Department of Health and Human Services

Agency Financial Report

FY 2017

Certificate of Excellence in Accountability Reporting

In May 2017, the United States Department of Health and Human Services (HHS) received the Certificate of Excellence in Accountability Reporting (CEAR) from the Association of Government Accountants (AGA) for its Fiscal Year (FY) 2016 Agency Financial Report. The CEAR Program was established by the AGA in collaboration with the Chief Financial Officers Council and the Office of Management and Budget to further performance and accountability reporting. Through the program, agencies improve accountability by streamlining reporting and improving the effectiveness of such reports to clearly show what an agency accomplished with taxpayer dollars and the challenges that remain. FY 2016 marked the fourth consecutive year the Department received this prestigious award.

AGA also presented HHS with a Best-In-Class Award for the Best Description of Financial Management Systems Strategy and Status.

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MESSAGE FROM THE ACTING SECRETARY

Eric D. Hargan

I am pleased to present the Fiscal Year (FY) 2017 Agency Financial Report for the U.S. Department of Health and Human Services (HHS). This report features our financial and performance highlights over the FY ending September 30, 2017.

Our mission at HHS is to enhance and protect the health and well-being of all Americans. We fulfill this mission by administering more than 300 programs across our Operating Divisions, providing for effective health care and human services, and fostering advances in the world of science.

In 2017, the Department took on a number of complex challenges and projects that have already yielded real benefits for the American people. Some of them include:

ReImagine HHS

In March, the President issued an Executive Order directing each department across the federal government to put together a plan to reorganize its operations with the goal of delivering critical services to the American people in the most efficient and effective manner possible. Pursuant to the President's call for each Cabinet Department to reform and reconsider how it is organized, HHS launched ReImagine HHS in April, our effort to evaluate how we can better perform our mission.

Through deep consultation with the career staff and the generation of hundreds of separate ideas, the Department has identified strategic shifts to transform how we operate. These shifts will create efficiencies within our Department, improve customer service for the American people, eliminate redundancies within our work and, most importantly, enable us to achieve our mission more effectively than we do today.

The goals of these shifts are to make HHS more effective at fulfilling our mission, more focused on serving the American people, and a better place to work.

Opioid Crisis

Opioid addiction is one of the most critical public health crises facing our nation, and addressing it is one of HHS's top priorities. The crisis has left no corner of America untouched, and each day we lose more than 175 Americans to drug overdoses while millions more struggle with opioid addiction.

In April, HHS outlined a new, comprehensive five-point strategy for combating the crisis: (1) improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatment; (2) targeting availability and distribution of overdose-reversing drugs; (3) strengthening public health data and reporting; (4) supporting cutting-edge research on pain and addiction; and (5) advancing the practice of pain management. As part of a holistic range of actions on this priority, HHS disbursed $811 million in grant funding specifically to fight the opioid epidemic in Fiscal Year 2017; more support than any previous year.

In August, the Centers for Disease Control and Prevention released a "Vital Signs" report showing the amount of opioids prescribed in the United States decreased each year from 2010 to 2015; however, the amount prescribed is still three times higher nationally than it was in 1999. Meanwhile, the number of overdose deaths in 2016 is expected to exceed the number from 2015, which in one year was roughly equivalent to the number of Americans who died in the entire Vietnam War.

HHS has actively supported the President's Commission on Combating Drug Addiction and the Opioid Crisis, which was established in March 2017 to study the scope and effectiveness of the federal response to this crisis and provide recommendations for improving the response. On October 26, 2017, we declared the opioid crisis a nationwide public health emergency. HHS will continue to contribute to this important effort as a key agency providing critical resources for care, treatment, and scientific advancement.

Health Care Reform

HHS is committed to ensuring that the American people have access to a health care system that provides high-quality care for the individual patient. The *Patient Protection and Affordable Care Act* (PPACA), as it stands, has presented major challenges to achieving that goal within certain parts of our health care system. The Department has taken numerous steps to increase choices within the constraints of the PPACA, including efforts to return states to their primary role as insurance regulators. HHS has also specifically encouraged states to pursue innovations within their Medicaid programs that enable patients to take charge of their own health care, through solutions such as health-savings-account-like programs for enrollees.

This approach also undergirds HHS's approach to Medicare. In 2018, the average premium for a Medicare Part D prescription drug plan is projected to decline. This is encouraging news for the nearly 43 million seniors who are enrolled in the program, and proof of the successes of a patient-centered, market-driven approach to health care. Meanwhile, enrollment in Medicare Advantage continues to grow, another sign of the appeal of health care plans that offer Americans real choices and private competition.

Lowering drug costs is a key principle of the Administration's efforts to address the challenges in our health care system, and HHS is committed to increasing the affordability and accessibility of care. HHS has initiated a broad effort to make drugs more affordable, particularly for America's seniors, including aggressive efforts at the Food and Drug Administration to boost competition in drug markets.

We remain committed to improving our health care system to better serve the American people. It is our goal to foster a patient-centered health care system where Americans have more choices and lower costs, and where patients, families, and doctors are in charge of medical decisions.

Hurricane Response

The 2017 hurricane season has been extremely active, bringing destructive storms to the Southeastern United States and the Caribbean. HHS plays four major roles in dealing with such serious storms. First, the Agency deploys medical assets, such as members of the Public Health Service Commissioned Corps, the National Disaster Medical System, and mobile hospitals, ready to move in and fill gaps left in a region's hospital system. Second, HHS provides data and expertise to first responders and local officials that aid them in identifying residents whose health may be especially impacted by the storm. Third, the Agency issues waivers in Medicare, Medicaid, and the Children's Health Insurance Program to enable people to get the care they need, and help to evacuate hospitals or move patients if needed. Finally, the Agency supplies recovery assistance to address ongoing public health, health care, and human services issues, from the threats of mosquito-borne diseases and food safety to maintaining continuity of social services for the elderly and disabled.

All four of these activities have been necessary for Hurricanes Harvey, Irma, and Maria. In addition to engaging in collaborative efforts across the Administration, we continue to work closely with state, tribal, county, and local officials to respond to their needs and to assist in rescue and recovery efforts. The HHS team is serving alongside the many heroic first responders and ordinary citizens in local communities to help alleviate the suffering brought on by these hurricanes.

We will continue to provide the proper resources to help restore health and social services to communities affected by Hurricanes Harvey, Irma, and Maria, and other emergencies still to come.

Fiscal Accountability

HHS is committed to ensuring transparency and accountability of the funds the public and Congress entrust to us. For the 18th consecutive year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed an opinion on the Sustainability financial statements which are comprised of the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2017 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" of this report includes more detailed information.

As required by the *Federal Managers' Financial Integrity Act of 1982* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, we also evaluated our internal controls and financial management systems. We identified two material noncompliances relating to Error Rate Measurement and the Medicare appeals process. The "Management's Discussion and Analysis" section of this report includes further details. Based on our internal assessments, I can provide reasonable assurance that the financial and performance information contained in this report is complete, reliable, and accurate.

Future Challenges and Priorities

While HHS takes great pride in our accomplishments this year, we believe there are plenty of opportunities for improvement. We worked closely with the Office of Inspector General to gain its perspective about our most significant management and performance challenges, which are presented in the "Other Information" section under *FY 2017 Top Management and Performance Challenges Identified by the Office of Inspector General*. We are committed to addressing these challenges, including delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity.

Conclusion

Employees of HHS are proud of the tremendous work they carried out in 2017 on behalf of our fellow Americans. Working with our partners and colleagues in Congress, we will continue our focus on improving how we enhance and protect the health and well-being of the American people in the years to come.

/Eric D. Hargan/

Eric D. Hargan
Acting Secretary
November 14, 2017

ABOUT THE AGENCY FINANCIAL REPORT

The HHS FY 2017 Agency Financial Report (AFR) provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2016, through September 30, 2017. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report in accordance with the requirements of Office of Management and Budget Circular A-136, *Financial Reporting Requirements.* This document consists of three primary sections and supplemental appendices.

Section 1: Management's Discussion and Analysis

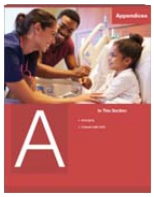
This section provides an overview of HHS's mission, activities, organizational structure, and program performance. It also includes an overview of the systems environment; a summary of the Department's financial results and compliance with laws and regulations; and provides management's assurances on HHS's internal control.

Section 2: Financial Section

This section begins with the independent auditor's report and management's response to the audit report. It also includes the financial statements with accompanying notes, and required supplementary information, including the Combining Statement of Budgetary Resources, Deferred Maintenance and Repairs, and Social Insurance information.

Section 3: Other Information

This section contains additional financial information and real property footprint data. It also includes a summary of the financial statement audit and management assurances, civil monetary penalties, grant closeout efficiencies, and a detailed payment integrity report. It concludes with the Inspector General's assessment of the Department's management and performance challenges.



Appendices

This section includes data that support the main sections of the AFR. This includes a glossary of acronyms used in the report and resources for connecting with the Department.

The Department has chosen to produce an AFR and *Annual Performance Plan and Report*. In conjunction with the release of the *President's Budget* in February 2018, additional reports that will be available on our website include:

1. FY 2019 *Annual Performance Plan and Report*
2. FY 2019 *Congressional Budget Justification*

Management's Discussion and Analysis

1

In This Section

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Looking Ahead to 2018
- Systems, Legal Compliance, and Internal Control
- Management Assurances
- Financial Summary and Highlights

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ABOUT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Our Mission

The mission of the United States (U.S.) Department of Health and Human Services (HHS or the Department) is to enhance the health and well-being of Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences, underlying medicine, public health, and social services.

Our Vision

The vision of HHS is to provide the building blocks that Americans need to live healthy, successful lives.

Who We Are

HHS is the U.S. government's principal agency for protecting the health of all Americans, providing essential human services, and promoting economic and social well-being for individuals, families, and communities, including seniors and individuals with disabilities. HHS is responsible for more than a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for 1 in 3 Americans.

What We Do

HHS works closely with state, local, and tribal governments; and many HHS-funded services are provided at the local level by state or county agencies, private sector grantees, tribes, tribal organizations, or Urban Indian organizations. The HHS Office of the Secretary and its 11 Operating Divisions (OpDivs) administer more than 300 programs covering a wide spectrum of activities. In addition to the services they deliver, HHS programs provide for equitable treatment of beneficiaries nationwide and enable the collection of national health and other data. HHS, through its programs and partnerships:

- Provides health care coverage to more than 100 million people through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
- Promotes patient safety and health care quality in health care settings and by health care providers, by assuring the safety, effectiveness, quality, and security of foods, drugs, vaccines, and medical devices;
- Conducts health and social science research with the largest source of funding for medical research in the world, while creating hundreds of thousands of high-quality jobs for scientists in universities and research institutions in every state across America and around the globe;
- Leverages health information technology to improve the quality of care and to use HHS data to drive innovative solutions to health, public health, and human services challenges;

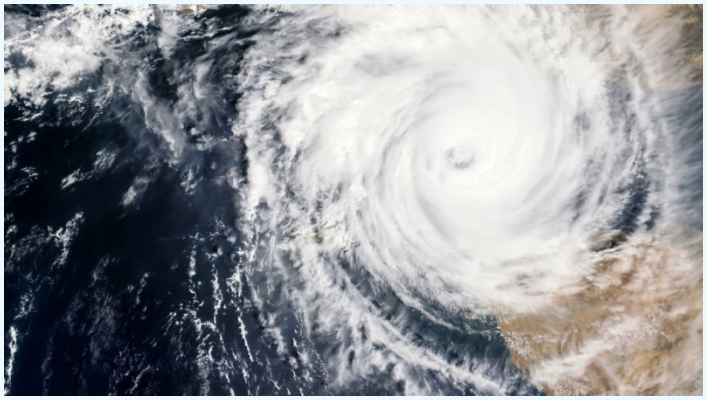
Did you know?

HHS got its start on April 11, 1953, as the Department of Health, Education and Welfare under President Dwight D. Eisenhower.

- Improves maternal and infant health; promotes the safety, well-being, and healthy development of children and youth; and supports young people's successful transition to adulthood;
- Supports wellness efforts across the life span, from protecting mental health, to preventing risky behaviors such as tobacco use and substance abuse, to promoting better nutrition and physical activity;
- Prevents and manages the impacts of infectious diseases and chronic diseases and conditions, including the top causes of disease, disability, and death;
- Prepares Americans for, protects Americans from, and provides comprehensive responses to health, safety, and security threats, both foreign and domestic, whether natural or man-made; and
- Serves as responsible stewards of the public's investments.

Did you know?

The Substance Abuse and Mental Health Services Administration's Disaster Distress Helpline is available to provide immediate crisis counseling for people experiencing emotional distress related to the California wildfires, the hurricanes impacting the Gulf Coast and Puerto Rico, or other disasters and traumatic events. Residents can call 800-985-5990 to speak with a trained crisis counselor, or to get help connecting with local behavioral health professionals.



Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework for sound business operations and management controls. The Office of the Secretary, with the Secretary, provides the overarching vision and strategic direction for the Department, and leads HHS and its 11 OpDivs to provide a wide range of services and benefits to the American people. The HHS organizational chart is presented on the next page.

*Components of the Public Health Service

Each OpDiv contributes to our mission and vision as follows:

Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. Visit ACF for more information.

Administration for Community Living (ACL) was created around the fundamental principle that all people, regardless of age or disability, should be able to live independently, and fully participate in their communities. By advocating for older adults and people with disabilities, and the families and caregivers of both across the federal government; funding services and support provided by networks of community-based organizations; and investing in research and innovation, ACL helps make this principle a reality for millions of Americans. Visit ACL for more information.

Agency for Healthcare Research and Quality (AHRQ) produces evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. This mission is supported by focusing on (1) improving health care quality, (2) making health care safer, (3) increasing accessibility, and (4) improving health care affordability, efficiency, and cost transparency. Visit AHRQ for more information.

Agency for Toxic Substances and Disease Registry (ATSDR) is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. Visit ATSDR for more information.

Centers for Disease Control and Prevention (CDC) collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC works to protect America from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, curable or preventable, human error or deliberate attack, CDC fights diseases and supports communities and citizens to do the same. Visit CDC for more information.

Centers for Medicare & Medicaid Services (CMS) administers Medicare, Medicaid, CHIP, and the Health Insurance Exchanges, which together provide health care coverage for more than 100 million people. CMS acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and to promote quality care for beneficiaries. Visit CMS for more information.

Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information it needs to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. Visit FDA for more information.

Health Resources and Services Administration (HRSA) is responsible for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, and economically or medically vulnerable. Visit HRSA for more information.

Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for the Indian people, with the goal of raising Indian health status to the highest possible level. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 36 states. Visit IHS for more information.

National Institutes of Health (NIH) seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. Visit NIH for more information.

Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. Visit SAMHSA for more information.

In addition, the following Staff Divisions (StaffDivs) report directly to the Secretary, managing programs and supporting the OpDivs in carrying out the Department's mission. The primary goal of the Department's StaffDivs is to provide leadership, direction, and policy and management guidance to the Department. The StaffDivs are:

- **Immediate Office of the Secretary (IOS)**. IOS oversees the Secretary's operations and coordinates the Secretary's work.
    - **The Executive Secretariat (ES).** ES manages the Department's policy review and decision-making processes, coordinating the development, clearance, and submission of all policy documents for the Secretary's review and approval.
    - **Office of Health Reform (OHR).** OHR helps guide and oversee the implementation of the health care legislation and policy.

  - **Office of Intergovernmental and External Affairs (IEA).** IEA represents both the government and external perspective in federal policymaking and clarifies the federal perspective to government officials and external parties.
  - **Office of the Chief Technology Officer (CTO).** CTO harnesses the power of data, technology, and innovation to create a more modern and effective government that works to improve the health of the nation.

- **Office of the Assistant Secretary for Administration (ASA)**. ASA provides leadership for HHS departmental management, including human resource policy and departmental operations.
  - **Program Support Center (PSC).** PSC is a shared services organization dedicated to providing support services to help its customers achieve mission-critical results.
- **Office of the Assistant Secretary for Financial Resources (ASFR)**. ASFR provides advice and guidance to the Secretary on budget, financial management, acquisition policy and support, grants management, and small business programs. It also directs and coordinates these activities throughout the Department.
- **Office of the Assistant Secretary for Health (OASH)**. OASH advises on the nation's public health and oversees HHS's U.S. Public Health Service for the Secretary.
- **Office of the Assistant Secretary for Legislation (ASL)**. ASL provides advice on legislation and facilitates communication between the Department and Congress.
- **Office of the Assistant Secretary for Planning and Evaluation (ASPE)**. ASPE advises on policy development and contributes to policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.
- **Office of the Assistant Secretary for Preparedness and Response (ASPR)**. ASPR advises on matters related to bioterrorism and other public health emergencies.
- **Office of the Assistant Secretary for Public Affairs (ASPA)**. ASPA provides centralized leadership and guidance on public affairs for HHS's StaffDivs, OpDivs, and regional offices. ASPA also administers the *Freedom of Information and Privacy Act*.
- **Office for Civil Rights (OCR)**. OCR enforces federal laws that prohibit discrimination by health care and human services providers that receive funds from HHS.
- **Departmental Appeals Board (DAB)**. DAB provides impartial review of disputed legal decisions involving HHS.
- **Office of the General Counsel (OGC)**. OGC provides quality representation and legal advice on a wide range of highly visible national issues.
- **Office of Global Affairs (OGA)**. OGA provides leadership and expertise in global health diplomacy and policy to protect the health and well-being of Americans.
- **Office of Inspector General (OIG)**. OIG protects the integrity of HHS programs as well as the health and welfare of the program participants.
- **Office of Medicare Hearings and Appeals (OMHA)**. OMHA administers nationwide hearings for the Medicare program.
- **Office of the National Coordinator for Health Information Technology (ONC)**. ONC provides counsel for the development and implementation of a national health information technology framework.

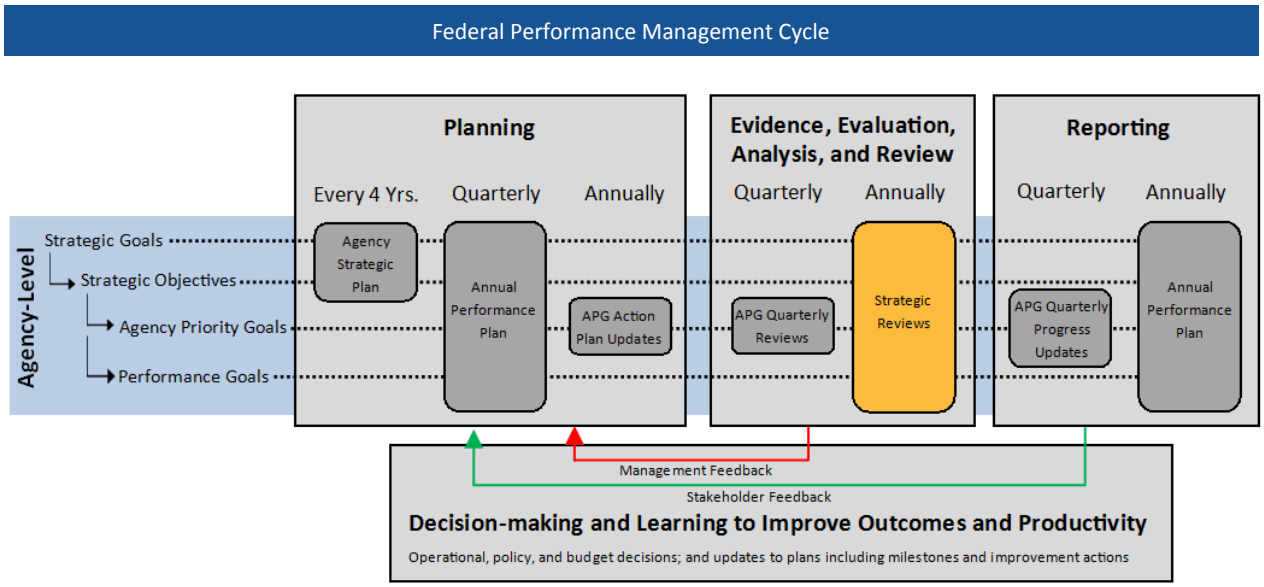
For more information regarding our organization, components, and programs, visit our website.

PERFORMANCE GOALS, OBJECTIVES, AND RESULTS

Overview of Strategic and Agency Priority Goals

Every 4 years, at the beginning of an Administration's new term, federal agencies update their strategic plans. Strategic plans present an organization's mission, vision, and the long-term objectives an agency hopes to accomplish, actions the agency will take in coordinating resources to realize those goals, and how the agency will address challenges or risks that hinder progress. An agency strategic plan is 1 of 3 main elements required by the *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010*.

HHS's strategic plan defines its mission, goals, and the means by which the Department will measure its progress in addressing specific national problems over a 4-year period. It also describes its work to address complex, multifaceted, and evolving health and human services issues. Each of the Department's OpDivs and StaffDivs contribute to the development of the strategic plan, as reflected in strategic goals, associated objectives, and strategies within each objective for accomplishing the strategic goals. Refer to the Federal Performance Management Cycle graphic below for details on the strategic plan process.



*Source: OMB Circular A-11, *Preparation, Submission and Execution of the Budget*

Strategic Goals

We are currently in the process of updating the HHS Strategic Plan Fiscal Year (FY) 2018 – 2022 (Plan). Under the *GPRA Modernization Act*, federal agencies are required to consult with Congress and to solicit and consider the views of external parties before updating their strategic plan. HHS is updating its Plan to reflect input received from the public and Congressional consultation that was conducted in the fall of 2017. The final Plan is expected to be published in February 2018, concurrent with the release of the *FY 2019 President's Budget*.

While the details of the Plan are still being refined, it will help guide the Department in fulfilling its mission. The mission of HHS is to enhance the health and well-being of Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. The Department accomplishes its mission by making strategic investments to protect the

health and well-being of Americans; delivering hope and healing to the American people; promoting patient-centered care; strengthening services to tribes; investing in the health of America's future; and ensuring responsible stewardship of taxpayer dollars for long-term sustainability. Achieving these goals will require HHS to make strategic investments and carry out our mission in the most effective manner possible. For more information about our strategic plans and investments, please visit the HHS Budget & Performance page.

Agency Priority Goals

Using the strategic goals and objectives established in the Plan, HHS begins its annual process to set and monitor performance goals and Agency Priority Goals (APGs). HHS uses APGs to improve performance and accountability, and develops APGs by collaborating across the Department to identify activities that reflect HHS priorities and activities benefiting from the focus of the APG process. These goals are ambitious but realistic performance objectives that the Department will strive to achieve within a 24-month period. The Department is currently in the process of developing APGs in support of the Plan. These new APGs will use the knowledge gained through collaboration and data-driven reviews of past processes to deliver results to the public. For more information on HHS's FY 2018 – 2019 APGs, please visit Performance.gov. Please note that Performance.gov is currently being revised as agencies update goals and objectives for release in February 2018 with the *FY 2019 President's Budget* submission to Congress. Please check periodically for updates. HHS performance initiatives, including APGs, continue to influence plans and policies that guide our future efforts.

Performance Management

HHS continues to engage with individuals across the federal performance management community to implement best practices and refine processes. These refinements and lessons learned have also influenced future plans and priorities. HHS actively monitors APG progress and works toward achieving our APGs through quarterly data-driven reviews and other mechanisms. Agencies are required to report quarterly APG progress updates on Performance.gov, and summarize the full year's past performance results in annual performance reports.

Performance Results

The performance results in this section represent a small sample of key HHS measures across the Department. For some of these measures, a data lag exists and some results are not yet known. This is reflected with "Pending" in the status field of the related measure. For more information on HHS performance measures across the Department, please refer to the HHS Budget & Performance page, expected to be updated in February 2018 concurrent with the *FY 2019 President's Budget*.

Serious Mental Illness. Individuals with serious mental illness are a high-need, high-cost population. They frequently use emergency departments and have high readmission rates to inpatient care, especially when co-occurring substance use disorders are present. In addition, people with serious mental illness often have co-morbid physical health conditions and shorter life expectancies than people without serious mental illness, primarily due to co-occurring physical health conditions that too often go unaddressed. Individuals with serious mental illness often experience barriers to treatment, including difficulty accessing and initiating treatment. Significant delays in the identification and treatment of serious mental illness are common; for example, research has repeatedly found that individuals with psychosis in the U.S. often do not receive appropriate treatment for that condition for 1 to 3 years. HHS's Serious Mental Illness Initiative builds on activities that are currently underway in various HHS agencies; these activities are coordinated through the HHS Behavioral Health Coordinating Council.

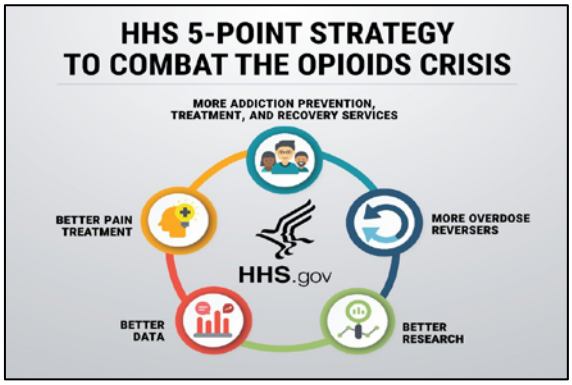
Increase access to early intervention services by increasing the number of states with early intervention programs

Unit of Measurement: States

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			N/A	13 states	30 states
Result			13 states	25 states	Sept 30, 2017
Status			Historical Actual	Target Exceeded	Pending*

*Data results were not available at the time of publication.

Opioid Morbidity and Mortality. Opioid abuse and overdose present a nationwide public health challenge. Death by drug overdose is the leading cause of injury death in the U.S., with deaths from opioids in particular increasing precipitously in the twenty-first century. Estimates for 2016 indicate that over 64,000 people in the U.S. died of a drug overdose, with the majority of these deaths involving opioids. Overdose deaths involving heroin have increased significantly in recent years, jumping by a factor of five between 2010 – 2016, while the surge of fentanyl use has been the main driver in increasing synthetic opioid deaths. Agencies across HHS recognize the urgency of halting the rise of opioid abuse and overdose, and are working to develop and implement the most effective interventions, from prevention through treatment, including making sure first responders are equipped with naloxone to use in emergencies. It should be noted that the historical results for the opioid performance measures were recalculated since originally reported. In previous years the entries reflected quarterly data rather than annual results. The reported results now reflect annual figures.



HHS 5-Point Strategy to Combat the Opioid Crisis

Decrease the total morphine milligram equivalents (MMEs) dispensed

Unit of Measurement: MMEs

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	N/A	N/A	N/A	201,741,825,837
Result	245,476,926,576	237,556,023,763	224,157,584,265	214,000,950,917	Nov 30, 2017
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending

Increase the number of prescriptions dispensed for naloxone

Unit of Measurement: Prescriptions

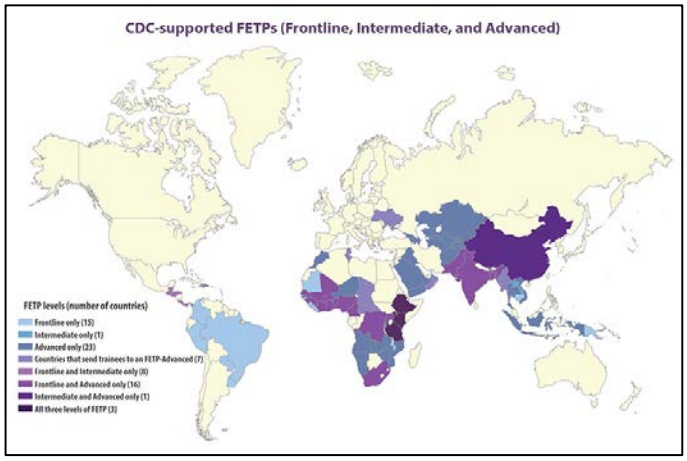
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	N/A	N/A	4,771	5,104
Result	1,585	6,575	26,223	99,407	Nov 30, 2017
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending

The FY 2017 APG target for the number of dispensed naloxone prescriptions is much lower (5,104) than the FY 2016 actual result (99,407). The FY 2017 goal was based on lower historical actuals from earlier years. Future goals will likely be significantly higher based on more recent higher historical actuals.

Increase the number of unique patients receiving prescriptions for buprenorphine (BUP) and naltrexone (NAL) in a retail setting

Unit of Measurement: Patients

	FY 2013	FY 2014 (BUP)	FY 2014 (NAL)	FY 2015 (BUP)	FY 2015 (NAL)	FY 2016 (BUP)	FY 2016 (NAL)	FY 2017 (BUP)	FY 2017 (NAL)
Target		N/A	N/A	N/A	N/A	915,207	112,398	958,788	117,750
Result		834,352	141,110	921,329	197,410	982,488	254,654	Nov 30, 2017	Nov 30, 2017
Status		Historical Actual	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending



Countries participating in FETPs as of April 2017

International Field Epidemiology Training Programs (FETPs). Since 1980, CDC has developed FETPs that have graduated over 3,700 epidemiologists in over 70 countries. Through FETPs, CDC helps establish a network of disease detectives around the globe to serve as the first line of defense in detecting and responding to outbreaks in their respective regions as well as neighboring countries. In FY 2016, there were 470 new residents of the FETP program, exceeding CDC's target for new residents by 40. On average, over 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions, such as the National Director of Tuberculosis program and National Director of Chronic Disease program in the Dominican Republic. Their presence strengthens global health ministries' ability to detect and respond to outbreaks and enhances sustainable public health capacity in these countries, which is critical in transitioning U.S.-led global health investments to long-term host-country ownership. FETP activities are supported by funding from CDC appropriations and inter-agency agreements with the Department of Defense, Department of State, and the U.S. Agency for International Development.

Increase epidemiology and laboratory capacity within global health ministries through the FETP New Residents

Unit of Measurement: New Residents

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	255	430	430	430	430
Result	300	402	483	470	June 30, 2018
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending

Reduction in Head Start Grantees Receiving a Low Score on the Classroom Assessment Scoring System (CLASS: Pre-K). ACF is striving to increase the percentage of Head Start children in high quality classrooms. CLASS: Pre-K is a research-based tool that measures, on a seven-point scale, teacher-child interaction in three broad domains: (1) Emotional Support, (2) Classroom Organization, and (3) Instructional Support. Progress is measured by reducing the proportion of Head Start grantees that score in the "low" range on any of the three domains. An analysis of CLASS scores for FY 2016 indicates that 24 percent of grantees scored in the "low" range, exceeding the target of 25 percent. All "low" range scores were in the Instructional Support domain.

ACF continues to invest in expanding its CLASS related resources and making those resources available to grantees. ACF provides more intentional targeted assistance to those grantees that score in the "low" range on CLASS. ACF continues to conduct more analysis on the specific dimensions that are particularly challenging for those grantees, such as concept development and language modeling, and tailor the technical assistance for grantees based on their specific needs.

Recent data analysis from the Family and Child Experience Survey (FACES), a federally funded nationally representative survey of Head Start programs, provides some evidence that grantee scores on CLASS domains have improved over time. This analysis demonstrates that over time fewer classrooms scored in the "low" range and more classrooms scored in the "mid" to "high" range on Instructional Support. FACES data also shows a statistically significant increase in the average score and the percentage of Head Start classrooms scoring three or higher on Instructional Support between 2006 and 2014. Overall, Head Start classrooms regularly score above a five (on a scale of one to seven) in Emotional Support and Classroom Organization. The FACES data analysis showed that over time fewer classrooms scored in the "mid" range and more classrooms scored in the "high" range on Emotional Support. FACES data also includes another measure of classroom quality using the Early Childhood Environment Rating Scale where items are rated on a seven-point scale, ranging from inadequate to excellent. There was a statistically significant increase of classrooms moving into the "good" and "excellent" category on the *Teaching and Environments* and *Provisions to Learning* items from 2006 to 2014. For example, the percent of classrooms in the "good" and "excellent" category in *Teaching and Environments* item moved from 13 percent in 2006 to 54 percent in 2014.

Reduce the proportion of Head Start grantees receiving a score in the low range on the basis of CLASS: Pre-K

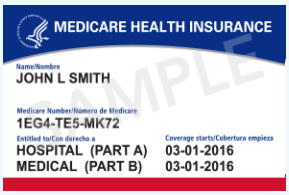
Unit of Measurement: Percent

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	23%	27%	26%	25%	24%
Result	31%	23%	22%	24%	Jan 31, 2018
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending

Medicare Fee-For-Service (FFS), Medicaid, and CHIP Improper Payment Rates. One of HHS's key goals is to pay Medicare, Medicaid, and CHIP 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 correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable dollars. The decrease from the prior year's reported Medicare FFS improper payment estimate of 11.00 percent was driven by a reduction in improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims. Although the improper payment rate for these services and the national Medicare FFS improper payment rate decreased, improper payments for home health, Skilled Nursing Facility, and IRF claims were the major contributing factors to the FY 2017 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors. HHS uses data from the Comprehensive Error Rate

Did you know?

New Medicare cards are coming. The new card contains a unique, randomly-assigned number that replaces the current Social Security-based number. The change will help to prevent fraud, fight identity theft, and protect taxpayer dollars.



Testing program and other sources of information to address improper payments in Medicare FFS through various corrective actions, such as policy clarifications and simplifications, when appropriate, as well as Probe and Educate reviews, which include more individualized education through smaller probe reviews, followed by specific education based on review findings. HHS is also continuing prior authorization initiatives, as appropriate, which help to make sure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to care and quality of care.

Since one-third of the states are measured annually to calculate the Medicaid and CHIP improper payment rates, these measures are calculated as a rolling rate that includes the reporting year and the previous 2 years. Similar to recent years, the driver of each rate was state difficulties complying with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Although the 17 states reviewed this year had better compliance results for Medicaid compared to their previously measured cycle, non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the Medicaid improper payment rate. Additionally, Medicaid improper payments due to no or insufficient medical documentation increased in FY 2017. For CHIP, the 17 states reviewed this year did not have better compliance results. A higher percentage of CHIP providers are not enrolled in Medicare and, therefore, there are more cases where states are not able to rely on provider screening conducted by Medicare and must conduct their own screening. Additionally, there was an increase in managed care improper payments in FY 2017 due to recipients that aged out of CHIP. States are required to develop and submit corrective action plans. HHS is working with states to improve compliance with the requirements and address all errors that contributed to the improper payment rates. Refer to "Section 3, Payment Integrity Report" for further details.

Reduce the Percentage of Improper Payments Made Under the Medicare FFS Program

Unit of Measurement: Percent

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	8.3%	9.9%	12.50%	11.50%	10.40%
Result	10.1%	12.7%	12.09%	11.00%	9.51%
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded

Reduce the Improper Payment Rate in the Medicaid Program

Unit of Measure: Percent

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6.4%	5.6%	6.70%	11.53%	9.57%
Result	5.8%	6.7%	9.78%	10.48%	10.10%
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Target Not Met

Reduce the Improper Payment Rate in CHIP

Unit of Measurement: Percent

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			6.50%	6.81%	7.38%
Result			6.80%	7.99%	8.64%
Status			Target Not Met	Target Not Met	Target Not Met

LOOKING AHEAD TO 2018

HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities. Eleven OpDivs, including eight agencies in the U.S. Public Health Service and three human services agencies, administer HHS's programs. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. In addition, StaffDivs provide leadership, direction, and policy guidance to the Department.

As described in the Performance Goals, Objectives and Results section, concurrent with the *FY 2019 President's Budget* submission, HHS will update its Strategic Plan to align with the priorities of this Administration. The Strategic Plan's goals and related objectives will drive HHS's service to the American people. Along with a new Strategic Plan, the next *President's Budget* submission will also include a new set of APGs. These goals are a set of ambitious but realistic performance objectives that the Department will strive to achieve within a 24-month period. These new APGs will use the knowledge gained through collaboration and data-driven reviews of past processes to deliver results to the public.

While the *Patient Protection and Affordable Care Act* (PPACA) is established law, health care reform to better serve the American people is expected. HHS remains committed to fostering a high-quality health care system that effectively and efficiently serves our citizens. We aim to facilitate a patient-centered approach that offers ample consumer choice and lower overall costs to stakeholders. Patients, families, and doctors should be in charge of the medical decisions impacting them. HHS will continue to work with states to advance their health-related programs, and to improve the accessibility and affordability of health care.

The Message from the Acting Secretary addresses one of the most pressing issues facing the American public—the ongoing opioid crisis. Acting Secretary Hargan took action on October 26, 2017, by declaring a nationwide public health emergency. According to the CDC, more than 175 Americans die every day from drug overdoses, with 91 of those deaths occurring specifically from opioids. HHS developed a five-point strategy to combat opioids, which includes the following steps:

- Improve access to prevention, treatment, and recovery support services;
- Target the availability and distribution of overdose-reversing drugs;
- Strengthen public health data and reporting;
- Support cutting-edge research on addiction and pain; and
- Advance the practice of pain management.

Acting Secretary Hargan signs public health emergency declaration in response to the opioid crisis.

The Administration has made combating opioid abuse and fighting addiction an Administration-wide effort and priority, and the Budget submission reflects this commitment. HHS will continue to invest in activities to fight opioid abuse, provide funding for substance abuse treatment, and seek to improve prescribing practices and the use of medication-assisted treatment.

SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL

Systems

Financial Systems Environment

HHS's Chief Financial Officer (CFO) Community strives to enhance and sustain a financial management environment that supports the HHS mission by promoting accountability and managing risk. To support this vision, the HHS financial systems environment forms the financial and accounting foundation for managing the $1.7 trillion in budgetary resources entrusted to the Department in FY 2017. These resources represent more than a quarter of all federal outlays and encompass more grant dollars than all other federal agencies combined.

The robust financial systems environment sustains HHS's diverse portfolio of mission-oriented programs, as well as business operations. Its purpose is to: efficiently process financial transactions in support of program activities and HHS's mission; provide complete and accurate financial information for decision-making; improve data integrity; strengthen internal control; and mitigate risk.

The HHS financial systems environment consists of a core financial system (with three instances) and two Department-wide reporting systems used for financial and managerial reporting that together support the Department's financial accounting and reporting needs.

Core Financial System

HHS's core financial system's three instances all operate on the same commercial off-the-shelf (COTS) platform to support data standardization and facilitate Department-wide reporting.

- The Healthcare Integrated General Ledger Accounting System (HIGLAS) supports CMS. HIGLAS serves CMS's Medicare Administrative Contractor organizations, Administrative Program Accounting, and the Center for Consumer Information and Insurance Oversight. It processes an average of five million transactions daily.
- The NIH Business System (NBS) combines NIH administrative processes and financial information under one centralized component, supporting NIH's diverse biomedical research program; and business, financial, acquisition and logistics requirements for 27 NIH Institutes and Centers. NBS supports grant funding to more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every state and around the world.
- The Unified Financial Management System (UFMS) serves 10 OpDivs (including the Office of the Secretary) and 14 StaffDivs across the Department. The following accounting centers utilize UFMS: CDC, FDA, IHS, and PSC. PSC provides shared service accounting support for all other Divisions utilizing UFMS.

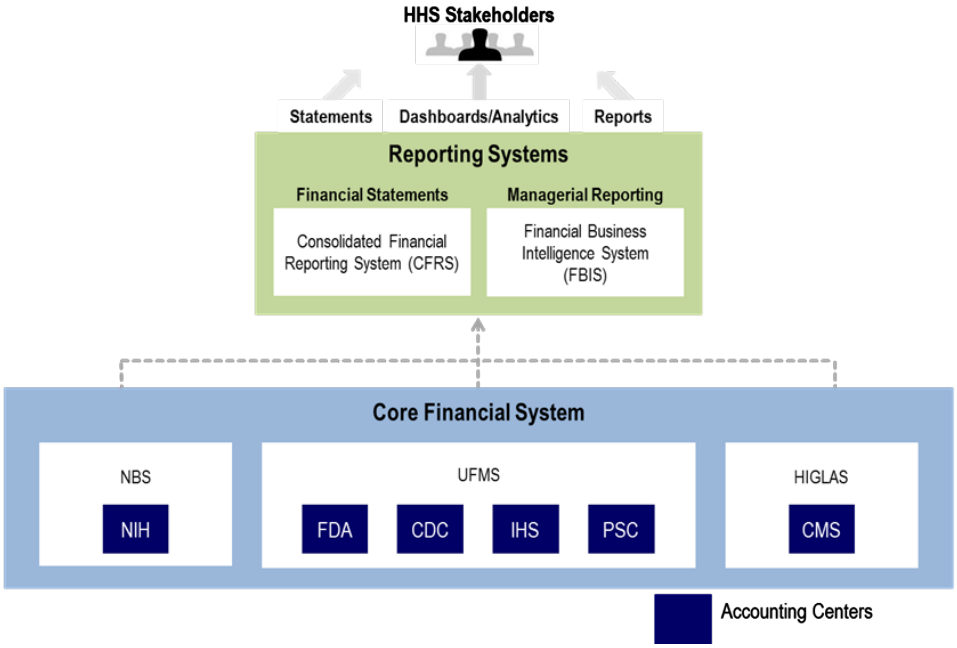
Reporting Systems

Reporting components within the HHS financial systems environment consist of two Department-wide applications: the Consolidated Financial Reporting System (CFRS) and the Financial Business Intelligence System (FBIS). These reporting systems facilitate data reconciliation, financial and managerial reporting, and data analysis.

- CFRS systematically consolidates information from all three instances of the core financial system. It generates Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis, while supporting HHS in meeting regulatory reporting requirements.
- FBIS is the financial enterprise business intelligence application that supports the information needs of HHS stakeholders at all levels by retrieving, combining, and consolidating data from the core financial

system. It provides tools for analyzing data and presenting actionable information including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting. FBIS enables executives, managers, and operational end users to make informed business decisions to support their organization's mission.

The figure below graphically depicts the current financial systems environment.



Relevant Legislation and Guidance

The HHS financial systems environment must comply with all relevant federal laws, regulations, and authoritative guidance. In addition, HHS must conform to federal financial management and systems requirements including:

- *Federal Managers' Financial Integrity Act of 1982*;
- *Chief Financial Officers Act of 1990*;
- *Government Management Reform Act of 1994*;
- *Federal Financial Management Improvement Act of 1996*;
- *Clinger-Cohen Act of 1996*;
- *Federal Information Security Management Act of 2002,* as amended by the *Federal Information Security Modernization Act of 2014*;
- *Digital Accountability and Transparency Act of 2014*;
- *Federal Information Technology Acquisition Reform Act of 2014*;
- *Fraud Reduction and Data Analytics Act of 2015*; and
- Office of Management and Budget (OMB) directives and U.S. Department of the Treasury (Treasury) guidance related to these laws.

Financial Systems Environment Improvement Strategy

HHS continues to implement a Department-wide strategy to advance its financial systems environment through the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program (FBIP). The portfolio of projects within these programs addresses immediate business needs and positions the Department to take advantage of state-of-the-art tools and technology. The goals of the strategy are to improve the effectiveness and efficiency of the Department's financial management capabilities, mature the overall financial systems

environment, and strengthen accountability and financial stewardship. This is a multi-year initiative, and the Department continues to make significant progress in each of the following key strategic areas.

Financial Systems Modernization

- *Strategy*: As a critical component of the multi-year initiative, the core financial system was upgraded to the most current version of its COTS software to maintain a secure and reliable financial systems environment. Concurrently, HHS also transitioned key financial systems to a cloud service provider for hosting and application management. With those major initiatives completed successfully, HHS is now directing resources towards incrementally improving the efficiency and effectiveness of the upgraded financial system. Taken together, these projects are designed to significantly mature the HHS financial systems environment, offering benefits that include: safeguarding system security and privacy; enhancing information access; complying with and implementing evolving federal requirements; achieving efficiencies and promoting standardization; eliminating security and control vulnerabilities; and maximizing the return on existing system investments.

- *Progress*: HHS completed the major upgrade of its core financial system in December 2015 and, as part of the upgrade, transitioned three key financial management systems – UFMS, FBIS, and CFRS – to a Federal Risk and Authorization Management Program certified cloud service provider. This year, HIGLAS was successfully migrated to a new, *Federal Information Security Management Act* High certified operating environment – completing the migration in just 7 months and processing over $2 billion in claims on the first day following go-live. With the financial system stabilized on the upgraded platform, particular focus was given in FY 2017 to strengthening the system security and control environment. This included implementing encryption and compression in key systems to secure data-at-rest, improve performance, and reduce the overall storage footprint; completing a major UFMS security redesign to resolve long-standing control weaknesses; and enabling single sign-on across multiple systems to meet federal requirements and enhance overall security posture. Maturing the financial system infrastructure, applications, and security controls has provided HHS with a strong foundation. Current FSIP projects – such as the recent completion of a business case for a Department-wide electronic invoicing solution – build on this foundation, improving business functionality, and enhancing the effectiveness and efficiency of the Department's financial management capabilities.

Business Intelligence and Analytics

- *Strategy*: Leveraging the FBIS platform, HHS is expanding the use of business intelligence and analytics across the Department to establish an information-driven financial management environment in which stakeholders at all levels have access to timely and accurate information required for measuring performance, increasing transparency, and enhancing decision-making. This will allow the Department to more effectively and sustainably meet evolving information demands for fiscal accountability, performance improvement, and external compliance requirements.

- *Progress*: Since first deployed in FY 2012, FBIS has been providing operational and business intelligence to users across the HHS financial management community. FBIS offers accurate, consistent, near real-time data from UFMS and NBS (together comprising five of HHS's six accounting centers) and summary data from HIGLAS, supporting over 2,100 users across the Department. Key accomplishments in FY 2017 include: integration of NBS transaction-level data and development of reconciliation dashboards prioritized by the NIH Office of Financial Management, as well as development of new global dashboards and reports that enable more efficient budget execution and tracking/closeout of unliquidated obligations. As FBIS continues to expand to include new users and business domains, HHS is also focused

on optimizing the underlying solution architecture to improve performance and take full advantage of the cutting-edge capabilities of the FBIS commercial cloud hosting environment.

Systems Policy, Security, and Controls

- *Strategy*: The reliability, availability, and security of HHS's financial systems are of paramount importance. HHS has placed a high-priority on enhancing its financial systems security and controls environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress toward remediating the Department's information technology (IT) material weakness. HHS has implemented a comprehensive, enterprise-wide financial systems policy, security, and controls program to mature and decrease risk across the environment.

