.8 %	10.1 %	5.2 %	4.4%

**Data Collection**

CMS calculates the Medicare Fee-For-Service error rate using a methodology approved by the OIG. The methodology includes:

- Randomly selecting a sample of approximately 180,000 submitted claims;
- Requesting medical records from providers who submitted the claims; and
- Reviewing the claims and medical records for compliance with Medicare coverage, coding, and billing rules.

**Completeness and Reliability**

The data for this program are complete and reliable. CMS and the CERT contractors and HPMP contractors audit the data through ongoing quality control measures that include comparison of the number of claims in the CERT and HPMP universe (i.e., all claims Medicare contractors receive) to an independent CMS report of the number of claims Medicare contractors received and verification that paid amounts for sampled claims match independent CMS records of claims payments. The data are audited through the CMS Chief Financial Officer Report.

**8b CMS Medicaid and the State Children’s Health Insurance Program (SCHIP)**

*Centers for Medicare & Medicaid Services (CMS)*

**Significance**

CMS implemented the Payment Error Rate Measurement (PERM) program to comply with the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300).<sup>6</sup> In FY 2006, CMS implemented the PERM program in 17 States, using a national contracting strategy, to produce a Medicaid fee-for-service (FFS) error rate, which will be reported in the FY 2007 Performance and Accountability Report (PAR). In FY 2007, we plan to measure improper payments in the FFS, managed care, and eligibility components of Medicaid and SCHIP and report the national program error rates in the FY 2008 PAR.

The benefits to achieving these goals are that CMS will become fully compliant with the IPIA and States will be able to glean information from the reviews that can be used to formulate corrective actions designed to reduce improper payments in these programs. The value added to society is that the measurement will help to ensure that individuals and families are receiving the program benefits for which they are eligible.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Estimate the payment error rate in the Medicaid and SCHIP	Begin to implement error measurement for Medicaid fee-for-service in 17 States.	9/2007	Deferred
<b>Data Source:</b> Payment Error Rate Measurement Program.			

**Result Analysis**

The PERM program is a new program designed to produce national Medicaid and SCHIP error rates for each fiscal year measured. CMS met the target to implement the program in FY 2006 to measure Medicaid FFS error rates using a national contracting strategy. The results of this measurement, the national Medicaid FFS error rate, will be available September 2007.

Performance Goal	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Estimate the payment error rate in the Medicaid and SCHIP	N/A	N/A	N/A	N/A	9/2007

**Data Collection**

In FY 2006, CMS implemented the PERM program to measure improper payments in Medicaid FFS using a national contracting strategy. The contractors gather adjudicated claims data and medical policies from the States. The adjudicated claims are used to draw a sample of claims for review. The medical policies are used to guide the reviewers to a determination that the payment was correctly or incorrectly made based on medical necessity and appropriateness.

Each year 17 States will participate in the Medicaid measurement. At the end of a three-year period each State will have been measured once and will rotate in that cycle in future years (e.g., the States selected in year one will be measured again in year four).

<sup>6</sup> The IPIA requires each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to annually review all programs that it administers and identify programs that may be susceptible to significant improper payments. For those programs that are at risk, the agency shall estimate the annual amount of improper payments, and submit those estimates to Congress. OMB identified Medicaid and SCHIP as programs at risk for significant improper payments.

**Completeness**

The claims data collected from the States are reviewed by the Federal contractor for completeness. The contractor uses the State's prior fiscal year's expenditure data to determine if the universe and strata for each quarter's claims submission appears complete. The contractor also compares claims from each subsequent quarter to claims from the previous quarter(s).

The contractor also reviews the claims data to determine whether the data includes needed information, e.g., the payment dates are within the quarter, paid amounts are included; the categories of service correspond to the correct strata.

**Reliability**

The sample selected from the claims data from each State is designed to ensure a State-specific program error rate that meets a 95 percent confidence level with +/- 3 percent precision. The States' error rates will be used as the basis for the national Medicaid FFS error rate that we expect will meet the confidence and precision requirements in OMB guidance.