- *Progress*: HHS addresses the Department's IT material weakness by analyzing internal and external audit findings, identifying root causes, and implementing solutions collaboratively. Persistent weaknesses are being addressed, with 86 percent of Federal Information System Controls Audit Manual (FISCAM) findings identified prior to FY 2014 not being reissued by the independent auditor. Targeted efforts are continuing to further reduce risk across the financial management systems portfolio, as the annual closure rate of findings in high-risk control areas (access controls, configuration management, and segregation of duties) has increased over 45 percent from FY 2013 to FY 2016. Initiatives in FY 2017 have significantly matured the Department-wide security and control environment, with system owners having completed corrective actions for 97 percent of FISCAM weaknesses identified through prior year's audit. Beyond simply tracking closure of individual weaknesses to assess progress, HHS also developed a comprehensive management framework – including evaluation criteria and target measurements – to better inform HHS leadership and other stakeholders of overall progress made, the current maturity level of the security and control environment, and the associated level of risk. The FY 2017 Assessment highlights HHS's demonstrated year-over-year progress since FY 2015 in remediating control deficiencies, institutionalizing governance and oversight, and strengthening the IT controls environment – providing management a holistic view of HHS's security and control posture, as well as aggregated data to substantiate assurances.

  To lead and sustain these efforts, the Financial Management Governance Board (FGB) chartered the IT Material Weakness Working Group (MWWG), with members from OpDiv CFO, Chief Information Officer (CIO), and Chief Information Security Officer communities. The IT MWWG has met monthly since FY 2015 and is executing against its planned roadmap to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. Working on two fronts – coordinating responsive efforts to address current audit findings as well as proactive efforts to mature the security and controls environment going forward – HHS is managing a portfolio of projects to address and minimize vulnerabilities and risks related to data and system security, access management, configuration management, and segregation of duties.

Governance

- *Strategy*: In November 2013, the Department established the FGB as an executive-level forum to address enterprise-wide issues, including those related to financial management policies and procedures, financial data, and technology. The FGB's goals include establishing HHS financial management governance; providing people, processes, and technology to support governance; engaging stakeholders through effective communication and management strategies; and supporting project alignment with federal and HHS mandates and priorities.

- *Progress:* The FGB has convened monthly and facilitated executive-level oversight of financial management-related areas. Its role and impact continue to grow since its inception 4 years ago. It promotes collaboration among stakeholders from the different disciplines within the financial

management community by engaging senior leadership from HHS OpDivs and StaffDivs and across functions such as finance, budget, grants, human resources, and IT. The FGB has effectively transformed the way in which financial management initiatives and activities are accomplished in HHS, moving from a Division-specific, vertical focus to a more enterprise-wide approach to solving problems and implementing standards for financial management excellence. Beyond improving collaboration and strengthening oversight across HHS's financial management and systems environment, the FGB serves as an advisory body, providing actionable recommendations to support project teams and guide future initiatives. Recent areas of focus have included risk and change management for the financial systems modernization effort, as well as forward-looking discussions on key topics – for example, shared services and financial transparency – that will inform strategic planning and enable the HHS financial management community to effectively address evolving opportunities and challenges.

Program Management

- *Strategy*: To support FSIP and FBIP, HHS established a Department-wide program management framework to facilitate effective implementation of projects and to enhance collaboration across project teams. This includes the Financial Systems Consortium: a body of federal project managers, contractors, and federal contracting officers representing NBS, UFMS, and HIGLAS, that fosters communication and implementation of program and project management best practices.

- *Progress*: Department-wide program management and the Financial Systems Consortium played critical roles in coordinating both the successful upgrade of the HHS core financial system and subsequent financial systems modernization projects. Within this framework, project teams are able to share industry best practices, lessons learned, and risks identified, while minimizing overall costs. This includes sharing solutions across system teams to streamline implementation, as well as coordinating vendor support to resolve software issues. Effective program management has reduced duplication of effort and costs by identifying potential sharing opportunities and improvements. Though developed initially to facilitate the major financial systems upgrade, both the Enterprise Program Management Office and the Financial Systems Consortium continue to exist as forums to support on-going collaboration and coordination across the financial systems environment and modernization initiatives.

Sharing Opportunities

- *Strategy*: As a key FSIP component, HHS is actively pursuing multiple initiatives to generate efficiencies and improve effectiveness through implementing shared solutions. The Department has also established a framework for continuously identifying sharing opportunities in its financial systems environment.

- *Progress*: Examples of sharing opportunities pursued to date include transitioning key financial systems to a cloud service provider; the use of shared acquisition contracts and streamlining of system operations and maintenance contracts; the implementation of a Department-wide Accounting Treatment Manual; consolidation of three legacy managerial reporting systems into FBIS; and sharing solutions across the HHS financial community. Currently, the HHS finance, acquisition, and IT communities are collaboratively pursuing a Department-wide solution for electronic invoicing, supporting compliance with OMB direction as well as specific business needs identified across HHS. The FGB continues to assess future sharing opportunities across the enterprise to further align with financial management and system policies, business processes and operations, and the overall financial system vision and architecture.

Legal Compliance

Anti-Deficiency Act

The *Anti-Deficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found on GAO - ADA.

HHS management is taking necessary steps to prevent violations. On August 1, 2016, the Director of OMB approved HHS's updated Administrative Control of Funds policy, as required by United States Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments." This policy provides HHS's guidelines to follow in budget execution and to specify basic fund control principles and concepts, including the administrative control of all funds for HHS and its OpDivs, StaffDivs, and Accounting Centers. With respect to two possible issues, we are working through investigations and further assessment where necessary. We remain fully committed to resolving these matters appropriately and complying with all aspects of the law.

Improper Payments Information Act of 2002, Improper Payments Elimination and Recovery Act of 2010, and Improper Payments Elimination and Recovery Improvement Act of 2012

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment. The *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA), requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments, test for improper payments in high risk programs, and develop and implement corrective action plans for high risk programs. HHS works to better detect and prevent improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.

HHS has shown tremendous leadership in the improper payments arena. HHS has a robust improper payments estimation and reporting process that has been in place for many years, and has taken many corrective actions to prevent and reduce improper payments in our programs. In compliance with the IPIA as amended, HHS completed 24 improper payment risk assessments in FY 2017 (representing risk assessments of programs and charge cards), and determined that these programs were not susceptible to significant improper payments. In addition, HHS is publishing improper payment estimates and associated information for nine high risk programs in this year's AFR, of which six programs reported lower improper payment rates in FY 2017 compared to FY 2016. Lastly, HHS also utilizes the Do Not Pay portal to check payments and awardees to identify potential improper payments or ineligible recipients. In FY 2017, HHS screened more than $419 billion in Treasury-disbursed payments through the Do Not Pay portal; HHS identified no improper payments. A detailed report of HHS's improper payment activities and performance is presented in the "Other Information" section of this AFR, under "Payment Integrity Report."

Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* (PPACA) established Health Insurance Exchanges through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in Qualified Health Plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit (PTC) to reduce their costs for health insurance premiums. PTCs can be paid in advance directly to the consumer's QHP insurer. Consumers then claim the PTC on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service on this process.

The PPACA also included provisions that address fraud and abuse in health care by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, and enhancing the monitoring of

providers. These authorities have facilitated the government's efforts to reduce improper payments. For detailed information on improper payment efforts, see "Section 3, Payment Integrity Report."

Digital Accountability and Transparency Act of 2014

The *Digital Accountability and Transparency Act of 2014* (DATA Act) expands the *Federal Funding Accountability and Transparency Act of 2006* (FFATA) to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the federal government to use governmentwide data standards for developing and publishing reports, and to make more information, including award-related data, available on USAspending.gov. Among other goals, the DATA Act aims to improve the quality of the information on USAspending.gov, as verified through regular reviews of posted data, and to streamline and simplify reporting requirements through clear data standards. Additionally, the DATA Act accelerated the referral of delinquent debt owed to the federal government to the Treasury's Offset Program after 120 days of delinquency.

Since 2014, HHS has played an integral role in the iterative development of data requirements and policy, utilizing internal and governmentwide working groups to analyze and provide feedback to the Treasury. HHS provided feedback on policy guidance through formal OMB policy review periods and by actively participating in various forums such as OMB Office Hours, Senior Accountable Official calls, and DATA Act Tech Thursdays. These forums help shape the evolution of the governmentwide DATA Act implementation and enhance existing FFATA reporting by providing a platform in which federal agencies collaborate and share information. HHS also collaborated extensively within the Interagency Advisory Committee, which represents the federal communities impacted by the DATA Act, to provide substantive community-specific and cross-cutting feedback to OMB and Treasury in support of governmentwide standardization and related policy considerations.

To support the initial DATA Act reporting requirements for May 2017, HHS established solution teams aligned with the Financial Management, Financial Assistance, Acquisition and Budget business lines that are operationally responsible for generating and validating submissions to ensure transparency, consistency, and compliance. HHS also established working groups to target specific challenges such as Award ID linkage, Aggregated Data, and Activity Address Code. The HHS DATA Act Program Management Office (DAP) continued work with these solution teams and working groups to coordinate overall activities and track progress towards completing key HHS milestones. These efforts enabled HHS to compile data consistent with submission requirements and to iteratively test this data using the DATA Act Information Model Schema available on its new USAspending.gov (Beta)[1] to support initial compliance with the DATA Act. Finally, HHS executed the implementation strategy by leveraging existing processes for data validation, error handling, and internal controls in order to effectively identify and address data discrepancies in a timely manner and build the certification process for DATA Act reporting in May 2017. This enabled HHS to successfully complete the initial submission and certification in April 2017 for second quarter FY 2017 data as well as subsequent reporting in August 2017 for third quarter data.

The DATA Act aims to standardize data and make it more transparent to the public by requiring the federal government to establish governmentwide data standards and publish all appropriate federal spending data so that it is accessible, searchable, and reliable. The information is now available, to the public for searching and extracting spending data across the government. Previously, data had been published over contract and grant awards, now users have access to a broader scope of information that includes funding and financing, program-level spending, and links to supplemental data sources such as vendor data. The new website provides graphics that interactively display funds available, program size, recipient distribution, and much more. For further details on how to explore the data, see USAspending.gov (Beta)[1].

[1] At the time of this AFR's publication, data on the new USASpending site was accessible for the public's interaction and viewing; however, the site was formally still in "beta" phase. There are plans to transfer the pre-2017 data on the existing USASpending site once the new (beta) USASpending site is fully functional.

Section 5 of the DATA Act calls for a Grants Pilot to help form recommendations to Congress on methods for (1) standardized reporting; (2) elimination of duplication; and (3) reduction of compliance costs. The Grants Pilot was divided into a Grants portion led by HHS and a Contracts portion led by OMB/Office of Federal Procurement Policy. Since May 2015, HHS worked in partnership with OMB, as its executing agent for the Grants Section 5 Pilot, to develop and execute pilot test models that focus on finding ways to promote government efficiency and improve the public's experience throughout the grants lifecycle. Test Models include the Common Data Element Repository Library, Consolidated Federal Financial Reporting, Single Audit, Notice of Award - Proof of Concept, and Learn Grants. DAP used these existing tools, forms, and/or processes to collaborate with stakeholders in ascertaining where grant recipient burden could be reduced.

HHS engaged the public in this area collecting data through May 2017. The test model results collected by HHS between May 2016 and May 2017 were summarized in OMB's report to Congress for legislative action including, but not limited to, consolidating/automating aspects of the federal financial reporting process, simplifying reporting requirements for federal awards, and improving financial transparency. As a result of its efforts, HHS was able to provide OMB with six actionable recommendations based on the areas covered under the Grants portion of this Pilot.

These separately run Pilots culminated in a final report to Congress outlining three overarching recommendations that were based on common themes recognized independently within both the Grants and Contracts pilots. The Report to Congress: DATA Act Pilot Program was submitted to Congress in August of 2017.

Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA), enacted on December 19, 2014, established an enterprise-wide approach to federal IT investments and provides the CIO of CFO Act agencies with greater authority over IT investments, including authoritative oversight of IT budgets and budget execution, and IT-related personnel practices and decisions.

As part of OMB's approval of HHS's FITARA Implementation Plan, one of the four conditions was for HHS to publicly post a revised HHS IT Governance Framework. In the fall of 2016, HHS revised its IT Governance Framework, which establishes the Department's approach for overseeing and managing IT. The HHS CIO completed all 39 elements and actions from the HHS FITARA Implementation Plan. The HHS CIO issued 10 delegations of authority to the HHS OpDiv CIOs, conducted annual reviews of all IT budgets, and reviewed all major IT acquisitions. In addition, the CIO made progress on the Data Center Optimization Initiative Strategic Plan, enhanced transparency and IT risk management processes, and initiated a Department-wide effort focused on software license management. FITARA implementation has strengthened relationships with the OpDivs as well as the CFO, Chief Human Capital Officer, and the Chief Acquisition Officer.

HHS developed a FITARA Dashboard based on legislative metrics, and will further engage the OpDivs in identifying additional metrics to demonstrate HHS's progress in FITARA. In FY 2018, HHS will focus on improving the metrics for CIO authority enhancements, transparency and risk management, portfolio review, data center optimization, and the software license management. For more information on HHS's progress with implementing FITARA requirements, please visit Digital Strategy at HHS.

Fraud Reduction and Data Analytics Act of 2015

The Department has engaged in various fraud reduction efforts, including activities to meet the requirements under the *Fraud Reduction and Data Analytics Act of 2015* (FRDAA), which was enacted in June 2016. In FY 2017, HHS participated with OMB and other agencies in the working group required by FRDAA. As part of this working group, OMB submitted an implementation plan to Congress in May 2017 for an interagency library of data

analytics and data sets as required by the law. HHS will also continue working with OMB and other agencies to implement the FRDAA by participating in the OMB-led inter-agency working group.

In addition to the OMB-led efforts to implement the FRDAA, HHS also has other activities underway to meet the intent of the new law. First, in accordance with the law and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, HHS's internal control assessments include the consideration of fraud and financial management risks, as well as the control activities designed to mitigate these risks. Second, HHS is reviewing and updating its financial policies, as needed, which will help to address the law's requirements. Third, HHS continues to take steps to implement leading practices in fraud risk management, per the Government Accountability Office's (GAO) *Fraud Risk Management Framework and Selected Leading Practices* published in July 2015. As recommended by GAO, HHS is assessing the federally facilitated exchange's fraud risk, leveraging GAO's fraud risk framework to identify and prioritize key areas of potential risk. When this assessment is complete, HHS will apply the lessons learned in assessing this program to fraud risk assessments of other programs.

Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to annually evaluate and assert on the effectiveness and efficiency of their internal control and financial management systems. Agency heads must annually provide a statement on whether there is reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to governmentwide requirements. Section 2 of FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, GAO released an updated edition of its *Standards of Internal Control in the Federal Government*, effective FY 2016. The document takes a principles-based approach to internal control, with a balanced focus over operations, reporting, and compliance. In July 2016, OMB released revised Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. The new Circular complements GAO's *Standards*, and it implements requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of Enterprise Risk Management. The Department with its OpDiv and StaffDiv stakeholders are working together to implement the new requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring that agencies implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to risk management. Based on thorough ongoing internal assessments and FY 2017 audit findings, HHS provides reasonable assurance that controls are operating effectively. For further information, see the "Management Assurances" section. We are actively engaged with our OpDivs to correct the identified material weaknesses through a corrective action process focused on addressing the true root cause of deficiencies, and supported by active management oversight. More information on the Department's internal control efforts and the HHS Statement of Assurance follows.

Internal Control

FMFIA requires agency heads to annually evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS performs rigorous, risk-based evaluations of its internal controls in compliance with OMB Circular A-123*, Management's Responsibility for Enterprise Risk Management and Internal Control*.

HHS management is directly responsible for establishing and maintaining effective internal controls in their respective areas of responsibility. As part of this responsibility, management regularly evaluates internal control and HHS executive leadership provides annual assurance statements reporting on the effectiveness of controls at meeting objectives. The HHS Risk Management and Financial Oversight Board evaluates the OpDivs' management assurances and recommends a Department assurance for the Secretary's consideration and approval, resulting in the Secretary's annual Statement of Assurance.

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2017 OMB Circular A-123 assessment recognizes one material noncompliance with IPIA regarding Error Rate Measurement and one material noncompliance with the *Social Security Act* related to the Medicare appeals process. Beginning in FY 2015, HHS implemented a comprehensive strategy to strengthen the HHS Financial Systems Controls Environment and address the IT material weakness. Since then, significant progress has been made in resolving audit findings, reducing risk across the operating environment, and maturing the security and controls posture of HHS's financial systems. As part of the strategy, HHS established a Management Assessment Framework that defines the conditions and criteria to evaluate the severity of control deficiencies found in Information System Controls and Security in HHS's financial systems. Evaluation criteria include four key components: (1) Leadership Commitment and Sustained Governance; (2) Reduced Risk through Corrective Actions; (3) Demonstrated Measurable Remediation Progress; and (4) Mature Controls Environment. While control deficiencies still exist across several HHS FISCAM systems, our evaluation based on the HHS Management Assessment Framework demonstrates that these deficiencies, in aggregate, no longer rise to the level of a "material weakness" under OMB Circular A-123, as of September 30, 2017.

Maintaining integrity and accountability in all programs and operations is critical to HHS's mission and demonstrates responsible stewardship over assets and resources. It also promotes responsible leadership, ensures the effective delivery of high quality services to the American people, and maximizes desired program outcomes.

MANAGEMENT ASSURANCES

Statement of Assurance

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Washington, DC 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA). These objectives are to ensure (1) effective and efficient operations; (2) reliable financial reporting; and (3) compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives.

HHS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2017, with the exception of two material noncompliances: one involving noncompliance with the *Improper Payments Information Act* (IPIA) related to Error Rate Measurement, and the second involving noncompliance with the *Social Security Act* related to the Medicare appeals process.

HHS is taking steps to address the material noncompliance related to the Medicare appeals process, as described in the "Corrective Action Plans for Material Weaknesses" section. Remediation for the material noncompliance related to Error Rate Measurement relies on a modification to legislation to require states to participate in an improper payment rate measurement.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. HHS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMIA and substantially conform to the objectives of FMFIA, Section 4.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars, and strive for the continuing progress and enhancement of its internal control and financial management programs.

/Eric D. Hargan/

Eric D. Hargan
Acting Secretary
November 14, 2017

Summary of Material Weaknesses

1. Error Rate Measurement

HHS reports a statutory limitation relating to the Temporary Assistance for Needy Families (TANF) program that results in a material noncompliance with IPIA. The TANF program is not reporting an error rate for FY 2017, as required by IPIA, because statutory limitations currently preclude HHS from requiring states to provide information needed for determining a TANF improper payment measurement.

2. Medicare Appeals Process

Several factors, including the growth in Medicare claims and HHS's continued investment and focus on ensuring program integrity, have led to more appeals than Levels 3 and 4 of the Medicare appeals process can adjudicate within the timeframes required by the *Social Security Act*.

From FY 2010 through FY 2016 (most recent complete year data available), the HHS Office of Medicare Hearings and Appeals (OMHA) experienced an overall 315 percent increase in the number of Level 3 appeals received annually. During the same timeframe, the HHS Departmental Appeals Board (DAB) experienced an overall 405 percent increase in the number of Level 4 appeals it received annually. However, while the volume of appeals has increased dramatically, funding has remained comparatively stagnant for the relevant OMHA and DAB operations. As a result, at the end of FY 2017, approximately 532,000 appeals were waiting to be adjudicated by OMHA and over 29,000 appeals were waiting to be reviewed at the DAB Medicare Appeals Council. This has led to the inability to meet statutory decisional timeframes of 90 days at Levels 3 and 4 of the Medicare appeals process.

Corrective Action Plans for Material Weaknesses

1. Error Rate Measurement

Current statutory limitations restrict corrective actions HHS can take to develop an error rate for TANF. HHS plans to work with Congress to consider statutory modifications that would allow for greater accountability, including a reliable error rate measurement if appropriate when legislation is considered to reauthorize TANF.

2. Medicare Appeals Process

HHS has a strategy to improve the Medicare Appeals process by investing new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; taking administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and proposing legislative reforms that provide additional funding and new authorities to address the appeals volume.

HHS has undertaken, and continues to explore new administrative actions expected to have a favorable impact on the Medicare Appeals Backlog. Under current resources and continuing ongoing administrative actions (and without receiving any additional appeals), it would take 7 years for OMHA and 12 years for the DAB Medicare Appeals Council to process their respective backlogs. The *FY 2018 President's Budget* request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA. It also provides additional funding for the Medicare Appeals process, along with new authorities that will help resolve the backlog. With both funding and authorities in place, HHS projects that the backlog will be resolved at some point after FY 2021 at the earliest.

FINANCIAL SUMMARY AND HIGHLIGHTS

HHS received an unmodified audit opinion on the principal financial statements and notes[2] for the year ending September 30, 2017. This is the 18th year for an unmodified opinion. HHS takes pride in the preparation of the financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the principal financial statements, which include the Consolidated Balance Sheets, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as selected notes to the principal financial statements. HHS presents these in the "Financial Section" of this report. Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2016 Financial Report of the United States Government*, HHS's net operating cost was larger than any single agency across the entire federal government[3]. A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv, this is CMS. CMS alone consistently stewards the largest share of HHS's resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

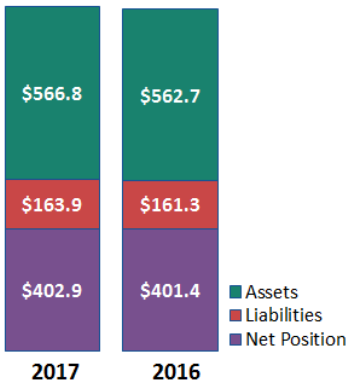
Balance Sheets

To communicate performance for HHS at fiscal year-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2017 and FY 2016 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Financial Condition Summary
(in Billions)

	2017	2016	$ Change (2017-2016)	% Change (2017-2016)
Fund Balance with Treasury	$ 209.8	$ 237.8	$ (28.0)	(12)%
Investments, Net	275.5	262.1	13.4	5%
Accounts Receivable	34.0	25.2	8.8	35%
Advances	31.1	21.7	9.4	43%
Other Assets	16.4	15.9	0.5	3%
Total Assets	$ 566.8	$ 562.7	$ 4.1	1%
Accounts Payable	$ 1.3	$ 1.3	$0.0	0%
Entitlement Benefits Due and Payable	108.3	108.2	0.1	0%*
Accrued Liabilities	11.9	14.4	(2.5)	(17)%
Federal Employee and Veterans' Benefits	13.5	12.9	0.6	5%
Other Liabilities	28.9	24.5	4.4	18%
Total Liabilities	$ 163.9	$ 161.3	$ 2.6	2%
Net Position	$ 402.9	$ 401.4	$ 1.5	0%*
Total Liabilities & Net Position	$ 566.8	$ 562.7	$ 4.1	1%

*Change is less than one percent



[2] Due to the uncertainty of the long-range assumptions used in the Statement of Social Insurance model, the auditors were not able to express an opinion on the Statement of Social Insurance, the Statement of Changes in Social Insurance Amounts, and associated footnotes.

[3] HHS's net cost is 24 percent of the federal government's total costs, the Social Security Administration's net costs is 22 percent, Department of Veterans Affairs's net cost is 15 percent, Department of Defense's net cost is 14 percent, and Treasury's Interest on Treasury Security Held by the Public's net cost is 6 percent. All remaining agencies combined only represent 18 percent. Source: *FY 2016 Financial Report of the United States Government*

Assets

The total Assets for HHS were $566.8 billion at year-end, representing the value of what HHS owns and manages. This is an increase of approximately $4.1 billion or 1 percent over September 30, 2016.

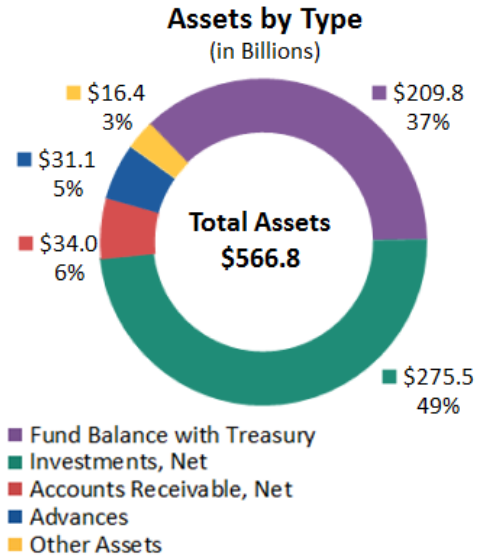
The Fund Balance with Treasury (FBwT) line contains the largest net change between FY 2017 and FY 2016 with a $28.0 billion or 12 percent decrease. This primarily consists of a $24.3 billion decrease for the Supplemental Medical Insurance (SMI) due to increased return of cancelled and indefinite authority of $19.8 billion.

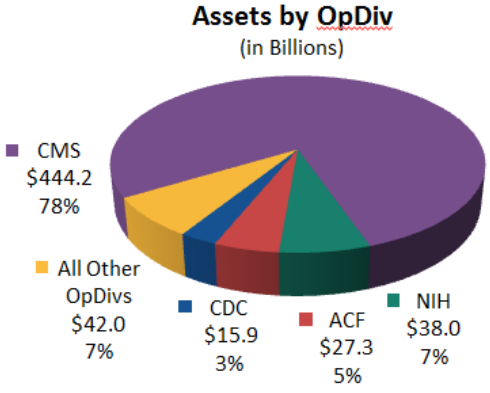
Investments, Net and FBwT comprise $485.3 billion or 86 percent of HHS's total assets, which is a 3 percent decrease. The FBwT decrease mentioned above was offset by increases in the remaining asset categories. Investments had an increase of $13.4 billion mostly due to CMS increases in Medicare Hospital Insurance (HI) of $7.3 billion and SMI of $5.6 billion.

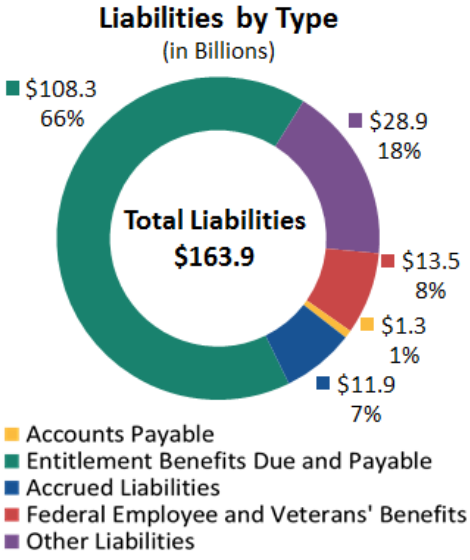
The HHS "Assets by OpDiv" chart demonstrates asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $337.4 million at AHRQ (shown in All Other OpDivs) to $444.2 billion at CMS. ACF had one of the largest percentage and dollar value asset increases at $2.9 billion or 12 percent over FY 2016 mostly due to an expansion of the TANF program and additional resources provided to Foster Care, Children and Family Services, and Child Support Enforcement.

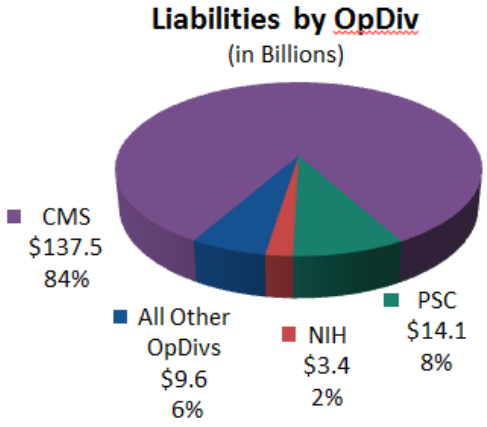
Liabilities

The total Liabilities for HHS were $163.9 billion at year-end, representing the amounts HHS owes from past transactions or events. This represents an increase of $2.6 billion or 2 percent over September 30, 2016. The increase can be found in the Other Liabilities line, with an increase of $4.4 billion or 18 percent from FY 2016. This increase is mainly due to Contingencies and Commitments of $2.4 billion mostly from Medicaid State Plan Amendments, and Other Liabilities of $2.0 billion mostly due to the *Hold Harmless Provision Act* related to Medicare Part B premium increases. These increases are offset by a decrease of $2.5 billion in Accrued Liabilities due to CMS no longer recording accruals for the Reinsurance program since the program ended in December 2016.





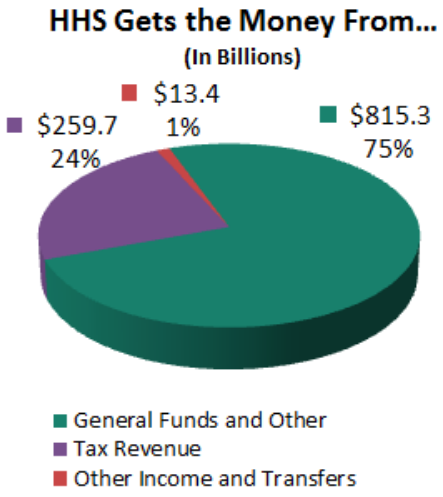




The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports $137.5 billion or 84 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $32.2 million. Other than CMS, PSC had the largest OpDiv dollar value increase in liabilities over FY 2016 of $724 million. Of which, $634 million is an increase to the Commissioned Corps pension liability to capture updated estimates based on mid-year and year-end reviews of the pension liability.

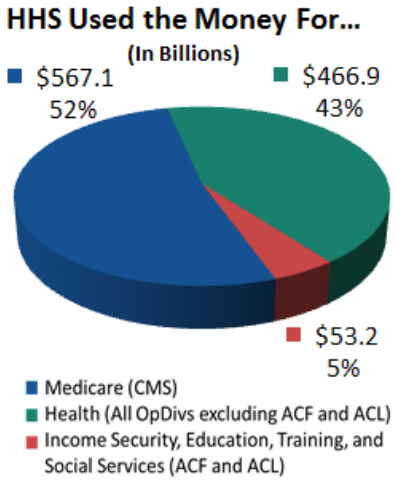
Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities.



Changes in assets are shown by breaking out where HHS gets the money from, known as financing sources. Total financing sources include both the Total Financing Sources and Total Budgetary Sources lines from the Statement of Changes in Net Position.

HHS receives the majority of the funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS's largest financing source, General Funds and Other, decreased since FY 2016 by $21.1 billion or 3 percent from $836.4 billion to $815.3 billion. Fluctuations in tax revenue collected are due to *Federal Insurance Contributions Act* (FICA) and *Self Employed Contributions Act* (SECA) increases. The increase in tax revenue of $9.3 billion or 4 percent is comparable to the prior year 5 percent increase in tax revenue.



Statement of Net Cost

The Consolidated Statement of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS's programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2017, totaled approximately $1.1 trillion. The "HHS Used the Money For …" chart shows consolidating costs by major budget function[4], which are the categories displayed in the federal budget. Most agencies have one or two budget functions, where HHS has many.

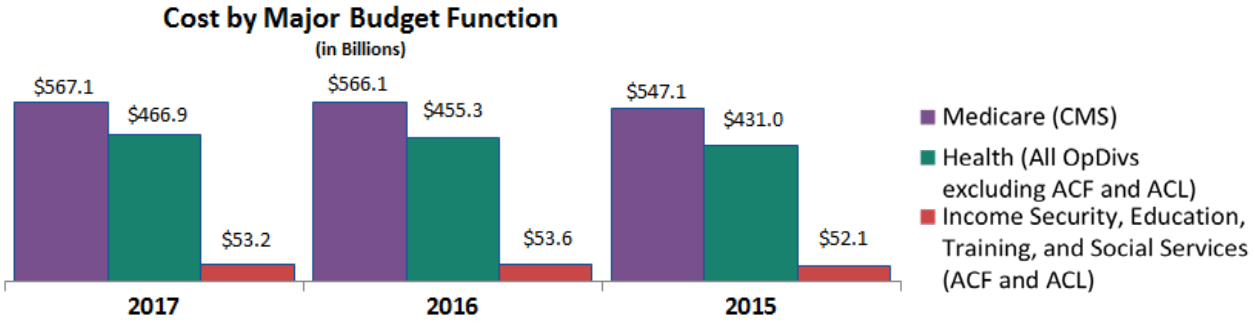
[4] Totals in the chart are exclusive of Intra-HHS Eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section III, Other Information.

The table below presents FY 2017 Consolidated Net Cost of Operations, which HHS breaks out costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by $10.8 billion or 1 percent between FY 2017 and FY 2016. The majority of this increase relates to benefit expenses reflecting an expansion of Medicaid with increases of costs approximately totaling $9.9 billion, as well as benefit expense increases for the Medicare HI of $9.4 billion. These benefit expenses are offset by SMI premium of $8.3 billion. There was a nominal increase in total Net Cost of Operations for the remaining HHS segments at $1.2 billion or 1 percent.

Net Cost of Operations
(in Billions)

	2017	2016	$ Change (2017-2016)	% Change (2017-2016)
Responsibility Segments:				
CMS Gross Cost	$ 1,060.8	$ 1,044.6	$ 16.2	2%
CMS Exchange Revenue	(97.3)	(91.9)	(5.4)	6%
CMS Net Cost of Operations	**$ 963.5**	**$ 952.7**	**$ 10.8**	**1%**
Other Segments:				
Other Segments Gross Cost	$ 128.3	$ 127.2	$ 1.1	1%
Other Segments Exchange Revenue	(5.0)	(5.1)	0.1	(2)%
Other Segments Net Cost of Operations	**$ 123.3**	**$ 122.1**	**$ 1.2**	**1%**
Net Cost of Operations	**$ 1,086.8**	**$ 1,074.8**	**$ 12.0**	**1%**

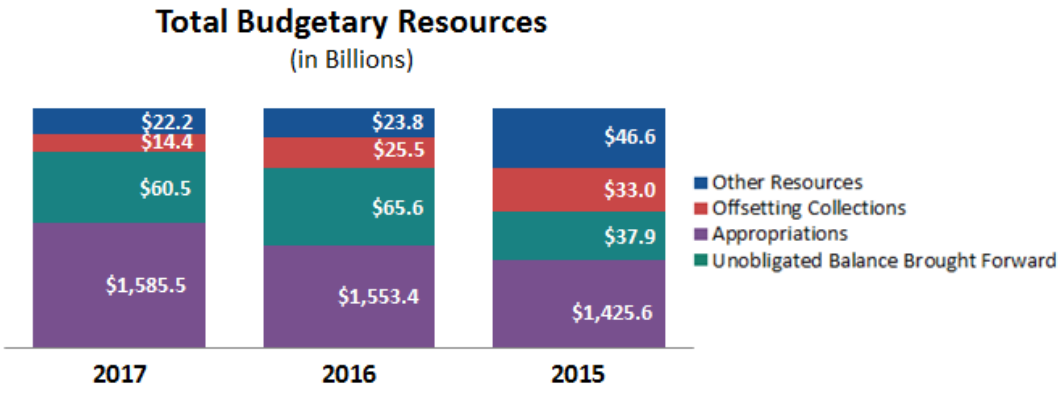
HHS classifies costs by major budget function such as Medicare, Health, Income Security, and Education, Training and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in the "Other Information" section of this report. The graph below shows the three-year cost trends for these major budget functions[5]. In FY 2017, total net costs for Medicare of $567.1 billion and Health of $466.9 billion account for 95 percent of HHS's annual net costs.



Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout 2017 and 2016, and the status of those resources at the fiscal year-end. The primary components of HHS's resources, totaling approximately $1.7 trillion for FY 2017, are appropriations from Congress, resources not yet used from previous years (unobligated balances brought forward), spending authority from offsetting collections, and other budgetary resources. This represents an increase of $14.3 billion or 1 percent, over FY 2016. The following chart highlights trends in these balances over the past 3 fiscal years.

[5] Totals in the chart are exclusive of Intra-HHS Eliminations from the Consolidating Statement of Net Cost by Budget Function.



The increase in appropriations is primarily related to increases in Medicare Part D of $16.6 billion, Medicaid of $9.4 billion, Payments to Trust Funds of $0.5 billion, and Medicare HI of $0.4 billion. For further details, see the Combining Statement of Budgetary Resources in the "Financial Section" of this report.

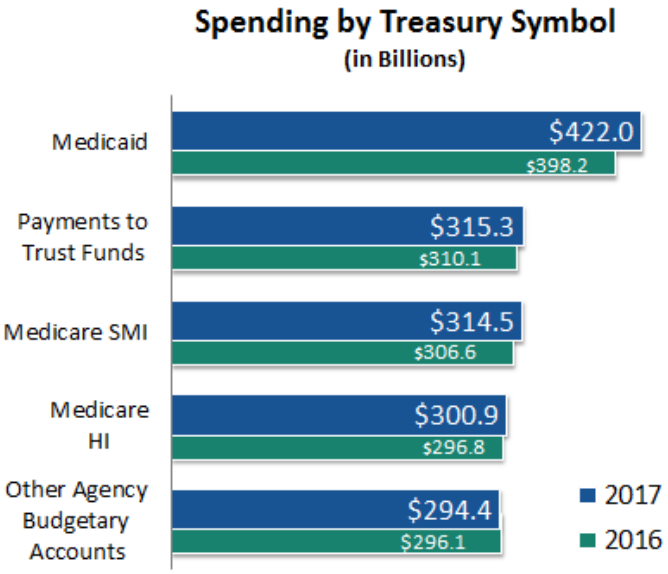
Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The chart below illustrates spending as of September 30, 2017 and 2016, for the top four Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.

The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2017 were approximately $1.6 trillion or 2 percent increase over FY 2016.

The HHS's total spending is once again significantly represented by four of CMS's TAS (Medicaid, Medicare HI, Medicare SMI, and Payments to Trust Funds) at 82 percent of HHS total obligations.

As the American public will soon be able to see more clearly on the USAspending.gov website, the majority of all HHS spending was made through Grants, Subsidies, and Contributions at $792.8 billion or 48 percent. HHS is the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling $708.0 billion or 43 percent. HHS classifies obligations by items or services provided into categories known as object classes. For more information refer to Note 23, Combined Schedule of Spending.



Statement of Social Insurance

The Statement of Social Insurance presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

Did you know?

86.7 million people are projected to be 65 or older in 2050.

The Statement of Social Insurance presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, *plus* the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(3.8) trillion, determined as of January 1, 2016, to $(3.5) trillion, determined as of January 1, 2017.

Including the combined HI and SMI trust fund assets as of January 1, 2017, the future cash flow for all current and future participants was $(3.2) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(10.4) trillion.

HI TRUST FUND SOLVENCY

Pay-as-you-go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have

been declining. The following table shows that HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 86 percent at the beginning of FY 2013 to 66 percent at the beginning of FY 2017.

Trust Fund Ratio Beginning of Fiscal Year					
	2017	2016	2015	2014	2013
HI	66%	67%	73%	77%	86%

Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2017 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2017 Trustees Report, the HI Trust Fund ratio is estimated to remain at approximately 68 percent through 2021 and to continue decreasing through 2026. From the end of 2016 to the end of 2022, assets are expected to increase, from $199 billion to $266 billion, but then decrease to $179 billion by the end of 2026.

Long-Term Financing

The short-range outlook for the HI Trust Fund has improved compared to what was projected last year. After 2021, the trust fund ratio starts to decline quickly until the fund is depleted in 2029, one year later than projected last year. HI financing is not projected to be sustainable over the long term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 88 percent in 2029 to 81 percent in 2041 and then to increase to about 88 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3.1 in 2016 to about 2.1 by 2091. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.3 trillion, which is 0.6 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period.

Significant uncertainty surrounds the estimates for the Statement of Social Insurance. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board.

SMI TRUST FUND SOLVENCY

The SMI Trust Fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues,

and transfers from state governments. Unlike the Part B account, the appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account five business days before the benefit payments to the plans. This transfer occurred again in February 2016 and has been consistently applied since then. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect the new policy.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(30.0) trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2016, SMI expenditures were 2.1 percent of GDP. By 2091, SMI expenditures are projected to grow to 3.7 percent of the GDP.

The following table presents key amounts from CMS's basic financial statements for fiscal year 2015 through 2017.

Table of Key Measures[6]

Table of Key Measures (in Billions)	2017	2016	2015
Net Position (end of fiscal year)			
Assets	$ 444.2	$ 446.0	$ 418.6
Less Total Liabilities	137.5	137.3	129.1
Net Position (assets net of liabilities)	**$ 306.7**	**$ 308.7**	**$ 289.5**
Costs (end of fiscal year)			
Net Costs	$ 963.3	$ 953.1	$ 913.8
Total Financing Sources	984.6	960.1	910.3
Net Change in Cumulative Results of Operations	**$ 21.3**	**$ 7.0**	**$ (3.5)**
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$ (3,532)	$ (3,822)	$ (3,187)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$ (3,822)	$ (3,187)	$ (3,823)
Change in Present Value	**$ 290**	**$ (635)**	**$ 636**

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and

[6] The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, CMS presents the closed group measure and open group measure.

future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2017, decreased by $187 billion due to advancing the valuation date by one year and including the additional year 2091, and by $102 billion due to changes in demographic assumptions. However, changes in projection base, economic and health care assumptions, and legislation changes increased the present value of future cash flows by $342 billion, $233 billion, and $4 billion, respectively.

Did you know?

CMS Program Data - Populations[1]

Medicare (avg monthly)	CY 2015	CY 2016	CY 2017[2]
Parts A and/or B	55.6	57.1	58.0
Aged	46.7	48.3	49.1
Disabled	8.9	8.9	8.9
Original Medicare Enrollment	37.8	38.4	38.0
MA & Other Health Plan Enrollment	17.8	18.7	20.0
MA Enrollment	16.5	17.6	18.6
Part D (MA PD+PDP)	39.5	41.2	42.5
Medicaid (avg monthly)[3]	**FY 2015**	**FY 2016**	**FY 2017**
Total	68.5	70.9	72.3
Aged	5.5	5.7	5.8
Blind/Disabled	10.5	10.6	10.6
Children	28.0	28.0	28.2
Adults	15.4	15.5	15.7
Expansion Adult	9.1	11.2	12.0
CHIP (avg monthly)[3]	**5.9**	**6.5**	**6.7**

[1] Populations are in millions and may not add due to rounding.
[2] Preliminary and Subject to change
[3] Projected estimates

MA - Medicare Advantage, MA PD - Medicare Advantage Prescription Drug Plan, PDP - Prescription Drug Plan, CHIP - Children's Health

SOURCES: CMS/Office of Enterprise Data & Analytics/Office of the Actuary

Medicare Deductibles, Coinsurance, Premiums

	CY 2016	CY 2017
Part A		
Inpatient Hospital Deductible	$1,288.00	$1,316.00
Coinsurance/Day	$322.00	$329.00
Coinsurance/LTR Day	$644.00	$658.00
Coinsurance/SNF Day	$161.00	$164.50
Part B		
Deductible	$166.00	$183.00
Part D		
Maximum Deductible	$360.00	$400.00
Initial Coverage Limit	$3,310.00	$3,700.00
Out-of-Pocket Threshold	$4,850.00	$4,950.00
Premiums		
Part A	$411.00	$413.00
Part B	$104.90-$389.80	$134.00-$428.60

NOTE: The inpatient hospital deductible applies per benefit period.

LTR - Life Time Reserve
SNF - Skilled Nursing Facility

SOURCE: CMS/Office of the Actuary

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, *Accounting for Social Insurance* (as amended by *SFFAS Number 37, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS has included information about the Medicare trust funds – HI and SMI. The Required Supplementary Information (RSI) presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

Limitation of the Principal Financial Statements

The principal financial statements in the "Financial Section" have been prepared to report HHS's financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from HHS's books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

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Financial Section

2

In This Section

- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Stewardship Information
- Required Supplementary Information

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REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV 14 2017

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2017 (A-17-17-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2017 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS (1) consolidated balance sheets as of September 30, 2017 and 2016, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the sustainability statements that comprise the statement of social insurance as of January 1, 2017, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 17-03, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

On the basis of its audit, Ernst & Young found that the FY 2017 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. With respect to the estimates for the statement of social insurance as of January 1, 2017 and 2016, and the related Statement of Changes in Social Insurance Amounts, HHS management described in the financial statement footnotes the Medicare Board of Trustees alternative scenario that illustrates, when possible, the

potential understatement of Medicare cost and projection results. This scenario assumes that the various cost-reduction measures will occur as current law requires. The most important of these measures are the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP[1] Reauthorization Act of 2015 (MACRA) (P.L. No. 114-10). Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

> The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the cost-reduction provisions of the Affordable Care Act[2] and MACRA would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2017, 2016, 2015, 2014, and 2013, and the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016. Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young identified a material weakness in HHS's Financial Information Systems and significant deficiencies in Financial Reporting Systems, Analyses, and Oversight at the National Institutes of Health (NIH) and the Centers for Medicare and Medicaid Services (CMS):

- *Financial Information Systems*—Ernst & Young noted that HHS had continued to make strides to improve information technology (IT) controls within its financial systems. The IT Material Weakness Working Group has had a positive impact in focusing HHS on corrective actions that has led to the remediation of a number of prior-year IT control deficiencies. Ernst & Young noted improvements as a result of investments in key financial systems, which have provided a control baseline that will allow these key systems to be relied upon. Ernst & Young also noted the IT Material Weakness Working

[1] Children's Health Insurance Program.

[2] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act."

Group has continued its enterprise-wide focus on corrective actions that has led to the remediation of a subset of high-risk prior-year control deficiencies. As in previous fiscal years, Ernst & Young concluded control deficiencies related to segregation of duties, configuration management, and access to HHS systems could have a material effect on the HHS financial statements. Ernst & Young continued to conclude these control deficiencies and other factors described in its report represent a material weakness in internal control.

- *NIH and CMS Financial Systems, Analysis, and Reporting*—During the FY 2017 audit, Ernst & Young noted that HHS made significant progress addressing certain issues that have impaired its ability to overcome significant deficiencies reported in prior years. HHS resolved issues related to calculating its grants accruals, developing policies and procedures over financial processes, remediating data quality issues, and reducing the number of manual journal entries through improved controls and updates to HHS financial systems. Although HHS made significant progress in these areas, the FY 2017 audit identified a series of deficiencies at NIH and CMS in financial systems and processes for producing financial statements, including the lack of integrated financial management systems, antiquated processes that affected journal entries to their financial and budgetary amounts, and insufficient analysis and oversight of certain significant accounts or programs.

  AT NIH, Ernst & Young noted a significant number of manual journal entries compared to NIH's overall financial activities, accruals for grants estimates in one institute's accounts even though grant activity occurred at all of NIH's 27 institutes, and the need to refine NIH-specific procedures to ensure all entries are recorded appropriately and are complete. For CMS, Ernst & Young noted deficiencies in the oversight of the Medicaid program. CMS continued to experience delays in receiving quarterly expenditure report certifications, which resulted in a backlog of uncertified claims and delays in grant finalizations. CMS also still does not perform a claim-level detailed look-back analysis for the Medicaid Benefits Due and Payable to determine the reasonableness of various State calculations of unpaid claims that have not yet been reported in liabilities. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2017, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. HHS reported an error rate of over 10 percent for the Medicaid program, which is a violation of the IPIA. Two other HHS high-priority programs reported error rates that did not meet their FY 2017 target error rates, which is another violation of the IPIA. We will report further on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2018. HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. No. 101-508) related to an obligation of funds for conference spending at FDA and certain contract obligations at the PSC occurring between FY 2006 and FY 2011. HHS's management also determined that

the agency's Medicare appeals process did not adjudicate appeals within the statutory timeframes required by the Social Security Act (P.L No. 74-271).

On the basis of the material weakness reported over Financial Information Systems and the significant deficiency reported in NIH and CMS's Financial Reporting Systems, Analyses, and Oversight, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L. No.104-208).

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 17-03, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports, and;
- reviewing the HHS *FY 2017 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carrie A. Hug, Assistant Inspector General for Audit Services, at (202) 619-3972 or through e-mail at Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-17-00001.

Attachment

Page 5 – The Secretary

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Chief Financial Officer

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

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Report of Independent Auditors

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2017 and 2016, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2017, 2016, 2015, 2014, and 2013, the related statement of changes in social insurance amounts for the periods ended January 1, 2017 and 2016, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statement of social insurance as of January 1, 2017, 2016, 2015, 2014, and 2013, the related statement of changes in social insurance amounts for the periods ended January 1, 2017 and 2016, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 17-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 17-03 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to HHS's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing

an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2017 and 2016, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program

As discussed in Note 24 to the principal financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the *Patient Protection and Affordable Care Act* (ACA) and the *Medicare Access and CHIP Reauthorization Act* (MACRA).

As further described in Note 25 to the principal financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2017, 2016, 2015, 2014, and 2013, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the

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potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 25, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for most health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to passage of MACRA and may be necessary in the future if cost rates prove inadequate, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2017, 2016, 2015, 2014, and 2013, and the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016.

Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2017, 2016, 2015, 2014, and 2013, and the related changes in the social insurance program for the periods ended January 1, 2017 and 2016.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of HHS as of September 30, 2017 and 2016, and its consolidated net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the Management's Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board, which considers it to be an essential part of financial reporting for placing the basic financial statements

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in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information and Other Information

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS's basic financial statements. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Except for the Other Financial Information described above, the Other Information has not been subjected to the auditing procedures applied in the audits of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 14, 2017, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 14, 2017

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Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 17-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2017, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017, and have issued our report thereon dated November 14, 2017. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 17-03. We did not test all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982*, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and

corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies; therefore, material weaknesses or significant deficiencies may exist that have not been identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Systems, described below, to be a material weakness. We also identified certain deficiencies related to NIH and CMS Financial Systems, Analysis and Reporting, described below, to be a significant deficiency.

Material Weakness

Financial Information Systems

The Department continued to make strides during fiscal year (FY) 2017 to improve the information technology (IT) controls within its financial systems. The IT Material Weakness Working Group (MWWG) has the leadership role in monitoring remediation of the most significant deficiencies reported in prior years across IT systems in scope of the consolidated Financial Statement Audit and Federal Information Security Modernization Act of 2014 (FISMA). The MWWG has had a positive impact on the enterprise-wide focus on corrective actions that has led to the remediation of number of prior year (PY) control deficiencies. The following summarizes some of the improvements achieved that resulted from this increased attention:

- Differential investments in key financial systems (i.e. Unified Financial Management System (UFMS) access control / segregation of duties redesign) have provided a more mature controls baseline that allows for reliance on the application; and

- HHS MWWG has continued their enterprise-wide focus on corrective actions that has led to the remediation of a subset of high risk PY control deficiencies.

Remediating deficiencies is inherently an iterative process, which frequently takes multiple years to come to complete resolution. The MWWG has overseen the implementation of specific action plans to decrease the number and severity of the deficiencies in the most critical financial systems. However, some of those plans did not reach completion during the fiscal year and others, while reporting as complete during the year, did not reach completion in time to cover the majority of the fiscal year activity. Accordingly, those findings remain for the current year. In particular, the differential investments made in UFMS/CFRS have led to the strengthening of those very important systems' control maturity. However, our findings in regards to other major systems, including Center for Information Technology (CIT) and National Institutes of Health Business System (NBS), actually increased over previous years partially offsetting the impact of the

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improvements in our overall conclusions. We also observed a combined number of remaining deficiencies that in aggregate continue to constitute an IT material weakness in internal control.

The IT material weakness determination is driven by four (4) overarching factors, which are listed below:

- Incomplete remediation of PY control deficiencies in Access Control, Segregation of Duties and Configuration Management;
- Identification of new high risk control deficiencies on non-CMS systems focused on access controls, configuration management and segregation of duties;
- Consideration that the areas of weakness identified exist across multiple physical layers of systems; and
- A conclusion that ineffective centralized oversight / monitoring of IT controls allowed new deficiencies to occur without timely detection.

The following is a summary of the deficiencies that we considered most critical at the application layer. When assessed in aggregate, we continue to conclude they could have a material effect on the financial statements and, as a result, they forms the basis for our conclusion of an IT material weakness:

- Access controls – We identified access controls exceptions across six (6) of the eight (8) applications in scope of our review, which spanned non-CMS systems Specifically, we noted (1) inactive users are identified with active application-level access, (2) unauthorized changes to user access are not proactively monitored, (3) inconsistent monitoring of the removal of terminated users to ensure the timely removal of access, (4) a system generated listing of system administrators does not exist, (5) inconsistent monitoring of user activity for powerful elevated access user accounts, and (6) inconsistent recertification of user access. Similarly, CMS did not perform or adequately perform management reviews of user access and system parameters for key financially significant applications. In addition, procedures for adding users were not consistently followed.
- Configuration management – We identified configuration management exceptions in five (5) of the eight (8) applications in scope of our review, which spanned non-CMS systems Specifically, we noted (1) application level baseline configurations were not documented, or changes made monitored for two (2) applications in scope, (2) inconsistent documentation supporting the monitoring of all database and development changes, (3) no formal process in place to periodically monitor for unauthorized changes or activity performed by individuals with access to both development and production environments, (4) we were not able to validate the full population of changes made to an application in

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order to verify that only changes that went through the change management and approval process were put into production, and (5) changes made to the Oracle front-end application configurable settings were not monitored. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security policies at both the Medicare fee-for-service contractors and the Central Office. Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems.

- Segregation of duties – We identified segregation of duties exceptions across five (5) of our eight (8) applications in scope of our review, which spanned non-CMS systems. Specifically, we noted (1) restricted roles are assigned to several user accounts that have been identified as prohibited combinations of roles, per the Segregation of Duties policy, (2) users possess security administrator role while also having separate business user accounts with the ability to input and/or approve transactions, (3) administrators have the ability to modify the workflow of a grant to avoid required approvals, (4) business justification is not consistently documented for all users with access to roles with SOD conflicts, (5) users with SOD conflicts did not have SOD waiver in place nor could we determine if monitoring of user activities was taking place, and (6) users with excessive access to the application, identified during the user recertification process, did not have their access removed in a timely manner. CMS did not monitor the use of privileged access for key applications.

During this year's audit, we also identified a number of high-risk findings on the supporting infrastructure that four (4) non-CMS systems in scope of the audit reside on. The issues identified also span the three (3) control domains of Access Controls, Configuration Management and Segregation of Duties. When assessed in aggregate, we noted that the findings, identified at the infrastructure layer, also contributed to the IT Material Weakness:

- Login to the root account on the UNIX servers was not restricted to the console
- User accounts set to be deleted continued to have active access to the infrastructure
- Baseline configurations for UNIX Hosting Servers have not defined a listing of restrictive permissions
- Inconsistent review / monitoring of multiple critical system level reports by UNIX administrators
- Excessive access granted to a privileged access management utility

Recommendations

HHS should continue the focus achieved in FY 2018 to remediate the remaining deficiencies contributing to material weakness. The following are some specific considerations:

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- Department and HHS MWWG should work to strengthen overarching governance / oversight to improve sustainability of remediation activities limiting the identification of new , high risk observations in access controls, configuration management, and segregation of duties during the audit;

- HHS MWWG should continue to focus on high priority remediation activities ultimately strengthening the controls maturity; and

- A focused effort should be made to decommission systems that are being planned to retire and in which the Department is no longer making a differential investment in remediating the issues identified within the system.

We have performed a separate financial statement audit of CMS for FY 2017 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

Significant Deficiency

NIH and CMS Financial Systems, Analysis, and Reporting

During FY 2017, HHS made significant progress in addressing certain issues that have impaired its ability to overcome its significant deficiencies in the past. Improvements included:

- Resolving issues related to its grant accruals,

- Continued development of policies and procedures over financial processes,

- Implementation of processes and controls related to requirements under the DATA Act,

- Implementation of certain processes to strengthen controls around NIH's manual journal entries,

- Execution of analyses to remediate certain data quality issues allowing for data cleanup activities, and

- Continued reduction of the number of manual journal entries through improved approval controls and updates to financial systems.

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Although progress in certain areas has been identified, our review of internal control disclosed a series of deficiencies at NIH and CMS in financial systems and processes for producing financial statements, including lack of integrated financial management systems, antiquated processes that impacted journal entries to their financial and budgetary amounts, and/or insufficient analysis and oversight of certain significant accounts or programs. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

National Institutes of Health

During FY 2017, NIH continued its efforts in resolving deficiencies in its financial systems and processes. HHS and NIH took a series of steps to overcome certain deficiencies in internal controls, including: executing additional analyses in its efforts to improve data quality; developing policies and procedures; combining its financial and budgeting systems; and updating and establishing processes surrounding manual journal entries. However, NIH management, the Department, along with the results of our audit, continue to identify deficiencies that require additional focus in FY 2018 and beyond. For example:

- *Manual Entries* –HHS posts a significant number of manual journal vouchers, with the majority of the entries being generated by NIH. During FY 2017, although NIH's annual total budgetary resources was $38 billion, NIH was required to process approximately 11,000 manual entries totaling an absolute value of more than $ 670 billion to its National Institutes of Health Business System (NBS). These entries consist of nonstandard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by NIH personnel. Although necessary to ensure balances are accurate, the volume and dollar value of manual entries is significant compared to the NIH's overall activity.

  Additionally, although a system for tracking, approving and recording manual entries was implemented during FY 2017, we continue to observe certain weaknesses in the manual journal entry process, including:

  – Improper or lack of approvals to both routine and non-routine manual journal entries;

  – Posting of certain entries that were in error and required reversal;

  – Untimely identification and recording of certain manual entries to resolve issues noted; and

  – Limited descriptions and insufficient documentation to support the purpose of certain non-routine entries recorded prior to the implementation of new processes to track and record routine entries.

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NIH management indicated that the reason for the large number of manual entries is due to clean-up efforts to improve data quality and system and resource limitations. Additionally, management indicated that further training would reduce the number of mistakes and provide for more consistency in manual entry processing.

- *NIH's Grant Accrual* – Quarterly, NIH recorded an estimated grant accrual to its financial data to ensure that reported financial statement balances were correct. NIH recorded its estimate to only one institute's appropriation, although the grant accrual supports all 27 institutes and centers. NIH corrected its process later in the fiscal year by posting accrual estimates to each of its approximately 200 appropriations rather than the one. At September 30, 2017, the estimated grant accrual totaled $2.1 billion. While the process of recording this type of entry has been mostly automated in FY 2017, it is still a manually intensive process and could lead to mistakes during the posting in the current month and the reversal during the future period.

- *Policies and Procedures* – Although NIH initiated the development of documented financial policies and procedures, NIH should continue to refine NIH-specific desk procedures for its financial processes and period-end closing procedures to ensure all entries are recorded appropriately and completely, and that the volume of entries is reduced

Centers for Medicare & Medicaid Services

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls, dated November 3, 2017. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting. The most significant of those deficiencies fell within the oversight of the Medicaid program and the coordination between CMS actuaries and the CMS Office of Financial Management, which is further discussed below.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters. Beginning January 1, 2014, the Affordable Care Act expanded eligibility for Medicaid to certain low-income adults and increased the Federal medical assistance percentage to 100 percent for those qualifying claims for the first three years, and gradually decreasing to 90 percent by FY 2020 and beyond, for states that elected to participate in the program (Medicaid Expansion). During our FY 2017 audit, we noted the following deficiencies related to the Medicaid Program:

- While there have been improvements, we continue to see delays receiving certain quarterly expenditure report certifications which results in a backlog of uncertified claims as well as delays in grant finalizations as the regional offices and Centers for Medicaid and CHIP Services (CMCS) reviews are not completed.

- We noted that CMCS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures.

- During the FY 2017 audit, we observed that while progress has been made CMS management has not updated its quantification of prior year recovery estimates. Discussions were held with management to understand the steps taken to gather additional data necessary to quantify the recoveries for more recent periods, however, due to limitations on the data available, no further quantification was feasible. We believe that the efforts to collect information from the individual states and evaluate the necessary recovery efforts should be augmented. As this process further develops, we expect that management will be able to record estimates related to these recoveries.

- CMS does not perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. CMS has indicated that it currently does not have timely access to the states' claim data nor the ability to accumulate the detailed claim data by state to perform the analysis described above. Additionally, CMS is not able to validate its methodology by using a claims-based approach due to the lack of individual claims-level detail and continues to rely on its estimation process to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

Coordination between the Office of the Actuary and OFM

In September 2017, CMS made advance prospective payments related to October 2017 for the Medicare Part D Program which were appropriately recorded within other assets; however, CMS also included the advance payments as a component of its Part D accrual estimate, resulting in an overstatement of accounts receivable. This was not identified through the normal financial statement close process because there was a gap in communication between the Office of the Actuary and OFM regarding a change in methodology.

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Recommendations

We recommend that NIH and CMS continue to develop and refine their financial management systems and processes to improve their accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding their financial information management systems. Specifically, we recommend the following:

For NIH, we recommend:

- Continue to focus on automating and reducing the number of manual journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate. Additionally, we believe that NIH should continue to strengthen controls surrounding review and approval functions around manual journal vouchers and reconciliations to provide for timely identification of errors and remediation of differences. As a new process was implemented during FY 2017, we recommend NIH monitor the new process to determine if further improvements are warranted.

- Enhance its internal control processes including the continued development of NIH-specific procedures and training to ensure its policy is consistently applied.

- Continue to strengthen the newly implemented process in allocating NIH's grant accruals to each of its 27 institutes to allow for accurate Government-wide Treasury Account Symbols and Adjusting Trial Balances System (GTAS) reporting.

Additionally, we recommend that CMS continue to develop and refine its financial management controls as a means to improve its accounting, analysis, and oversight of financial management activity, primarily relating to the oversight of the Medicaid program. Further, when considering changes to established methodologies, we recommend that the Office of the Actuary work with CMS' Office of Financial Management prior to implementation of such changes within their calculations so that all relevant accounting consequences have been considered. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Status of Prior Year Findings

In the reports on the results of the FY 2016 audit of the HHS financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Material Weakness		
Issue Area	**Summary Control Issue**	**FY 2017 Status**
Financial Information Systems	• Access Controls • Configuration Management • Segregation of Duties • FISMA Compliance	Certain progress noted; certain issues need continued focus. Modified Repeat Condition
Significant Deficiencies		
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight	Progress noted with OPDIV financial reporting processes. This significant deficiency is combined with the NIH Financial Management Systems Review Process significant deficiency discussed below. Our concern regarding information technology controls within the Commissioned Corps process continues to exist; however balances have been deemed insignificant for purposes of this report.
NIH Financial Management Systems and Review Processes	NIH Financial Reporting Processes—deficiencies noted related to NIH's manual journal entries, grant accruals, policy and procedure documentation and security controls for IT System's infrastructure.	Progress noted. This significant deficiency is combined with the Financial Reporting Systems, Analyses, and Oversight significant deficiency, discussed above.

HHS's Response to Findings

HHS's response to the findings identified in our audit and examination are included in the accompanying letter dated November 14, 2017. HHS's response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control, and, accordingly, we express no opinion on it.

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Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 14, 2017

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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance With *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 17-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2017, and the related consolidated statement of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017, and have issued our report thereon dated November 14, 2017. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 17-03, including the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). However, providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit, and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS.

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The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 17-03, as described below.

During fiscal year (FY) 2017, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to an obligation of funds for conference spending at FDA and certain contract obligations serviced by the PSC occurring between FY 2006 and FY 2011. Additionally, HHS's management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*.

The *Improper Payments Information Act of 2002* (IPIA) (P.L. 107-300) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) (P.L. 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Acts. For example, HHS has reported improper payment error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the *Social Security Act*, which specifies the data elements that HHS may require states to report, and Section 417 of the same *Social Security Act*, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS feels that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the *Social Security Act*. Additionally, we noted certain high-risk programs that did not meet their identified targets or exceeded the maximum 10% threshold stipulated by OMB. Also, HHS is not in full compliance with Section 6411 of the *Patient Protection and Affordable Care Act*, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS's financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of noncompliance related to FFMIA:

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- During FY 2017, HHS recorded approximately $750 billion in manual journal entries as these transactions are either corrections, reversals or transactions not currently configured correctly within the financial systems and are for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements and other required reporting.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Modernization Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB Circular A-123 processes.

* * * * *

HHS's Response to Findings

Our Report on Internal Control dated November 14, 2017, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management generally concurs with the facts as presented and that relevant comments from HHS's management responsible for addressing the noncompliance are provided in its letter dated November 14, 2017. HHS's response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control, and, accordingly, we express no opinion on it. Additionally, HHS is updating its Department-wide corrective action plan to address the financial management issues discussed above.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 14, 2017

DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Washington, DC 20201

To: Daniel R. Levinson, Inspector General

From: Jen Moughalian, Acting Assistant Secretary for Financial Resources and Acting Chief Financial Officer

Subject: FY 2017 Financial Statement Audit

We appreciate the opportunity to comment on the Independent Auditors' Report concerning the audit of our Fiscal Year (FY) 2017 financial statements. We are pleased that the independent auditors determined that HHS's FY 2017 financial statements and notes were presented fairly, in all material respects, and conform with U.S. generally accepted accounting principles. We generally concur with the auditor's findings as presented in the Report on Internal Control, and we are eager to develop corrective action plans to correct those deficiencies and strengthen our controls.

Beginning in FY 2015, HHS implemented a comprehensive strategy to strengthen the Department's financial systems controls environment and address the longstanding IT material weakness. Since then, significant progress has been made in resolving audit findings, reducing risk across the operating environment, and maturing the security and controls posture of HHS's financial systems. As part of the strategy, HHS established a Management Assessment Framework that defines the conditions and criteria for evaluating the maturity of HHS's financial systems environment. Evaluation criteria include four key components: (1) Leadership Commitment and Sustained Governance; (2) Reduced Risk through Corrective Actions; (3) Demonstrated Measurable Remediation Progress; and (4) Mature Controls Environment. While control deficiencies still exist across several HHS Federal Information System Controls Audit Manual systems, our evaluation based on the HHS Management Assessment Framework demonstrates that these deficiencies, in aggregate, no longer rise to the level of a "material weakness" under Office of Management and Budget Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, as of September 30, 2017.

We attribute the Department's progress on addressing our significant deficiencies to a structured corrective action planning process that benefits from effective communication and collaboration with the OpDivs. Corresponding policy, guidance, training, and on-site technical assistance to the OpDivs are key components of the process. Moving forward, the Department and its OpDivs are committed to this collaborative approach to correct existing deficiencies, strengthen our controls, and prevent future deficiencies.

We would like to thank the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the continued collaboration of the OIG to improve our stewardship and transparency of taxpayer funds.

/Jen Moughalian/

Jen Moughalian
Acting Assistant Secretary for Financial Resources and
Acting Chief Financial Officer
November 14, 2017

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services
Consolidated Balance Sheets
As of September 30, 2017 and 2016
(in Millions)

	2017	2016
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 209,753	$ 237,759
Investments, Net (Note 4)	275,524	262,077
Accounts Receivable, Net (Note 5)	968	1,012
Advances (Note 8)	233	239
Total Intragovernmental Assets	486,478	501,087
Accounts Receivable, Net (Note 5)	33,081	24,203
Inventory and Related Property, Net (Note 6)	9,698	9,399
General Property, Plant and Equipment, Net (Note 7)	6,248	5,665
Advances (Note 8)	30,859	21,480
Other Assets	459	819
Total Assets	$ 566,823	$ 562,653
Stewardship Land (Note 20)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 239	$ 339
Other Liabilities (Note 13)	9,661	7,063
Total Intragovernmental Liabilities	9,900	7,402
Accounts Payable	1,099	981
Entitlement Benefits Due and Payable (Note 10)	108,347	108,230
Accrued Liabilities (Note 12)	11,872	14,420
Federal Employee and Veterans' Benefits (Note 11)	13,532	12,892
Contingencies and Commitments (Note 14)	14,797	12,394
Other Liabilities (Note 13)	4,358	4,963
Total Liabilities	163,905	161,282
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	17,284	35,912
Unexpended Appropriations - All Other funds	129,688	128,129
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	257,676	233,470
Cumulative Results of Operations - All Other funds	(1,730)	3,860
Total Net Position - Funds from Dedicated Collections	274,960	269,382
Total Net Position - All Other Funds	127,958	131,989
Total Net Position	402,918	401,371
Total Liabilities and Net Position	$ 566,823	$ 562,653

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements

U.S. Department of Health and Human Services
Consolidated Statement of Net Cost
For the Years Ended September 30, 2017 and 2016
(in Millions)

	2017	2016
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,060,793	$ 1,044,615
Exchange Revenue	(97,294)	(91,964)
CMS Net Cost of Operations	963,499	952,651
Other Segments:		
Administration for Children and Families (ACF)	51,187	51,515
Administration for Community Living (ACL)	1,948	2,058
Agency for Healthcare Research and Quality (AHRQ)	340	348
Centers for Disease Control and Prevention (CDC)	11,945	12,098
Food and Drug Administration (FDA)	4,860	4,617
Health Resources and Services Administration (HRSA)	10,724	10,223
Indian Health Service (IHS)	6,456	6,204
National Institutes of Health (NIH)	31,376	30,790
Office of the Secretary (OS)	3,278	3,176
Program Support Center (PSC)	2,313	2,033
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,625	3,636
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 128,052	$ 126,698
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	261	483
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 128,313	$ 127,181
Exchange Revenue	(4,963)	(5,060)
Other Segments Net Cost of Operations	123,350	122,121
Net Cost of Operations (Note 15)	$ 1,086,849	$ 1,074,772

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2017
(in Millions)

	2017			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 233,470	$ 3,860	$ -	$ 237,330
Budgetary Financing Sources:				
Other Adjustments (+/-)	(3)	(4)	-	(7)
Appropriations Used	325,452	506,888	-	832,340
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	259,740	-	-	259,740
Nonexchange Revenue - Investment Revenue	9,818	6	-	9,824
Nonexchange Revenue – Other	4,904	-	-	4,904
Donations and Forfeitures of Cash and Cash Equivalents	70	-	-	70
Transfers-in/out without Reimbursement (+/-)	(4,950)	3,145	-	(1,805)
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	(40)	-	(40)
Transfers-in/out Without Reimbursement (+/-)	(2)	2	-	-
Imputed Financing	37	682	(347)	372
Other (+/-)	4	63	-	67
Total Financing Sources	595,070	510,742	(347)	1,105,465
Net Cost of Operations (+/-)	570,864	516,332	(347)	1,086,849
Net Change	24,206	(5,590)	-	18,616
Cumulative Results of Operations:	$ 257,676	$ (1,730)	$ -	$ 255,946
Unexpended Appropriations:				
Beginning Balance	$ 35,912	$ 128,129	$ -	$ 164,041
Budgetary Financing Sources:				
Appropriations Received	348,468	605,538	-	954,006
Appropriations Transferred in/out (+/-)	-	(10)	-	(10)
Other Adjustments (+/-)	(41,644)	(97,081)	-	(138,725)
Appropriations Used	(325,452)	(506,888)	-	(832,340)
Total Budgetary Financing Sources	(18,628)	1,559	-	(17,069)
Total Unexpended Appropriations	17,284	129,688	-	146,972
Net Position	$ 274,960	$ 127,958	$ -	$ 402,918

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2016
(in Millions)

	2016			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 221,480	$ 9,654	$ -	$ 231,134
Budgetary Financing Sources:				
Other Adjustments (+/-)	-	(857)	-	(857)
Appropriations Used	323,452	495,197	-	818,649
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	250,472	-	-	250,472
Nonexchange Revenue - Investment Revenue	9,938	17	-	9,955
Nonexchange Revenue – Other	3,980	-	-	3,980
Donations and Forfeitures of Cash and Cash Equivalents	80	-	-	80
Transfers-in/out without Reimbursement (+/-)	(4,447)	2,768	-	(1,679)
Other (+/-)	-	1	-	1
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out Without Reimbursement (+/-)	(4)	7	-	3
Imputed Financing	38	736	(294)	480
Other (+/-)	134	(257)	-	(123)
Total Financing Sources	583,643	497,619	(294)	1,080,968
Net Cost of Operations (+/-)	571,653	503,413	(294)	1,074,772
Net Change	11,990	(5,794)	-	6,196
Cumulative Results of Operations:	$ 233,470	$ 3,860	$ -	$ 237,330
Unexpended Appropriations:				
Beginning Balance	$ 30,184	$ 116,089	$ -	$ 146,273
Budgetary Financing Sources:				
Appropriations Received	351,309	596,875	-	948,184
Appropriations Transferred in/out (+/-)	-	(16)	-	(16)
Other Adjustments (+/-)	(22,129)	(89,622)	-	(111,751)
Appropriations Used	(323,452)	(495,197)	-	(818,649)
Total Budgetary Financing Sources	5,728	12,040	-	17,768
Total Unexpended Appropriations	35,912	128,129	-	164,041
Net Position	$ 269,382	$ 131,989	$ -	$ 401,371

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2017 and 2016
(in Millions)

	2017		2016	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources				
Unobligated Balance, Brought Forward, Oct 1	$ 59,883	$ 627	$ 65,622	$ 2
Recoveries of Unpaid Prior Year Obligations	51,358	3	36,333	-
Other Changes in Unobligated Balance	(32,548)	(477)	(16,309)	-
Unobligated Balance from Prior Year Budget Authority, Net	78,693	153	85,646	2
Appropriations (Discretionary and Mandatory)	1,585,571	(96)	1,553,444	-
Borrowing Authority (Discretionary and Mandatory)	3,720	151	3,720	19
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	14,238	122	24,844	638
Total Budgetary Resources (Note 23)	$ 1,682,222	$ 330	$ 1,667,654	$ 659
Status of Budgetary Resources				
New Obligations and Upward Adjustments (Notes 18, 22 and 23)	$ 1,647,010	$ 152	$ 1,607,771	$ 32
Unobligated Balance, End of Year:				
Apportioned, Unexpired Accounts	15,373	3	24,982	8
Exempt from Apportionment, Unexpired Accounts	(12,103)	-	(7,710)	-
Unapportioned, Unexpired Accounts	7,822	175	5,082	619
Unexpired Unobligated Balance, End of Year	11,092	178	22,354	627
Expired Unobligated Balance, End of Year	24,120	-	37,529	-
Unobligated Balance, End of Year	35,212	178	59,883	627
Total Budgetary Resources (Note 23)	$ 1,682,222	$ 330	$ 1,667,654	$ 659
Change in Obligated Balance				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 257,598	$ 37	$ 236,348	$ 375
New Obligations and Upward Adjustments (Notes 18, 22 and 23)	1,647,010	152	1,607,771	32
Outlays (Gross)	(1,599,130)	(181)	(1,550,188)	(370)
Recoveries of Prior Year Unpaid Obligations	(51,358)	(3)	(36,333)	-
Unpaid Obligations, End of Year	$ 254,120	$ 5	$ 257,598	$ 37
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (26,466)	$ (15)	$ (22,124)	$ (160)
Change in Uncollected Customer Payments from Federal Sources	7,213	12	(4,342)	145
Uncollected Payments from Federal Sources, End of Year	$ (19,253)	$ (3)	$ (26,466)	$ (15)
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 231,132	$ 22	$ 214,224	$ 215
Obligated Balance, End of Year	$ 234,867	$ 2	$ 231,132	$ 22
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,603,529	$ 177	$ 1,582,008	$ 657
Actual Offsetting Collections (Discretionary and Mandatory)	(36,481)	(134)	(22,019)	(782)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	7,213	12	(4,342)	145
Recoveries of Prior Year Paid Obligations (Discretionary and Mandatory)	15,521	-	513	-
Budget Authority, Net (Discretionary and Mandatory)	$ 1,589,782	$ 55	$ 1,556,160	$ 20
Outlays, Gross (Discretionary and Mandatory)	$ 1,599,130	$ 181	$ 1,550,188	$ 370
Actual Offsetting Collections (Discretionary and Mandatory)	(36,481)	(134)	(22,019)	(782)
Outlays, Net (Discretionary and Mandatory)	1,562,649	47	1,528,169	(412)
Distributed Offsetting Receipts	(446,103)	-	(428,128)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 1,116,546	$ 47	$ 1,100,041	$ (412)

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services

Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2017 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2017	2016	2015	2014	2013
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 10,679	$ 10,294	$ 9,134	$ 8,398	$ 8,147
SMI Part B	21,641	19,386	17,027	17,127	15,227
SMI Part D	6,929	7,659	6,424	5,928	5,871
Have attained eligibility age (age 65 or over)					
HI	492	455	382	332	301
SMI Part B	4,122	3,660	3,300	2,873	2,620
SMI Part D	958	952	887	775	722
Those expected to become participants					
HI	10,567	9,952	8,386	7,812	7,744
SMI Part B	5,019	4,437	3,668	4,311	3,530
SMI Part D	2,869	3,602	2,845	2,609	2,617
All current and future participants					
HI	21,738	20,701	17,902	16,542	16,192
SMI Part B	30,783	27,484	23,995	24,311	21,377
SMI Part D	10,756	12,213	10,156	9,312	9,211
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 17,193	$ 16,800	$ 14,494	$ 14,117	$ 14,629
SMI Part B	21,392	19,178	16,818	17,003	15,075
SMI Part D	6,929	7,659	6,424	5,928	5,871
Have attained eligibility age (age 65 and over)					
HI	4,539	4,285	3,803	3,484	3,422
SMI Part B	4,531	4,026	3,637	3,171	2,887
SMI Part D	958	952	887	775	722
Those expected to become participants					
HI	3,539	3,437	2,791	2,764	2,913
SMI Part B	4,860	4,281	3,540	4,137	3,415
SMI Part D	2,869	3,602	2,845	2,609	2,617
All current and future participants:					
HI	25,270	24,523	21,089	20,365	20,963
SMI Part B	30,783	27,484	23,995	24,311	21,377
SMI Part D	10,756	12,213	10,156	9,312	9,211
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (3,532)	$ (3,822)	$ (3,187)	$ (3,823)	$ (4,772)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (3,532)	$ (3,822)	$ (3,187)	$ (3,823)	$ (4,772)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	199	194	197	205	220
SMI Part B	88	68	68	74	66
SMI Part D	8	1	1	1	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 24 and 25)					
HI	$ (3,333)	$ (3,628)	$ (2,990)	$ (3,618)	$ (4,551)
SMI Part B	88	68	68	74	66
SMI Part D	8	1	1	1	1

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services

Statement of Social Insurance (Continued) (Unaudited)

75-Year Projection as of January 1, 2017 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2017	2016	2015	2014	2013
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 5,572	$ 5,067	$ 4,569	$ 3,980	$ 3,643
Expenditures	10,027	9,263	8,328	7,430	7,031
Income less expenditures	(4,455)	(4,196)	(3,759)	(3,450)	(3,388)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	39,250	37,339	32,585	31,453	29,244
Expenditures	45,514	43,637	37,736	37,048	35,574
Income less expenditures	(6,264)	(6,298)	(5,151)	(5,595)	(6,330)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(10,719)	(10,493)	(8,909)	(9,045)	(9,718)
Combined Medicare Trust Fund assets at start of period	295	263	266	280	288
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(10,425)	(10,230)	(8,643)	(8,764)	(9,430)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	18,456	17,992	14,898	14,732	13,891
Expenditures	11,268	11,320	9,176	9,510	8,945
Income less expenditures	7,187	6,672	5,722	5,222	4,946
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,532)	(3,822)	(3,187)	(3,823)	(4,772)
Combined Medicare Trust Fund assets at start of period	295	263	266	280	288
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (3,237)	$ (3,559)	$ (2,921)	$ (3,542)	$ (4,484)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Unaudited)

January 1, 2016 to January 1, 2017

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2016	$ 60,398	$ 64,220	$ (3,822)	$ 263	$ (3,559)
Reasons for change					
Change in the valuation period	2,481	2,669	(187)	24	(163)
Change in projection base	(136)	(479)	342	8	350
Changes in the demographic assumptions	(122)	(20)	(102)	-	(102)
Changes in economic and health care assumptions	617	384	233	-	233
Changes in law	40	36	4	-	4
Net changes	2,880	2,590	290	31	321
As of January 1, 2017	$ 63,277	$ 66,809	$ (3,532)	$ 295	$ (3,237)
HI - Part A (Note 26)					
As of January 1, 2016	$ 20,701	$ 24,523	$ (3,822)	$ 194	$ (3,628)
Reasons for change					
Change in the valuation period	792	979	(187)	1	(186)
Change in projection base	133	(209)	342	4	346
Changes in the demographic assumptions	(152)	(50)	(102)	-	(102)
Changes in economic and health care assumptions	265	32	233	-	233
Changes in law	-	(4)	4	-	4
Net changes	1,037	748	290	5	295
As of January 1, 2017	$ 21,738	$ 25,270	$ (3,532)	$ 199	$ (3,333)
SMI - Part B (Note 26)					
As of January 1, 2016	$ 27,484	$ 27,484	$ -	$ 68	$ 68
Reasons for change					
Change in the valuation period	1,115	1,115	-	17	17
Change in projection base	281	281	-	3	3
Changes in the demographic assumptions	7	7	-	-	-
Changes in economic and health care assumptions	1,856	1,856	-	-	-
Changes in law	40	40	-	-	-
Net changes	3,299	3,299	-	20	20
As of January 1, 2017	$ 30,783	$ 30,783	$ -	$ 88	$ 88
SMI - Part D (Note 26)					
As of January 1, 2016	$ 12,213	$ 12,213	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	575	575	-	5	5
Change in projection base	(550)	(550)	-	1	1
Changes in the demographic assumptions	22	22	-	-	-
Changes in economic and health care assumptions	(1,504)	(1,504)	-	-	-
Changes in law	-	-	-	-	-
Net changes	(1,457)	(1,457)	-	6	6
As of January 1, 2017	$ 10,756	$ 10,756	$ -	$ 8	$ 8

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (Unaudited)

January 1, 2015 to January 1, 2016

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2015	$ 52,053	$ 55,240	$ (3,187)	$ 266	$ (2,921)
Reasons for change					
Change in the valuation period	2,162	2,330	(169)	2	(167)
Change in projection base	306	595	(289)	(5)	(294)
Changes in the demographic assumptions	(391)	(573)	182	-	182
Changes in economic and health care assumptions	6,501	6,867	(366)	-	(366)
Changes in law	(232)	(239)	6	-	6
Net changes	8,345	8,980	(635)	(3)	(638)
As of January 1, 2016	$ 60,398	$ 64,220	$ (3,822)	$ 263	$ (3,559)
HI - Part A (Note 26)					
As of January 1, 2015	$ 17,902	$ 21,089	$ (3,187)	$ 197	$ (2,990)
Reasons for change					
Change in the valuation period	687	855	(169)	2	(167)
Change in projection base	63	352	(289)	(6)	(294)
Changes in the demographic assumptions	63	(120)	182	-	182
Changes in economic and health care assumptions	1,987	2,353	(366)	-	(366)
Changes in law	-	(6)	6	-	6
Net changes	2,799	3,434	(635)	(4)	(638)
As of January 1, 2016	$ 20,701	$ 24,523	$ (3,822)	$ 194	$ (3,628)
SMI - Part B (Note 26)					
As of January 1, 2015	$ 23,995	$ 23,995	$ -	$ 68	$ 68
Reasons for change					
Change in the valuation period	990	990	-	-	-
Change in projection base	(113)	(113)	-	-	-
Changes in the demographic assumptions	(350)	(350)	-	-	-
Changes in economic and health care assumptions	3,183	3,183	-	-	-
Changes in law	(221)	(221)	-	-	-
Net changes	3,489	3,489	-	-	-
As of January 1, 2016	$ 27,484	$ 27,484	$ -	$ 68	$ 68
SMI - Part D (Note 26)					
As of January 1, 2015	$ 10,156	10,156	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	485	485	-	-	-
Change in projection base	356	356	-	1	1
Changes in the demographic assumptions	(103)	(103)	-	-	-
Changes in economic and health care assumptions	1,330	1,330	-	-	-
Changes in law	(11)	(11)	-	-	-
Net changes	2,057	2,057	-	-	-
As of January 1, 2016	$ 12,213	$ 12,213	$ -	$ 1	$ 1

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

The accompanying financial statements include activities and operations of the U.S. Department of Health and Human Services (HHS or the Department).

HHS is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law. The law established a new federal entity, Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Organization and Structure of HHS

HHS is composed of the Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) with diverse missions and programs. OS and the OpDivs are each responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department's top management and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

CMS, the largest HHS OpDiv, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and other health related programs. CMS is also a separate reporting entity. The CMS annual financial report can be found at CMS website.

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officers Act of*

1990 (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 214 appropriation fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets, Statement of Net Cost, and Statement of Changes in Net Position. The Combined Statement of Budgetary Resources are presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the OpDivs, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

C. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

D. *Patient Protection and Affordable Care Act*

The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the PPACA, became law in FY 2010. Further information is available at Healthcare.gov.

The PPACA provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). One of the main programs under CCIIO is the Affordable Insurance Exchanges (the "Exchanges"). A brief description of these programs is presented below.

Affordable Insurance Exchanges

Grants have been provided to the States to establish Affordable Insurance Exchanges. The initial grants were made by HHS to the States "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

Transitional Reinsurance Program

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators, on behalf of self-insured group health plans, made contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Exchange.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individuals and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a risk adjustment program. States operating a risk adjustment program may have an entity other than the Exchange perform this function. CMS operates a risk adjustment program for each state that does not operate its own.

Risk Corridors Program

The temporary Risk Corridors program operated for benefit years 2014 through 2016. This program applies to Qualified Health Plans in the individual and small group markets, inside and outside the Exchanges and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and Qualified Health Plans.

E. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from Department of Homeland Security to HHS for the Biodefense Countermeasures Fund for Fiscal Year (FY) 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the PPACA, HHS has established a child relationship with the Internal Revenue Service (IRS) of the Department of the Treasury (Treasury) for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Treasury, and Social Security Administration (SSA).

F. Reclassifications and Adjustments

Certain FY 2016 balances have been reclassified to conform to FY 2017 financial statement presentations. The effects are immaterial.

G. Funds from Dedicated Collections

Generally, funds from dedicated collections are financed by specifically identified revenues, provided to the government by non-federal sources, often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government from a non-federal source only for designated activities, benefits, or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
3. A requirement to account for and report on the receipt, use, and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the federal government's general revenues.

HHS's major funds from dedicated collections are described in the sections below.

Medicare Hospital Insurance (HI) Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare HI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for hospital in-patient services, hospice, and select skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as administrative costs are charged to the HI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include the HI Trust Fund activities administered by Treasury. The HI Trust Fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for the Medicare HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contributions Act* (FICA) (26 U.S.C. Ch. 21) and *Self Employment Contributions Act of 1954* (SECA [Ch. 2 of Subtitle A of the Internal Revenue Code, 26 U.S.C. §1401 through §1403]). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the Treasury General Fund to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the SSA records of wages. The SSA uses the wage totals reported by employers to the IRS via the Employer's Quarterly Federal Tax Return, as the basis for its quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, ambulatory surgical centers, end–stage renal disease treatment, rural health clinics, laboratory services, and select skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services as well as administrative costs are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are generally financed by monthly premiums paid by Medicare beneficiaries and are matched by the federal government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and prescribes the ratio for the match as well as the method to fully compensate the Trust Fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare SMI Trust Fund – Part D

The *Medicare Modernization Act of 2003* established the Medicare Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to Medicare beneficiaries enrolled in Medicare Part A and/or Part B. Beneficiaries eligible for both Medicare and Medicaid are automatically enrolled unless they have other

credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to fee-for-service Medicare; and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. Medicare helps employers and unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. The Low Income Subsidy helps those with limited income and resources.

Medicare Integrity Program

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program and codified the Medicare Integrity Program activities previously known as "payment safeguards." The HIPAA also established the Health Care Fraud and Abuse Control Account, which includes a dedicated appropriation for carrying out the Medicare Integrity Program. Through the Medicare Integrity Program, HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, and cost report audits. In addition, the Department educates providers and beneficiaries, with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund.

H. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriation and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year. Funds for long-term projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Borrowing Authority

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act of 1990*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next fiscal year. The CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program is the only borrowing authority program within HHS.

HHS's budgetary activity related to loans is reported separately within the Combined Statement of Budgetary Resources.

Exchange Revenue

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its services. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless of whether they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally-enforceable claim to resources arises, but only to the extent that collection is probable and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management (OPM) and certain legal judgments against HHS are paid from the Judgment Fund maintained by Treasury's Bureau of Fiscal Service (Fiscal Service). When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statement of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

I. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies including SSA and Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments for Social Security beneficiaries who elect to enroll in the Medicare Part B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part B Trust Fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund as well as beneficiary premiums and payments from states.

J. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are related to delinquent child support payments withheld from federal tax refunds for the Child Support Enforcement program, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

K. Fund Balance with Treasury (FBwT)

The FBwT is the aggregate amount of funds in the Department's accounts with Treasury. FBwT is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles FBwT accounts with Treasury on a regular basis.

L. Custodial Activity

HHS reports custodial activities on its Consolidated Balance Sheets in accordance with OMB Circular A-136. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties that are assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

M. Investments, Net

HHS invests entity Medicare Trust Fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI Trust Funds not needed to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Fiscal Service to the HI and SMI Trust Funds as evidence of their receipt and are reported as an asset for the Trust Funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI Trust Funds.

The Treasury securities provide the HI and SMI Trust Funds with authority to draw upon the Fiscal Service to make future benefit payments or other expenditures. When the Trust Funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI Trust Funds are Non-marketable (Par Value) securities. These investments are carried at face value as determined by the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service; and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation Trust Fund, a dedicated collections fund similar to the HI and SMI Trust Funds, invests in Non-Marketable, Market-Based securities issued by the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities, since it is HHS's intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act of 2009* established a Child Enrollment Contingency Fund to provide additional funding to states that experience shortfalls in their CHIP. The PPACA extended the availability of the fund through 2015, and *Medicare Access and CHIP Reauthorization Act of 2015* (*MACRA*) extended the fund for an additional 2 years, through 2017. This fund is invested in Treasury bills issued by the Fiscal Service. These investments will be redeemed as funds are needed by the states to cover short-term shortfalls in the program.

N. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible accounts on public receivables. Intragovernmental accounts receivable consist of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public are primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties and other restitutions, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, and Medicare Secondary Payer accounts receivable.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, HHS calculates the allowance for uncollectible accounts based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding 5 years. The Medicaid accounts receivable have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the states. Other accounts receivable have been recorded to account for amounts due from exchange activities.

O. Advances and Accrued Grant Liability

HHS awards grants and provides advance payments to meet grantees' cash needs in carrying out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability is shown on the Consolidated Balance Sheets when the accrued grant expenses exceed the outstanding advances to grantees.

For most grants, grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an amount accrued for unreported grant expenditures estimated for the fourth quarter based on the grantees' historical spending patterns.

Formula grants and block grants are funded differently. Grantees provide services or payments to individuals and local agencies from a fixed amount of money. These grants are funded based on allocations determined by

budgets and agreements approved by the sponsoring OpDiv. The expenses are recorded as the grantees draw funds; therefore, no year-end accrual is required.

P. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian flu pandemic declaration. The stockpile contains several million doses of vaccine in bulk which are stored and maintained for possible use.

Project Bio Shield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.

Q. General Property, Plant and Equipment, Net

General Property, Plant, and Equipment, Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment, assets under capital lease, leasehold improvements, construction-in-progress, and internal use software. The basis for recording purchased Property, Plant and Equipment is full cost, including all costs incurred to bring the Property, Plant, and Equipment to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of General Property, Plant, and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of General Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all General Property, Plant, and Equipment with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or more.

HHS has commitments under various operating leases with private entities as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years; however, some GSA leases are cancelable with 120 days' notice. Under an operating lease, the cost of the lease is expensed as incurred.

General Property, Plant and Equipment is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal use software costs for appropriated fund accounts is $1.0 million and the threshold for revolving fund accounts is $500,000. Costs below the threshold levels are expensed. Software is amortized using the straight line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

R. Stewardship Land

HHS stewardship land (i.e., land not acquired for or in connection with general property, plant, and equipment) is Indian Trust land used to support the IHS day-to-day operations of providing health care to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS 29*, Heritage Assets and Stewardship Land,* HHS does not report a related amount on the Consolidated Balance Sheets.

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon.

S. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI Trust Fund, since liabilities are only those items that are present obligations of the government. HHS's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category.