**8c Health Care Fraud and Abuse Control Program (HCFAC)**

*Office of Inspector General (OIG)*

**Significance**

The primary function of the OIG is to detect and prevent fraud and abuse and to recommend policies designed to promote economy, efficiency, and effectiveness in the administration of HHS and its programs. OIG accomplishes its purpose by conducting and supervising audits, inspections, and investigations of HHS programs, and providing guidance to the health care industry. Over 80 percent of FY 2006 OIG resources were devoted to combating fraud and abuse in health care, one of the largest segments of the United States economy and the largest programs under HHS management. OIG carries out its work through the Health Care Fraud and Abuse Control Program (HCFAC) of the Health Insurance Portability and Accountability Act of 1996, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and the Medicaid Integrity Program of the Deficit Reduction Act of 2005. The remaining OIG resources are devoted to other programs, including HHS public health and human services programs and general departmental oversight.

Return on Investment (ROI) is a performance measure that reveals the effectiveness and efficiency of OIG in helping to restrain the rising cost of the most expensive programs managed by HHS. It is a ratio that directly links the cost of operating the OIG to the financial savings to society that its audits, inspections, and investigations were instrumental in helping to bring about. Inasmuch as (1) it is impossible to predict the timing or amount of court ordered fines, penalties, restitution, out of court settlements, and audit disallowances, and (2) it takes several years for any specific instance of OIG work to show monetary results, substantial year to year fluctuation is inevitable. OIG addresses this by using annualized three-year moving averages for reporting monetary targets and documented results.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Return on Investment (ROI) <sup>7</sup>	\$11.9:1	\$12.9:1	Met
<b>Data Source:</b> Department of Justice and HHS data systems that track judicial and administrative obligations and audit receivables required to be paid to the Federal government			

**Result Analysis**

OIG’s annualized \$12.9:1 Return on Investment for the three-year period ended September 30, 2006 surpassed the target of \$11.9:1. This was achieved by documenting \$2.391 Billion of identified expected recoveries (the “return”) for FY 2006,. When the FY 2006 result is added to the FY 2004 and FY 2005 identified expected recoveries of \$2.760 Billion, and \$2.883 Billion, respectfully, the return for the three-year period ended September 30, 2006 averages \$2.678 Billion per year. The average annual “investment” in the OIG over this period was \$207.8 Million. The historical annualized three-year moving averages of actual results for the years ending FY 2002 to 2006 are in the following table

Performance Measure	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Return on Investment (ROI)	\$18.2:1	\$12.1:1	\$10.5:1	\$11.6:1	\$12.9:1

<sup>7</sup> The returns used for calculating ROI were redefined last year to exclude savings estimates scored by the Congressional Budget Office or HHS from enactment of legislation or adoption of administrative changes recommended by OIG. The returns are now limited to identify and document expected recoveries of funds that result from: (1) investigations that led to successful prosecutions of fraud or out of court settlements, and (2) audit disallowances.

**Data Collection and Completeness**

Actual expected recoveries that resulted from OIG investigations are identified by tracking cases as they proceed through the Department of Justice for a judicial decision or out of court settlement. Audit disallowances that are resolved and result in obligations to repay the Federal government are identified from the HHS audit resolution tracking system. These data collection sources are considered complete and accurate for tracking obligations to pay judicial and audit resolution obligations to the Federal government.

**Data Reliability**

The source data used for these results are the following: expected recoveries from investigations are entered into the OIG investigations data system "IRIS." Documents that officially report the conclusion of criminal and civil proceedings, including the amount of fines, penalties, and restitution must be received by OIG before the expected recoveries are allowed into the IRIS system. Audit disallowances are entered into the OIG WEB AIMS system by the Audit Resolution staff of the HHS Office of the Assistant Secretary for Resources and Technology, and are reconciled to the OIG audit disallowance issuances. The data have been audited in the past by the Government Accountability Office (GAO) and are available for GAO audit at any time.