T. Accounts Payable

Accounts Payable primarily consist of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

U. Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned

and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability, since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consist primarily of HHS's current FECA liability to DOL.

V. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims Incurred But Not Reported (IBNR) as of the end of the reporting period.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;
- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year;
- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid and CHIP

The Medicaid and the CHIP estimates represent the net federal share of expenses incurred by the states but not yet reported to HHS.

W. Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits on the Consolidated Balance Sheets. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statement of Net Cost.

The liability for federal employee and veterans' benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has 3 parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes 1 percent of each employee's pay to the Thrift Savings Plan and matches the first 3 percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

OPM is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, or other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does recognize an expense in the Consolidated Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

X. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which may require future financial obligations.

Y. Statement of Social Insurance (unaudited)

The Statement of Social Insurance presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. The projections in this report (with one exception related to depletion of the HI Trust Fund), are based on current law; that is, they assume that laws on the books will be implemented and adhered to with respect to scheduled taxes, premium revenues, and payments to providers and health plans. The estimates depend on many economic, demographic, and health care-specific assumptions. These include changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the Statement of Social Insurance actuarial projections are drawn from the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund* and *Social Security* (Medicare Trustees Report) and the *2017 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (OASDI Trustees Report). Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

Note 2. Entity and Non-Entity Assets (in Millions)

	2017	2016
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ 2	$ -
Accounts Receivable	6	5
Total Non-Entity Intragovernmental Assets	8	5
Accounts Receivable With the Public	41	37
Total Non-Entity Assets	49	42
Total Entity Assets	566,774	562,611
Total Assets	$ 566,823	$ 562,653

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2017	2016
Trust Funds	$ 28,588	$ 54,050
Revolving Funds	1,956	2,443
Appropriated Funds	174,946	172,984
Special Funds and Other Funds	4,263	8,282
Total	$ 209,753	$ 237,759

Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 3,273	$ 17,280
Unavailable	32,117	43,230
Obligated Balance not yet Disbursed	234,869	231,154
Non-Budgetary Fund Balance with Treasury	(60,506)	(53,905)
Total	$ 209,753	$ 237,759

The FBwT are funds primarily available to pay current expenditures and liabilities. Special Funds include the PPACA Risk Programs of $3.2 billion. Other Funds include balances in deposit funds, management funds and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $11.2 billion and $8.8 billion as of September 30, 2017, and September 30, 2016, respectively. The restricted amount is primarily for the PPACA programs, CHIP, CMS Program Management, and State Grants and Demonstrations.

Note 4. Investments, Net (in Millions)

2017	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 268,423	$ -	$ 2,278	$ 270,701	$ 270,701
Non-Marketable: Market-Based	5,000	(210)	33	4,823	4,823
Total, Intragovernmental	$ 273,423	$ (210)	$ 2,311	$ 275,524	$ 275,524

2016	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 255,545	$ -	$ 2,256	$ 257,801	$ 257,801
Non-Marketable: Market-Based	4,446	(195)	25	4,276	4,276
Total, Intragovernmental	$ 259,991	$ (195)	$ 2,281	$ 262,077	$ 262,077

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2018 through June 30, 2032 with interest rates ranging from 1.875 percent to 5.125 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2018 with an interest rate from 2.125 percent to 2.25 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2018 through FY 2022. The Market-Based Notes paid from 1.0 percent to 3.875 percent during October 1, 2016 to September 30, 2017, and 1.0 percent to 3.875 percent during October 1, 2015 to September 30, 2016. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Securities held in the NIH gift funds held during 12 months of FY 2017, yielded from 0.3153 percent to 1.1483 percent depending on date purchased and length of time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of $1.1 billion as of September 30, 2017, are short term Treasury Bills purchased at a discount which are fully amortized at the maturity date.

Note 5. Accounts Receivable, Net (in Millions)

2017	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 962	$ -	$ 962	$ -	$ 962
Non-Entity	6	-	6	-	6
Total, Intragovernmental	$ 968	$ -	$ 968	$ -	$ 968
With the Public					
Entity					
Medicare	$ 23,192	$ -	$ 23,192	$ (2,520)	$ 20,672
Medicaid	7,029	-	7,029	(993)	6,036
Other	6,806	288	7,094	(762)	6,332
Non-Entity	6	67	73	(32)	41
Total With the Public	$ 37,033	$ 355	$ 37,388	$ (4,307)	$ 33,081

2016	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 1,007	$ -	$ 1,007	$ -	$ 1,007
Non-Entity	5	-	5	-	5
Total, Intragovernmental	$ 1,012	$ -	$ 1,012	$ -	$ 1,012
With the Public					
Entity					
Medicare	$ 10,193	$ -	$ 10,193	$ (2,740)	$ 7,453
Medicaid	8,382	-	8,382	(1,186)	7,196
Other	9,722	278	10,000	(483)	9,517
Non-Entity	3	58	61	(24)	37
Total With the Public	$ 28,300	$ 336	$ 28,636	$ (4,433)	$ 24,203

As of September 30, 2017, the other accounts receivable with the public is primarily related to collections for Exchange activities.

Note 6. Inventory and Related Property, Net (in Millions)

	2017	2016
Inventory Held for Current Sale, Net	$ 10	$ 7
Operating Materials and Supplies Held for Use	64	68
Stockpile Materials Held for Emergency or Contingency	9,624	9,324
Inventory and Related Property, Net	$ 9,698	$ 9,399

Note 7. General Property, Plant and Equipment, Net (in Millions)

			2017		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	682	-	682
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,149	(3,072)	3,077
Equipment	Straight Line	3-20 Yrs	2,064	(1,235)	829
Internal Use Software	Straight Line	5-10 Yrs	2,918	(1,383)	1,535
Assets Under Capital Lease	Straight Line	1-30 Yrs	124	(67)	57
Leasehold Improvements	Straight Line	*Life of Lease	55	(41)	14
Totals			$ 12,046	$ (5,798)	$ 6,248

			2016		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	772	-	772
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,980	(2,919)	3,061
Equipment	Straight Line	3-20 Yrs	2,029	(1,208)	821
Internal Use Software	Straight Line	5-10 Yrs	1,998	(1,132)	866
Assets Under Capital Lease	Straight Line	1-30 Yrs	139	(63)	76
Leasehold Improvements	Straight Line	*Life of Lease	52	(37)	15
Totals			$ 11,024	$ (5,359)	$ 5,665

*7 to 15 years or the life of the lease, whichever is shorter.

Note 8. Advances (in Millions)

	2017	2016
Intragovernmental		
Advances to Other Federal Entities	$ 233	$ 239
With the Public		
Prescription Drug and Medicare Advantage	29,233	21,460
Grant Advances	1,591	-
Other Prepayments & Deferred Charges	34	18
Travel Advances & Emergency Employee Salary Advances	1	2
Total With the Public	$ 30,859	$ 21,480

As of September 30, 2017, advances with the public primarily represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2017 that occurred on September 29 instead of October 1.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2017	2016
Intragovernmental		
Accrued Payroll and Benefits	$ 58	$ 59
Other	1,510	4,867
Total Intragovernmental	$ 1,568	$ 4,926
Federal Employee and Veterans' Benefits (Note 11)	13,532	12,892
Accrued Payroll and Benefits	663	650
Contingencies and Commitments (Note 14)	14,797	12,394
Accrued Liabilities	5,984	7,758
Other	228	210
Total Liabilities Not Covered by Budgetary Resources	$ 36,772	$ 38,830
Total Liabilities Covered by Budgetary Resources	127,133	122,452
Total Liabilities	$ 163,905	$ 161,282

Note 10. Entitlement Benefits Due and Payable (in Millions)

	2017	2016
Medicare Fee-For-Service	$ 48,029	$ 44,866
Medicare Advantage/Prescription Drug Program	12,596	19,045
Medicaid	34,070	35,419
CHIP	1,345	978
Other	12,307	7,922
Totals	$ 108,347	$ 108,230

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (d) periodic interim payments for services rendered in the current Fiscal Year but paid in the subsequent Fiscal Year; and (e) an estimate of retroactive settlements of cost reports. The September 30, 2017 and 2016 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2017. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2017.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

The Other line item includes estimates of payments due to those participating in Exchange activities.

Note 11. Federal Employee and Veterans' Benefits (in Millions)

	2017	2016
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 12,603	$ 11,995
PHS Commissioned Corp Post-Retirement Health Benefits	650	625
Workers' Compensation Benefits (Actuarial FECA Liability)	279	272
Total, Federal Employee and Veterans' Benefits	$ 13,532	$ 12,892

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,480 active duty officers and 6,872 retiree annuitants and survivors. As of September 30, 2017, the actuarial accrued liability for the retirement benefit plan was $12.6 billion and $0.7 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commission Corp Retirement System and Post-Retirement Health Benefits are not funded. Therefore, in accordance with SFFAS 33*, Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates* (SFFAS 33), the discount rate should be based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2017, and September 30, 2016, were:

	2017	2016
Discount rate	4.05 percent	4.26 percent
Annual basic pay scale increase	2.56 percent	2.51 percent
Annual inflation	2.06 percent	2.01 percent

	2017	2016
Beginning Liability Balance	$ 12,620	$ 11,801
Expense		
Normal Cost	339	326
Interest on the liability balance	527	493
Actuarial (Gain)/Loss		
From experience	(188)	107
From assumption changes		
Change in discount rate assumption	381	303
Change in inflation/salary increase assumption	85	(259)
Change in mortality rate/others	(17)	332
Net Actuarial (Gain)/Loss	261	483
Total expense	$ 1,127	$ 1,302
Less amounts paid	(494)	(483)
Ending Liability Balance	$ 13,253	$ 12,620

The above shows key valuation results as of September 30, 2017 and 2016, in conformance with the actuarial reporting standards set forth in the SFFAS 5, *Accounting for Liabilities of the Federal Government* and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2017, and actuarial assumptions. The September 30, 2017 valuation includes an increase in liabilities of $633 million resulting from an increase in normal cost and interest, which is offset by actuarial changes in assumptions for salary scale and discount rate in combination with a decrease in the actual plan experience. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. In FY 2015, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2017, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior 4 years for FY 2017 and FY 2016, respectively. Interest rate assumptions utilized for discounting as of September 30, 2017, and September 30, 2016, as follows.

	2017	2016
Wage Benefits	2.683% in Year 1 and years thereafter	2.781% in Year 1 and years thereafter
Medical Benefits	2.218% in Year 1 and years thereafter	2.261% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPIM]) are applied to the calculations of projected future benefits. These factors are also used to adjust historical payments to current year constant dollars. The compensation COLAs and CPIMs used in the projections are:

FY	COLA	CPIM
2017	N/A	N/A
2018	1.22%	3.20%
2019	1.35%	3.52%
2020	1.59%	3.80%
2021	1.99%	3.99%
2022	2.26%	3.91%

Note 12. Accrued Liabilities (in Millions)

	2017	2016
Grant Liability	$ 5,888	$ 4,915
Other Accrued Liabilities	5,984	9,505
Accrued Liabilities	$ 11,872	$ 14,420

Note 13. Other Liabilities (in Millions)

	2017		2016	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 139	$ 988	$ 136	$ 960
Advances from Others	750	356	609	744
Deferred Revenue	-	1,421	-	1,066
Custodial Liabilities	362	7	407	5
Legal Liabilities	1,088	-	1,021	-
Other	7,322	1,586	4,890	2,188
Total Other Liabilities	$ 9,661	$ 4,358	$ 7,063	$ 4,963

The *Balanced Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums. Section 601 created an "additional premium" charged alongside the normal Medicare Part B monthly premiums, beginning in 2016, which will be used to pay back the General Fund transfer without interest. As of September 30, 2017, $6.4 billion ($3.3 billion in FY 2016) is still owed

and reported under Other Liabilities. Legal Liabilities of $1.1 billion as of September 30, 2017, ($1.0 billion as of September 30, 2016) consist of reimbursable claims due to the Judgment Fund, which is administered by the Fiscal Service.

Note 14. Contingencies and Commitments (in Millions)

HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances

The Medicaid amount of $12.2 billion ($10.2 billion in FY 2016) consists of Medicaid audit and program disallowances of $1.2 billion ($2.8 billion in FY 2016) and of $11.0 billion ($7.4 billion in FY 2016) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2017, 10,067 cases (10,005 in FY 2016) remain on appeal. A total of 2,251 new cases (2,515 in FY 2016) were filed and 11 cases were reopened (10 in FY 2016). The PRRB rendered decisions on 128 cases (66 in FY 2016) and an additional 2,072 cases (2,191 in FY 2016) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*, dated June 18, 2012, is likely to result in increased claims against the IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment value of injury claims.

Note 15. Revenue (in Millions)

2017 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 137	$ 7,522	$ 674	$ 88	$ 8,421	$ (3,468)	$ 4,953
Exchange Revenue	(26)	(3,929)	(384)	(8)	(4,347)	3,121	(1,226)
Net Cost, *Intragovernmental*	111	3,593	290	80	4,074	(347)	3,727
With the Public							
Gross Cost	14,344	474,890	656,248	38,671	1,184,153	-	1,184,153
Exchange Revenue	-	(11,586)	(89,409)	(36)	(101,031)	-	(101,031)
Net Cost, *With the Public*	14,344	463,304	566,839	38,635	1,083,122	-	1,083,122
Total Gross Cost	14,481	482,412	656,922	38,759	1,192,574	(3,468)	1,189,106
Total Exchange Revenue	(26)	(15,515)	(89,793)	(44)	(105,378)	3,121	(102,257)
Total Net Cost of Operations	$ 14,455	$ 466,897	$ 567,129	$ 38,715	$ 1,087,196	$ (347)	$ 1,086,849

2016 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OpDiv Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 119	$ 6,275	$ 840	$ 73	$ 7,307	$ (2,338)	$ 4,969
Exchange Revenue	(17)	(2,973)	(12)	(7)	(3,009)	2,044	(965)
Net Cost, *Intragovernmental*	102	3,302	828	66	4,298	(294)	4,004
With the Public							
Gross Cost	14,823	467,160	646,201	38,643	1,166,827	-	1,166,827
Exchange Revenue	-	(15,113)	(80,915)	(31)	(96,059)	-	(96,059)
Net Cost, *With the Public*	14,823	452,047	565,286	38,612	1,070,768	-	1,070,768
Total Gross Cost	14,942	473,435	647,041	38,716	1,174,134	(2,338)	1,171,796
Total Exchange Revenue	(17)	(18,086)	(80,927)	(38)	(99,068)	2,044	(97,024)
Total Net Cost of Operations	$ 14,925	$ 455,349	$ 566,114	$ 38,678	$ 1,075,066	$ (294)	$ 1,074,772

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $102.3 billion and $97.0 billion through September 30, 2017 and 2016, respectively. HHS's exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

Note 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for 5 subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All Trust Fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of Trust Fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation, as needed. The entire Trust Fund balances in the amount of $207.4 billion, as of September 30, 2017, ($201.6 billion as of September 30, 2016), are included in Investments on the Consolidated Balance Sheets.

Exempt from Apportionment

This amount includes the FY 2017 recording of obligations required by law, where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The *Anti-Deficiency Act* has not been violated, as "[t]he prohibitions contained in the *Anti-Deficiency Act* are directed at discretionary obligations entered into by administrative officers." B-219161 (Oct. 2, 1985).

Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

2016	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 1,668,313	$ 1,607,803	$ 428,128	$ 1,527,757
Expired Accounts	(38,021)	-	-	-
Other	(1,023)	(22)	223	(96)
Budget of the U.S. Government	$ 1,629,269	$ 1,607,781	$ 428,351	$ 1,527,661

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2017, has not been published, therefore, no comparisons can be made between FY 2017 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2019 President's Budget* is expected to be released in February 2018 and may be obtained from OMB or from GPO.

HHS reconciled the amounts of the FY 2016 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2016 from the Appendix in the *FY 2018 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays (i.e., gross outlays less offsetting collections), as presented above.

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources and new obligations and upward adjustments are due to gift funds and trust funds reported on the HHS Combined Statement of Budgetary Resources but not in the *President's Budget*. Governmentwide Treasury Account Symbol revision window adjustments are not included in the HHS Combined Statement of Budgetary Resources but are included in the *President's Budget*. In addition, there are differences related to adjustments made to recoveries and spending authority.

Note 18. Apportionment Categories of New Obligations and Upward Adjustments: Direct vs. Reimbursable Obligations and Undelivered Orders (in Millions)

	2017		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 106,332	$ 8,587	$ 114,919
Category B (Restricted and Distributed by Activity)	795,136	4,750	799,886
Exempt from Apportionment	732,341	16	732,357
Total New Obligations and Upward Adjustments	$ 1,633,809	$ 13,353	$ 1,647,162

	2016		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 102,101	$ 8,418	$ 110,519
Category B (Restricted and Distributed by Activity)	768,700	4,293	772,993
Exempt from Apportionment	724,276	15	724,291
Total New Obligations and Upward Adjustments	$ 1,595,077	$ 12,726	$ 1,607,803

New Obligations and Upward Adjustments consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular Number A-11, *Preparation, Submission and Execution of the Budget*, requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, *Report on Budget Execution and Budgetary Resources*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported $151.6 billion of budgetary resources obligated for undelivered orders as of September 30, 2017, and $140.2 billion as of September 30, 2016.

Note 19. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table below. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B, medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare Integrity Program. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the funds.

	2017			
Balance Sheet as of September 30	Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 28,284	$ 7,881	$ -	$ 36,165
Investments	270,702	3,680	-	274,382
Other Assets	122,260	7,704	(72,739)	57,225
Total Assets	$ 421,246	$ 19,265	$ (72,739)	$ 367,772
Entitlement Benefits Due and Payable	$ 60,625	$ 12,303	$ -	$ 72,928
Accrued Liabilities (Note 12)	-	5,984	-	5,984
Other Liabilities	83,628	3,011	(72,739)	13,900
Total Liabilities	$ 144,253	$ 21,298	$ (72,739)	$ 92,812
Unexpended Appropriations	17,287	(3)	-	17,284
Cumulative Results of Operations	259,706	(2,030)	-	257,676
Total Liabilities and Net Position	$ 421,246	$ 19,265	$ (72,739)	$ 367,772
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 656,922	$ 13,903	$ (418)	$ 670,407
Less: Exchange Revenues	89,793	10,168	381	99,580
Net Cost of Operations	$ 567,129	$ 3,735	$ (37)	$ 570,827
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 268,602	$ 780	$ -	$ 269,382
Nonexchange Revenue	274,135	327	-	274,462
Other Financing Sources	301,385	595	(37)	301,943
Net Cost of Operations	(567,129)	(3,735)	37	(570,827)
Change in Net Position	$ 8,391	$ (2,813)	$ -	$ 5,578
Net Position End of Period	$ 276,993	$ (2,033)	$ -	$ 274,960

	2016			
Balance Sheet as of September 30	Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 53,806	$ 6,892	$ -	$ 60,698
Investments	257,801	3,706	-	261,507
Other Assets	103,171	10,470	(74,786)	38,855
Total Assets	$ 414,778	$ 21,068	$ (74,786)	$ 361,060
Entitlement Benefits Due and Payable	$ 63,911	$ 7,915	$ -	$ 71,826
Accrued Liabilities (Note 12)	-	9,505	-	9,505
Other Liabilities	82,265	2,868	(74,786)	10,347
Total Liabilities	$ 146,176	$ 20,288	$ (74,786)	$ 91,678
Unexpended Appropriations	36,012	(100)	-	35,912
Cumulative Results of Operations	232,590	880	-	233,470
Total Liabilities and Net Position	$ 414,778	$ 21,068	$ (74,786)	$ 361,060
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 647,041	$ 18,653	$ -	$ 665,694
Less: Exchange Revenues	80,927	13,114	-	94,041
Net Cost of Operations	$ 566,114	$ 5,539	$ -	$ 571,653
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 246,863	$ 4,801	$ -	$ 251,664
Nonexchange Revenue	264,044	346	-	264,390
Other Financing Sources	323,809	1,172	-	324,981
Net Cost of Operations	(566,114)	(5,539)	-	(571,653)
Change in Net Position	$ 21,739	$ (4,021)	$ -	$ 17,718
Net Position End of Period	$ 268,602	$ 780	$ -	$ 269,382

Note 20. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.2 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 36 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

	2017	2016
Albuquerque	4	4
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	77	77

Note 21. Incidental Custodial Collections

Custodial collections represent revenue that was or will be collected on behalf of another entity, and the disposition of that revenue, for the General Fund of U.S. Government, a trust fund, or other recipient entities. HHS reports custodial activities on the Consolidated Balance Sheets; however, HHS does not prepare a separate Statement of Custodial Activity, since custodial activities are incidental to its operations and the amounts collected are immaterial.

The majority of the custodial collections is funding ACF receives from the IRS for outlays to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. In addition, ACF transfers to the General Fund the federal share of state collections that were collected on behalf of children in the Temporary Assistance for Needy Families program and Foster Care Programs.

HHS's custodial collections were $3.1 billion of which $2.5 billion was related to ACF in FY 2017, while the collections were $2.9 billion of which $2.6 billion was related to ACF in FY 2016. HHS transferred the collections to the General Fund. HHS does not have the authority to retain any collections.

Note 22. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2017	2016
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
New Obligations and Upward Adjustments	$ 1,647,162	$ 1,607,803
Spending Authority from Offsetting Collections and Recoveries	(80,751)	(63,331)
Obligations Net of Offsetting Collections and Recoveries	1,566,411	1,544,472
Distributed Offsetting Receipts	(446,103)	(428,128)
Net Obligations	$ 1,120,308	$ 1,116,344
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	399	367
Total Resources Used to Finance Activities	$ 1,120,707	$ 1,116,711
Resources Used to Finance Items Not Part of the Net Cost of Operations:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ 13,270	$ 33,922
Resources That Fund Expenses Recognized in Prior Periods	15	12
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	7,292	10,092
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	556	694
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	3,935	(2,511)
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	25,068	42,209
Total Resources Used to Finance the Net Cost of Operations	$ 1,095,639	$ 1,074,502
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	$ (7,832)	$ (1,024)
Components Not Requiring or Generating Resources	(958)	1,294
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	(8,790)	270
Net Cost of Operations	$ 1,086,849	$ 1,074,772

Note 23. Combined Schedule of Spending (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies spend (i.e., obligate) money. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

OMB makes available a searchable website, USAspending.gov[7], that provides information on federal awards of contracts and financial assistance awards (including grants) and is accessible to the public at no cost. When comparing USAspending.gov data to the Combined Schedule of Spending one must take into account that the website has a fundamentally different purpose. There are differences due to object classes not reported to

[7] The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

USAspending.gov that include but are not limited to personnel compensation, travel, utilities, and leases, intra-departmental and interagency spending, and various other categories of financial awards. In addition, the reporting entity between the financial statements and USAspending.gov differs for awards resulting from funding allocations between agencies, and/or HHS OpDivs. Also, recovery of prior year obligations are reported as deobligations on USAspending.gov but are not reported on the Combined Schedule of Spending. As a result, USAspending.gov data will differ from the Combined Schedule of Spending.

What Money is Available to Spend? This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the FY. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current FY. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, purchase orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amount agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by Treasury Symbol. Those Treasury Account Symbols with spending greater than $1.0 billion are presented separately.

Combined Schedule of Spending
For the Years Ended September 30, 2017 and 2016
(in Millions)

	FY 2017	FY 2016
What Money is Available to Spend		
Total Resources	$ 1,682,552	$ 1,668,313
Less Amount Available but Not Agreed to be Spent	3,273	17,280
Less Amount Not Available to be Spent	32,117	43,230
Total Amounts Agreed to be Spent	$ 1,647,162	$ 1,607,803
Who did the Money Go To		
Federal	$ 10,498	$ 9,105
Non-Federal	1,636,664	1,598,698
Total Amounts Agreed to be Spent	$ 1,647,162	$ 1,607,803

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2017

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims and Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2017
Medicaid	$ 417,710	$ -	$ 103	$ 19	$ 4,213	$ 422,045
Payments to Trust Funds	231,663	-	-	-	83,621	315,284
Federal Supplementary Medical Insurance Trust Fund	4	308,851	141	1	5,546	314,543
Federal Hospital Insurance Trust Fund	-	296,222	359	-	4,322	300,903
Medicare Prescription Drug Account	-	88,260	-	1	828	89,089
Taxation on OASDI Benefits, HI	24,206	-	-	-	-	24,206
Temporary Assistance for Needy Families	16,618	-	91	10	2	16,721
State Children's Health Insurance Fund	15,964	-	2	-	-	15,966
Children and Families Services Programs	10,871	1	317	157	16	11,362
Payments for Foster Care and Permanency	8,392	-	33	-	1	8,426
National Cancer Institute	3,337	-	1,702	542	108	5,689
Indian Health Services	2,441	1	841	1,413	744	5,440
National Institute of Allergy and Infectious Diseases	3,091	-	1,685	335	96	5,207
Primary Health Care	4,751	-	222	75	9	5,057
Transitional Reinsurance Program	-	4,639	1	-	76	4,716
Payments to States for Child Support Enforcement and Family Support Programs	3,807	-	647	-	1	4,455
Risk Adjustment Program Payments	-	3,768	-	-	-	3,768
Low Income Home Energy Assistance	3,391	-	3	-	-	3,394
National Heart, Lung, and Blood Institute	2,554	-	502	164	32	3,252
Child Care Entitlement to States	2,925	-	19	-	-	2,944
Payment to States for the Child Care and Development Block Grant	2,816	-	39	-	-	2,855
Substance Abuse Treatment	2,545	-	156	10	3	2,714
National Institute of General Medical Sciences	2,517	-	112	32	1	2,662
Public Health and Social Services Emergency Fund	471	1	1,298	140	487	2,397
Ryan White HIV/AIDS Program	2,226	-	87	27	5	2,345
Refugee and Entrant Assistance	1,711	-	389	14	9	2,123
National Institute of Diabetes and Digestive and Kidney Diseases	1,733	-	219	120	25	2,097
National Institute on Aging	1,792	-	179	76	31	2,078
Aging and Disability Services Programs	1,955	-	47	31	4	2,037
Health Care Fraud and Abuse Control Account	1	-	1,429	74	471	1,975
NIH Service and Supply Fund	-	-	1,252	285	360	1,897
National Institute of Neurological Disorders and Stroke	1,463	-	228	88	26	1,805
Social Services Block Grant	1,647	-	12	1	-	1,660
PSC Service and Supply Fund	-	-	1,388	149	79	1,616
National Institute of Mental Health	1,278	-	215	101	20	1,614
National Institute of Child Health and Human Development	972	-	317	103	22	1,414
Public Health Preparedness and Response	623	-	250	117	408	1,398
CDC-Wide Activities and Program Support	635	-	372	170	100	1,277
National Institute on Drug Abuse	876	-	248	68	11	1,203
Mental Health	1,066	-	124	5	2	1,197
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	743	-	191	173	14	1,121
Chronic Disease Prevention and Health Promotion	726	-	256	127	8	1,117
Medicare Health Information Technology Incentive	-	1,003	-	-	-	1,003
Centers for Medicare and Medicaid Innovation	375	40	502	81	3	1,001
Other Agency Budgetary Accounts	12,944	5,183	13,516	7,154	3,292	42,089
Total Amounts Agreed to be Spent	$ 792,840	$ 707,969	$ 29,494	$ 11,863	$ 104,996	$ 1,647,162

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2016

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims and Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	FY 2016
Medicaid	$ 393,919	$ -	$ 108	$ 18	$ 4,172	$ 398,217
Payments to Trust Funds	215,830	-	-	-	94,282	310,112
Federal Supplementary Medical Insurance Trust Fund	-	300,768	126	-	5,668	306,562
Federal Hospital Insurance Trust Fund	-	291,252	2	-	5,594	296,848
Medicare Prescription Drug Account	-	92,039	-	-	765	92,804
Taxation on OASDI Benefits, HI	23,022	-	-	-	-	23,022
Temporary Assistance for Needy Families	16,649	-	71	2	-	16,722
State Children's Health Insurance Fund	14,002	-	4	-	64	14,070
Children and Families Services Programs	10,509	-	291	151	24	10,975
Payments for Foster Care and Permanency	7,822	-	35	-	1	7,858
National Cancer Institute	3,300	-	1,457	511	124	5,392
Indian Health Services	2,339	1	847	1,361	702	5,250
National Institute of Allergy and Infectious Diseases	3,384	-	1,222	319	94	5,019
Primary Health Care	4,733	-	232	64	12	5,041
Transitional Reinsurance Program	-	7,842	-	-	4	7,846
Payments to States for Child Support Enforcement and Family Support Programs	3,683	-	684	-	-	4,367
Risk Adjustment Program Payments	-	3,544	-	-	-	3,544
Low Income Home Energy Assistance	3,369	-	3	-	-	3,372
National Heart, Lung, and Blood Institute	2,465	-	525	158	35	3,183
Child Care Entitlement to States	2,928	-	23	-	-	2,951
Payment to States for the Child Care and Development Block Grant	2,719	-	42	-	-	2,761
Substance Abuse Treatment	2,045	-	144	9	2	2,200
National Institute of General Medical Sciences	2,442	-	83	31	1	2,557
Public Health and Social Services Emergency Fund	348	-	853	122	478	1,801
Ryan White HIV/AIDS Program	2,149	-	92	24	4	2,269
Refugee and Entrant Assistance	1,502	-	346	13	4	1,865
National Institute of Diabetes and Digestive and Kidney Diseases	1,662	-	218	116	22	2,018
National Institute on Aging	1,383	-	154	71	25	1,633
Aging and Disability Services Programs	1,956	-	47	29	4	2,036
Health Care Fraud and Abuse Control Account	-	-	1,267	74	533	1,874
NIH Service and Supply Fund	46	-	1,108	264	352	1,770
National Institute of Neurological Disorders and Stroke	1,416	-	215	89	31	1,751
Social Services Block Grant	1,657	-	10	1	-	1,668
PSC Service and Supply Fund	-	-	1,108	149	96	1,353
National Institute of Mental Health	1,261	-	206	95	16	1,578
National Institute of Child Health and Human Development	982	-	311	99	18	1,410
Public Health Preparedness and Response	613	-	300	110	350	1,373
CDC-Wide Activities and Program Support	518	-	367	179	121	1,185
National Institute on Drug Abuse	864	-	194	66	9	1,133
Mental Health	1,069	-	118	4	3	1,194
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	738	-	200	171	14	1,123
Chronic Disease Prevention and Health Promotion	762	-	283	127	7	1,179
Medicare Health Information Technology Incentive	-	2,794	-	-	-	2,794
Centers for Medicare and Medicaid Innovation	464	109	645	74	3	1,295
Other Agency Budgetary Accounts	14,609	6,063	13,021	6,814	2,321	42,828
Total Amounts Agreed to be Spent	$ 749,159	$ 704,412	$ 26,962	$ 11,315	$ 115,955	$ 1,607,803

Note 24. Statement of Social Insurance (Unaudited)

The Statement of Social Insurance presents, for the 75-year projection period, the present values of the income and expenditures of the HI and SMI trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2017 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The 2017 Trustees Report was developed based on the assumptions and review from the 2010-2011 Technical Review Panel (the 2011 Panel). In September 2017, a more recent final review of the Technical Review Panel (the 2017 Panel) was released. The 2017 Panel generally found that the baseline assumptions used in the Medicare projections under current law to be reasonable. Also, the 2017 Panel felt the assumptions used in long- range projections were broadly reasonable.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on July 13, 2017, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the HI trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The Statement of Social Insurance sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The Statement of Social Insurance also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to

economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the Statement of Social Insurance also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the Statement of Social Insurance. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on July 13, 2017, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2017 Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2017*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website at http://www.cms.hhs.gov/CFOReport/.[8]

[8]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2017

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2017	1.90	1,559,000	772.1	1.84	4.00	2.17	2.9	0.5	3.1	−0.2	−0.3
2020	1.98	1,512,000	750.2	1.87	4.47	2.60	2.9	4.1	5.1	5.4	1.7
2030	2.00	1,332,000	686.1	1.29	3.89	2.60	2.1	3.8	4.8	4.5	2.7
2040	2.00	1,282,000	630.8	1.21	3.81	2.60	2.2	4.6	4.2	4.7	2.7
2050	2.00	1,257,000	582.3	1.24	3.84	2.60	2.2	3.8	3.7	4.7	2.7
2060	2.00	1,243,000	539.7	1.21	3.81	2.60	2.1	3.6	3.6	4.5	2.7
2070	2.00	1,234,000	502.0	1.15	3.75	2.60	2.1	3.8	3.6	4.4	2.7
2080	2.00	1,229,000	468.6	1.13	3.73	2.60	2.1	3.8	3.6	4.4	2.7
2090	2.00	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the Statement of Social Insurance are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 below summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2017-2013

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2014	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2013	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 12th year of the projection period.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 795,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[4]Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Note 25. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide private nonfarm business multifactor productivity and the specified physician updates put in place by *MACRA*—will occur as current law requires. In order for this outcome to be achievable, health care providers would have to realize productivity improvements at a faster rate than experienced historically. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to

widen throughout the projection, and the Trustees estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2026, physician payments transition from a payment update of 0.6 percent to an increase of 2.2 percent. In addition, the illustrative alternative assumes the continuation of the 5 percent bonuses for physicians in advanced alternative models (APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS). In addition, the projection assumes that the Independent Payment Advisory Board (IPAB) requirements would not be implemented.[9] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$21,738	$21,888
Part B	30,783	38,712
Part D	10,756	10,946
Expenditures		
Part A	25,270	31,529
Part B	30,783	38,712
Part D	10,756	10,946
Income less expenditures		
Part A	(3,532)	(9,641)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2017 Trustees Report.

[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

[9]The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of *MACRA* in 2015 replaced the SGR with specified physician updates.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.1-percent reduction in annual cost growth each year for these providers. If the productivity adjustments were gradually phased out, the physician updates transitioned to the Medicare Economic Index update of 2.2 percent, the 5-percent bonuses paid to physicians in APMs did not expire, and the IPAB requirements were not implemented, as illustrated under the alternative scenario, the estimated present values of Part A and Part B expenditures would each be higher than the current-law projections by roughly 25 and 26 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 26 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor effect is the result of the removal of the IPAB impact and a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

Note 26. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2016 to the period beginning on January 1, 2017, and the reconciliation from the period beginning on January 1, 2015 to the period beginning on January 1, 2016. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 24 summarizes these assumptions for the current year.

Period beginning on January 1, 2016 and ending January 1, 2017

Present values as of January 1, 2016 are calculated using interest rates from the intermediate assumptions of the 2016 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2017. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2016 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2017 Trustees Report.

Period beginning on January 1, 2015 and ending January 1, 2016

Present values as of January 1, 2015 are calculated using interest rates from the intermediate assumptions of the 2015 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2016. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2015 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2016 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2016-90) to the current valuation period (2017-91) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2016, replaces it with a much larger negative net cash flow for 2091, and measures the present values as of January 1, 2017, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2016-90 to 2017-91. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2016 are realized. The change in valuation period increased the starting level of assets in the combined Medicare Trust Funds.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2015-89) to the current valuation period (2016-90) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2015, replaces it with a much larger negative net cash flow for 2090, and measures the present values as of January 1, 2016, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2015-89 to 2016-90. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2015 are realized. The change in valuation period slightly increased the starting level of assets in the combined Medicare Trust Funds.

Change in Projection Base

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

Actual income and expenditures in 2016 were different than what was anticipated when the 2016 Trustees Report projections were prepared. Part A income was higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2016 and January 1, 2017 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

Actual income and expenditures in 2015 were different than what was anticipated when the 2015 Trustees Report projections were prepared. Part A income and expenditures were higher than anticipated, based on actual experience. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2015 and January 1, 2016 is incorporated in the current valuation and is slightly less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2017), with the exception of a small change in marriage rates, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2015 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2014 mortality data obtained from the National Center for Health Statistics at ages under 65 and preliminary 2014 mortality data from Medicare experience at ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were no consequential changes in demographic methodology.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in a decrease in the estimated future net cash flow. The present value of estimated expenditures is lower for Part A but slightly higher for Parts B and D; and the present value of estimated income is also higher for Parts B and D but lower for Part A.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016
The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2016), with the exception of a small change in marriage rates, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2013 and 2014 indicated lower birth rates than were expected in the prior valuation. The data also show an increase in birth rates starting in 2014, one year later than assumed in the prior valuation.
- Incorporating mortality data obtained from the National Center for Health Statistics at ages under 65 for 2012 and 2013 and from Medicare experience at ages 65 and older for 2013 resulted in slightly higher death rates than were projected in the prior valuation.
- Assumed ultimate marriage rates were decreased somewhat to reflect a continuation of recent trends.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were two changes in demographic methodology:

- The transition from recent mortality rates to the ultimate rates starts sooner, immediately after the year of final data. The approach used for the prior valuation extended the trend of the last 10 years through the valuation year for the report and only thereafter started the transition to assumed ultimate rates of decline.
- Historical non-immigrant population counts were revised to match recent totals provided by the Department of Homeland Security. In addition, emigration rates for the never-authorized and visa-overstayer populations were recalibrated to reflect a longer historical period and to be less influenced by the high emigration rates experienced during the recent recession. Finally, the method for projecting emigration of the never-authorized population was altered to reflect lower rates of emigration for those who have resided here longer.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated expenditures is lower for all parts of Medicare; and the present value of estimated income is also lower for Parts B and D but very slightly higher for Part A.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017
The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2017), there was one change to the ultimate economic assumptions.

- The ultimate average real-wage differential is assumed to be 1.20 percent in the current valuation, which is close to a 0.01 percent decrease relative to the previous valuation (even though both ultimate average real-wage differentials are 1.20 when rounded to two decimal places).

In addition to this change in assumption, the assumed real-wage differential for the first ten years of the projection period averaged 0.05 percent lower than in the previous valuation. The lower long-term and near-term real-wage differential assumptions are based on new projections of faster growth in employer sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, faster growth in these premiums means that a smaller share of employee compensation will be in the form of wages that are subject to the payroll tax.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed. Most significantly, an assumed weaker recovery from the recent recession than previously expected led to a reduction in the ultimate level of actual and potential GDP of about 1.0 percent for all years after the short-range period.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rate assumptions for inpatient hospital and skilled nursing facilities services were decreased.
- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year's assumptions.
- Lower productivity increases through 2025, resulting in higher provider payment updates.
- Higher projected drug rebates.
- Change in projection methodology of drug spending for Part B patients with end-stage renal disease.

The net impact of these changes resulted in an increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, these changes decreased the present value of estimated expenditures (and also income).

For the period beginning on January 1, 2015 to the period beginning on January 1, 2016

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2016), there were three changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.1 percentage point, to 2.6 percent from 2.7 percent for the previous valuation.
- The ultimate average real wage differential is assumed to be 1.20 percent in the current valuation period, compared to 1.17 percent in the previous valuation period.

- The ultimate real interest rate was lowered by 0.2 percentage point, to 2.7 percent from 2.9 percent for the previous valuation period.

While very low inflation in recent years is reflective of U.S. and international supply and demand factors that have been affected by the global recession, the average rate of change in the CPI-W over the last two complete business cycles (from 1989 to 2007) is 2.63 percent.

The higher real wage differential assumption is based on new projections by the CMS of slower growth in employer-sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.

Real interest rates have been low since 2000, and particularly low since the start of the recent recession. An ongoing and much-debated question among experts is how much of this change is cyclic or a temporary response to extraordinary events, versus a fundamental permanent change. The Trustees believe that lowering the long-term ultimate real interest rate somewhat is appropriate at this time. The long-range present values are very sensitive to the ultimate interest rate assumption because they are used as the discount factor. The reduction in the ultimate interest rate assumption from 2.9 percent to 2.7 percent increases each of the present values by roughly 15-16 percent.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- A reduction in the ultimate level of actual and potential gross domestic product (GDP) of about 1.0 percent is assumed. Thus, by the end of the short-range period (2025) and for all years thereafter, projected GDP in 2009 dollars is about 1.8 percent below the level in last year's report.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rate assumptions for inpatient hospital services were increased.
- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year’s assumptions.
- Lower productivity increases through 2021, resulting in higher provider payment updates.
- Greater reductions in expenditures attributable to the Independent Payment Advisory Board.
- Inclusion of the income and expenditures for aged non-insured beneficiaries in the Part A long-range analysis.
- Higher projected drug cost trend, particularly for certain high-cost specialty drugs.

The net impact of these changes resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall decrease in the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

Changes in Law

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *21st Century Cures Act* included provisions that affect the HI and SMI Part B programs.
  - For inpatient hospital services, the adjustment to the payment rate increase of 0.5 percentage point for FY 2018, as established by the *Medicare Access and CHIP Reauthorization Act of 2015* (*MACRA*), is reduced to an adjustment of 0.4588 percentage point. (The adjustments to the rate increases of 0.5 percentage point for each of FYs 2019 through 2023, as also established by *MACRA*, are unchanged.)
  - For long-term care hospital (LTCH) discharges occurring during FY 2017, the LTCH 25-percent rule is suspended.
  - A change is made to the moratorium that prohibits the classification of new LTCHs and new LTCH satellite facilities and an increase in beds for existing LTCHs and existing LTCH satellite facilities. No exceptions to the moratorium had been provided to allow existing LTCHs and existing LTCH satellite facilities to increase their number of certified beds; however, under the *Cures Act*, these existing facilities are permitted to do so. This provision is effective as if the exception for these bed increases had always applied during the moratorium. A reduction to high-cost outlier payments to LTCH standard rate cases, through an increase to the qualifying threshold, is also provided for and is intended to offset costs of the moratorium exceptions provision.
  - Several changes are made that involve the LTCH site-neutral provision.
    - The first modification is to the calculation of the average length of stay for certain LTCHs. Under prior law, discharges paid at the site-neutral payment rate or by an MA plan were excluded from calculations determining the hospital's average length of stay, effective for cost-reporting periods starting on or after October 1, 2015. Under the *Cures Act*, this carve-out of site-neutral and MA discharges (which is generally advantageous to LTCHs) applies to the average length of stay calculation for newer LTCHs as well. Thus, the average length of stay calculation methodology is now the same for all LTCHs. This provision is effective retroactively, for cost-reporting periods starting on or after October 1, 2015.
    - Next, a temporary exception to the site-neutral criteria is provided for certain LTCHs that primarily treat patients with brain and spinal cord injuries, are non-profit, and have a significant number of admissions from out of state, for all discharges in cost-reporting periods beginning during FYs 2018 and 2019.
    - Finally, a temporary exception to the site-neutral criteria is created for certain discharges from certain LTCHs for beneficiaries receiving treatment for specified types of severe wounds. To qualify for the exception, the stay for one of the specified types of severe wounds must be classified under one of four specified Medicare severity LTCH diagnosis-related groups (MS-LTC-DRGs). Further, the facility must be a grandfathered LTCH. This provision is effective for these specified discharges occurring in cost-reporting periods that begin during FY 2018.
  - The Secretary of HHS is authorized to deny payment for services provided in temporary moratorium areas (which are geographic areas that have been established by CMS for specified types of providers, for the development and improvement of investigating and prosecuting fraud). Previously, denial was based on the location of the provider rather than on the location of the patient; this provision

eliminates the ability of a provider to locate a business office outside of a moratorium area but be paid for services furnished within it.

- Medicare beneficiaries with end-stage renal disease are allowed to enroll in MA plans, effective for plan years beginning in 2021 and later. Standard acquisition costs for kidneys are to be removed from the capitation rates and paid for by traditional Medicare.
- Additional requirements are established for assigning Medicare FFS beneficiaries to accountable care organizations (ACOs) under the Medicare shared savings program. Specifically, the basis for assignment is required to reflect beneficiaries' utilization of not only primary care services provided by ACO physicians but also services furnished in federally qualified health centers or rural health clinics, effective for performance years beginning on or after January 1, 2019.
- Under the competitive bidding program for certain durable medical equipment (DME) items, the transition period is extended, such that the implementation of payments based entirely on the competitively bid rates (rather than on a blend of these rates and rates under the prior fee schedule payment methodology) is delayed retroactively, from July 1, 2016 to January 1, 2017.
  - Also, for DME providers in non-competitively bid, new considerations are stipulated for determining adjustments to the competitively bid prices. Specifically, the Secretary of HHS is required to take into account stakeholder input and the highest winning bid in the competitively bid areas and to compare, with respect to non-competitively and competitively bid areas, the average travel distance and cost associated with furnishing the items and services, the average volume of the items and services furnished by suppliers, and the number of suppliers. This provision is effective for services furnished on or after January 1, 2019.
- For infusion drugs furnished by suppliers of DME, the reimbursement methodology is changed from 95 percent of the average wholesale price to the average sales price plus 6 percent (that is, to the methodology used for most physician-administered drugs), effective January 1, 2017. Also, these drugs are removed from the DME competitive acquisition areas, beginning on the date of enactment.
- Qualified home infusion therapy suppliers are to be reimbursed for administering home infusion therapy, effective January 1, 2021. Certain requirements and standards for suppliers, as well as payment methodology, are established.
- As described in last year's report, the *Bipartisan Budget Act of 2015* (BBA) directed that outpatient hospital services provided by new off-campus hospital-based outpatient entities (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the hospital campus) are excluded from the outpatient hospital PPS, effective for services provided on or after January 1, 2017 (with certain exceptions, particularly for specific dedicated emergency departments). These services are instead to be reimbursed under the Medicare physician fee schedule or the ambulatory surgical center PPS (both of which provide lower reimbursement rates than the outpatient hospital PPS).
  - The *Cures Act* provides an exception for off-campus hospital provider-based outpatient entities that were "mid-build" on November 2, 2015. A mid-build entity is one that had a binding written agreement, before November 2, 2015, with an outside unrelated party for actual construction of the new off-campus department. To be eligible under this exception, the host hospital must (i) file a certification that the department meets the mid-build status requirement; (ii) file an attestation that the department is provider-based; and (iii) add the department to the host hospital's Medicare enrollment form. Entities that qualify will be eligible to bill under the outpatient PPS for services provided on or after January 1, 2018.
  - Under the *Cures Act*, an off-campus outpatient department can also be eligible for payment under the outpatient hospital PPS for services furnished in 2017 if the host hospital submitted a voluntary attestation, prior to December 2, 2015, stating that the department is provider-based.

(Under separate guidance from CMS that governs submission of provider-based attestations, for a hospital to have taken this step, the construction of the new off-campus outpatient department would have been completed and the hospital accepting, or poised to accept, patients. Thus, this exception benefits only a small number of departments that fell just outside of the deadline contained in the BBA.)

- To clarify, while the relief for 2017 applies only to off-campus outpatient departments with provider-based attestations filed before December 2, 2015, the relief for 2018 and beyond applies more broadly to off-campus outpatient departments with construction agreements in place as of November 2, 2015 (including hospitals eligible for the 2017 exception). Hence, most hospitals that qualify for the exception under this provision are not eligible for payment under the outpatient PPS during 2017 and are, instead, subject to lower payments for services furnished during that year, with return to the outpatient hospital PPS effective for services furnished on or after January 1, 2018.

- Off-campus outpatient departments of certain cancer hospitals are also granted exception from the BBA provision described above, thereby confirming that the BBA legislation intended these facilities to remain under their existing separate payment system. To qualify, these locations must file attestations stating that they are provider-based, within 60 days of the date of enactment or within 60 days of meeting the provider-based requirement. The attestations are subject to audit. A reduction to the additional payments that cancer hospitals receive (relative to payments under the inpatient hospital PPS) is also provided for and is intended to offset costs of the BBA exception for off-campus outpatient cancer hospital departments.
- Enforcement is delayed an additional year, through December 31, 2016, for the regulation requiring that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure.
- For wheelchair accessories and seat and back cushions furnished in connection with complex rehabilitative power wheelchairs, fee schedule adjustments do not apply until July 1, 2017 (which is a delay of 6 months relative to the previously stipulated date of January 1, 2017).

For the period beginning on January 1, 2015 to the period beginning on January 1, 2016

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *Trade Preference Extension Act of 2015* requires Medicare coverage for renal dialysis services provided by outpatient renal dialysis facilities to individuals with acute kidney injury, effective January 1, 2017.
- The *Bipartisan Budget Act of 2015* (BBA) included provisions that affect the HI and SMI programs.
  - The BBA required that the 2016 actuarial rate for enrollees aged 65 and older be determined as if the hold-harmless provision did not apply, thereby lowering the standard Part B premium rate from what it otherwise would have been. The premium revenue that was lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was replaced by a transfer of general revenue from the Treasury, which will be repaid over time to the general fund. Starting in 2016, in order to repay the balance due (which is to include the transfer amount and the forgone income-related premium revenue), the monthly Part B premium otherwise determined is to be increased by $3.00. These repayment amounts are to be added to the Part B premium otherwise determined each year and paid back to the general fund of the Treasury. This $3.00 increase will not

be matched by government contributions. These repayment amounts are to continue until the total amount collected is equal to the beginning balance due. (In the final year of the repayment, the additional amounts may be modified to avoid an overpayment). The repayment amounts (excluding those for high-income enrollees) are subject to the hold-harmless provision. The BBA also stipulated that if the Social Security cost-of-living adjustment (COLA) was 0 percent in 2017, then an additional transfer (and $3 repayment amount) would have again applied. However, the 2017 COLA of 0.3 percent was released on October 18, 2016.

- Most outpatient hospital services provided on or after January 1, 2017 by new off-campus hospital provider-based outpatient departments (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the campus) are excluded from the outpatient hospital prospective payment system, and are instead to be reimbursed under the applicable Part B payment system.
- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by one year, through FY 2025. In addition, Medicare benefit payments for services provided under periods of sequestration incur a payment reduction limited to 2 percent, so that the former differential payment reduction limits imposed for FY 2023 and 2024 are replaced with 2 percent limits. Finally, the 2 percent limit is raised to 4.0 percent for the first six months of FY 2025 and reduced to 0.0 percent for the last six months of FY 2025.

- The *Consolidated Appropriations Act of 2016* included provisions that affect the HI and SMI programs.
  - The payment calculation associated with inpatient hospital operating costs for Puerto Rico hospital discharges on or after January 1, 2016 is to be based on 0 percent of the applicable Puerto Rico percentage and 100 percent of the applicable Federal percentage. (In addition, CMS announced that both the FY 2016 Inpatient Prospective Payment System Pricer and the Long-Term Care Hospital Pricer, which are used to determine all inpatient hospital payment rates and certain long-term care hospital payment rates, respectively, for providers nationwide, are to incorporate the Puerto Rico inpatient hospital payment modification. These conforming changes are applicable to inpatient hospital discharges and long-term care hospital discharges on or after January 1, 2016.)
  - Puerto Rico hospitals are eligible to receive incentive payments under the Medicare Electronic Health Records Incentive Program, effective January 1, 2016.
  - Effective January 1, 2017, separate Medicare payment is authorized to home health agencies when they use cost-effective disposable alternatives to negative pressure wound therapy equipment.
  - To incentivize the transition from traditional x-ray imaging to digital radiography, Part B payment for the technical component of film x-rays, under the hospital outpatient prospective payment system and under the physician fee schedule, is reduced by 20 percent beginning in 2017. In addition, payment for the technical component of x-rays taken using computed radiography technology is reduced by 7 percent during 2018 through 2022 and by 10 percent beginning in 2023. Also, the discount in payment for the professional component of multiple imaging services furnished on or after January 1, 2017 is reduced from 25 percent to 5 percent, and the reduction is taken in a non-budget neutral manner.
  - A one-year moratorium for calendar year 2017 is placed on the annual fee to be paid by health insurance providers. This fee, which was established by the *Affordable Care Act*, is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D. (Since Medicare Advantage is paid for by the HI trust fund and the Part B account of the SMI trust fund, this provision affects all parts of Medicare.)

Overall these provisions resulted in a slight increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a slight decrease to the present value of estimated future expenditures, with an

overall increase in the estimated future net cash flow. For Part B, these changes decreased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes also resulted in a lower present value of estimated future expenditures (and also income) but only very slightly.

Potential Impact on the Social Insurance Statements of the September 5, 2017 Rescission of the 2012 DACA Policy Directive

The Deferred Action for Childhood Arrivals (DACA) policy directive was implemented on June 15, 2012. On September 5, 2017, the Department of Homeland Security rescinded the 2012 DACA policy directive and scheduled an orderly phase out of the DACA program. The SSA Office of the Chief Actuary has concluded that the phase out of the DACA program has an effect on the actuarial methods and assumptions used in developing the estimates presented in the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. We expect that the phase-out of the DACA program, which affects the demographic assumptions used in the Medicare projections, will not have a material impact on the present value estimates in the Statement of Social Insurance and Statement of Changes in Social Insurance Amounts.

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2017

Responsibility Segment Program	2017	2016	2015	2014	2013
National Institutes of Health					
Research Training and Career Development	$ 1,807	$ 1,745	$ 1,631	$ 1,541	$ 1,621
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	1,047	935	828	660	766
Other HRSA Training Investments	88	90	-	-	-
Other Investments in Human Capital					
Other	21	17	14	8	6
Totals	$ 2,963	$ 2,787	$ 2,473	$ 2,209	$ 2,393

Investments in Human Capital are expenses incurred by federal education and training programs for the public, intended to maintain or increase national productive capacity. The following OpDivs conduct education and training programs under this category:

National Institutes of Health

The NIH Research Training and Career Development Programs address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for research training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's major research training and career development programs include institutional research training grants for graduate students and post-doctoral scholars, individual pre- and post-doctoral fellowships, individual and institutional research career development awards for advanced post-doctorates and early-stage faculty, loan repayment programs, and research education awards that promote research experiences, curriculum development, and other related activities. These programs are administered by NIH institutes and centers with awarding authority, and are key to NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research.

Health Resources and Services Administration

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs support a diverse, culturally competent workforce by addressing components including education, training, and financial support for students, faculty, practitioners, and supporting institutions. These efforts support development of a skilled health workforce serving in areas of the nation with the greatest need. BHW obligated approximately $1.0 billion to BHW's scholarships, loans, loan repayment programs, health professions training programs, and programs supporting graduate medical education. BHW awarded to the following programs: Children's Hospitals Graduate Medical Education Payment Program; Nursing Workforce Development; and Teaching Health Center Graduate Medical Education Payment Program.

In addition to BHW loans and scholarships, HRSA made 131 grant awards to Maternal and Child Health (MCH) Workforce Development to prepare the current and future generation of MCH professionals through

interdisciplinary graduate training programs and continuing education, as well as to enhance the pipeline of high school and undergraduate students to enter MCH professions and graduate training programs.

Furthermore, the National Health Service Corps (NHSC) awarded to scholarships and loan repayment to health care providers in eligible discipline who work in areas with shortage designation. NHSC currently support over 10,200 medical, dental, and mental, and behavioral health professionals who provide care to nearly 11 million patients at NHSC sites in communities in urban, rural and frontier areas, regardless of the patient's ability to pay.

For more information visit HRSA Loans & Scholarships.

Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants and contracts are awarded to public and private non-profit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. As of September 30, 2017, 19 grants (totaling $7.1 million) and 8 contracts (totaling $2.7 million) have been awarded for FY 2017. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

In addition, ACL's National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) administers the Advanced Rehabilitation Research and Training (ARRT) Program to increase capacity for high-quality rehabilitation research by supporting grants to institutions to provide advanced research training to individuals with doctorates or similar advanced degrees who have clinical or other relevant experience. Grants are made to institutions to recruit qualified persons, including individuals with disabilities, and to prepare them to conduct independent research related to disability and rehabilitation, with particular attention to research areas that support the implementation and objectives of the Rehabilitation Act and that improve the effectiveness of services authorized under the Act.

Furthermore, AHRQ provides an array of pre-doctoral and postdoctoral educational and career development grants and opportunities in health services research training. Research training and career development activities are administered by the Division of Research Education in the Office of Extramural Research, Education, and Priority Populations.

Investment in Research and Development (in Millions)

For the Year Ended September 30, 2017

Responsibility Segments	Basic	Applied	Develop-mental	2017 Total	2016	2015	2014	2013	Grand Total
AHRQ	$ -	$ 217	$ -	$ 217	$ 213	$ 167	$ 250	$ 372	$ 1,219
CDC	72	410	27	509	502	490	394	457	2,352
FDA	135	-	7	142	170	129	103	94	638
NIH	17,679	11,786	-	29,465	28,258	28,093	27,719	29,328	142,863
Other	3	105	-	108	32	26	3	1	170
Totals	$ 17,889	$ 12,518	$ 34	$ 30,441	$ 29,175	$ 28,905	$ 28,469	$ 30,252	$ 147,242

The research and development programs in HHS include the following:

Administration for Community Living

ACL, through the NIDILRR, conducts research to generate new knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities.

Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence based decision making.

Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Health Promotion, and Injury Prevention were the primary areas where CDC's research and development was invested. CDC works with partners around the country and world to protect Americans from infectious diseases; prevent the leading causes of disease, disability, and death; ensure global disease protection; keep Americans safe from environmental and work-related hazards; protect Americans from natural and bioterrorism threats; monitor health; and ensure laboratory excellence. CDC programs provide partners and Americans with the essential health information and tools they need to protect and advance their health.

In FY 2017, Congress, recognizing the gravity of the threat, appropriated $163 million for CDC to continue to fight Antibiotic Resistance (AR). With these investments, CDC fortified the AR Solutions Initiative, which has supported the national infrastructure to detect, respond, and prevent resistant infections across healthcare settings, food, and communities since 2016. AR Solutions Initiative activities include putting state and local AR laboratory and epidemiological expertise in every state and making investments in public and private sector innovation to fight AR threats.

CDC has distributed the largest extramural portion of this funding to support all 50 state health departments, the six local health departments, and Puerto Rico.

For more information visit Antibiotic Resistance Solutions Initiative.

Food and Drug Administration

In 1994, the FDA Office of Women's Health (OWH) established a research and development program to advance the evaluation of sex-based differences in the safety and efficacy of FDA-regulated products; conduct research on health conditions and diseases that solely or disproportionately affect women; track the participation of women and special populations in clinical studies and improve demographic subset analyses; and advance scientific knowledge through advanced professional training and education in subpopulation analysis and women's health.

As of 2017, OWH had funded 368 research projects. Projects have ranged from investigating listeria in pregnancy and cosmetic safety to the study of, sexually transmitted infections, cardiovascular disease, breast cancer, reproductive health, endocrine and neurological disorders, and psychiatric disorders, among other conditions. This research has contributed to safety labeling changes for medical products, new guidance for industry on product

development, data standardization for vaccine clinical data, standards for evaluation of tampons and condoms, and evidence-based support for consumer decision about products recommended for use by pregnant women.

OWH funded research has also served as the foundation for the development and expansion of other women's health research activities, including, for example, the National Center for Toxicological Research's annual Women's Health Research Program.

For more information, visit OWH Research and Development.

National Institutes of Health

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research, observational, and population-based research, behavioral research and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches, and health services research. NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products an immediate benefit to improved health and an important mandate.

Congress passed the *21st Century Cures Act* (Cures Act) in December 2016 authorizing $1.8 billion in funding for the Cancer Moonshot over 7 years. In addition, the Cures Act provides multiyear funding to three other highly innovative scientific initiatives: 1) the *All of Us* Research Program in the amount of $1.5 billion; 2) the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative in the amount of $1.5 billion; and 3) the Regenerative Medicine Innovation Project in the amount of $30 million.

The Cancer Moonshot aims to accelerate cancer research making more therapies available to more patients, improving the ability to prevent cancer, detecting it at the earliest stage possible and improving symptom management. Under the initiative, the research community identified 10 areas of research opportunity where progress could be accelerated with additional funding. In FY 2017, an initial $300 million was appropriated to fund Cancer Moonshot initiatives. The legislation provides NIH with critical tools and resources to advance biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials of promising new therapies. The BRAIN initiative seeks to better understand how the brain encodes, stores, and retrieves information, which will transform the ability to diagnose and treat neurological/mental disorders. Furthermore, the Regenerative Medicine Innovation Project will support clinical research in coordination with the FDA using adult stem cells to further the field of regenerative medicine.

For more information visit the 21st Century Cures Act.

Additionally, two scientists at the National Cancer Institute (NCI), part of the NIH, received the 2017 Lasker-DeBakey Clinical Medical Research Award for their significant research leading to the development of human papillomavirus vaccines. The award is the country's most prestigious biomedical research prize, and will be presented to John T. Schiller, Ph.D., of NCI's Center for Cancer Research (CCR), and Douglas R. Lowy, M.D., also in CCR and acting director of NCI.

For more information visit 2017 Lasker-DeBakey Clinical Medical Research Award.

Other Investments in Research and Development

ACF oversees research and development programs that contribute to a better understanding of how to improve the economic and social well-being of families and children so that they may lead healthier and more productive

lives. HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision making. Applied research includes MCH research programs to solve needs for current and emerging maternal and child health programs and help MCH professionals with planning and policymaking. Healthcare Systems conduct research for public outreach campaigns to promote organ, eye, and tissue donation. Rural Health programs produce policy-relevant research on health care and population health in rural areas. HRSA's basic research supports the causes, diagnosis, prevention, and cure of Hansen's disease.

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2017

Budgetary Resources:	CMS				Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
	Medicare HI	Medicare SMI	Payments to Trust Fund	Medicaid			
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 23,833	$ 413	$ 35,637	$ 59,883	$ 627
Recoveries of Unpaid Prior Year Obligations	2	2	12,732	34,493	4,129	51,358	3
Other Changes in Unobligated Balance	6	5	(29,175)	(2,842)	(542)	(32,548)	(477)
Unobligated Balance from Prior Year Budget Authority, Net	8	7	7,390	32,064	39,224	78,693	153
Appropriations (Discretionary and Mandatory)	300,894	310,816	338,236	384,922	250,703	1,585,571	(96)
Borrowing Authority (Discretionary and Mandatory)	-	3,720	-	-	-	3,720	151
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	941	13,297	14,238	122
Total Budgetary Resources	$ 300,902	$ 314,543	$ 345,626	$ 417,927	$ 303,224	$ 1,682,222	$ 330
Status of Budgetary Resources:							
New Obligations and Upward Adjustments	$ 300,902	$ 314,543	$ 339,542	$ 417,617	$ 274,406	$ 1,647,010	$ 152
Unobligated Balance, End of Year:							
Apportioned, Unexpired Accounts	-	-	-	2	15,371	15,373	3
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	(12,103)	(12,103)	-
Unapportioned, Unexpired Accounts	-	-	-	308	7,514	7,822	175
Unexpired Unobligated Balance, End of Year	-	-	-	310	10,782	11,092	178
Expired Unobligated Balance, End of Year	-	-	6,084	-	18,036	24,120	-
Unobligated Balance, End of Year	-	-	6,084	310	28,818	35,212	178
Total Status of Budgetary Resources	$ 300,902	$ 314,543	$ 345,626	$ 417,927	$ 303,224	$ 1,682,222	$ 330
Change in Obligated Balance:							
Unpaid Obligation:							
Unpaid Obligations, Brought Forward, Oct 1	$ 32,259	$ 26,022	$ 27,070	$ 40,054	$ 132,193	$ 257,598	$ 37
New Obligations and Upward Adjustments	300,902	314,543	339,542	417,617	274,406	1,647,010	152
Outlays (Gross)	(297,566)	(314,067)	(335,137)	(383,847)	(268,513)	(1,599,130)	(181)
Recoveries of Prior Year Unpaid Obligations	(2)	(2)	(12,732)	(34,493)	(4,129)	(51,358)	(3)
Unpaid Obligations, End of Year	$ 35,593	$ 26,496	$ 18,743	$ 39,331	$ 133,957	$ 254,120	$ 5
Uncollected Payments:							
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ -	$ -	$ -	$ (105)	$ (26,361)	$ (26,466)	$ (15)
Change in Uncollected Customer Payments from Federal Sources	-	-	-	(289)	7,502	7,213	12
Uncollected Payments from Federal Sources, End of Year	$ -	$ -	$ -	$ (394)	$ (18,859)	$ (19,253)	$ (3)
Memorandum (non-add) Entries:							
Obligated Balance, Start of Year	$ 32,259	$ 26,022	$ 27,070	$ 39,949	$ 105,832	$ 231,132	$ 22
Obligated Balance, End of Year	$ 35,593	$ 26,496	$ 18,743	$ 38,937	$ 115,098	$ 234,867	$ 2

[1] Other Agency Budgetary Accounts includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $4.4 billion and net outlays of $4.3 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Combining Statement of Budgetary Resources (continued) (in Millions)

For the Year Ended September 30, 2017

	CMS						
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:							
Budget Authority, Gross (Discretionary and Mandatory)	$ 300,894	$ 314,536	$ 338,236	$ 385,863	$ 264,000	$ 1,603,529	$ 177
Actual Offsetting Collections (Discretionary and Mandatory)	(6)	(5)	(2,237)	(13,456)	(20,777)	(36,481)	(134)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	-	-	(289)	7,502	7,213	12
Recoveries of Prior Year Paid Obligations (Discretionary and Mandatory)	6	5	2,237	12,803	470	15,521	-
Budget Authority, Net (Discretionary and Mandatory)	$ 300,894	$ 314,536	$ 338,236	$ 384,921	$ 251,195	$ 1,589,782	$ 55
Outlays, Gross (Discretionary and Mandatory)	$ 297,566	$ 314,067	$ 335,137	$ 383,847	$ 268,513	$ 1,599,130	$ 181
Actual Offsetting Collections (Discretionary and Mandatory)	(6)	(5)	(2,237)	(13,456)	(20,777)	(36,481)	(134)
Outlays, Net (Discretionary and Mandatory)	297,560	314,062	332,900	370,391	247,736	1,562,649	47
Distributed Offsetting Receipts	(36,146)	(407,733)	-	-	(2,224)	(446,103)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 261,414	$ (93,671)	$ 332,900	$ 370,391	$ 245,512	$ 1,116,546	$ 47

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 56,707	$ 56,707	$ 51,357
ACL	2,069	2,069	1,897
AHRQ	369	369	317
CDC	15,347	15,347	12,292
CMS	148,768	148,768	122,786
FDA	6,223	6,223	3,282
HRSA	11,690	11,690	10,894
IHS	8,204	8,204	4,775
NIH	40,439	40,439	31,085
OS	6,494	6,494	2,887
PSC	2,495	2,495	526
SAMHSA	4,419	4,419	3,414
Totals	$ 303,224	$ 303,224	$ 245,512

1] Other Agency Budgetary Accounts includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $4.4 billion and net outlays of $4.3 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Deferred Maintenance and Repairs

For the Years Ended September 30, 2017 and 2016

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32 effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repair activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes, and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred.

CDC, NIH, and FDA use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. The landholding OpDivs prioritize their maintenance activities based on urgency and the best use of their limited resources, with life safety the top priority. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include Property, Plant and Equipment location, age, design etc. Equipment affixed to real property should be appropriately reflected in building and other structures. Prior year numbers reported for equipment have been adjusted to reflect this change.

	Estimated Cost to Return to Acceptable Condition (in Millions)	
Category of Asset	2017	2016
General PP&E		
Buildings	$ 2,399	$ 2,068
Other Structures	40	25
Total	$ 2,439	$ 2,093

In a condition assessment survey, asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A “fair” or 3 rating is considered acceptable operating condition. Although Property, Plant and Equipment categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of “fair” or above may still report necessary costs to return them to acceptable condition.

Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this year's report are based on current law and include the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (*MACRA*; Public Law 114-10), which repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments. While the physician payment updates and new incentives put in place by *MACRA* avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of $500 million per year for one group of physicians and 5-percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to widen throughout the projection, and the Trustees estimated that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may become a significant issue in the long term under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011 (*Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); and the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2025 and by 4 percent from April 1, 2025 through September 30, 2025. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2025.

These projections also incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *Affordable Care Act*, contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to

identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act* and *MACRA* that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The current-law expenditure projections reflect the physicians' payment levels expected under the *MACRA* payment rules and the *Affordable Care Act* -mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes legislative changes that result in (i) physician payment updates that transition from the average 0.6-percent update for 2026 to the rate of growth in the Medicare Economic Index of 2.2 percent for 2041 and later; (ii) no expiration of the 5-percent bonuses for physicians in advanced alternative payment models (APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS); (iii) a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates from 2020 through 2034; and (iv) an elimination of the cost-reducing actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the *MACRA*[10] and *Affordable Care Act*[11] cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 25 in these financial statements, in appendix V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds.

[10]Under *MACRA*, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced APMs or MIPS, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

[11]Under the *Affordable Care Act*, Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth in economy-wide private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI-U) and CPI-medical care increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the "factors contributing to growth" model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection. The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel.[12]

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding Gross Domestic Product (GDP) plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).[13] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre- *Affordable Care Act* baseline cost growth assumption for Medicare to GDP plus 1.4 percent.
- The "factors contributing to growth" model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[14] It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to

[12]The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.
[13]For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.
[14]Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276-1284.

produce the health care goods and services.[15] To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10 year moving average increase in economy-wide private nonfarm business multifactor productivity,[16] which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

(i) ***All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.***

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 3.9 percent in 2041, or GDP plus 0.0 percent, declining gradually to 3.5 percent in 2091, or GDP minus 0.3 percent.[17]

(ii) ***Physician services***

Payment rate updates are 0.75 percent per year for those physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year per capita growth rates for physician payments are assumed to be 3.6 percent in 2041, or GDP minus 0.3 percent, declining to 2.8 percent in 2091, or GDP minus 1.0 percent.

(iii) ***Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.***

Such services include durable medical equipment,[18] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.1 percent in 2041, or GDP minus 0.8 percent, declining to 2.7 percent in 2091, or GDP minus 1.1 percent.

(iv) ***All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services.***

These Part B outlays constitute an estimated 16 percent of total Part B expenditures in 2026 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[19] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed

[15] Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices.

[16] For convenience the term economy-wide private nonfarm business multifactor productivity will henceforth be referred to as economy-wide productivity.

[17] These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

[18] Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

[19] For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.8 percent in 2041, or GDP plus 0.9 percent, declining to 4.3 percent by 2091, or GDP plus 0.5 percent.

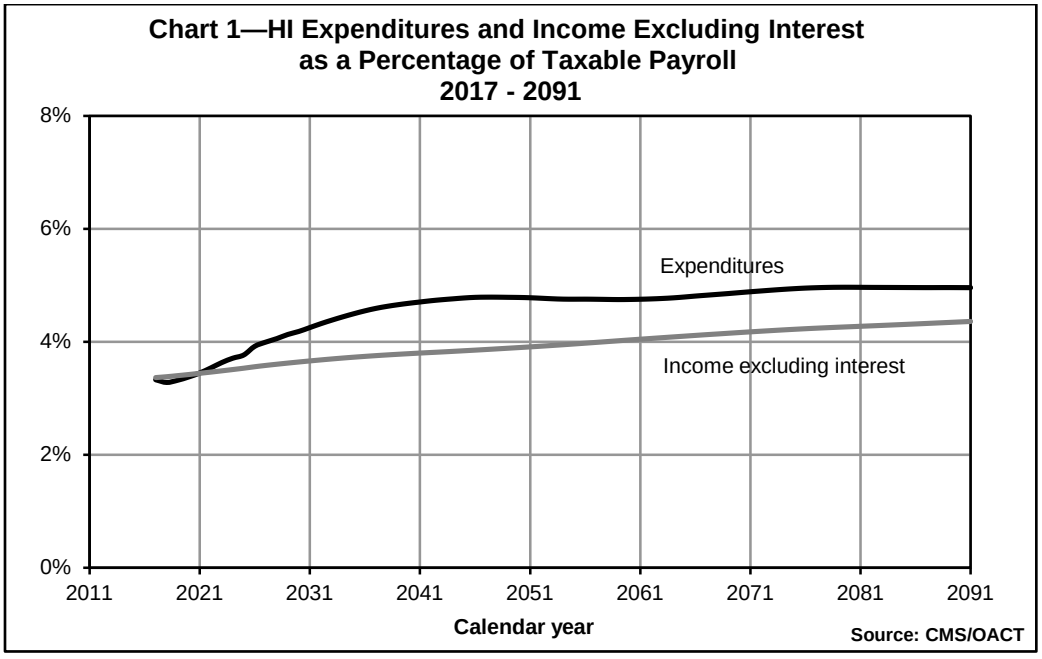
In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 3.6 percent per year for the last 50 years of the projection period, or GDP minus 0.3 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.7 percent over this same time period or GDP minus 0.2 percent, while the growth rate in 2091 is 3.7 percent or GDP minus 0.1 percent.

HI Cash Flow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2017 report are lower than those from the 2016 report for all years largely due to lower utilization assumptions for inpatient hospital services, which were primarily based on lower-than-expected utilization in 2016.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, since

2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows the income rate is expected to gradually increase over current levels.

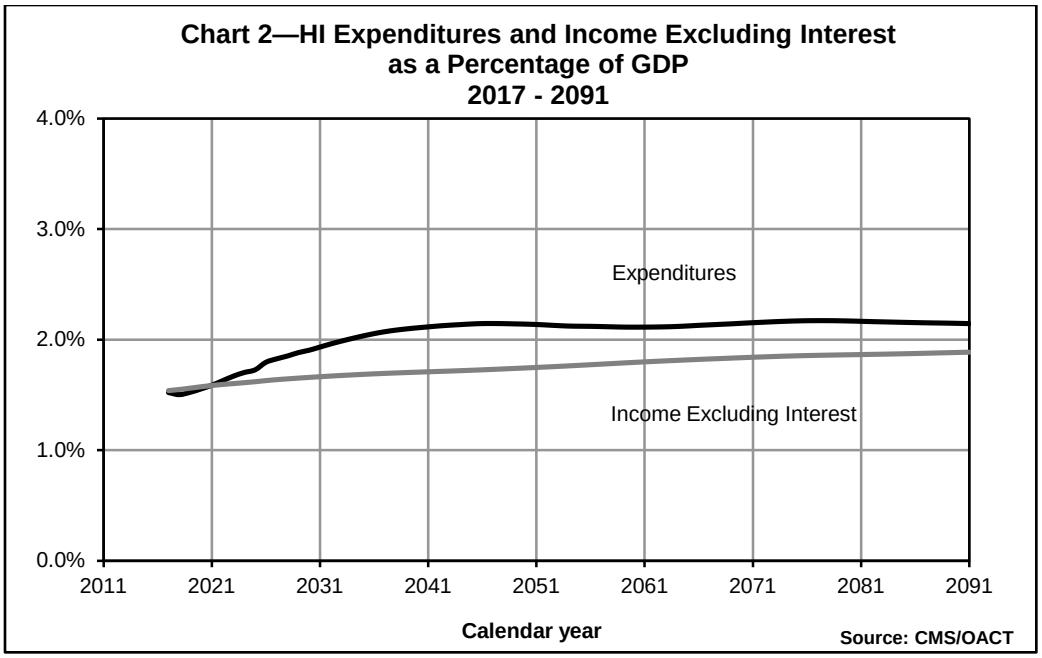
As indicated in Chart 1, the cost rate is projected to decline through 2018, largely due to (i) expenditure growth that was constrained in part by low utilization and low payment updates and (ii) a rebound of taxable payroll growth from 2007-2009 recession levels. After 2018 the cost rate is projected to rise primarily due to retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2026 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.8 percent in 2035 and 8.2 percent in 2091. These levels are about 7 percent and 65 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the U.S. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2016, the expenditures were $285.4 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.5 percent in 2091.

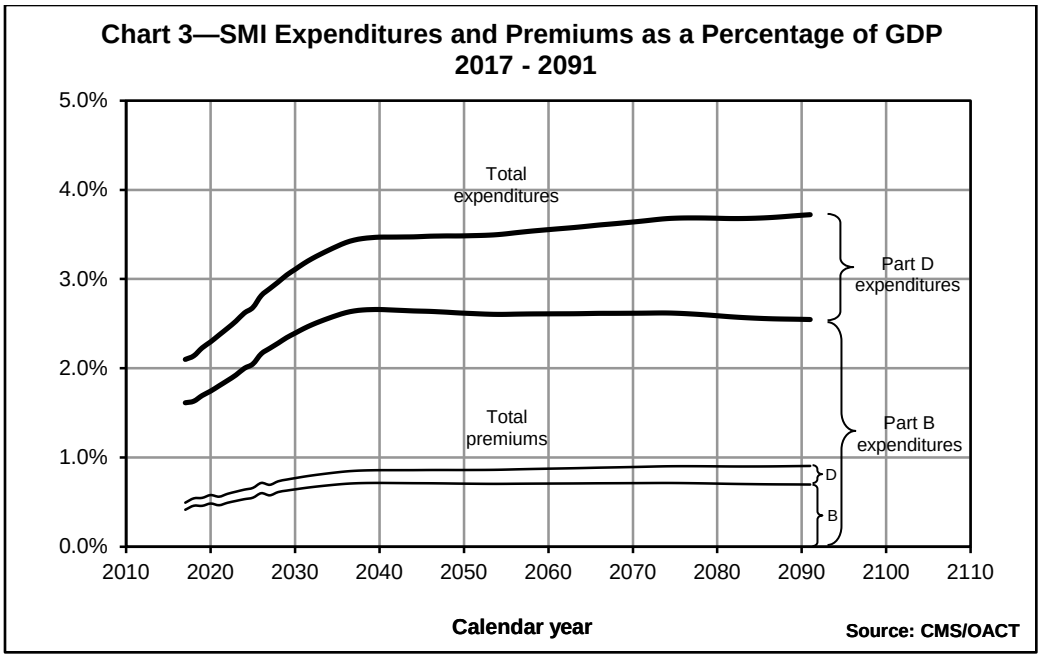


SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

In 2016, SMI expenditures were $393.3 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.7 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2091 would be 5.4 percent of GDP.)

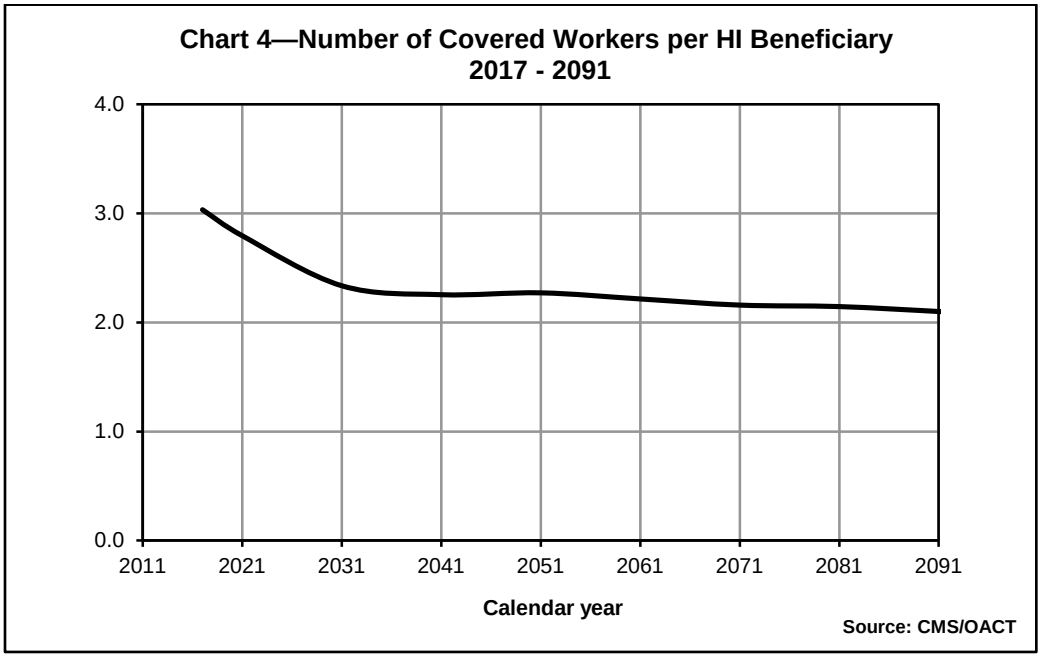


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2016 by about 4.2 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2016, every beneficiary had 3.1 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2091.



Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[20] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[21]

[20]Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

For this analysis, the intermediate economic and demographic assumptions in the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2017 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.

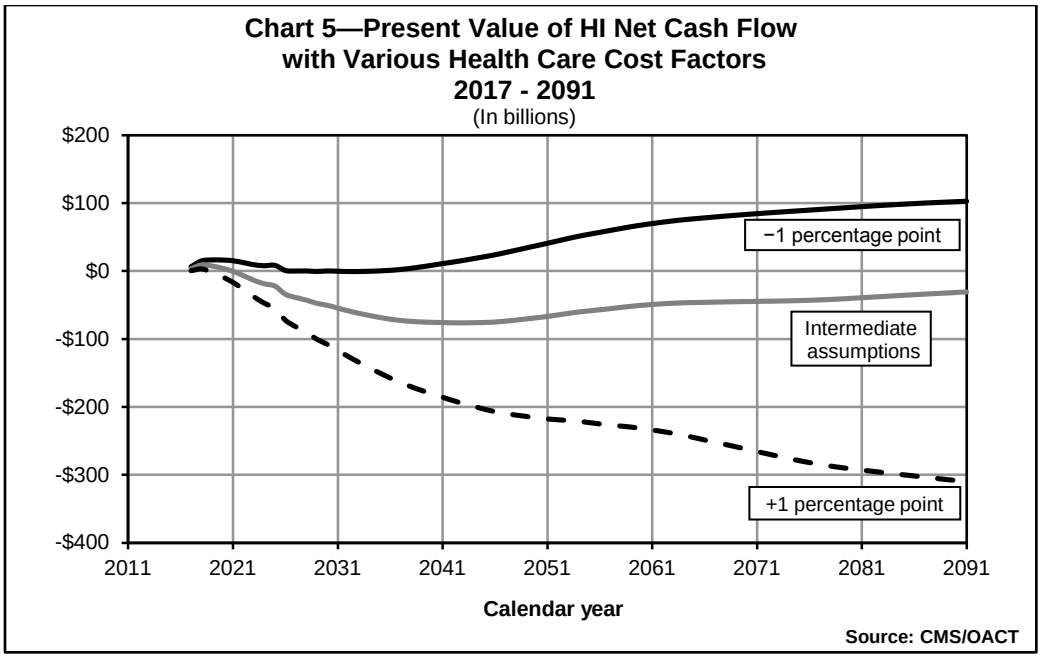
Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$3,662	−$3,532	−$15,028

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,194 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $11,495 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.

[21]The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[22] In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

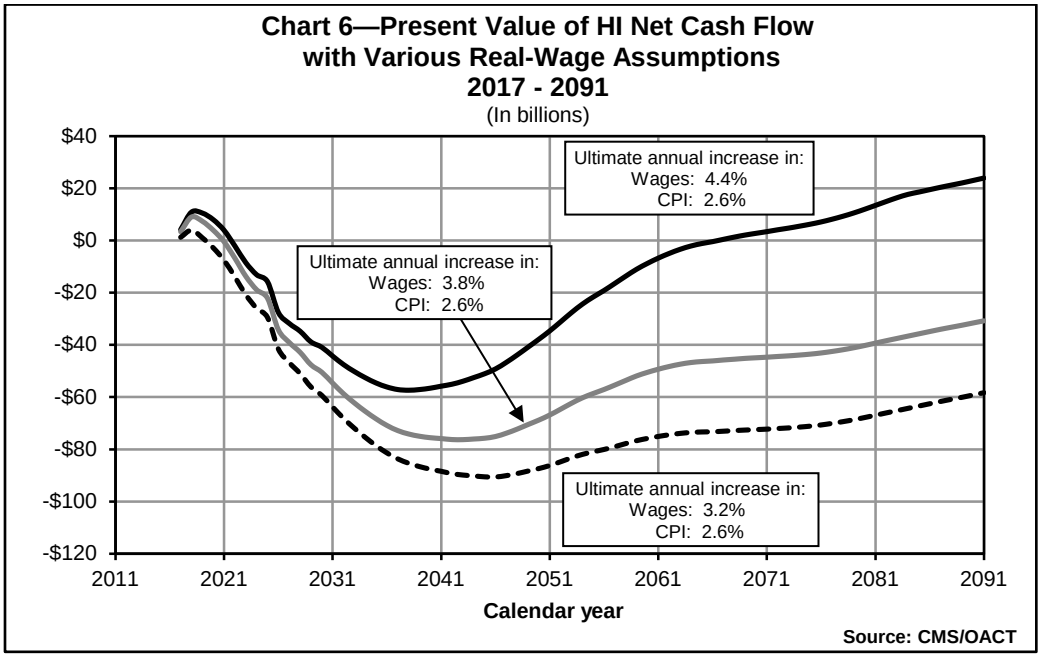
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages − CPI	3.2 − 2.6	3.8 − 2.6	4.4 − 2.6
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	−$4,961	−$3,532	−$1,135

[22]The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,000 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,190 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage differential assumptions presented in Table 2.



As illustrated in Chart 6, faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the *Affordable Care Act* and *MACRA* depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

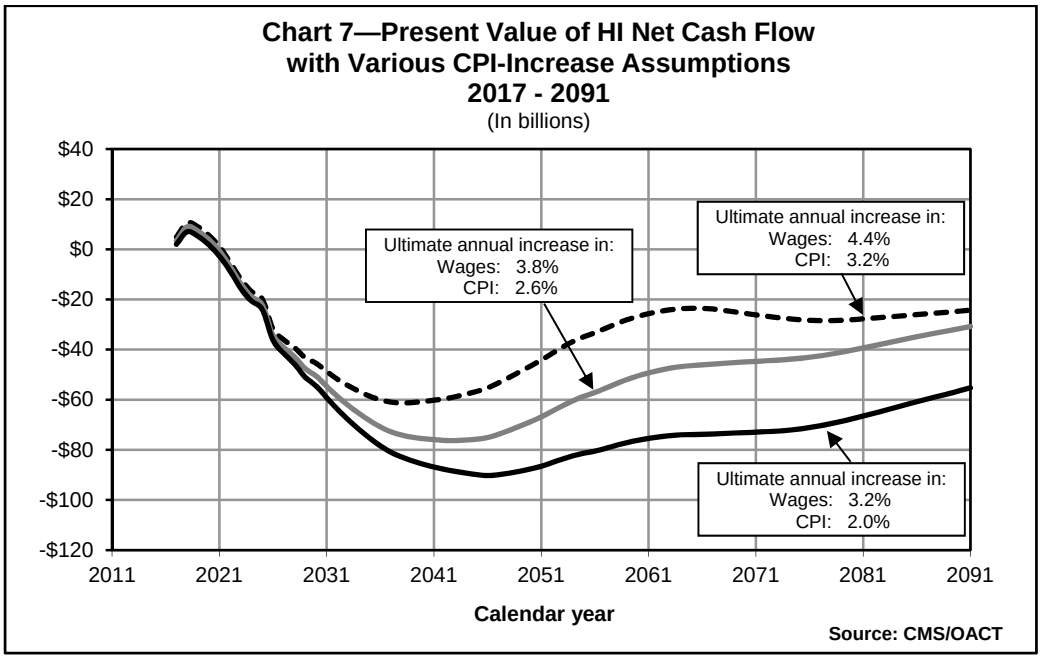
Consumer Price Index

Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.4, 3.8, and 3.2 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in wages − CPI	4.4 – 3.2	3.8 − 2.6	3.2 – 2.0
Income minus expenditures (in billions)	−$2,494	−$3,532	−$4,852

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by $1,038 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,320 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in table 3.



As Chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the *Affordable Care Act* for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

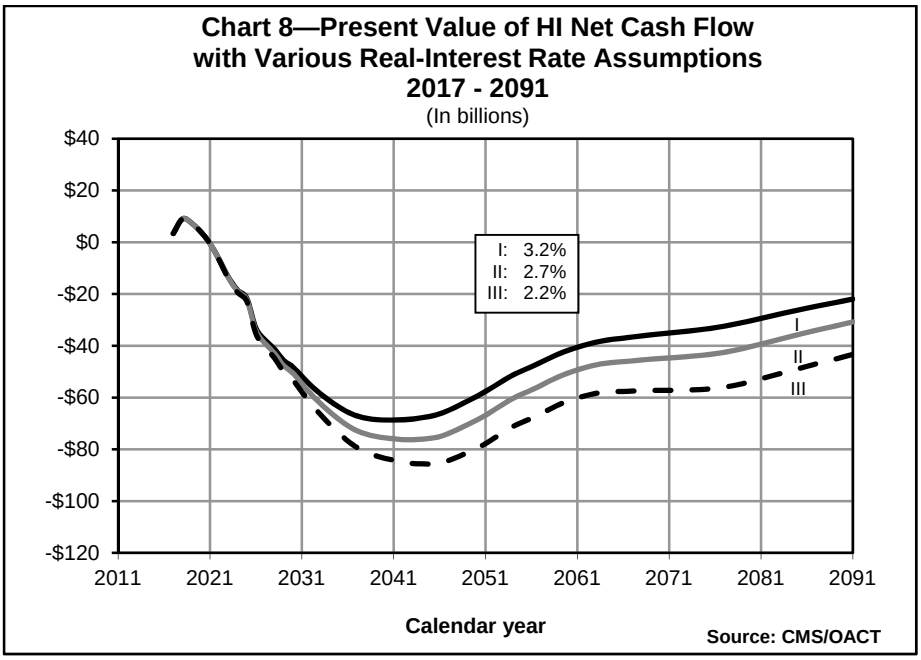
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.2, 2.7, and 3.2 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.8, 5.3, and 5.8 percent, respectively.

Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.2 percent	2.7 percent	3.2 percent
Income minus expenditures (in billions)	−$4,197	−$3,532	−$3,006

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $120 billion.

Chart 8 shows projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.



As shown in Chart 8, the projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2029. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

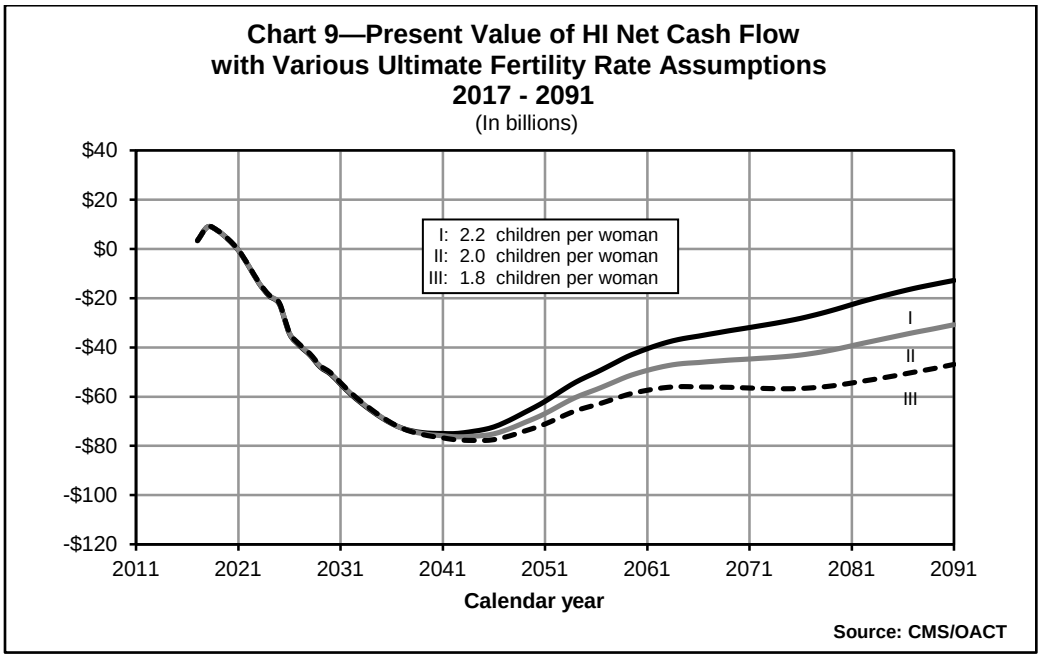
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures (in billions)	−$4,018	−$3,532	−$2,995

[1]The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $510 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.



As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cash flows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-

dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

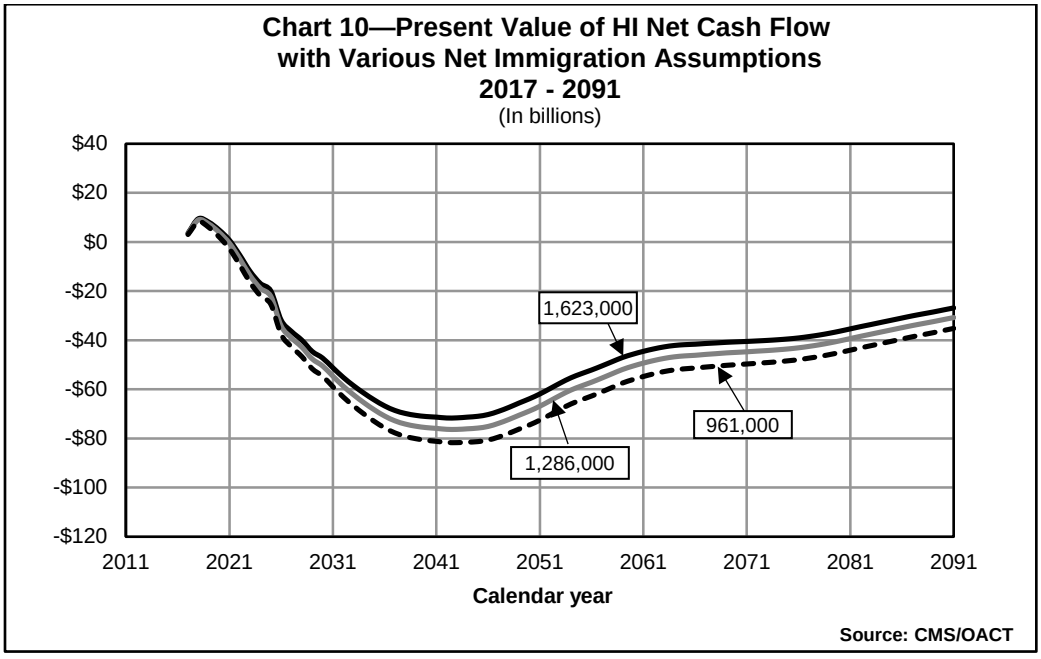
Table 6 shows the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 961,000 persons, 1,286,000 persons, and 1,623,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	961,000	1,286,000	1,623,000
Income minus expenditures (in billions)	−$3,879	−$3,532	−$3,240

As indicated in Table 6, if the average annual net immigration assumption is 961,000 persons, the deficit—expressed in present-value dollars—increases by $347 billion. Conversely, if the assumption is 1,623,000 persons, the deficit decreases by $292 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.



Higher net immigration results in smaller HI cash flow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund has improved as compared to the projections in last year's annual report. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2029, one year later than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI expenditures are projected to be lower than last year's estimates, mostly due to lower inpatient hospital utilization assumptions and lower-than-expected spending in 2016.

HI expenditures exceeded income each year from 2008 through 2015. In 2016, however, there was a fund surplus amounting to $5.4 billion. The Trustees project modest surpluses to continue in 2017 through 2022, with a return to deficits in subsequent years until the trust fund becomes depleted in 2029. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2017 is adequate to cover 2017 expected expenditures.[23] Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

[23] A hold-harmless provision restricted Part B premium increases for most beneficiaries in 2017. However, for beneficiaries to whom the provision did not apply, there was a substantial increase in the 2017 Part B premium.

Medicare Overall

Federal law requires the Board of Trustees to test whether the difference between Medicare outlays and dedicated financing sources[24] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 FYs (2017-2023). If this level is attained within the 7 year timeframe, the law requires a determination of projected excess general revenue Medicare funding. For the 2017 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in FY 2023, and therefore the Trustees are issuing this determination.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2017 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

[24]Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

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Other Information

3

In This Section

- Other Financial Information
- Reduce the Footprint
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty Adjustment for Inflation
- Grants Oversight & New Efficiency Act Report
- Payment Integrity Report
- FY 2017 Top Management and Performance Challenges Identified by the Office of Inspector General

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OTHER FINANCIAL INFORMATION

Consolidating Balance Sheet by Budget Function

As of September 30, 2017

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 10,951	$ 154,021	$ 28,284	$ 16,497	$ 209,753	$ -	$ 209,753
Investments, Net (Note 4)	-	4,822	270,702	-	275,524	-	275,524
Accounts Receivable, Net (Note 5)	149	5,096	71,570	6	76,821	(75,853)	968
Advances (Note 8)	17	333	25	40	415	(182)	233
Total Intragovernmental Assets	11,117	164,272	370,581	16,543	562,513	(76,035)	486,478
Accounts Receivable, Net (Note 5)	-	12,343	20,672	66	33,081	-	33,081
Inventory and Related Property, Net (Note 6)	-	9,698	-	-	9,698	-	9,698
General Property, Plant and Equipment, Net (Note 7)	-	5,547	701	-	6,248	-	6,248
Advances (Note 8)	97	662	29,292	808	30,859	-	30,859
Other Assets	-	459	-	-	459	-	459
Total Assets	$ 11,214	$ 192,981	$ 421,246	$ 17,417	$ 642,858	$ (76,035)	$ 566,823
Stewardship Land (Notes 20)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 17	$ 592	$ 75,466	$ 1	$ 76,076	$ (75,837)	$ 239
Other Liabilities (Note 13)	2	3,385	6,407	65	9,859	(198)	9,661
Total Intragovernmental Liabilities	19	3,977	81,873	66	85,935	(76,035)	9,900
Accounts Payable	22	988	84	5	1,099	-	1,099
Entitlement Benefits Due and Payable (Note 10)	-	47,722	60,625	-	108,347	-	108,347
Accrued Liabilities (Note 12)	772	9,754	-	1,346	11,872	-	11,872
Federal Employee and Veterans Benefits (Note 11)	4	13,519	9	-	13,532	-	13,532
Contingencies and Commitments (Note 14)	-	13,871	926	-	14,797	-	14,797
Other Liabilities (Note 13)	19	3,594	736	9	4,358	-	4,358
Total Liabilities	836	93,425	144,253	1,426	239,940	(76,035)	163,905
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	-	(3)	17,287	-	17,284	-	17,284
Unexpended Appropriations - Other funds	10,286	103,451	-	15,951	129,688	-	129,688
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	-	(2,030)	259,706	-	257,676	-	257,676
Cumulative Results of Operations - Other funds	92	(1,862)	-	40	(1,730)	-	(1,730)
Total Net Position - Funds from Dedicated Collections	-	(2,033)	276,993	-	274,960	-	274,960
Total Net Position - Other Funds	10,378	101,589	-	15,991	127,958	-	127,958
Total Net Position	10,378	99,556	276,993	15,991	402,918	-	402,918
Total Liabilities and Net Position	$ 11,214	$ 192,981	$ 421,246	$ 17,417	$ 642,858	$ (76,035)	$ 566,823

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2017

(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations: Cost (-)	Intra-HHS Eliminations: Revenue	Consolidated Totals
ACF	$ 12,498	$ -	$ -	$ 38,715	$ 51,213	$ (94)	$ 24	$ 51,143
ACL	1,957	-	-	-	1,957	(10)	1	1,948
AHRQ	-	319	-	-	319	(25)	39	333
CDC	-	12,080	-	-	12,080	(429)	85	11,736
CMS	-	396,203	567,129	-	963,332	(418)	585	963,499
FDA	-	3,047	-	-	3,047	(290)	19	2,776
HRSA	-	10,932	-	-	10,932	(270)	9	10,671
IHS	-	5,054	-	-	5,054	(187)	220	5,087
NIH	-	31,272	-	-	31,272	(549)	368	31,091
OS	-	3,259	-	-	3,259	(1,045)	968	3,182
PSC	-	1,191	-	-	1,191	(76)	653	1,768
SAMHSA	-	3,540	-	-	3,540	(75)	150	3,615
Net Cost of Operations	$ 14,455	$ 466,897	$ 567,129	$ 38,715	$ 1,087,196	$ (3,468)	$ 3,121	$ 1,086,849

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2017

(in Millions)

Responsibility Segments	Intragovernmental: Gross Cost: Combined	Intragovernmental: Gross Cost: Eliminations	Intragovernmental: Gross Cost: Consolidated	Intragovernmental: Less: Exchange Revenue: Combined	Intragovernmental: Less: Exchange Revenue: Eliminations	Intragovernmental: Less: Exchange Revenue: Consolidated	With the Public: Gross Cost	With the Public: Less: Exchange Revenue	Consolidated Net Cost of Operations
ACF	$ 202	$ (94)	$ 108	$ (32)	$ 24	$ (8)	$ 51,079	$ (36)	$ 51,143
ACL	22	(10)	12	(1)	1	-	1,936	-	1,948
AHRQ	43	(25)	18	(39)	39	-	322	(7)	333
CDC	1,115	(429)	686	(252)	85	(167)	11,259	(42)	11,736
CMS	1,079	(418)	661	(595)	585	(10)	1,060,132	(97,284)	963,499
FDA	1,344	(290)	1,054	(26)	19	(7)	3,806	(2,077)	2,776
HRSA	379	(270)	109	(10)	9	(1)	10,615	(52)	10,671
IHS	703	(187)	516	(276)	220	(56)	5,940	(1,313)	5,087
NIH	1,689	(549)	1,140	(498)	368	(130)	30,236	(155)	31,091
OS	1,389	(1,045)	344	(1,004)	968	(36)	2,934	(60)	3,182
PSC	337	(76)	261	(1,454)	653	(801)	2,313	(5)	1,768
SAMHSA	119	(75)	44	(160)	150	(10)	3,581	-	3,615
Totals	$ 8,421	$ (3,468)	$ 4,953	$ (4,347)	$ 3,121	$ (1,226)	$ 1,184,153	$ (101,031)	$ 1,086,849

REDUCE THE FOOTPRINT

For the Year Ended September 30, 2017

	Reduce the Footprint Baseline Comparison (in Square Footage)		
	2015 Baseline	2016 Year End	Change
Total Leased	13,014,210	14,183,422	1,169,212
Total Owned	6,273,290	5,274,225	(999,065)
Total	19,287,500	19,457,647	170,147

	Reporting of O&M Costs - Owned and Direct Lease Buildings (in Millions)		
	2015 Baseline	2016 Year End	Change
Operation and Maintenance Costs	$ 92.2	$ 84.7	$ (7.5)

OMB Memorandum 12-12, *Promoting Efficient Spending to Support Agency Operations*, and OMB Management Procedures Memorandum 2015-01, *Implementation of OMB Memorandum M-12-12 Section 3: Reduce the Footprint*, require CFO Act Departments to set annual targets for reducing the total square footage of their domestic office and warehouse space compared to the FY 2015 baseline.

In FY 2016 HHS office and warehouse space inventory increased by 170,147 square feet (sq.) or 0.8 percent; as compared to the Reduce the Footprint baseline of 19,287,500 sq. established for FY 2015. HHS was unable to meet the FY 2015 target due to delays in disposing of assets planned for FY 2016 and program growth at FDA and Office of Medicare Hearings and Appeals. However, HHS significantly reduced its inventory of office and warehouse space over the past several years with a decrease from 20,346,775 sq. in FY 2014 to the current level in FY 2016 of 19,457,647 sq. HHS expects to reduce the inventory of office and warehouse space by 159,203 sq. by the end of FY 2017 and will continue to review its warehouse inventory to identify future reduction opportunities.

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to the material weakness identified during the audit, as well as conformance with FMFIA and compliance with FFMIA.

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Four Financial Statements Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
Financial Information Systems	1	–	–	–	1
Total Material Weaknesses	***1***	–	–	–	***1***

Definition of Terms – Tables 1 and 2
(Reference: OMB Circular A-136, *Financial Reporting Requirements*, August 15, 2017, page 107)

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

New: The total number of material weaknesses that have been identified during the current year.

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

Consolidated: The combining of two or more findings.

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

Ending Balance: The agency's year-end balance of material weaknesses.

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA #2)						
Statement of Assurance	Modified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
No Material Weaknesses Noted						
Total Material Weaknesses	***0***	**-**	**-**	**-**	**-**	***0***

Effectiveness of Internal Control over Operations (FMFIA #2)						
Statement of Assurance	Modified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	1	-	1[25]	-	-	0
Error Rate Measurement	1	-	-	-	-	1
Medicare Appeals Process	1	-	-	-	-	1
Total Material Weaknesses	***3***	-	***1***	**-**	**-**	***2***

Compliance with Federal Financial Management System Requirements (FMFIA #4)						
Statement of Assurance	Federal Systems comply to financial management system requirements					
Non-Compliance	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Information System Controls and Security	0	-	-	-	-	0
Total Non-Compliance	***0***	**-**	**-**	**-**	**-**	***0***

Compliance with Section 803(a) of the *Federal Financial Management Improvement Act* (FFMIA)		
	Agency	**Auditor**
1. Federal Financial Management System Requirements	No lack of compliance noted	Lack of compliance noted
2. Applicable Federal Accounting Standards	No lack of compliance noted	No lack of compliance noted
3. USSGL at Transaction Level	No lack of compliance noted	No lack of compliance noted

[25] Beginning in FY 2015, HHS implemented a comprehensive strategy to strengthen the HHS Financial Systems Controls Environment and address the IT material weakness. Since then, significant progress has been made in resolving audit findings, reducing risk across the operating environment, and maturing the security and controls posture of HHS's financial systems. As part of the strategy, HHS established a Management Assessment Framework that defines the conditions and criteria to evaluate the severity of control deficiencies found in Information System Controls and Security in HHS's financial systems. Evaluation criteria include four key components: (1) Leadership Commitment and Sustained Governance; (2) Reduced Risk through Corrective Actions; (3) Demonstrated Measurable Remediation Progress; and (4) Mature Controls Environment. While control deficiencies still exist across several HHS FISCAM systems, our evaluation based on the HHS Management Assessment Framework demonstrates that these deficiencies, in aggregate, no longer rise to the level of a "material weakness" under OMB Circular A-123, as of September 30, 2017.

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

On November 2, 2015, the President signed into law the *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act) (Sec. 701 of Public Law 114-74), which further amended the *Federal Civil Penalties Inflation Adjustment Act of 1990* (Public Law 104-410), to improve the effectiveness of civil monetary penalties and to maintain their deterrent effect. Agencies must report the most recent inflationary adjustments to civil monetary penalties in order to ensure penalty adjustments are both timely and accurate.

The 2015 Act applies to eight Operating Divisions (OpDivs) and Staff Divisions (StaffDivs): ACF, AHRQ, HRSA, FDA, CMS, Office for Civil Rights, Office of the General Counsel, and Office of Inspector General. The table below illustrates HHS's civil monetary penalties by OpDivs and StaffDivs. Supporting details can be found in Federal Register 82, No. 22 (February 3, 2017): 9174-9189.

Administration for Children and Families				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for Misuse of Information in the National Directory of New Hires.	42 U.S.C. 653(l)(2)	2016	2017	$ 1,474

Agency for Healthcare Research and Quality				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an establishment or person supplying information obtained in the course of activities for any purpose other than the purpose for which it was supplied.	42 U.S.C. 299c—(3)(d)	2016	2017	$ 14,371

Health Resources and Services Administration				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each instance of overcharging a 340B covered entity.	42 U.S.C. 256b(d)(1)(B)(vi)	2016	2017	$ 5,526

Office for Civil Rights				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violation of confidentiality provision of the *Patient Safety and Quality Improvement Act*.	42 U.S.C. 299b-22(f)(1)	2016	2017	$ 12,135
Penalty for each pre-February 18, 2009 violation of the HIPAA administrative simplification provisions.	42 U.S.C. 1320(d)-5(a)	2016	2017	152
Calendar Year Cap		2016	2017	38,175
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the covered entity or business associate did not know and by exercising reasonable diligence, would not have known that the covered entity or business associate violated such a provision.			2017	
Minimum		2016	2017	112
Maximum		2016	2017	55,910
Calendar Year Cap		2016	2017	1,677,299

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to reasonable cause and not to willful neglect.	42 U.S.C. 1320(d)-5(a)		2017	
Minimum		2016	2017	1,118
Maximum		2016	2017	55,910
Calendar Year Cap		2016	2017	1,677,299
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or, by exercising reasonable diligence, would have known that the violation occurred.			2017	
Minimum		2016	2017	11,182
Maximum		2016	2017	55,910
Calendar Year Cap		2016	2017	1,677,299
Penalty for each February 18, 2009 or later violation of a HIPAA administrative simplification provision in which it is established that the violation was due to willful neglect and was not corrected during the 30-day period beginning on the first date the covered entity or business associate knew, or by exercising reasonable diligence, would have known that the violation occurred.			2017	
Minimum		2016	2017	55,910
Maximum		2016	2017	1,677,299
Calendar Year Cap		2016	2017	1,677,299

Office of the General Counsel				
Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for the first time an individual makes an expenditure prohibited by regulations regarding lobbying disclosure, absent aggravating circumstances.	31 U.S.C. 1352	2016	2017	$ 19,246
Penalty for second and subsequent offenses by individuals who make an expenditure prohibited by regulations regarding lobbying disclosure.			2017	
Minimum		2016	2017	19,246
Maximum		2016	2017	192,459
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.		2016	2017	19,246
Penalty for second and subsequent offenses by individuals who fail to file or amend a lobbying disclosure form, absent aggravating circumstances.			2017	
Minimum		2016	2017	19,246
Maximum		2016	2017	192,459

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for failure to provide certification regarding lobbying in the award documents for all sub-awards of all tiers.	31 U.S.C. 1352		2017	
Minimum		2016	2017	19,246
Maximum		2016	2017	192,459
Penalty for failure to provide statement regarding lobbying for loan guarantee and loan insurance transactions.			2017	
Minimum		2016	2017	19,246
Maximum		2016	2017	192,459
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department	31 U.S.C. 3801-3812	2016	2017	10,056
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department		2016	2017	10,056

Office of Inspector General

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each individual who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2016	2017	$ 333,327
Penalty for any other person who violates safety and security procedures related to handling dangerous biological agents and toxins.		2016	2017	666,656
Penalty per violation for committing information blocking.	42 U.S.C. 300jj-51	2016	2017	1,016,360
Penalty for knowingly presenting or causing to be presented to an officer, employee, or agent of the United States a false claim.	42 U.S.C. 1320a-7a(a)	2016	2017	15,270
Penalty for knowingly presenting or causing to be presented a request for payment which violates the terms of an assignment, agreement, or PPS agreement.		2016	2017	15,270
Penalty for knowingly giving or causing to be presented to a participating provider or supplier false or misleading information that could reasonably be expected to influence a discharge decision.		2016	2017	22,906
Penalty for an excluded party retaining ownership or control interest in a participating entity.		2016	2017	15,270
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.		2016	2017	15,270
Penalty for employing or contracting with an excluded individual.		2016	2017	14,959
Penalty for knowing and willful solicitation, receipt, offer, or payment of remuneration for referring an individual for a service or for purchasing, leasing, or ordering an item to be paid for by a Federal health care program.		2016	2017	74,792

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for ordering or prescribing medical or other item or service during a period in which the person was excluded.	42 U.S.C. 1320a-7a(a)	2016	2017	11,052
Penalty for knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider or supplier.		2016	2017	55,262
Penalty for knowing of an overpayment and failing to report and return.		2016	2017	11,052
Penalty for making or using a false record or statement that is material to a false or fraudulent claim		2016	2017	55,262
Penalty for failure to grant timely access to HHS OIG for audits, investigations, evaluations, and other statutory functions of HHS OIG.		2016	2017	16,579
Penalty for payments by a hospital or critical access hospital to induce a physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	2016	2017	4,384
Penalty for physicians who knowingly receive payments from a hospital or critical access hospital to induce such physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.		2016	2017	4,384
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.		2016	2017	7,635
Penalty for failure to report any final adverse action taken against a health care provider, supplier, or practitioner.	42 U.S.C. 1320a-7e(b)(6)(A)	2016	2017	37,396
Penalty for the misuse of words, symbols, or emblems in communications in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(1)	2016	2017	10,055
Penalty for the misuse of words, symbols, or emblems in a broadcast or telecast in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(2)	2016	2017	50,276
Penalty for certification of a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(1)	2016	2017	2,097
Penalty for causing another to certify or make a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(2)	2016	2017	10,483
Penalty for any individual who notifies or causes to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1395i-3(g)(2)(A)	2016	2017	4,194
Penalty for a Medicare Advantage organization that substantially fails to provide medically necessary, required items and services.	42 U.S.C. 1395w-27(g)(2)(A)	2016	2017	38,175

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a Medicare Advantage organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	2016	2017	37,396
Penalty for a Medicare Advantage organization that improperly expels or refuses to reenroll a beneficiary.		2016	2017	37,396
Penalty for a Medicare Advantage organization that engages in practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		2016	2017	149,585
Penalty per individual who does not enroll as a result of a Medicare Advantage organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		2016	2017	22,438
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to Secretary.		2016	2017	149,585
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to individual or other entity.		2016	2017	37,396
Penalty for Medicare Advantage organization interfering with provider's advice to enrollee and non-MCO affiliated providers that balance bill enrollees.		2016	2017	37,396
Penalty for a Medicare Advantage organization that employs or contracts with excluded individual or entity.		2016	2017	37,396
Penalty for a Medicare Advantage organization enrolling an individual in without prior written consent.		2016	2017	37,396
Penalty for a Medicare Advantage organization transferring an enrollee to another plan without consent or solely for the purpose of earning a commission.		2016	2017	37,396
Penalty for a Medicare Advantage organization failing to comply with marketing restrictions or applicable implementing regulations or guidance.		2016	2017	37,396
Penalty for a Medicare Advantage organization employing or contracting with an individual or entity who violates 1395w-27(g)(1)(A)-(J).		2016	2017	37,396
Penalty for a prescription drug card sponsor that falsifies or misrepresents marketing materials, overcharges program enrollees, or misuse transitional assistance funds.	42 U.S.C. 1395w-141(i)(3)	2016	2017	13,066
Penalty for improper billing by Hospitals, Critical Access Hospitals, or Skilled Nursing Facilities.	42 U.S.C. 1395cc(g)	2016	2017	5,082
Penalty for a hospital or responsible physician dumping patients needing emergency medical care, if the hospital has 100 beds or more.	42 U.S.C. 1395dd(d)(1)	2016	2017	104,826
Penalty for a hospital or responsible physician dumping patients needing emergency care, if the hospital has less than 100 beds.		2016	2017	52,414

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a HMO or competitive plan is such plan substantially fails to provide medically necessary, required items or services	42 U.S.C. 1395mm(i)(6)(B)(i)	2016	2017	52,414
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts		2016	2017	52,414
Penalty for a HMO or competitive medical plan that expels or refuses to reenroll an individual per prescribed conditions		2016	2017	52,414
Penalty for a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in future.		2016	2017	209,653
Penalty per individual not enrolled in a plan as a result of a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in the future.		2016	2017	30,166
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to the Secretary.		2016	2017	209,653
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to an individual or any other entity.		2016	2017	52,414
Penalty for failure by HMO or competitive medical plan to assure prompt payment of Medicare risk sharing contracts or incentive plan provisions.		2016	2017	52,414
Penalty for HMO that employs or contracts with excluded individual or entity.		2016	2017	48,114
Penalty for submitting or causing to be submitted claims in violation of the Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(3)	2016	2017	24,253
Penalty for circumventing Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	2016	2017	161,692
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	2016	2017	10,055
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	2016	2017	10,055
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2016	2017	45,268
Penalty for someone other than issuer that sells health insurance that duplicates benefits.		2016	2017	27,160
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	2016	2017	10,055
Penalty for a Medicaid MCO that substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1396b(m)(5)(B)(i)	2016	2017	50,276

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1396b(m)(5)(B)(i)	2016	2017	50,276
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.		2016	2017	201,106
Penalty per individual who does not enroll as a result of a Medicaid MCO's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.		2016	2017	30,166
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.		2016	2017	201,106
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.		2016	2017	50,276
Penalty for a Medicaid MCO that fails to comply with contract requirements with respect to physician incentive plans.		2016	2017	45,268
Penalty for willfully and knowingly certifying a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(I)	2016	2017	2,097
Penalty for willfully and knowingly causing another individual to certify a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(II)	2016	2017	10,483
Penalty for notifying or causing to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1396r(g)(2)(A)(i)	2016	2017	4,194
Penalty for the knowing provision of false information or refusing to provide information about charges or prices of a covered outpatient drug.	42 U.S.C. 1396r-8(b)(3)(B)	2016	2017	181,071
Penalty per day for failure to timely provide information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(i)	2016	2017	18,107
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	2016	2017	181,071
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	2016	2017	3,621
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	2016	2017	21,916
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	2016	2017	21,916

Food and Drug Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violations related to drug samples resulting in a conviction of any representative of manufacturer or distributor in any 10-year period.	21 U.S.C. 333(b)(2)(A)	2016	2017	$ 100,554
Penalty for violation related to drug samples resulting in a conviction of any representative of manufacturer or distributor after the second conviction in any 10-yr period.	21 U.S.C. 333(b)(2)(B)	2016	2017	2,011,061
Penalty for failure to make a report required by 21 U.S.C. 353(d)(3)(E) relating to drug samples.	21 U.S.C 333(b)(3)	2016	2017	201,106
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C 333(f)(1)(A)	2016	2017	27,160
Penalty for aggregate of all violations related to devices in a single proceeding.		2016	2017	1,810,706
Penalty for any individual who introduces or delivers for introduction into interstate commerce food that is adulterated per 21 U.S.C. 342(a)(2)(B) or any individual who does not comply with a recall order under 21 U.S.C. 350l.	21 U.S.C 333(f)(2)(A)	2016	2017	76,352
Penalty in the case of any other person other than an individual) for such introduction or delivery of adulterated food.		2016	2017	381,758
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.		2016	2017	763,515
Penalty for all violations adjudicated in a single proceeding for any person who fails to submit certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification.	21 U.S.C 333(f)(3)(A)	2016	2017	11,569
Penalty for all violations adjudicated in a single proceeding for any person who violates 21 U.S.C. 331(jj)(1) by failing to submit the certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification; by failing to submit clinical trial information under 42 U.S.C 282(j); or by submitting clinical trial information under 42 U.S.C. 282(j) that is false or misleading in any particular under 42 U.S.C. 282(j)(5)(D).	21 U.S.C 333(f)(3)(B)	2016	2017	11,569
Penalty for any responsible person that violates a requirement of 21 U.S.C. 355(o) (post-marketing studies, clinical trials, labeling), 21 U.S.C. 355(p) (risk evaluation and mitigation (REMS)), or 21 U.S.C. 355-1 (REMS).	21 U.S.C 333(f)(4)(A)(i)	2016	2017	289,239
Penalty for aggregate of all such above violations in a single proceeding.		2016	2017	1,156,953
Penalty for REMS violation that continues after written notice to the responsible person for the first 30–day period (or any portion thereof) the responsible person continues to be in violation.	21 U.S.C 333(f)(4)(A)(ii)	2016	2017	289,239
Penalty for REMS violation that continues after written notice to responsible person doubles for every 30–day period thereafter the violation continues, but may not exceed penalty amount for any 30–day period.		2016	2017	1,156,953
Penalty for aggregate of all such above violations adjudicated in a single proceeding.		2016	2017	11,569,531
Penalty for any person who violates a requirement which relates to tobacco products for each such violation	21 U.S.C 333(f)(9)(A)	2016	2017	16,773
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.		2016	2017	1,118,199
Penalty per violation related to violations of tobacco requirements.	21 U.S.C 333(f)(9)(B)(i)(I)	2016	2017	279,550

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for aggregate of all such violations of tobacco product requirements adjudicated in a single proceeding.	21 U.S.C 333(f)(9)(B)(i)(I)	2016	2017	1,118,199
Penalty in the case of a violation of tobacco product requirements that continues after written notice to such person, for the first 30–day period (or any portion thereof) the person continues to be in violation.	21 U.S.C 333(f)(9)(B)(i)(II)	2016	2017	279,550
Penalty for violation of tobacco product requirements that continues after written notice to such person shall double for every 30–day period thereafter the violation continues, but may not exceed penalty amount for any 30–day period.	21 U.S.C 333(f)(9)(B)(i)(II)	2016	2017	1,118,199
Penalty for aggregate of all such violations related to tobacco product requirements adjudicated in a single proceeding.		2016	2017	11,181,993
Penalty for any person who either does not conduct post-market surveillance and studies to determine impact of a modified risk tobacco product for which the HHS Secretary has provided them an order to sell, or who does not submit a protocol to the HHS Secretary after being notified of a requirement to conduct post-market surveillance of such tobacco products.	21 U.S.C 333(f)(9)(B)(ii)(I)	2016	2017	279,550
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.		2016	2017	1,118,199
Penalty for violation of modified risk tobacco product post-market surveillance that continues after written notice to such person for the first 30–day period (or any portion thereof) that the person continues to be in violation.	21 U.S.C 333(f)(9)(B)(ii)(II)	2016	2017	279,550
Penalty for post-notice violation of modified risk tobacco product post-market surveillance shall double for every 30–day period thereafter that the tobacco product requirement violation continues for any 30–day period, but may not exceed penalty amount for any 30–day period.		2016	2017	1,118,199
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.		2016	2017	11,181,993
Penalty for any person who disseminates or causes another party to disseminate a direct-to-consumer advertisement that is false or misleading for the first such violation in any 3–year period.	21 U.S.C 333(g)(1)	2016	2017	289,239
Penalty for each subsequent above violation in any 3–year period.		2016	2017	578,477
Penalty to be applied for violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR Part 1140) with respect to a retailer with an approved training program in the case of a second regulation violation within a 12–month period.	21 U.S.C 333 note	2016	2017	279
Penalty in the case of a third tobacco product regulation violation within a 24–month period.		2016	2017	559
Penalty in the case of a fourth tobacco product regulation violation within a 24–month period.		2016	2017	2,236
Penalty in the case of a fifth tobacco product regulation violation within a 36–month period.		2016	2017	5,591
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48–month period as determined on a case-by-case basis.	21 U.S.C 333 note	2016	2017	11,182

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty to be applied for violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR Part 1140) with respect to a retailer that does not have an approved training program in the case of the first regulation violation.	21 U.S.C 333 note	2016	2017	279
Penalty in the case of a second tobacco product regulation violation within a 12-month period.		2016	2017	559
Penalty in the case of a third tobacco product regulation violation within a 24–month period.		2016	2017	1,118
Penalty in the case of a fourth tobacco product regulation violation within a 24–month period.		2016	2017	2,236
Penalty in the case of a fifth tobacco product regulation violation within a 36–month period.		2016	2017	5,591
Penalty in the case of a sixth or subsequent tobacco product regulation violation within a 48–month period as determined on a case-by-case basis.		2016	2017	11,182
Penalty for each violation for any individual who made a false statement or misrepresentation of a material fact, bribed, destroyed, altered, removed, or secreted, or procured the destruction, alteration, removal, or secretion of, any material document, failed to disclose a material fact, obstructed an investigation, employed a consultant who was debarred, debarred individual provided consultant services.	21 U.S.C 335b(a)	2016	2017	426,180
Penalty in the case of any other person (other than an individual) per above violation.		2016	2017	1,704,720
Penalty for any person who violates any such requirements for electronic products, with each unlawful act or omission constituting a separate violation.	21 U.S.C 360pp(b)(1)	2016	2017	2,795
Penalty imposed for any related series of violations of requirements relating to electronic products.		2016	2017	952,838
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	2016	2017	219,156
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C.263b(h)(3)	2016	2017	17,047
Penalty per occurrence for any vaccine manufacturer that intentionally destroys, alters, falsifies, or conceals any record or report required.	42 U.S.C. 300aa-28(b)(1)	2016	2017	219,156

Centers for Medicare & Medicaid Services

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a clinical laboratory's failure to meet participation and certification requirements and poses immediate jeopardy.	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)		2017	
Minimum		2016	2017	$ 6,134
Maximum		2016	2017	20,111
Penalty for a clinical laboratory's failure to meet participation and certification requirements and the failure does not pose immediate jeopardy.			2017	
Minimum		2016	2017	101
Maximum		2016	2017	6,033
Failure to provide the Summary of Benefits and Coverage (SBC)	42 U.S.C. 300gg-15(f)	2016	2017	1,105

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	42 U.S.C. 300gg-18	2016	2017	111
Penalty for manufacturer or group purchasing organization failing to report information required under 42 USC 1320a-7h(a), relating to physician ownership or investment interests	42 U.S.C. 1320a-7h(b)(1)		2017	
Minimum		2016	2017	1,105
Maximum		2016	2017	11,052
Calendar Year Cap		2016	2017	165,786
Penalty for manufacturer or group purchasing organization knowingly failing to report information required under 42 USC 1320a-7h(a) , relating to physician ownership or investment interests	42 U.S.C. 1320a-7h(b)(2)		2017	
Minimum		2016	2017	11,052
Maximum		2016	2017	110,524
Calendar Year Cap		2016	2017	1,105,241
Penalty for an administrator of a facility that fails to comply with notice requirements for the closure of a facility.	42 U.S.C. 1320a-7j(h)(3)(A)	2016	2017	110,524
Minimum penalty for the first offense of an administrator who fails to provide notice of facility closure.		2016	2017	553
Minimum penalty for the second offense of an administrator who fails to provide notice of facility closure.		2016	2017	1,658
Minimum penalty for the third and subsequent offenses of an administrator who fails to provide notice of facility closure.		2016	2017	3,315
Penalty for an entity knowingly making a false statement or representation of material fact in the determination of the amount of benefits or payments related to old-age, survivors, and disability insurance benefits, special benefits for certain World War II veterans, or supplemental security income for the aged, blind, and disabled.	42 U.S.C. 1320a-8(a)(1)	2016	2017	8,084
Penalty for the violation of 42 USC 1320a-8a(1) if the violator is a person who receives a fee or other income for services performed in connection with determination of the benefit amount or the person is a physician or other health care provider who submits evidence in connection with such a determination.		2016	2017	7,623
Penalty for a representative payee (under 42 USC 405(j), 1007, or 1383(a)(2)) converting any part of a received payment from the benefit programs described in the previous civil monetary penalty to a use other than for the benefit of the beneficiary.	42 U.S.C. 1320a-8(a)(3)	2016	2017	6,331
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility.	42 U.S.C. 1320b-25(c)(1)(A)	2016	2017	221,048
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility if such failure exacerbates the harm to the victim of the crime or results in the harm to another individual.	42 U.S.C. 1320b-25(c)(2)(A)	2016	2017	331,572
Penalty for a long-term care facility that retaliates against any employee because of lawful acts done by the employee, or files a complaint or report with the State professional disciplinary agency against an employee or nurse for lawful acts done by the employee or nurse.	42 U.S.C. 1320b-25(d)(2)	2016	2017	221,048

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any person who knowingly and willfully fails to furnish a beneficiary with an itemized statement of items or services within 30 days of the beneficiary's request.	42 U.S.C. 1395b-7(b)(2)(B)	2016	2017	149
Penalty per day for a Skilled Nursing Facility that has a Category 2 violation of certification requirements.	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)		2017	
Minimum		2016	2017	105
Maximum		2016	2017	6,289
Penalty per instance of Category 2 noncompliance by a Skilled Nursing Facility.			2017	
Minimum		2016	2017	2,097
Maximum		2016	2017	20,965
Penalty per day for a Skilled Nursing Facility that has a Category 3 violation of certification requirements.			2017	
Minimum		2016	2017	6,394
Maximum		2016	2017	20,965
Penalty per instance of Category 3 noncompliance by a Skilled Nursing Facility.			2017	
Minimum		2016	2017	2,097
Maximum		2016	2017	20,965
Penalty per day and per instance for a Skilled Nursing Facility that has Category 3 noncompliance with Immediate Jeopardy			2017	
Per Day (Minimum)		2016	2017	6,394
Per Day (Maximum)		2016	2017	20,965
Per Instance (Minimum)		2016	2017	2,097
Per Instance (Maximum)		2016	2017	20,965
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the upper range per day.			2017	
Minimum		2016	2017	6,394
Maximum		2016	2017	20,965
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the lower range per day.			2017	
Minimum		2016	2017	105
Maximum		2016	2017	6,289
Penalty per instance of a Skilled Nursing Facility that fails to meet certification requirements.			2017	
Minimum		2016	2017	2,097
Maximum		2016	2017	20,965
Penalty for knowingly, willfully, and repeatedly billing for a clinical diagnostic laboratory test other than on an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395l(h)(5)(D)	2016	2017	15,270
Penalty for knowingly and willfully presenting or causing to be presented a bill or request for payment for an intraocular lens inserted during or after cataract surgery for which the Medicare payment rate includes the cost of acquiring the class of lens involved.	42 U.S.C. 1395l(i)(6)	2016	2017	4,022

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for knowingly and willfully failing to provide information about a referring physician when seeking payment on an unassigned basis.	42 U.S.C. 1395l(q)(2)(B)(i)	2016	2017	3,849
Penalty for any durable medical equipment supplier that knowingly and willfully charges for a covered service that is furnished on a rental basis after the rental payments may no longer be made. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	2016	2017	15,270
Penalty for any nonparticipating durable medical equipment supplier that knowingly and willfully fails to make a refund to Medicare beneficiaries for a covered service for which payment is precluded due to an unsolicited telephone contact from the supplier. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(18)(B)	2016	2017	15,270
Penalty for any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge for radiologist services. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(b)(5)(C)	2016	2017	15,270
Penalty for any supplier of prosthetic devices, orthotics, and prosthetics that knowing and willfully charges for a covered prosthetic device, orthotic, or prosthetic that is furnished on a rental basis after the rental payment may no longer be made. (Penalties are assessed in the same manner as 42 USC 1395m(a)(11)(A), that is in the same manner as 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(h)(3)	2016	2017	15,270
Penalty for any supplier of durable medical equipment including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully distributes a certificate of medical necessity in violation of Section 1834(j)(2)(A)(i) of the Act or fails to provide the information required under Section 1834(j)(2)(A)(ii) of the Act.	42 U.S.C. 1395m(j)(2)(A)(iii)	2016	2017	1,617
Penalty for any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries for series billed other than on as assignment-related basis under certain conditions. (Penalties are assessed in the same manner as 42 USC 1395m(j)(4) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(j)(4)	2016	2017	15,270
Penalty for any person or entity who knowingly and willfully bills or collects for any outpatient therapy services or comprehensive outpatient rehabilitation services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395m(k)(6) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(k)(6)	2016	2017	15,270
Penalty for any supplier of ambulance services who knowingly and willfully fills or collects for any services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(b)(18)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(l)(6)	2016	2017	15,270

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(b)(18)(B)	2016	2017	15,270
Penalty for any physician who charges more than 125% for a non-participating referral. (Penalties are assessed in the same manner as 42 USC 1320a-7a(a)).	42 U.S.C. 1395u(j)(2)(B)	2016	2017	15,270
Penalty for any physician who knowingly and willfully presents or causes to be presented a claim for bill for an assistant at a cataract surgery performed on or after March 1, 1987, for which payment may not be made because of section 1862(a)(15). (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(k)	2016	2017	15,270
Penalty for any nonparticipating physician who does not accept payment on an assignment-related basis and who knowingly and willfully fails to refund on a timely basis any amounts collected for services that are not reasonable or medically necessary or are of poor quality under 1842(l)(1)(A). (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(l)(3)	2016	2017	15,270
Penalty for any nonparticipating physician charging more than $500 who does not accept payment for an elective surgical procedure on an assignment related basis and who knowingly and willfully fails to disclose the required information regarding charges and coinsurance amounts and fails to refund on a timely basis any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(m)(3)	2016	2017	15,270
Penalty for any physician who knowingly, willfully, and repeatedly bills one or more beneficiaries for purchased diagnostic tests any amount other than the payment amount specified by the Act. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(n)(3)	2016	2017	15,270
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services pertaining to drugs or biologics by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 USC 1395u(b)(18)(B) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(o)(3)(B)	2016	2017	15,270
Penalty for any physician or practitioner who knowingly and willfully fails promptly to provide the appropriate diagnosis codes upon CMS or Medicare administrative contractor request for payment or bill not submitted on an assignment-related basis.	42 U.S.C. 1395u(p)(3)(A)	2016	2017	4,022

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a pharmaceutical manufacturer's misrepresentation of average sales price of a drug, or biologic.	42 U.S.C. 1395w-3a(d)(4)(A)	2016	2017	13,066
Penalty for any nonparticipating physician, supplier, or other person that furnishes physician services not on an assignment-related basis who either knowingly and willfully bills or collects in excess of the statutorily-defined limiting charge or fails to make a timely refund or adjustment. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(1)(B)	2016	2017	15,270
Penalty for any person that knowingly and willfully bills for statutorily defined State-plan approved physicians' services on any other basis than an assignment-related basis for a Medicare/Medicaid dual eligible beneficiary. (Penalties are assessed in the same manner as 42 USC 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(3)(B)	2016	2017	15,270
Penalty for each termination determination the Secretary makes that is the result of actions by a Medicare Advantage organization or Part D sponsor that has adversely affected an individual covered under the organization's contract.	42 U.S.C. 1395w-27(g)(3)(A); 42 U.S.C. 1857(g)(3)	2016	2017	37,396
Penalty for each week beginning after the initiation of civil money penalty procedures by the Secretary because a Medicare Advantage organization or Part D sponsor has failed to carry out a contract, or has carried out a contract inconsistently with regulations.	42 U.S.C. 1395w-27(g)(3)(B);42 U.S.C. 1857(g)(3)	2016	2017	14,959
Penalty for a Medicare Advantage organization's or Part D sponsor's early termination of its contract.	42 U.S.C. 1395w-27(g)(3)(D); 42 U.S.C. 1857(g)(3)	2016	2017	138,925
Penalty for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits not to enroll under a group health plan or large group health plan which would be a primary plan.	42 U.S.C. 1395y(b)(3)(C)	2016	2017	9,054
Penalty for any non-governmental employer that, before October 1, 1998, willfully or repeatedly failed to provide timely and accurate information requested relating to an employee's group health insurance coverage.	42 U.S.C. 1395y(b)(5)(C)(ii)	2016	2017	1,474
Penalty for any entity that knowingly, willfully, and repeatedly fails to complete a claim form relating to the availability of other health benefits in accordance with statute or provides inaccurate information relating to such on the claim form.	42 U.S.C. 1395y(b)(6)(B)	2016	2017	3,234
Penalty for any entity serving as insurer, third party administrator, or fiduciary for a group health plan that fails to provide information that identifies situations where the group health plan is or was a primary plan to Medicare to the HHS Secretary.	42 U.S.C. 1395y(b)(7)(B)(i)	2016	2017	1,157
Penalty for any non-group health plan that fails to identify claimants who are Medicare beneficiaries and provide information to the HHS Secretary to coordinate benefits and pursue any applicable recovery claim.	42 U.S.C. 1395y(b)(8)(E)	2016	2017	1,157

GRANTS OVERSIGHT & NEW EFFICIENCY ACT REPORT

The *Grants Oversight and New Efficiency Act* (GONE Act) was signed into law on January 28, 2016, with the aim to facilitate the closing of expired grants and to improve government efficiency. The GONE Act requires agencies to submit annual reports to Congress that list each of their federal grant awards, the attributed dollar balances, and the challenges leading to delays in grant closeout. Agencies must also explain why, for the 30 oldest federal grant awards, each grant has not been closed out.

The GONE Act covers grants that have been expired for 2 or more years and have not been closed out. Agency heads must annually report to Congress whether the agency has closed out the covered grants discussed in previous reports. FY 2017 marks HHS's first GONE Act report submission. For more information on the GONE Act, please see GONE Act.

1. Challenges

Two primary challenges leading to delays in closing out grants and cooperative agreements relate to policy and system issues. HHS utilizes its Payment Management System (PMS) to disburse grant funding. HHS policy requires OpDivs to notify PMS when a grant should be closed; however, OpDivs are not required to monitor the action to ensure the grant is closed out. In addition, PMS does not close out a grant until three different financial reports have been reconciled. If the financial reports do not reconcile to the penny, the PMS system will not close out the grant. These reconciliation issues lead to a large number of expired grants with small, undisbursed balances remaining open.

The management of pooled accounts in PMS is a system-related issue affecting timely grants closeout, as identified in GAO report GAO-16-362, *Grants Management: Actions Needed to Address Persistent Grant Closeout Timeliness and Undisbursed Balance Issues.* Pooled accounts are created when a grantee wins multiple awards and the funding is pooled into the same account rather than delineated by funding source or project. Pooling of funds allows recipients to withdraw funds from the account without citing the specific project for which the funding is needed. As a result, HHS is unable to close pooled accounts until all associated funding in the account is reconciled.

2. Corrective Actions

HHS implemented measures to reduce the number of open but expired awards. These measures focus on closing expired reconciled accounts with zero dollar balances, developing strategies for resolving complex closeout issues, and monitoring the Department's efforts to close expired awards.

In December 2016, HHS implemented the Clean Sweep exercise. The Clean Sweep exercise engaged HHS OpDivs and PMS in a large-scale effort to identify and close federal awards whose accounts were reconciled and held zero dollar balances. Clean Sweep resulted in the closure of over 30,000 federal awards across HHS.

In March 2017, HHS implemented the HHS GONE Act Monthly Reporting initiative. The initiative required all OpDivs to submit monthly reports on their 30 oldest federal awards that met the GONE Act reporting criteria. The monitoring effort encouraged OpDivs to continue reducing the number of expired federal awards with undispersed balances or overdrawn accounts.

In June 2017, HHS began an effort to address more complex closeout issues, such as pooling, and reconciling accounts with balances less than one dollar. Working collaboratively with our OpDivs, HHS is in the process of identifying Department-wide strategies for closing accounts.

These efforts have culminated in the closure of 17,477 open but expired awards to date.

The GONE Act requires agencies to report grant and cooperative agreement data from their agency cash payment management system; however, some information is not practical to collect. HHS's PMS does not contain all of the data elements required for reporting (e.g., Federal Award Identification Number, Award Title, etc.). To improve our grant systems, HHS has completed a time-intensive, manual crosswalk between two complex data sets from HHS's PMS and the Tracking Accountability in Government Grants System, and is able to report all of its undisbursed and zero dollar balances in accordance with GONE Act reporting requirements. HHS plans to update its policy to require OpDivs to track the status of their submitted closeout requests. HHS is also striving to identify opportunities to eliminate the system-related issues in PMS that impede timely closeout of awards.

The table below summarizes HHS's open but expired awards.

Table 1: 2017 GONE Act Reporting – Summary Table of Open but Expired HHS Awards

Category	**Age of Expiration**		
	2-3 Years	**>3-5 Years**	**>5 Years**
Number of Grants/Cooperation Agreements with Zero Dollar Balances	2,711	1,411	2,390
Number of Grants/Cooperation Agreements with Undisbursed Balances	7,843	3,574	5,186
Total Amount of Undisbursed Balanced	$1,110,139,141.90	$319,994,880.31	$559,065,500.33

PAYMENT INTEGRITY REPORT

Overview

HHS is committed to improving payment accuracy in all of its programs. While the Department has previously identified many tools and resources to prevent, detect, and reduce improper payments, it continues efforts to find and implement innovative solutions to improve payment integrity among its programs while reducing the burden on its stakeholders.

HHS's FY 2017 Payment Integrity Report includes a discussion of the following information, as required by the *Improper Payments Information Act* (IPIA) *of 2002*, as amended by the *Improper Payments Elimination and Recovery Act* (IPERA) *of 2010* and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA) *of 2012*; Office of Management and Budget (OMB) Circular A-136; and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.0)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
    - Improper Payment Measurement Estimates (Section 3.1)
- Corrective Action Plans (CAPs) (Section 4.0)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- FY 2017 Achievements (Section 8.0)
- Improper Payment Reduction Outlook FY 2016 through FY 2018 (Section 9.0)
    - Accompanying Notes for Table 1 (Section 9.1)
- Improper Payment Root Cause Categories (Section 10.0)
- Program-Specific Reporting Information (Section 11.0)
    - Medicare Fee-for-Service (FFS) (Parts A and B) (Section 11.10)
    - Medicare Advantage (Part C) (Section 11.20)
    - Medicare Prescription Drug Benefit (Part D) (Section 11.30)
    - Medicaid (Section 11.40)
    - Children's Health Insurance Program (CHIP) (Section 11.50)
    - Temporary Assistance for Needy Families (TANF) (Section 11.60)
    - Foster Care (Section 11.70)
    - Child Care and Development Fund (CCDF) (Section 11.80)
- Superstorm Sandy Reporting Information (Section 12.0)
    - Head Start (Section 12.10)
    - Social Services Block Grant (SSBG) (Section 12.20)
- Recovery Auditing Reporting (Section 13.0)

Additional information on HHS's improper payment efforts may also be found at PaymentAccuracy.gov. This website includes detailed information on HHS's improper payment activities, including information that is not reported in the FY 2017 Payment Integrity Report.

1.0 Program Descriptions

The following list, organized by Division, is a brief description of the risk-susceptible programs discussed in this report (risk-susceptible programs are required to estimate improper payments and report other information, like reduction targets and corrective actions). For the programs that received funding under the Superstorm Sandy *Disaster Relief Appropriations Act* (*Disaster Relief Act*) *of 2013*, only two programs (Head Start and SSBG) are reporting improper payment estimates for FY 2017 (other programs that have expended all of the *Disaster Relief Act* funds are excluded from reporting improper payment estimates).

Risk-Susceptible Programs:

1. **Medicare FFS** – A federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD).
2. **Medicare Part C** – A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
3. **Medicare Part D** – A federal prescription drug benefit program for Medicare beneficiaries.
4. **Medicaid** – A joint federal/state program, administered by the states, that provides health insurance to qualifying low-income individuals.
5. **CHIP** – A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
6. **Advanced Premium Tax Credit (APTC)** – A federal insurance affordability program, administered by HHS and/or the states, to support enrollees in purchasing Qualified Health Plan (QHP) coverage from state and federal insurance exchanges.
7. **Cost-sharing Reduction (CSR)** – A federal insurance affordability program, administered by HHS and/or the states, operated on behalf of QHP enrollees to reduce the cost of deductibles, copayments, and coinsurance.
8. **TANF** – A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
9. **Foster Care** – A joint federal/state program, administered by the states, for children who need placement outside their homes in a foster family home or a child care facility.
10. **CCDF** – A joint federal/state program, administered by the states, that provides child care financial assistance to low-income working families.
11. **Superstorm Sandy Head Start** – A federal program that provides comprehensive developmental services for America's low-income children from birth to 5 years of age and their families. Head Start received additional appropriations through the *Disaster Relief Act* to address the construction and other needs that arose from Superstorm Sandy.
12. **Superstorm Sandy SSBG** – A joint federal/state program, administered by the states, that supports programs designed to reduce dependency and promote self-sufficiency; to protect children, adults, and people with disabilities from neglect, abuse, and exploitation; and to help individuals who are unable to take care of themselves to stay in their homes or to find the best institutional arrangement. SSBG received additional appropriations through the *Disaster Relief Act* to address services for individuals and construction costs for facilities that arose from Superstorm Sandy.

2.0 Risk Assessments

As required by the IPIA as amended and OMB implementing guidance, HHS reviews its non-risk-susceptible programs (including payment streams and activities) to determine if they are susceptible to significant improper payments. The HHS IPERIA Risk Assessment Tool contains nine required risk factors, specific risks identified by the

program that may lead to improper payments, and controls that may mitigate those risks. By examining these areas, the risk assessment tool provides a comprehensive review and analysis of selected programs' operations to determine if a payment risk exists and, if so, the nature and severity of the identified risks.

In FY 2017, HHS strengthened its risk assessment processes and reporting activities with added policies and procedures. For example, the Department improved the HHS IPERIA Risk Assessment Template by incorporating lessons learned from the previous year's risk assessments and by refining its approach for charge card risk assessments. HHS completed 24 risk assessments (representing risk assessments of programs and charge cards), and concluded that the 24 programs were not susceptible to the risk of significant improper payments. In addition, HHS is continuing to defer a final risk assessment conclusion for the Basic Health Program to allow the program to become more fully established.

3.0 Statistical Sampling Process

Each risk-susceptible program's statistical sampling process is discussed in *Section 11.0: Program-Specific Reporting Information* or *Section 12.0: Superstorm Sandy Reporting Information*. All programs that reported improper payment estimates complied with OMB-approved statistical sampling plans and confidence intervals, and are reporting improper payment estimates calculated by a statistical contractor. In addition, all of the programs utilized the same statistical sampling measurement approaches as in the previous year.

3.1 Improper Payment Measurement Estimates

Improper payments are not necessarily expenses that should not have occurred. For example, instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments under current OMB guidance. A significant amount of HHS's improper payments are due to documentation errors where a lack of documentation or errors in the documentation limited HHS's ability to verify information. However, if the documentation was submitted or maintained, then the improper payments may have been proper. A smaller proportion of improper payments are payments that should not have been made or should have been made in different amounts and are considered monetary losses to the government.

As mentioned earlier, statistical samples are used to calculate each program's estimated improper payment rate and a projected amount of improper payments. Table 1 in *Section 9.0: Improper Payment Reduction Outlook FY 2016 through FY 2018* presents each program's gross and net improper payment rates.

The *gross improper payment* is the official program improper payment rate; it is calculated by adding the sample's overpayments and underpayments and dividing by the sample's total dollar value. The *net improper rate* is calculated by subtracting the sample's underpayments from overpayments and dividing by the sample's total dollar value.

4.0 CAPs

Each program's CAP for reducing the estimated rate of improper payments can be found in *Section 11.0: Program-Specific Reporting Information* or *Section 12.0: Superstorm Sandy Reporting Information*. Generally, each program develops a multi-faceted approach to corrective actions with multiple efforts underway concurrently. CAPs are used to set aggressive, realistic targets for reducing improper payments, and outline a timetable to achieve scheduled targets. OMB approves all CAPs and reduction targets published in the Agency Financial Report (AFR). Corrective actions can be in different stages, from development, to piloting, to steady state implementation, to completion. The Department reviews CAPs annually to ensure plans focus on the root causes of the improper payments, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

5.0 Accountability in Reducing and Recovering Improper Payments

Strengthening program integrity throughout the organization is a top Departmental priority, extending to HHS senior executives and program officials at each of HHS's Divisions and programs. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals that are related to strengthening program integrity, protecting taxpayer resources, and reducing improper payments. Senior executives and program officials are assessed as part of their semi-annual and annual performance evaluations on their progress toward achieving these goals.

6.0 Information Systems and Other Infrastructure

Section 11.0: Program-Specific Reporting Information details each program's information systems and other infrastructure. Unless otherwise stated in *Section 11.0*, HHS has the information systems and other infrastructure it needs to reduce improper payments to the targeted levels in all of its programs that report an improper payment estimate.

7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

Section 11.0: Program-Specific Reporting Information reports each program's statutory or regulatory barriers, if any, to reducing improper payments.

8.0 FY 2017 Achievements

In FY 2017, HHS strengthened its efforts to reduce and recover improper payments in its programs. While a few of these efforts are highlighted below, more detailed information on the programs' performance and corrective actions can be found in *Section 11.0: Program-Specific Reporting Information* and *Section 12.0: Superstorm Sandy Reporting Information*.

Head Start

As of FY 2013, Head Start no longer reports annual improper payment estimates due to the strong internal controls, monitoring systems, and low reported error rates from FY 2009 through FY 2012. In lieu of an annual error rate measurement, HHS provides oversight through Head Start's existing internal controls and monitoring systems, and annually reports to OMB on its internal controls. Overall, FY 2017 onsite monitoring results determined that there were no grantees with erroneous payments related to eligibility, indicating that the Department's control and monitoring systems are working as intended.

Centers for Medicare & Medicaid Services (CMS) Program Integrity (PI) Board

CMS uses an agency-wide PI Board (comprised of CMS executive leaders) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in its programs; direct corrective actions; and track issues to resolution. To assist with these activities, the PI Board established an Improper Payment Action Plan workgroup to collect data from improper payment reports and formulate action plans for review by the PI Board. The PI Board also established smaller working groups—referred to as Integrated Project Teams (IPTs)—to focus on specific projects to address the vulnerabilities. Each IPT works independently under the PI Board's direction and provides regular updates. In FY 2017, the workgroups made significant strides.

- Health Insurance Exchange IPT: The Health Insurance Exchange IPT conducted a fraud risk assessment consistent with best practices developed by the Government Accountability Office. In its oversight role, the PI Board was briefed on the fraud risk profile and initial implementation activities. As a result of this assessment, the Department implemented steps to prevent fraud during the exchange enrollment process, including clarifying requirements and implementing system improvements to strengthen

enrollment controls and manage fraud risk related to data matching issues. Improvements include a complaints review process, agent broker license verification, and investigations, as described below.

- Complaints are reviewed for potential fraud and unauthorized enrollment of consumers and HHS works with issuers to rescind fraudulent policies. As of September 30, 2017, HHS has reviewed over 10,000 complaints.
- The license verification project ensures that agents and brokers are licensed in the states where they are assisting with plan enrollments.
- Finally, HHS works to screen, prioritize, and investigate potential fraud and abuse leads that come from data analysis and tips from external parties.

- Documentation Improvement IPT: The Documentation Improvement IPT transitioned into an agency-wide initiative known as the Documentation Requirements Simplification project. In FY 2017, the PI Board approved the initiative's goals, which are to clarify, simplify, and/or eliminate documentation requirements. This initiative will reduce provider burden and inappropriate appeals while balancing program integrity concerns. The PI Board approved the operational structure of the initiative and will inform topic selection and prioritization. This structure includes the Documentation Requirements Simplification Change Control Board, which facilitates stakeholder engagement and drives decision-making.
- ESRD Initiative and Opioid Misuse Initiative Workgroups: The PI Board directed the ESRD Initiative workgroup to determine payment, quality, and innovation policy levers to effectuate transformational change within ESRD programs, as well as the Opioid Misuse Initiative workgroup to facilitate cross-agency collaboration to help address this national epidemic. In January 2017, CMS released its Opioid Misuse Strategy paper, which outlines numerous efforts the agency has been and is taking to impact the national opioid misuse epidemic.

Provider Enrollment Moratorium

Section 1866(j)(7) of the *Social Security Act* authorizes HHS to impose a temporary moratorium on the enrollment of new providers and suppliers as a tool to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP in high-risk services and areas across the country. Establishing a moratorium in certain geographic areas allows HHS to analyze and monitor the existing provider and supplier base, in order to focus additional fraud prevention and detection tools in these areas, while continuing to monitor beneficiary access to care. HHS launched the first temporary (6-month) enrollment moratorium pursuant to this authority in 2013 for home health agencies (HHAs) and ground ambulance suppliers (emergency and non-emergency) in limited areas for Medicare, Medicaid, and CHIP. Since then, HHS has extended and modified the temporary enrollment moratoria. On July 29, 2016, HHS announced:

- The moratoria were expanded state-wide for HHAs in Florida, Illinois, Michigan, and Texas and for new Medicare Part B, Medicaid, and CHIP non-emergency ambulance suppliers in New Jersey, Pennsylvania, and Texas;
- HHS concurrently lifted the temporary moratoria on all Medicare Part B, Medicaid, and CHIP emergency ground ambulance suppliers; and
- HHS launched the Provider Enrollment Moratoria Access Waiver Demonstration, which grants waivers to the state-wide enrollment moratoria on a case-by-case basis in response to access to care issues in certain geographic areas and requires heightened initial review and ongoing oversight of newly enrolling providers and suppliers.

HHS extended the moratoria for an additional 6 months on January 29, 2017, and again for an additional 6 months on July 29, 2017. Due to the lags in billing, HHS is unable to report on the impact of statewide moratoria.

Fraud Prevention System (FPS)

In June 2011, HHS launched the FPS, which analyzes all Medicare FFS claims using risk-based algorithms to: target investigative resources; generate alerts for suspect claims or providers and suppliers; and investigate the most egregious, suspect, or aberrant activity. HHS and its program integrity contractors use the FPS information to prevent and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, Medicare billing privilege revocations, and law enforcement referrals.

In implementing FPS 2.0, HHS and its contractor are modernizing the FPS to decrease development and implementation time for new analytic models and edits; implement edits that will reject and deny claims that do not meet Medicare rules and requirements prior to payment; expand the toolset to include analysis of social networks; improve the user interface, model management, and evaluation of prioritization rules; include business intelligence reporting tools connected to the live FPS 2.0 system, and allow claim level drill-down capabilities; and provide a testing environment to evaluate how a new analytic model will interact with existing models to impact workload. HHS launched the FPS 2.0 on February 20, 2017.

During FY 2016, HHS took administrative action against 1,044 providers and suppliers, resulting in an estimated $527.06 million in identified savings. These FY 2016 savings represent a $6.34 to $1 return on investment. This return on investment calculation includes costs associated with both FPS 1.0 and the development of FPS 2.0, which became operational in FY 2017. If the FPS 2.0 costs are excluded from the calculation, the ROI would be $8.20 to $1. Simultaneously, the FPS also generated leads for 476 new investigations and augmented information for 212 ongoing investigations. HHS will report FY 2017 savings from the FPS in the FY 2018 AFR.

National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)

The NBI MEDIC performs data analysis to fight fraud, waste, and abuse in Medicare Part C and Part D. The NBI MEDIC identifies improper payments and notifies plan sponsors to recover the corresponding overpayments. HHS also utilizes the NBI MEDIC's data analysis to select Part D plan sponsors and drugs for review through Part D plan sponsor self-audits. As a result of the NBI MEDIC's data analysis projects including Part D plan sponsor self-audits, HHS recovered $4.95 million from Part D sponsors during the first three quarters of FY 2017. In addition, the NBI MEDIC refers certain information to law enforcement organizations. According to notifications received from law enforcement during the first three quarters of FY 2017, NBI MEDIC referrals to law enforcement resulted in recoveries of $3.1 million for Part C and $40.8 million for Part D. The majority of these savings were from court decisions ordering restitution.

Medicaid Integrity Program

Under the authority of Section 1936 of the *Social Security Act*, as amended by the *Deficit Reduction Act* (DRA) *of 2005*, HHS's Medicaid Integrity Program has two broad responsibilities:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To support and assist state efforts to combat Medicaid provider fraud, waste, and abuse.

Increased Medicaid recoveries demonstrate the increased focus on Medicaid integrity. For example, the Medicaid Integrity Program has provided federal staff specializing in program integrity and contractor support to states to bolster their activities and collections. Since enactment of the DRA, total state Medicaid program integrity collections have grown from $265 million in FY 2006 to $568.04 million in FY 2017. The Medicaid Integrity Program works in coordination with the Medicaid program integrity activities funded by the Health Care Fraud and Abuse Control program. For example, these program integrity activities improve HHS's financial oversight of Medicaid and CHIP by supporting reviews of proposed Medicaid state plan amendments; financial management reviews; and

other activities. These activities also recovered approximately $230 million and averted another $666 million in reimbursements in FY 2016. The DRA also required HHS to establish a Comprehensive Medicaid Integrity Plan to guide the Medicaid Integrity Program's development and operations. HHS's most recent Comprehensive Medicaid Integrity Plan for FYs 2014 through 2018 is available at Medicaid Integrity. As discussed in *Section 11.40,* HHS significantly expanded its efforts to assist states with meeting Medicaid screening and enrollment requirements throughout FY 2017.

Public Assistance Reporting Information System (PARIS)

PARIS is a federal/state partnership with all 50 states, the District of Columbia, and Puerto Rico that provides state public assistance agencies detailed information and data to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program.

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) partner to advance the PARIS project at no cost to states. The DOD's Defense Manpower Data Center provides computer resources to produce a match file using social security numbers submitted by the states, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by executing Computer Matching Agreements (CMA) and coordinating the quarterly matches. Since its establishment, PARIS has strengthened program administration among its programs and state public assistance agencies. For instance, New York closed or removed active individuals from 8,750 public assistance cases identified on the PARIS match for cost savings of $55.20 million during their most recent full state FY (April 2016 to March 2017). More information can be found at PARIS.

Results of the Do Not Pay (DNP) Initiative in Preventing Improper Payments

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List" in a network of databases where agencies can access relevant information before determining eligibility for federal funding. Since 2010, HHS has worked to implement the DNP initiative. HHS renewed a CMA with Treasury under the DNP initiative in FY 2017. In addition, several of HHS's Divisions are using DNP to check for recipients' or potential recipients' eligibility for payment and to prevent improper payments. Further, Treasury-disbursed payments are matched against the Social Security Administration's (SSA) Death Master File (DMF) and the General Services Administration's excluded parties' elements of the System for Award Management in the DNP portal to identify improper payments on a daily basis. In FY 2017, the Department screened 1.21 million payments against IPERIA listed databases, representing $419.26 billion. While the Department identified 22 potential improper payments over the past year as part of these daily matches, there were no confirmed matches in FY 2017. Lastly, CMS is also checking certain payments against IPERIA-listed databases outside of the DNP portal. In FY 2017, CMS screened 1.15 billion payments against IPERIA-listed databases, representing $390.8 billion. Through these checks, CMS stopped 504,200 payments representing $1.6 billion.

9.0 Improper Payment Reduction Outlook FY 2016 through FY 2018

The following table (Table 1) displays HHS's proper and improper payment estimates for the current year (CY) FY 2017, the prior year (PY) FY 2016, and targets for FY 2018. The table includes the following information by year and program, as applicable: FY outlays, the estimated improper payment rate or future target rate (IP%), and estimated amount and percent paid or projected to be paid properly (PP) and improperly (IP). In addition, for the CY, Table 1 includes: the estimated amount and percent of overpayments (CY Over Payments), the estimated amount and percent of underpayments (CY Under Payments), the estimated net improper payment rate (CY Net IP%) and amount (CY Net $), and the corresponding estimated overpayments (CY Over Payments), when available.

Table 1
Estimated Proper and Improper Payments for HHS's Risk-Susceptible Programs
FY 2016 – FY 2018 (in Millions)

Program or Activity	PY Outlays $	PY IP %	PY IP $	CY Outlays $	CY PP %	CY PP $	CY IP %	CY IP $	CY Over Payment %	CY Over Payment $	CY Under Payment %	CY Under Payment $	CY Net IP %	CY Net IP $	CY+1 Est. Outlays $	CY+1 IP %	CY+1 IP $
Medicare FFS	373,650.45 Note (a)	11.00	41,084.65	380,761.97 Note (b)	90.49	344,553.97	9.51 Note (1)	36,208.00	9.21	35,081.74	0.30	1,126.25	8.92	33,955.49	418,871.14 Note (c)	9.40	39,373.89
Medicare Part C	161,944.04 Note (d)	9.99	16,182.66	172,768.08 Note (e)	91.69	158,416.36	8.31	14,351.71	5.39	9,311.19	2.92	5,040.53	2.47	4,270.66	208,665.86 Note (f)	8.08	16,860.20
Medicare Part D	70,235.94 Note (g)	3.41	2,393.94	77,450.28 Note (h)	98.33	76,154.69	1.67	1,295.60	0.58	450.77	1.09	844.83	(0.51)	(394.06)	84,065.00 Note (i)	1.66	1,395.48
Medicaid	345,973.72 Note (j)	10.48	36,253.25	363,839.35 Note (k)	89.90	327,108.22	10.10 Note (2)	36,731.13	10.02	36,447.95	0.08	283.18	9.94	36,164.77	374,018.11	7.93	29,659.64
CHIP	9,233.06 Note (l)	7.99	737.59	14,305.14 Note (m)	91.36	13,069.09	8.64 Note (3)	1,236.05	8.59	1,229.31	0.05	6.74	8.55	1,222.57	16,645.08	8.20	1,364.90
APTC	23,843.66 Note (n)	N/A	N/A	28,330.67 Note (n)	N/A	N/A	Note (4)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	31,950.00 Note (n)	N/A	N/A
CSR	5,097.17 Note (o)	N/A	N/A	4,952.49 Note (o)	N/A	N/A	Note (4)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5,900.00 Note (o)	N/A	N/A
TANF	15,496.33 Note (p)	N/A	N/A	16,503.95 Note (q)	N/A	N/A	N/A Note (5)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	16,627.74 Note (q)	N/A	N/A
Foster Care	692.00 Note (r)	6.89	47.68	747.00 Note (s)	92.87	693.72	7.13	53.28	6.91	51.62	0.22	1.66	6.69	49.97	850.00 Note (s)	7.00	59.50
Child Care	5,547.09 Note (t)	4.34	240.74	5,746.27 Note (u)	95.87	5,508.95	4.13	237.32	3.85	221.14	0.28	16.18	3.57	204.97	5,721.74 Note (u)	8.00 Note (6)	457.74
Superstorm Sandy Head Start	71.78	0	0	2.91 Note (v)	100.00	2.91	0	0	0	0	0	0	0	0	N/A	N/A	N/A
Superstorm Sandy SSBG	198.33	0.68	1.35	63.61 Note (w)	99.99	63.60	0.014	0.009	0.014	0.009	0	0	0.014	0.009	N/A	N/A	N/A

Note: Totals do not necessarily equal the sum of the rounded components.

9.1 Accompanying Notes for Table 1: Estimated Proper and Improper Payments for HHS's Risk-Susceptible Programs

a) Medicare FFS PY outlays are from the FY 2016 Medicare FFS Improper Payments Report (based on claims from July 2014 – June 2015).
b) Medicare FFS CY outlays are from the FY 2017 Medicare FFS Improper Payments Report (based on claims from July 2015 – June 2016).
c) Medicare FFS CY+1 outlays are based on the FY 2018 Midsession Review (Medicare Benefit Outlays current law [CL]).
d) Medicare Part C PY outlays reflect 2014 Part C payments, as reported in the FY 2016 Medicare Part C Payment Error Final Report.
e) Medicare Part C CY outlays reflect 2015 Part C payments, as reported in the FY 2017 Medicare Part C Payment Error Final Report.
f) Medicare Part C CY+1 outlays are based on the FY 2018 Midsession Review (Medicare Benefit Outlays [CL]).
g) Medicare Part D PY outlays reflect 2014 Part D payments, as reported in the FY 2016 Medicare Part D Payment Error Final Report.
h) Medicare Part D CY outlays reflect 2015 Part D payments, as reported in the FY 2017 Medicare Part D Payment Error Final Report.
i) Medicare Part D CY+1 outlays are based on the FY 2018 Midsession Review (Medicare Benefit Outlays [CL]).
j) Medicaid PY outlays (based on FY 2015 expenditures) are based on the FY 2017 Midsession Review and exclude CDC Vaccine for Children program funding.
k) Medicaid CY (based on FY 2016 expenditures) and CY+1 outlays (Medicaid - Outlays [CL] exclude CDC Vaccine for Children program funding), are based on the FY 2018 Midsession Review.
l) CHIP PY outlays (based on FY 2015 expenditures) are based on the FY 2017 Midsession Review.
m) CHIP CY (based on FY 2016 expenditures) and CY+1 outlays (CHIP Total Benefit Outlays with *Children's Health Insurance Program Reauthorization Act* Bonus and Health Care Quality Provisions [CL]), are based on the FY 2018 Midsession Review.
n) APTC PY and CY outlays are comprised of FY 2015 and FY 2016 expenditures, respectively; and are based on the FY 2018 Midsession Review. CY+1 outlays are based on the FY 2018 Midsession Review.
o) CSR PY and CY outlays are comprised of FY 2015 and FY 2016 expenditures, respectively; and are based on the FY 2018 Midsession Review. CY+1 outlays are based on the FY 2018 Midsession Review.
p) TANF PY outlays are based on the FY 2017 Midsession Review.
q) TANF CY and CY+1 outlays are based on the FY 2018 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).
r) Foster Care PY outlays are based on the FY 2017 Midsession Review, and reflect the federal share of maintenance payments.
s) Foster Care CY and CY+1 outlays are based on the FY 2018 Midsession Review, and reflect the federal share of maintenance payments.
t) Child Care PY outlays are based on the FY 2017 Midsession Review.
u) Child Care CY and CY+1 outlays are based on the FY 2018 Midsession Review.
v) Superstorm Sandy Head Start CY outlays are based on the remaining grant award amounts (minus drawdowns) as of June 30, 2017, and grants ended on August 30, 2017. HHS identified $142,059 returned and estimated $234,770 will be de-obligated.
w) Superstorm Sandy SSBG CY outlays are based on grantee expenditure amounts during the FY 2017 review period, and grants ended on September 30, 2017.

1. Beginning in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e., improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology from FY 2013 through FY 2017. This approach is consistent with: (1) Administrative Law Judge and Departmental Appeals Board decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

   HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.13 percentage points to 9.51 percent or $36.21 billion in projected improper payments. Additional information regarding the adjustment factor can be found on pages 166-167 of HHS's FY 2012 AFR.
2. HHS calculated and is reporting the national Medicaid improper payment rate based on measurements conducted in FYs 2015, 2016, and 2017. The national Medicaid component improper payment rates are: Medicaid FFS: 12.87 percent and Medicaid managed care: 0.30 percent. The Medicaid eligibility component improper payment rate is held constant at the FY 2014 reported rate of 3.11 percent as described in *Section 11.40*.
3. HHS calculated and is reporting the national CHIP improper payment rate based on measurements conducted in FYs 2015, 2016, and 2017. The national CHIP component improper payment rates are: CHIP FFS: 10.29 percent and CHIP managed care: 1.62 percent. The CHIP eligibility component improper payment rate is held constant at the FY 2014 reported rate of 4.22 percent as described in *Section 11.50*.
4. The APTC and CSR programs are not reporting improper payment estimates for FY 2017. HHS completed a risk assessment on the APTC and CSR programs in FY 2016, and concluded the programs are likely susceptible to significant improper payments. HHS is committed to working towards implementing an improper payment measurement program as required by the IPIA; as with similar HHS programs, it typically takes years to develop an effective and efficient improper payment measurement program. The development of the measurement methodologies will be a multi-year process which consists of the development of measurement policies, procedures, and tools. It also includes extensive pilot testing to ensure an accurate and efficient improper payment estimate, as well as acquisition activities for procurement of improper payment measurement contractors. In FY 2017, HHS began developing improper payment measurement methodologies for the APTC and CSR programs, and will continue to pilot test these methodologies in FY 2018. Given the length of time needed to implement a measurement program, HHS will continue to monitor and assess the programs for any changes and adapt accordingly. HHS will continue to update its annual AFRs on the status of the measurement methodology development until each improper payment estimate is reported. See *Section 8.0* for information concerning program integrity activities relevant to the APTC and CSR programs.
5. The TANF program is not reporting an error rate for FY 2017. As discussed in *Section 11.60*, statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.
6. The *Child Care and Development Block Grant Act* (CCDBG) *of 2014* reauthorized the CCDF program for the first time since 1996. Regulations for the CCDBG, released in September 2016, will have a great impact on policies and procedures states put in place. While the FY 2017 improper payment rate

declined slightly from FY 2016, HHS anticipates increases in errors may occur as states implement new policies under CCDBG regulations. Future targets may be adjusted, depending on future performance.

10.0 Improper Payment Root Cause Categories

OMB guidance requires agencies to report improper payment root causes for risk-susceptible programs. The following table (Table 2A) displays HHS's improper payment root causes for FY 2017 for each risk-susceptible program. The table includes categories of improper payments and the estimated amount of overpayments or underpayments associated with each improper payment category. For reporting purposes, Administrative or Process Errors Made by Other Party may include health care providers, contractors, or any other organization administering federal dollars. Additional information on the root causes and corrective actions for each risk-susceptible program can be found in each program-specific reporting section.

Table 2A
Improper Payment Root Cause Category Matrix for HHS's Risk-Susceptible Programs
FY 2017 (in Millions)

Reason for Improper Payment		Medicare FFS		Medicare Part C		Medicare Part D		Medicaid		CHIP		Foster Care		Child Care		Superstorm Sandy Head Start		Superstorm Sandy SSBG	
		Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments	Overpayments	Underpayments
Inability to Authenticate Eligibility								11,152.53	275.34	555.85	5.97								
Failure to Verify Death Data								38.81											
Administrative or Process Error Made by:	State or Local Agency							21,791.19	7.84	580.40	0.66	51.62	1.66	65.28	16.18			0.009	
	Other Party	4,915.16	1,117.59		5,040.53		844.83	303.18		8.69	0.11								
Medical Necessity		6,334.76	8.67							0.13									
Insufficient Documentation to Determine		23,831.83		9,311.19		450.77		3,162.24		84.24				155.86					
Total		35,081.74	1,126.25	9,311.19	5,040.53	450.77	844.83	36,447.95	283.18	1,229.31	6.74	51.62	1.66	221.14	16.18	0.00	0.00	0.009	0.00

Note: Totals do not necessarily equal the sum of the rounded components.

OMB guidance also requires agencies to report the estimated amount of improper payments made directly by the federal government and the amount of improper payments made by recipients of federal money by program (as reported in Table 2B below). At HHS, all of the estimated improper payments for Medicare FFS, Medicare Part C, and Medicare Part D are made by the federal government or its representatives. For the remaining programs that report improper payment estimates—Medicaid, CHIP, Foster Care, Child Care, Superstorm Sandy Head Start, and Superstorm Sandy SSBG—the estimated improper payments are made by recipients (for example, state agencies or grantees) of federal money.

Table 2B
Estimated Improper Payments Made by the Federal Government or Recipients of Federal Funding
FY 2017 (in Millions)

Estimated Improper Payments Made by …	**Medicare FFS**	**Medicare Part C**	**Medicare Part D**	**Medicaid**	**CHIP**	**Foster Care**	**Child Care**	**Superstorm Sandy Head Start**	**Superstorm Sandy SSBG**
… Federal Government	36,208.00	14,351.71	1,295.60						
… Recipients of Federal Funding				36,731.13	1,236.05	53.28	237.32	0	0.009

11.0 Program-Specific Reporting Information

11.10 Medicare FFS (Parts A and B)

11.11 Medicare FFS Statistical Sampling Process

HHS uses the Comprehensive Error Rate Testing (CERT) program to estimate the Medicare FFS improper payments. A stratified random sample of Medicare FFS claims is reviewed to determine if HHS properly paid claims under Medicare coverage, coding, and billing rules. The CERT program considers any payment for a claim that should have been denied or that was made in the wrong amount (including both overpayments and underpayments) to be an improper payment. The claim can be counted as either a total or a partial improper payment, depending on the error. The Medicare FFS improper payment estimate includes improper payments due to insufficient or no documentation. Furthermore, CERT includes improper payments of all dollar amounts (i.e., there is no dollar threshold under which errors will not be cited), and improper payments caused by policy changes as of the effective date of the new policy (i.e., there is no grace period permitted).

HHS sampled approximately 50,000 claims during the FY 2017 report period. The CERT program ensures a statistically valid random sample of claims across four claim types:

1) Part A claims excluding hospital Inpatient Prospective Payment System (IPPS) (including but not limited to home health, Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and hospice);
2) Part A hospital IPPS claims;
3) Part B claims (e.g., physician, laboratory; and ambulance services); and
4) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

The improper payment rate estimated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166-167 of HHS's FY 2012 AFR.

Driver Service Areas

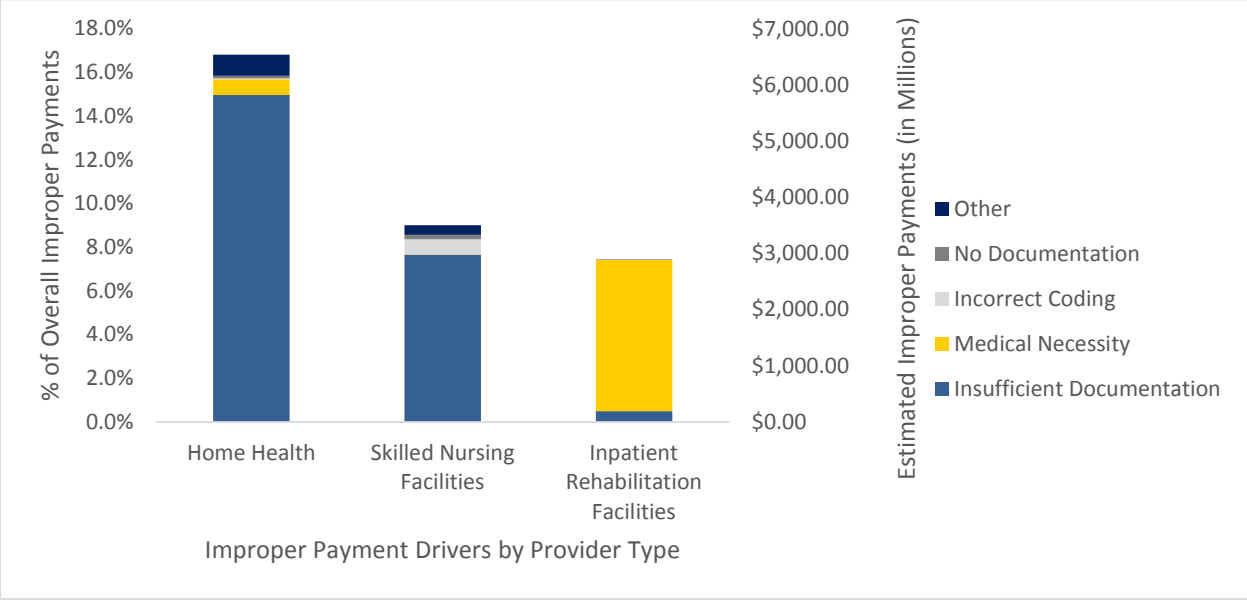
The Medicare FFS gross improper payment estimate for FY 2017 is 9.51 percent or $36.21 billion. The FY 2017 net improper payment estimate is 8.92 percent or $33.96 billion. The decrease from the prior year's reported improper payment estimate of 11.00 percent was driven by a reduction in improper payments for home health and IRF claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate decreased, improper payments for home health, SNF, and IRF claims were the major contributing factors to the FY 2017 Medicare FFS improper payment rate, comprising 33.25 percent of the overall estimated improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 42.01 percent in FY 2016 to 32.28 percent in FY 2017. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).
- Insufficient documentation was the major error reason for SNF claims. The improper payment rate for SNF claims increased from 7.76 percent in FY 2016 to 9.33 percent in FY 2017. The primary reason for these errors was that the certification/recertification statement was missing or insufficient (e.g., one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).
- Medical necessity (i.e., the services billed were not medically necessary) continues to be the major error reason for IRF claims, despite the improper payment rate decrease from 62.39 percent in FY 2016 to 39.74 percent in FY 2017. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires that there must be a reasonable expectation that the patient meets all of the coverage criteria at the time of admission to the IRF (42 CFR 412.622(a)(3)).

To help generate useful information on the root causes of improper payments for HHS, most CERT error categories are more detailed than the OMB root cause categories. The CERT error categories are listed and described below, while Figure 1 shows the FY 2017 Medicare FFS drivers for home health, SNF, and IRF claims by CERT error category.

CERT Error Category	Description
Insufficient Documentation	These errors occur when the medical records submitted are inadequate to support payment for the services billed.
Medical Necessity	These errors occur when the submitted medical records contain adequate documentation to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.
Incorrect Coding	These errors occur when the medical records submitted support a different diagnosis than that billed, the service was performed by someone other than the billing provider or supplier, the billed service was unbundled, or the beneficiary was discharged to a site other than the one coded on the claim.
No Documentation	These errors occur when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.
Other	These errors include improper payments that do not fit into any of the previous categories (e.g., duplicate payment error, non-covered or unallowable service, and ineligible Medicare beneficiary, among others).

Figure 1: FY 2017 Medicare FFS Percentage of Overall Improper Payments for Driver Services by CERT Error Category



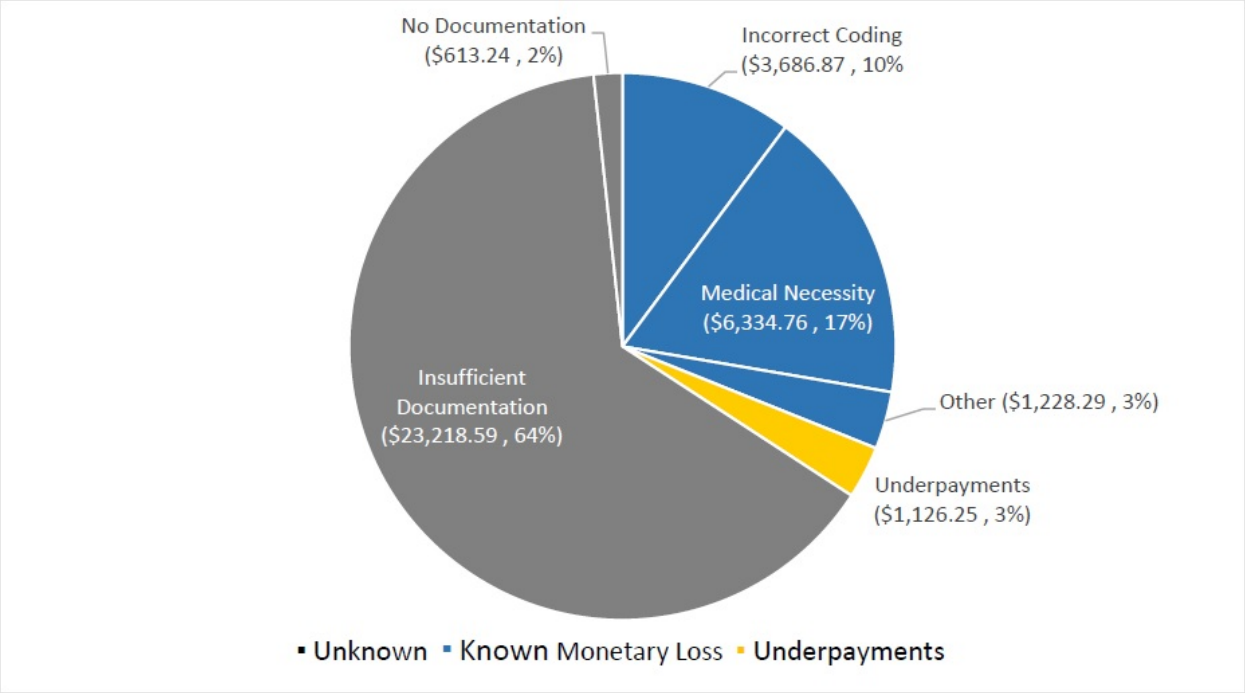
Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments. Of the documentation errors, at present, HHS is unable to track claims that would have resulted in proper payments, where the program would otherwise have made the payment in the same amount, but documentation did not comply with coverage, coding, and billing rules. The majority of Medicare FFS improper payments are due to documentation errors where HHS could not determine whether the billed services were actually provided, were provided at the level billed, and/or were medically necessary.

A smaller proportion of improper payments are claims where HHS has determined that the Medicare FFS payment should not have been made, or should have been made in a different amount. For this reason, medical necessity, incorrect coding, and other errors are considered monetary losses to the program. FY 2017 represents the first year that HHS is reporting the percent of Medicare FFS projected improper payments resulting in known monetary loss.

Figure 2 provides information on Medicare FFS improper payments that are in fact improper and a "monetary loss" to the program. In the figure, "unknown" represents payments where there was insufficient or no documentation to support the payment as proper or a known monetary loss. In other words, when payments lack the appropriate supporting documentation, their validity cannot be determined. These are payments where more documentation is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Figure 2: FY 2017 Medicare FFS Percentage and Estimated Improper Payments (in Millions) by Monetary Loss and Type of CERT Error[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

11.12 Medicare FFS CAP

HHS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions. This section includes information on key corrective actions to address driver service area errors and OMB root cause categories.

Corrective Actions to Address Driver Service Areas

HHS has developed a number of preventive and detective measures for specific service areas with high improper payment rates such as home health, SNF, and IRF claims. HHS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Service Area: Home Health

HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services, including errors resulting from insufficient or missing documentation to support the beneficiary's eligibility for home health services and/or for skilled services. Key home health corrective actions include:

- Probe and Educate for HHAs: During FY 2016, HHS's Medicare Administrative Contractors (MACs) continued pre-payment reviews of home health claims for episodes beginning on or after August 1, 2015. These reviews are designed to improve home health agencies' understanding of beneficiary home health eligibility certification requirements. Specifically, the MACs use a Probe and Educate strategy to review a small sample of home health claims for every HHA and provide education and/or training as needed. Round 1 results showed a high denial rate and many providers required a second round of Probe and Educate reviews, which were conducted throughout FY 2017. The errors identified in Round 1 were primarily insufficient documentation errors and HHS believes these errors can be corrected with additional provider education in Round 2. Providers who need additional education after Round 2 will be included in the Targeted Probe and Educate program. Targeted Probe and Educate is similar to this strategy but includes only providers who may need the additional education instead of all providers.
- Pre-Claim Review Demonstration: A Pre-Claim Review Demonstration for Home Health Services was operational in Illinois from August 2016 until March 2017, when it was paused by the Department. Under the demonstration, HHS reviewed pre-claim review requests and provisionally affirmed the requests as likely meeting Medicare rules and requirements prior to claim submission. Taking into account stakeholder feedback on this demonstration, HHS is considering a number of structural improvements.
- Home Health Recovery Audit Contractors (RAC): On October 31, 2016, HHS awarded a new Medicare FFS RAC contract to identify and correct improper payments for home health claims. The RAC will review all applicable claims types and work with HHS and the MACs to recoup overpayments and correct underpayments. HHS believes the use of RACs helps reduce improper payments and helps educate providers on Medicare policies. HHS also believes there is a sentinel effect in the provider community with more providers billing accurately because of the possibility of a RAC audit in the future.
- Home Health Plan of Care/Certification Template: In FY 2017, HHS released draft electronic and paper home health plan of care/certification templates. These voluntary templates will support HHAs and assist with improving physician documentation. In FY 2018, HHS will: (1) host special open-door forums to obtain industry feedback on improving the templates and, (2) complete the *Paperwork Reduction Act*'s approval process required to finalize these forms as OMB-approved collection instruments.

Service Area: Skilled Nursing Facilities

HHS has implemented corrective actions for payment errors related to SNF services resulting from missing or insufficient medical record documentation. Key SNF corrective actions include:

- Supplemental Medical Review Contractor (SMRC) SNF Review Projects: During FY 2017, HHS tasked the SMRC with performing medical reviews on a post-payment basis for SNF services nationwide. After the SMRC completes its medical review, the results are shared with the MACs for claim adjustment. The providers receive detailed review result letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers about what was incorrect in the original billing of the claim.
- RACs: On October 31, 2016, HHS awarded new Medicare FFS RAC contracts to identify and correct improper payments, which includes potential review of SNF claims. The RAC will review all applicable claims types and work with HHS and the MACs to recoup overpayments and correct underpayments. HHS believes the use of RACs helps reduce improper payments and helps educate providers on Medicare

policies. HHS also believes there is a sentinel effect in the provider community with more providers billing accurately because of the possibility of a RAC audit in the future.

- Medicare Learning Network (MLN) Article: An MLN article provided targeted education to physicians, non-physician practitioners, and providers who bill for SNF services.

Service Area: Inpatient Rehabilitation Facilities

HHS also continues focusing on addressing IRF payment errors, including errors resulting from medical necessity, as well as addressing therapy services provided in other settings. Key IRF corrective actions include:

- Inpatient Rehabilitation Facility Prospective Payment System: HHS issued an IRF Prospective Payment System final rule, CMS-1608-F (79 FR 45872, August 6, 2014), which required IRFs to record and report to HHS how much and what type of therapy (e.g., Individual, Concurrent, Group, and Co-Treatment) patients receive in each therapy discipline in the IRF setting. Data are still being collected as of September 2017. HHS will utilize these data for potentially informing future IRF rulemaking (for example, to clarify policies which could reduce improper payments).
- SMRC IRF Review Projects: In FY 2017, the SMRC continued performing targeted medical reviews on a post-payment basis for IRF services and other therapy services provided in various settings, potentially resulting in overpayment recoveries. The providers receive detailed review results letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers about what was incorrect in the original billing of the claim.
- IRF Industry Meetings: HHS held meetings with IRF industry representatives to provide education and clarification on IRF policy requirements.

Other Service Areas

HHS leverages prior corrective action successes in other service areas such as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), and other non-emergent services by working with providers to improve understanding of HHS policies and exploring new opportunities for corrective actions as described below.

- DME RAC: On October 31, 2016, HHS awarded the new Medicare FFS RAC contract to identify and correct improper payments for DMEPOS claims that began in FY 2017. The RAC will review all applicable claims types and work with HHS and the MACs to recoup overpayments and correct underpayments. HHS believes the use of RACs helps reduce improper payments and helps educate providers on Medicare policies. HHS also believes there is a sentinel effect in the provider community with more providers billing accurately because of the possibility of a RAC audit in the future.
- DMEPOS Prior Authorization Rule: Building on the Prior Authorization of Power Mobility Devices (PMDs) Demonstration, HHS issued a DMEPOS prior authorization final rule in FY 2016 (CMS–6050–F, 80 FR 81674, December 30, 2015) that establishes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization. The rule defines unnecessary utilization as "the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules." The rule also establishes a list of DMEPOS items that could be subject to prior authorization before items or services are provided and payment is made.
    - In FY 2017, HHS began implementing prior authorization for two types of group 3 power wheelchairs in a staggered approach. On March 20, 2017, prior authorization began in Illinois, Missouri, New York, and West Virginia. On July 17, 2017, HHS expanded prior authorization for these two types of power wheelchairs nationwide.
- PMD Prior Authorization: In FY 2017, HHS continued the Prior Authorization of PMDs Demonstration. On September 1, 2012, HHS instituted a prior authorization demonstration program in seven states (California, Illinois, Michigan, New York, North Carolina, Florida, and Texas) for PMDs. Feedback from the

industry and beneficiaries has been largely positive. HHS expanded the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19. Based on claims processed as of March 30, 2017, monthly expenditures for the PMD codes included in the demonstration decreased from $12 million in September 2012 to $2.2 million in September 2016 in the original seven demonstration states, $10 million in September 2012 to $1.7 million in September 2016 in the 12 additional expansion states, and $10 million in September 2012 to $2.2 million in September 2016 in the non-demonstration states.

- Ambulance Transport Prior Authorization: In FY 2017, HHS continued implementing a prior authorization model for repetitive scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, in accordance with Section 515 of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), HHS expanded the prior authorization model for repetitive scheduled, non-emergent ambulance transports to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia. Based on data from the program's first 2 years, spending decreased in the initial states from an average of $18.9 million to an average of $6.0 million per month. Based on data from the first year of the expansion, spending decreased from an average of $5.7 million to an average of $3.1 million per month.
- Hyperbaric Oxygen Therapy Prior Authorization: In FY 2017, HHS continued a prior authorization model for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey. Launched in 2015, the prior authorization model tests whether prior authorization reduces expenditures while maintaining or improving quality of care. This project will also help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before rendering services and paying claims. Prior to implementing the model, spending on outpatient hyperbaric oxygen therapy in the model states averaged $1.69 million per month. Based on data from the program's first 2 years, spending decreased to an average of $943,231 per month.

In addition to these initiatives, HHS has implemented further efforts to reduce improper payments in Medicare FFS that span multiple service areas and address the OMB root causes of improper payments as outlined below.

Corrective Actions to Address OMB Root Causes:

Root Cause: Administrative or Process Errors Made by Other Party

Administrative or process errors made by other party (16.66 percent) mainly consists of coding errors.

- Automated Edits: Due to the high volume of Medicare claims processed by HHS each day and the significant cost associated with conducting medical review of an individual claim, HHS relies on automated edits to identify inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims, and through these efforts, HHS prevents payment for many erroneous claims. HHS uses the National Correct Coding Initiative (NCCI) to stop claims that never should be paid. For example, this program prevents payments for services such as a hysterectomy for a man or a prostate exam for a woman. The NCCI edits saved the Medicare program $815.17 million in FY 2016. HHS will report FY 2017 savings from the NCCI edits in the FY 2018 AFR.
- Provider and Supplier Screening: HHS is statutorily required to revalidate all existing Medicare providers and suppliers. All Medicare providers and suppliers enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. HHS is revalidating all existing Medicare providers and suppliers on an ongoing basis to ensure that only qualified and legitimate providers and suppliers deliver health care items and services to Medicare beneficiaries. As of October 2017, these revalidation efforts resulted in approximately 379,000 deactivations, as well as the revocation

of approximately 24,500 providers' and suppliers' billing privileges, that did not meet Medicare requirements.

- Healthcare Fraud Prevention Partnership (HFPP): HHS continues to build the HFPP, a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse by exchanging data, information, and anti-fraud practices. During FY 2017, HFPP membership grew from 69 to 85 partner organizations, including federal and state partners, private payers, associations, and law enforcement organizations.
- Medical Review Strategies: HHS and its contractors develop medical review strategies using the improper payment data to ensure the areas of highest risk and exposure are targeted. HHS requires its Medicare review contractors to focus on identifying and preventing improper payments due to documentation errors in certain error-prone claim types, such as home health, IRF, and SNF claims.
- Overpayment Recoveries Related to Regulatory Provisions: In CMS-6037-F, "Medicare Program: Reporting and Returning of Overpayments" (81 FR 7654, February 12, 2016), HHS codified rules that require providers and suppliers to identify, report, and return any Medicare Part A or Part B overpayments. This rule implements Section 1128J(d) of the *Social Security Act* to create significant incentives for providers and suppliers to identify, report, and return any amounts they have been overpaid. This rule incentivizes providers and suppliers to maintain documentation and submit accurate claims, thus reducing potential improper payments.

Root Cause: Insufficient Documentation to Determine and Medical Necessity

The primary cause of improper payments in Medicare FFS is insufficient documentation errors (65.82 percent). For these claims, the submitted medical records are inadequate to conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order or a form that is required to be completed in its entirety. If the documentation had been submitted or providers had complete and sufficient documentation, then the claim may have been payable. Another cause of improper payments is medical necessity errors (17.52 percent). For these claims, the submitted medical records contain adequate documentation to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.

- SMRC Strategy: HHS contracted with the SMRC to perform medical reviews focused on vulnerabilities identified by HHS data analysis, the CERT program, professional organizations, and federal oversight entities. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules. In FY 2017, the SMRC performed post-payment reviews on IRFs, SNF therapy services, chiropractic services, Medicare Part B drugs, and ophthalmology services. HHS uses the reviewers' results to improve billing accuracy. The results are shared with providers through detailed review results letters and possible overpayment determinations. The providers receive detailed review results letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers about what was incorrect in the original billing of the claim.
- Medical Review Strategies: HHS is moving from a broad Probe and Educate program to a more targeted approach where MACs focus on specific providers and suppliers within a particular service type rather than all providers and suppliers billing the service. This eliminates burden to providers and suppliers who, based on data analysis, are already submitting claims that are compliant with Medicare policy. To further this strategy, in 2016, HHS began a pilot Targeted Probe and Educate process in one MAC jurisdiction to focus on aberrant providers and suppliers, and completed a small probe review with education offered to

the provider or supplier as necessary. In July 2017, HHS expanded the pilot to three additional MAC jurisdictions and will expand to all MAC jurisdictions at the beginning of FY 2018.

- Medical Review Accuracy Award Fee Metric: Beginning in FY 2014, HHS included the Medical Review Accuracy Award Fee Metric in the Award Fee Plan for MACs that process Part A, Part B, and DME claims. The Medical Review Accuracy Award Fee Metric measures the accuracy of the MAC's complex medical review decisions. This project assists with consistent medical review decisions across MACs, leading to uniform education to providers on all improper payments, including medical necessity and the impact of insufficient documentation errors. HHS is also considering implementing an accuracy review initiative for the MAC redetermination appeal units to ensure consistent medical review decisions are made at that level.
- Provider Billing Review Evaluation: HHS issues Comparative Billing Reports (CBRs) to help Part B providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive reports that enable providers to compare their billing patterns to their peers in the state and across the nation. By giving providers comparative information, HHS is empowering providers to review their own billing practices to determine if they are potentially aberrant. CBRs should be viewed as a non-intrusive corrective action and if a provider analyzes and makes modifications based on a CBR future corrective action may not be warranted.
- Provider Billing Self-Review: HHS launched a Provider Billing Self-Review Evaluation in one MAC jurisdiction in FY 2016 to help Part B providers analyze their coding and billing practices. The initiative expands the self-service exchange of information beyond the transaction-based activities of claims, eligibility, medical review, prior authorization, and payment to now include utilization data and information designed to support Part B providers' awareness and compliance. In addition, the system prompts users to utilize self-service educational materials that will be tracked via web analytics. The pilot attempts to create a partnership between the provider and the MAC to ensure claims are paid appropriately and seeks to determine if providers are willing to self-review and identify improper payments. Self-review and identification of incorrect claims reduces burden placed on a provider by traditional medical review processes.

11.13 Medicare FFS Information Systems and Other Infrastructure

HHS's systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor-level and the HHS-level are linked by a high-speed, secure network that allows for the rapid transmission of large data sets between systems. In addition, HHS continuously reviews opportunities for centralizing the development and implementation of automated edits based on national coverage determinations, medically unlikely units billed, and other relevant parameters to prevent improper payments on a prepayment basis.

11.14 Medicare FFS Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

11.20 Medicare Advantage (Part C)

11.21 Medicare Advantage Statistical Sampling Process

The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is based on clinical diagnoses submitted by the plan. If the diagnoses

submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual National Risk Adjustment Data Validation (RADV) process, where HHS identifies unsupported diagnoses and calculates corrected risk scores.

The FY 2017 methodology consisted of the following steps:

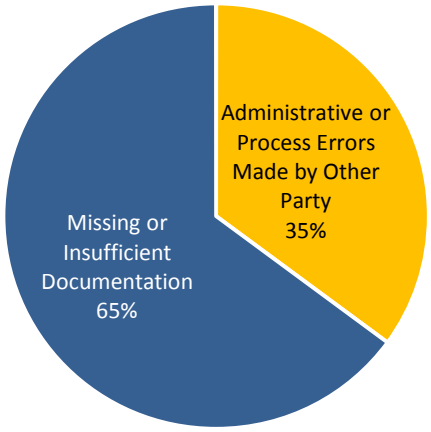
- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2015, where the strata are high, medium, and low risk scores;
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries;
- Calculation of beneficiary-level payment error for the sample; and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

The Medicare Part C gross improper payment estimate for FY 2017 is 8.31 percent or $14.35 billion. The FY 2017 net improper payment estimate is 2.47 percent or $4.27 billion. The decrease from the prior year's estimate of 9.99 percent was driven primarily by submission of more accurate diagnoses by Medicare Advantage (MA) organizations for payment.

11.22 Medicare Advantage CAP

The root causes of FY 2017 Medicare Part C improper payments consist of errors due to missing or insufficient documentation (65 percent) and administrative or process errors made by other party (the MA organizations) (35 percent), as displayed in Figure 3 below.

Figure 3: Root Causes of FY 2017 Medicare Part C Improper Payments



Corrective Actions to Address Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

HHS has implemented four key corrective actions to address the Part C improper payment estimate:

- Contract-Level Audits: Contract-level RADV audits are HHS's primary corrective action to recoup overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. HHS expects that payment recovery will have a

sentinel effect on the quality of risk adjustment data submitted by plans for payment, as contract-level RADV audits increase the incentive for MA organizations to submit valid and accurate diagnosis information, and encourage MA organizations to self-identify, report, and return overpayments they have received. Payment recovery for the pilot audits has been completed, totaling $13.7 million recovered in FYs 2012 through 2014. After completing the pilots, contract-level RADV audits of payment years 2011 through 2013 are in various stages of the audit process. For example, payment year 2013 audits continued in FY 2017, and HHS will initiate payment year 2014 audits in FY 2018. Furthermore, HHS expects to conduct recoveries for the 2011 and 2012 contract-level RADV audits (which began in FY 2014 and FY 2015, respectively) in FY 2018, which will be the first reviews to recoup funds based on extrapolated estimates.

- Overpayment Recoveries Related to Regulatory Provisions: As required by the *Social Security Act*, HHS regulations specify MA organizations report and return overpayments that they identify. In FY 2017, MA organizations reported and returned approximately $78.71 million in self-reported overpayments. HHS believes that this requirement will reduce improper payments by encouraging MA organizations to submit accurate payment information.
- Part C RAC: Section 1893(h) of the *Social Security Act* required the implementation of a Medicare Part C RAC program. HHS previously published a solicitation for comments and, in 2014, issued a request for proposal; however, no proposals were received. In 2015, HHS issued a request for information and reviewed comments received. Currently, HHS is exploring how to fit the Medicare Part C RAC program into the larger Medicare Part C program integrity efforts, and examining refinements that can be made to the operations of RACs such that their activities do not excessively burden plans.
- Training: Historically, HHS has conducted fraud, waste, and abuse in-person and webinar training sessions for MA plans. Only one training session for MA plans was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, HHS procured a new contractor to support this initiative and will resume training in FY 2018.

11.23 Medicare Advantage Information Systems and Other Infrastructure

HHS uses the following internal Medicare systems to make and validate Medicare Part C payments: the Medicare Beneficiary Database (MBD); the Risk Adjustment Processing System (RAPS); the Health Plan Management System (HPMS); and the Medicare Advantage Prescription Drug (MARx) payment system.

11.24 Medicare Advantage Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

11.30 Medicare Prescription Drug Benefit (Part D)

11.31 Medicare Prescription Drug Benefit Statistical Sampling Process

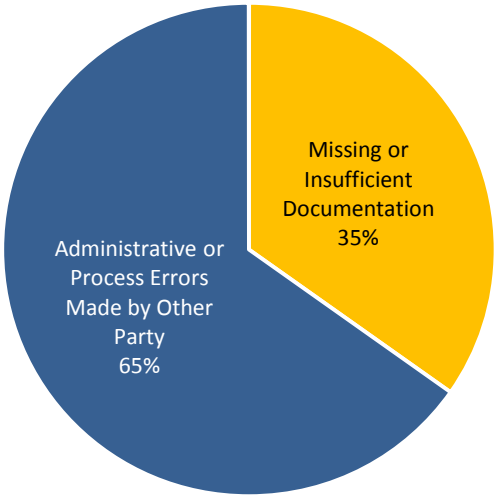
The Part D improper payment estimate measures the payment error related to prescription drug event (PDE) data, where the majority of error for the program exists. HHS measures the inconsistencies between the information reported on PDEs and the supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication order, as appropriate), and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error, which is simulated onto a representative sample of beneficiaries to determine the Part D improper payment estimate.

The Medicare Part D gross improper payment estimate for FY 2017 is 1.67 percent or $1.30 billion. The FY 2017 net improper payment estimate is negative 0.51 percent or negative $394.06 million. The decrease from the prior year's estimate of 3.41 percent was driven primarily by submission of more accurate data by Part D sponsors for payment.

11.32 Medicare Prescription Drug Benefit CAP

The root causes of the FY 2017 Part D improper payments are missing or insufficient documentation (35 percent) and administrative or process error made by other party (65 percent), as displayed in Figure 4 below.

Figure 4: Root Causes of FY 2017 Medicare Part D Improper Payments



Corrective Actions to Address Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

HHS conducted the following corrective actions to address payment errors in Part D:

- Training: HHS continued its national training sessions for Part D sponsors on payment and data submission. For example, HHS continued to offer training sessions with detailed instructions for Part D sponsors submitting documentation to support their PDEs as part of the improper payment estimation process. Historically, HHS has also conducted fraud, waste, and abuse in-person and webinar training sessions for Part D sponsors. Only one fraud, waste, and abuse training session for Part D sponsors was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, HHS procured a new contractor to support this initiative, and will resume trainings in FY 2018.
- Outreach: HHS continued formal outreach to plan sponsors for invalid/incomplete documentation. HHS distributed Plan Sponsor Summary Reports to all plans participating in the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.
- Overpayment Recoveries Related to Regulatory Provisions: As required by the *Social Security Act*, HHS requires that Part D sponsors report and return overpayments that they identify (See *Section 11.22* for more information on the rule). HHS believes the overpayment statute and regulation contribute to

increased attention paid by Part D sponsors to data accuracy. In FY 2017, Part D sponsors reported and returned approximately $2.83 million in self-reported overpayments.

11.33 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS uses the following internal Medicare systems to make and validate the Medicare Part D payments: the MBD; the RAPS; HPMS; the MARx payment system; and the Integrated Data Repository.

11.34 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

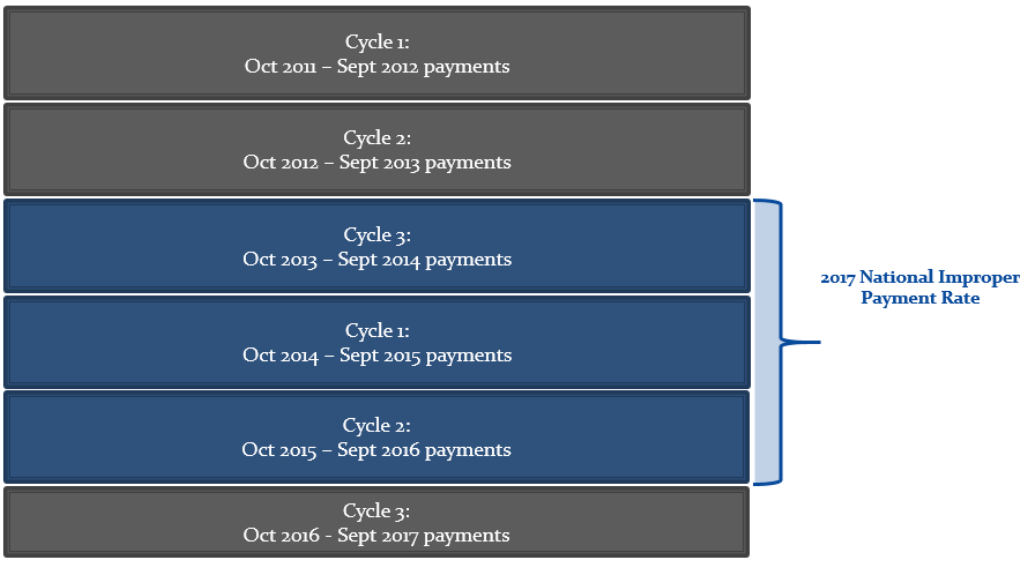
11.40 Medicaid

11.41 Medicaid Statistical Sampling Process

HHS estimates Medicaid improper payments on a federal FY basis and measures three components: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is paused as described in the eligibility component section below.

HHS's Payment Error Rate Measurement (PERM) program uses a 17-state three-year rotation for measuring Medicaid improper payments. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all 50 states and the District of Columbia are captured in one rate. Each time a group of 17 states is measured under the PERM program HHS removes the previous findings for that group of states from the calculation and includes the newest findings. The national FY 2017 Medicaid improper payment rate is based on measurements conducted in FYs 2015, 2016, and 2017 (see Figure 5 below).

Figure 5: FY 2017 Medicaid Cycle Measurements



To see how HHS grouped states into three cycles, refer to pages 177 – 179 of HHS's FY 2012 AFR.

FFS and Managed Care Components

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are only subjected to a data processing review. The FFS sample size was between 303 and 1,063 claims per state and the managed care sample size was between 230 and 287 payments per state. The sample sizes were based on each state's historical FFS and managed care improper payment rate data. When a state's FFS component or managed care component accounted for less than 2 percent of the state's total Medicaid expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

In light of changes to the way states adjudicate beneficiary eligibility for Medicaid under current law, in August 2013 and October 2015, HHS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, HHS will not conduct the eligibility measurement component of PERM. In place of these PERM eligibility reviews, all states are required to conduct eligibility review pilots that provide more targeted, detailed information on the accuracy of eligibility determinations to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; identify strengths and weaknesses in operations and systems leading to errors; and test the effectiveness of corrections and improvements in reducing or eliminating those errors. During this time, for the purpose of computing the overall national improper payment rate, the Medicaid eligibility component improper payment rate is held constant at the FY 2014 national rate of 3.11 percent.

HHS used the eligibility review pilots to test updated PERM eligibility processes, and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, HHS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017) to update the methodology for the PERM eligibility component. HHS will resume the eligibility component measurement under this final rule and report an updated national eligibility improper payment estimate in FY 2019.

Calculations and Findings

The national Medicaid program improper payment estimate combines each state's Medicaid FFS, managed care, and eligibility improper payment estimate. In addition, individual state component improper payment estimates are combined to calculate the national component improper payment estimates. National component improper payment rates and the Medicaid program improper payment rate are weighted by state size, such that a state with a $10 billion program is appropriately weighted more in the national rate than a state with a $1 billion program. A correction factor ensures that Medicaid eligibility improper payments are not "double counted." Additionally, HHS incorporates state-level improper payment rate recalculations for the states measured in prior FYs into the national Medicaid improper payment rate. For example, subsequent to FY 2016 reporting, HHS recalculated 13 state-level FFS improper payment rates to reflect appeal results and documentation that HHS received after the reporting deadline, but within the allowable timeframes for claims paid between October 1, 2014, and September 30, 2015. HHS incorporated these recalculations into FY 2017 improper payment rate reporting.

The national Medicaid gross improper payment estimate for FY 2017 is 10.10 percent or $36.73 billion. The FY 2017 net improper payment estimate is 9.94 percent or $36.16 billion.

The FY 2017 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 12.87 percent
- *Medicaid managed care*: 0.30 percent

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. First, all referring/ordering providers are required to be enrolled in Medicaid or CHIP and claims must contain the referring/ordering provider NPI. Second, states are required to screen providers under a risk-based screening process prior to enrollment. Finally, the attending provider NPI is required to be submitted on all electronically filed institutional claims. HHS began reviewing against these requirements for FY 2014 improper payment reporting. Therefore, in FY 2014, HHS saw the first ever increase in the Medicaid improper payment rate when the first cycle of states was reviewed against the new requirements. The Medicaid rate increased in FY 2015 when HHS reviewed the second cycle of states was reviewed against the new requirements. FY 2016 represented the first "baseline" improper payment rate reflecting the new requirements because all 50 states and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

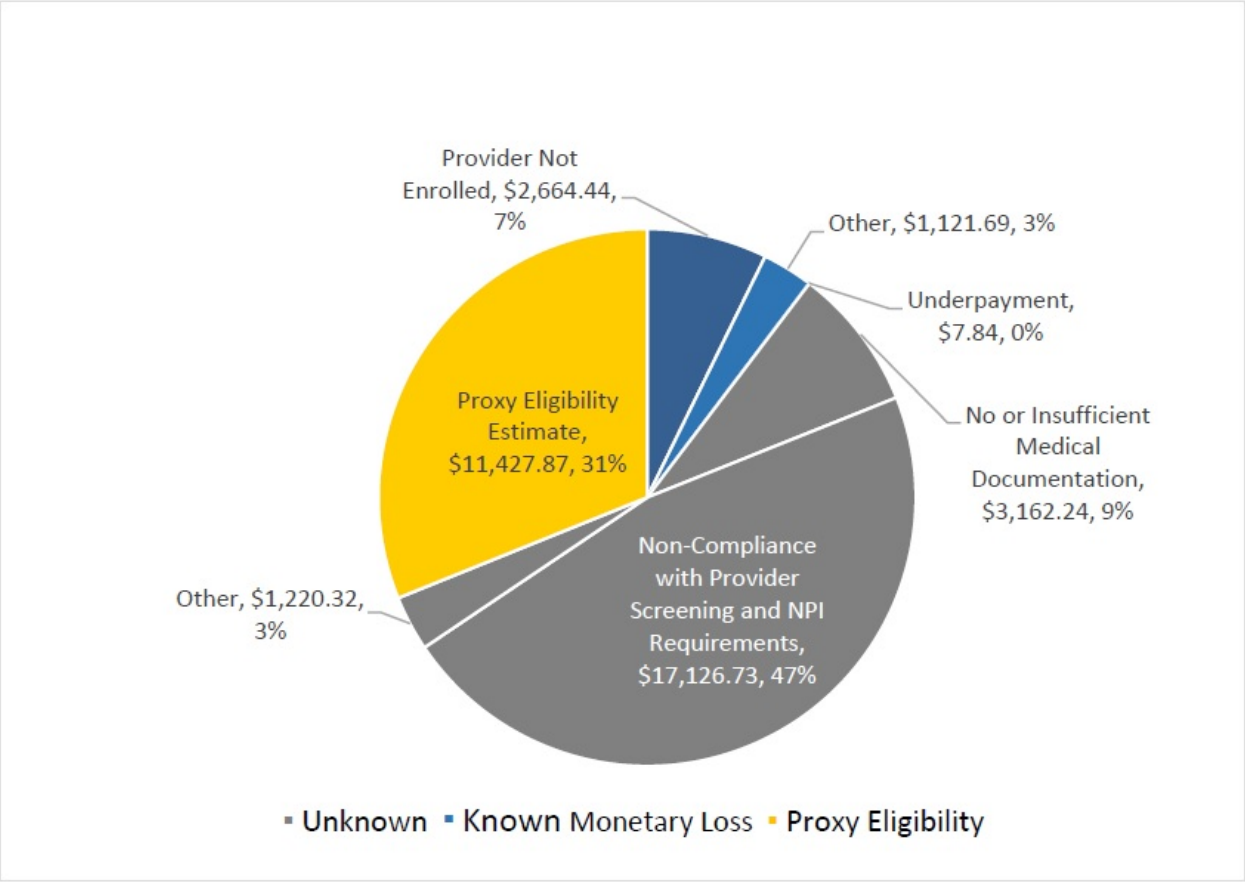
Compliance with provider screening, enrollment, and NPI requirements for the 17 states measured in FY 2017 improved, and improper payments related to non-compliance decreased. The Medicaid FFS improper payment rate for non-compliance with these requirements decreased for these states from 5.74 percent in FY 2014 to 4.03 percent in FY 2017. Although the 17 states reviewed this year had better compliance results compared to their previously measured cycle, non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the improper payment rate. Additionally, improper payments due to insufficient or no medical documentation increased in FY 2017.

Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments. A majority of Medicaid improper payments were due to instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. However, these improper payments do not necessarily represent payments to illegitimate providers and, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable. A smaller proportion of improper payments are claims where HHS determines that the Medicaid payment should not have been made or should have been made in a different amount and are considered a known monetary loss to the program.

Figure 6 provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the figure, "Unknown" represents payments where there was insufficient or no documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Figure 6: FY 2017 Medicaid Percentage and Improper Payments (in Millions) by Monetary Loss and Type of PERM Error[1]



[1] Note that the Proxy Eligibility Estimate includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments. The value of non-eligibility underpayments was too small to show up in the figure.

Eligibility Review Pilot Findings

The eligibility review pilots identify vulnerabilities in state processes and systems. States then take action to address these vulnerabilities, which is essential to preventing future improper payments and improving verification processes. In the most recent round of pilots, states continued to identify vulnerabilities related to caseworkers or systems not properly establishing income level. However, these vulnerabilities did not always lead to eligibility determination errors. States also identified issues related to failures in sending appropriate notices, delays in processing eligibility determinations, and failing to follow verification plans that outline each state's verification policies and procedures. States are implementing corrective action strategies and focusing on targeted caseworker training, systems fixes, and maintaining records as the pilots continue. More information can be found at Medicaid and CHIP Eligibility Review Pilots.

11.42 Medicaid CAP

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. When

developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns.

HHS also establishes corrective actions to reduce improper payments. For example, HHS is actively engaging with states by: conducting outreach during off-cycle PERM measurement years to address issues identified in CAPs; facilitating national best practice calls to share ideas across states; offering ongoing technical assistance; and providing additional guidance as needed. Additional information on states' and HHS's corrective actions are provided below.

Corrective Actions to Address OMB Root Causes:

Root Causes: Administrative or Process Errors Made by State or Local Agency and Failure to Verify

Administrative or process errors made by states or local agencies and failure to verify mainly consist of errors resulting from non-compliance with provider enrollment, screening, and NPI requirements described above.

Because these errors primarily drive the Medicaid improper payment estimate, state CAPs focus on system or process changes to reduce these errors. Specific actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and continuing to implement process improvements to the provider enrollment process to make it easier for ordering and referring providers to enroll in the program. For example, state Medicaid agencies may rely on Medicare's enrollment and screening of providers and on Medicare's site visits, where the provider is enrolled in Medicare and Medicaid.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented corrective actions to specifically address compliance with Medicaid provider screening, enrollment, and revalidation efforts to reduce errors related to this category:

- State Medicaid Provider Screening and Enrollment: HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements. Specifically, HHS shares with states the Medicare provider enrollment record via the Provider Enrollment, Chain and Ownership System (PECOS) administrative interface and via data extracts from the PECOS system and Office of Inspector General (OIG) exclusion data. Since May 2016, HHS has offered a data compare service that allows a state to rely on Medicare's screening, in lieu of conducting state screening, particularly during revalidation. This allows states to remove dually enrolled providers from their revalidation workload. Using the data compare service, a state provides an extract of Medicaid provider enrollment data to HHS and then HHS returns information indicating which providers the state can rely on Medicare's screening. Alabama, Arizona, California, Idaho, Iowa, Louisiana, Maine, Michigan, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, the District of Columbia, Vermont, and Virginia have participated in the data compare service.
- Enhanced Assistance on State Medicaid Provider Screening and Enrollment: HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid enrollment and screening. In addition, HHS updated the Medicaid Provider Enrollment Compendium in 2017 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements.
    - Technical Assistance for Provider Screening and Enrollment: In FY 2016, HHS procured a State Assessment contractor to assist with ongoing state technical assistance and process improvements related to provider screening and enrollment. In FY 2017, the State Assessment contractor visited Alabama, California, Connecticut, Indiana, Iowa, Nevada, Ohio, Oregon, and Texas. For these states, the contractor assessed compliance with provider screening and enrollment requirements, conducted a gap analysis, and developed strategic blueprints to help states improve processes.
    - Site Visits: HHS continued to conduct state site visits during FY 2017 to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage

Medicare screening and enrollment activities. In addition to the State Assessment contractor visits, HHS internally provided screening and enrollment assistance through visits to Delaware, Georgia, Minnesota, Missouri, North Carolina, South Carolina, Virginia, and the District of Columbia in FY 2017.

- Death Master File: To help alleviate state concerns with the cost of completing the SSA DMF check as part of provider screening, HHS worked with the SSA to provide the DMF to states. In May 2017, HHS made DMF data available to pilot states via the same file server where states currently also access PECOS provider file extracts, Medicare revocations, Medicaid terminations, and OIG sanctions (i.e., suspensions, debarments, and exclusions). HHS has begun expanding access to the DMF data to additional states, beyond the pilot states, and will continue to do so throughout FY 2018.

- Medicaid Integrity Institute: HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. The FY 2017 course schedule included a seminar in April 2017 that focused exclusively on complying with the provider screening and enrollment requirements. More information can be found at Medicaid Integrity Institute.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine errors mainly consist of errors resulting from insufficient or no medical documentation submitted by providers. Administrative or process errors made by other party mainly consist of other provider errors identified through medical review. State CAPs also include provider communication and education to reduce errors related to these categories. These methods include: holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented additional efforts to lower the improper payment rate in these two error categories:

- State Medicaid RAC Programs: From inception of the Medicaid RAC program in 2012 to the end of FY 2017, 47 states and the District of Columbia had cumulatively implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments in their Medicaid programs. However, each state has the flexibility to tailor its RAC program, where appropriate, with guidance from HHS. For example, several states that had implemented Medicaid RAC programs ended their RAC programs when HHS approved an exception because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS. As a result, 12 states currently have time-limited HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration, resulting in a total of 38 states and the District of Columbia that currently have RAC programs.
- Expanded Reviews/Oversight: HHS aligned state Program Integrity Reviews with off-cycle PERM reviews to maintain continuous oversight of states' corrective actions. During FY 2017, HHS completed its assessment of the status of states' PERM CAPs submitted in FY 2013 and provided feedback to states on actions needed to complete their CAPs. HHS also collected information in FY 2017 on the status of PERM CAPs submitted in FY 2014 related to Medicaid FFS and managed care, and expects to complete assessment and corresponding feedback to states on further corrective actions needed by December 2017. In FY 2018, HHS will collect, assess, and provide feedback to states on the status of PERM CAPs submitted in FY 2015 related to Medicaid FFS and managed care. Also during FY 2017, HHS conducted focused reviews in selected states on program integrity in managed care, Medicaid RAC implementation, safeguards in personal care services, terminated providers that should no longer be billing Medicaid, and on states' completion of corrective actions from previous program integrity reviews.

- Education: In FY 2017, HHS continued to maintain and provide educational resources in various formats to stakeholders on the Medicaid Program Integrity Education website. In FY 2017, HHS awarded a contract to address the educational needs of Medicaid stakeholders, provide educational resources on emerging trends, and maintain an online resource for stakeholders. Historically, HHS has published a variety of educational toolkits, which include presentations, fact sheets, and booklets that were made specifically for providers or beneficiaries. These educational resources are intended to educate providers, beneficiaries, and other stakeholders in promoting best practices and raising awareness of Medicaid fraud, waste, and abuse.

Root Cause: Medical Necessity

Although this has been identified as a minor issue seen in a few states, HHS works closely with those states to develop state-specific corrective actions to address such errors when they arise. In addition to the state-specific CAPs, many of the corrective actions discussed above also address medical necessity errors.

11.43 Medicaid Information Systems and Other Infrastructure

Because Medicaid payments occur at the state level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the state level. HHS has encouraged and supported state efforts to modernize and improve state Medicaid Management Information Systems, which will produce greater efficiencies in areas reflected in the PERM measurement and strengthen program integrity. In addition, HHS has approved enhanced federal funding for nine states to implement predictive analytics technologies that are integrated with state Medicaid Management Information Systems. Lastly, the state systems workgroup (composed of HHS and state staff representatives) meets regularly to identify and discuss system vulnerabilities and the impact on the measurement of improper payments.

HHS developed a comprehensive plan to modernize the federal Medicaid and CHIP data systems. The plan's primary goal is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also reduce state burden and provide more robust data for the PERM program.

HHS also developed the Transformed Medicaid Statistical Information System (T-MSIS) to facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of state MSIS submittals in real-time. Through the use of T-MSIS, HHS will acquire higher quality data and reduce data requests to the states. As of September 13, 2017, 47 states are submitting data into T-MSIS production, with the remaining states expected to submit data in the T-MSIS file format by early calendar year 2018. More information on states' overall progress transitioning can be found at T-MSIS.

11.44 Medicaid Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

11.50 CHIP

11.51 CHIP Statistical Sampling Process

HHS estimates CHIP improper payments on a federal FY basis and measures three components: FFS, managed care, and eligibility. HHS, through its use of federal contractors, measures the FFS and managed care components. The eligibility component measurement is paused, as described in the eligibility component section below.

CHIP utilizes the same state sampling process as Medicaid through the PERM program. HHS determined that CHIP can be measured in the same states selected for Medicaid review each FY with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. For information on how HHS grouped states into three cycles, refer to page 183 of HHS's FY 2012 AFR.

FFS and Managed Care Components

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are only subjected to a data processing review. The FFS sample size was between 302 and 996 claims per state and the managed care sample size was between 101 and 241 payments per state. When a FFS component or managed care component for a state accounted for less than 2 percent of the state's total CHIP expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

In light of changes to the way states adjudicate beneficiary eligibility for CHIP under current law, HHS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017). For the purpose of computing the overall national improper payment rate, the CHIP eligibility component improper payment rate is held constant at the FY 2014 national rate of 4.22 percent. HHS will resume the eligibility component measurement under the new rule and report an updated national eligibility improper payment estimate in FY 2019. Please see *Section 11.41* for more information.

Calculations and Findings

The national CHIP improper payment estimate combines each state's FFS, managed care, and eligibility improper payment estimate. In addition, individual state component improper payment estimates are combined to calculate the national component improper payment estimates. National component improper payment rates and the CHIP improper payment rate are weighted by state size, such that a state with a $1 billion program is appropriately weighted more in the national rate than a state with a $200 million program. A correction factor ensures that CHIP eligibility improper payments are not "double counted." Additionally, HHS incorporates state-level improper payment rate recalculations for the states measured in prior FYs into the national CHIP improper payment rate. For example, subsequent to FY 2015 reporting, HHS recalculated 12 state-level FFS improper payment rates to reflect appeal results and documentation that HHS received after the reporting deadline, but within the allowable timeframes for claims paid between October 1, 2014 and September 30, 2015. HHS incorporated these recalculations into FY 2017 improper payment rate reporting.

The national CHIP gross improper payment estimate for FY 2017 is 8.64 percent or $1.24 billion. The FY 2017 net improper payment estimate is 8.55 percent or $1.22 billion.

The FY 2017 national CHIP improper payment rate for each component is:

- *CHIP FFS:* 10.29 percent
- *CHIP managed care:* 1.62 percent

Similar to Medicaid, HHS began reviewing against provider screening, enrollment, and NPI requirements (described further in *Section 11.41)* for FY 2014 improper payment reporting. In FYs 2014 and 2015, the CHIP improper payment estimate increased when HHS reviewed the first two cycles of states against the new requirements. FY 2016 represented the first "baseline" improper payment rate reflecting the new requirements because all

50 states and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

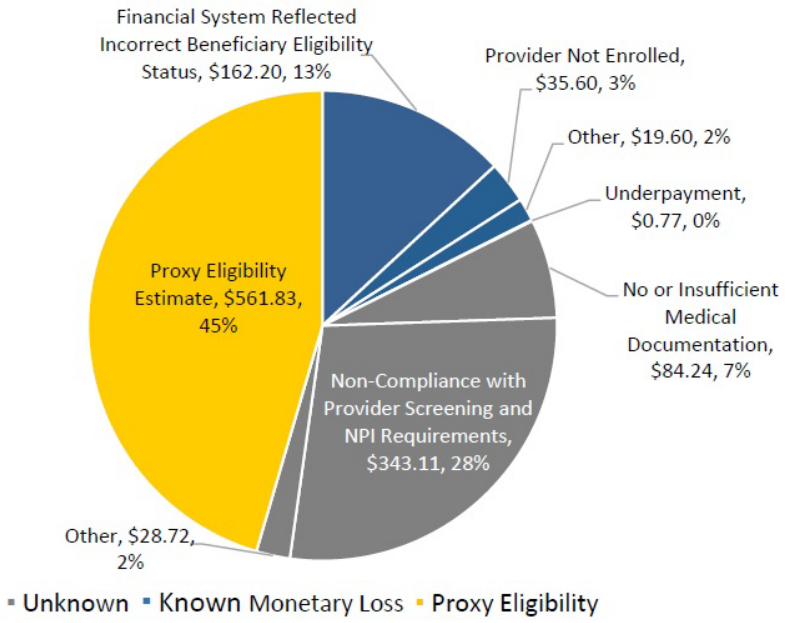
The CHIP improper payment estimate increased from 7.99 percent in FY 2016 to 8.64 percent in FY 2017 due to continued state difficulties coming into compliance with the provider screening, enrollment, and NPI requirements. The CHIP FFS improper payment rate for non-compliance with these requirements increased for these states from 4.69 percent in FY 2014 to 5.73 percent in FY 2017. A higher percentage of CHIP providers are not enrolled in Medicare and, therefore, there are more CHIP providers where states cannot rely on Medicare's screening in lieu of conducting state screening. Additionally, managed care improper payments increased in FY 2017 due to recipients that aged out of CHIP, yet continued to receive medical coverage.

Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments. A majority of CHIP improper payments were due to instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. However, these improper payments do not necessarily represent payments to illegitimate providers and, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable in whole or in part. A smaller proportion of improper payments are claims where HHS determines that the CHIP payment should not have been made or should have been made in a different amount and are considered a known monetary loss to the program.

Figure 7 provides information on CHIP improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the figure, "Unknown" represents payments where there was insufficient or no documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Figure 7: FY 2017 CHIP Percentage and Improper Payments (in Millions) by Monetary Loss and Type of PERM Error[1]



[1] Note that the Proxy Eligibility Estimate includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments. The value of non-eligibility underpayments was too small to show up in the figure. In addition, due to rounding, figures in this chart may not add up precisely to other tables in this document.

Eligibility Review Pilot Findings

Please refer to *Section 11.41* for information on the Medicaid and CHIP eligibility review pilots.

11.52 CHIP CAP

HHS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from HHS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. HHS also establishes corrective actions to reduce improper payments. For example, HHS is actively engaging with states to address these root causes by: conducting outreach during off-cycle PERM measurement years to address issues identified in CAPs; facilitating national best practice calls to share ideas across states; offering ongoing technical assistance; and providing additional guidance as needed. Additional information on states' and HHS's corrective actions are provided below.

Corrective Actions to Address Root Causes:

Root Causes: Administrative or Process Errors Made by State or Local Agency

Administrative or process errors made by states or local agencies errors mainly consist of errors resulting from non-compliance with provider enrollment, screening, and NPI requirements described above. This root cause category also consists of errors resulting from payments made to non-covered beneficiaries. These errors include payments made to recipients that aged out of CHIP and instances where the state's financial system paid based on an incorrect eligibility status. In many instances where the financial system paid based on the incorrect eligibility status, the state's eligibility system indicated that the beneficiary was eligible for Medicaid.

Since the CHIP improper payment rate was primarily driven by these errors, state CAPs focus on system or process changes to reduce these errors. Specific actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for ordering and referring providers to enroll in the program.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented generalized corrective actions to reduce errors related to this category. HHS's efforts include allowing states to rely on Medicare's enrollment screening of providers to help prevent PERM-related enrollment errors, sharing Medicare data to assist states with meeting screening and enrollment requirements, and providing ongoing education and outreach to states on federal requirements for enrollment and screening. More detailed information on these activities is provided in *Section 11.42: Medicaid CAP*.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine errors mainly consist of errors resulting from insufficient or no medical documentation submitted by providers. Administrative or process errors made by other party mainly consist of other provider errors identified through medical review. State CAPs include provider communication and education to reduce errors related to these categories. These methods include: holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys;

implementing improvements and clarifications to written state policies emphasizing documentation requirements; and performing more provider audits to identify areas of vulnerability and target solutions.

In addition to the development, execution, and evaluation of the state-specific CAPs, HHS has implemented additional efforts to lower the improper payment rate in these two error categories. More detailed information on these activities is provided in *Section 11.42: Medicaid CAP*.

Root Cause: Medical Necessity

Although this has been identified as a minor issue seen in a few states, HHS works closely with those states to develop state-specific corrective actions to address such errors when they arise. In addition to the development, execution, and evaluation of the state-specific CAPs, many of the CAPs mentioned in further detail in *Section 11.42: Medicaid CAP* also address issues with medical necessity.

11.53 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the state level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the state level. Please refer to *Section 11.43: Medicaid Information Systems and Other Infrastructure* for information on HHS and state-led efforts to modernize information and data systems at the national and state level.

11.54 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

11.60 TANF

11.61 TANF Statistical Sampling Process

Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an improper payment estimate for FY 2017.

11.62 TANF CAP

Since TANF is a state-administered program, corrective actions that could help reduce improper payments would have to be implemented at the state level. As HHS cannot require states to participate in a TANF improper payment measurement, HHS is also unable to compel states to collect the required information to implement and report on corrective actions. Despite these limitations, HHS uses a multi-faceted approach to support states in improving TANF program integrity and to prevent improper payments:

- Single Audit Findings: HHS works with states to analyze Single Audit material non-compliance findings related to TANF and to implement corrective actions to address these findings.
- Risk Assessment: In FY 2016, HHS performed a detailed risk assessment of the TANF program to determine susceptibility to significant improper payments. As part of this process, HHS identified potential payment risks at the federal level and worked to mitigate these payment risks in FY 2017. For example, HHS refers states to an Information Memorandum (IM) on strategies for reducing TANF improper payments (TANF-ACF-IM-2010-02) and disseminates information through other technical assistance resources.

- Promoting and Supporting Innovation in TANF Data: In FY 2017, HHS awarded a five-year contract for Promoting and Supporting Innovation in TANF Data. One component of the contract will be engaging TANF stakeholders to better understand how states assess proper payments and ensure program integrity in TANF. This assessment will help HHS understand existing state approaches and alternative approaches to measuring TANF improper payments, including the feasibility and cost-benefit analysis of different approaches.
- Final Regulation on Reporting of Electronic Benefit Transfer Policies and Practices: In FY 2016, HHS issued final regulations regarding "State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations" (81 FR 2092, January 15, 2016). The regulations require states, subject to penalty, to maintain policies and practices that prevent TANF funded assistance from being used in any electronic benefit transfer transaction in specified locations: liquor stores; any casino, gambling casino, or gaming establishment; and any retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

11.63 TANF Information Systems and Other Infrastructure

Information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the state level. States utilize PARIS, the National Directory of New Hires, and the Income and Eligibility Verification System to minimize improper payments.

11.64 TANF Statutory or Regulatory Barriers that Could Limit Corrective Actions

Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.

11.70 Foster Care

11.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for Title IV-E Foster Care in FY 2017. This program has taken the review cycle already in place (in compliance with 45 CFR 1356.71, Foster Care Eligibility Reviews) and, with OMB approval, leveraged the existing review cycle to provide a rolling, three-year weighted average improper payment estimate. Since each state is reviewed every 3 years, each year's improper payments estimate incorporates new review data for approximately one-third of the states for the period under review. For a more detailed description of the Foster Care improper payment methodology, refer to pages 189 – 190 of HHS's FY 2012 AFR.

As stated in the FY 2015 AFR, an increasing number of time-limited child welfare waiver demonstration projects (all of which must terminate no later than September 30, 2019 under current law) have temporarily reduced the number of jurisdictions subject to review and inclusion in the program improper payment estimate during the demonstration projects. More information on these demonstration projects—and their impact on the Foster Care improper payment rate calculation—can be found on pages 202-203 of the FY 2015 AFR.

The program's improper payment estimate includes data from the most recent review for states with non-statewide waivers, including subsequent reviews conducted on the non-waiver populations in those states following waiver implementation. This approach, approved by OMB, maintains continuity while also permitting consistent treatment of states with statewide and non-statewide waivers. Following this approach, the FY 2017

estimate is based on review data for 39 states operating traditional Title IV-E programs. The FY 2017 estimate excludes data for thirteen states operating statewide waiver demonstrations: four states that were due for a review this year (Hawaii, Kentucky, Washington, and West Virginia) and nine states that were due for a review in prior years (Arkansas, Colorado, District of Columbia, Florida, Indiana, Nebraska, Oklahoma, Utah, and Wisconsin).

The Foster Care gross improper payment estimate for FY 2017 is 7.13 percent or $53.28 million. The FY 2017 net improper payment estimate is 6.69 percent or $49.97 million. The primary factor that drove the program's slight increase from the prior year's estimate of 6.89 percent was the performance of one state with a relatively large program (sixth largest in terms of Title IV-E payments) that HHS reviewed this cycle. This state, which has a comparatively large influence on overall program performance due to its program size, had an improper payment estimate of over 18 percent. Had performance in this state remained at its previous level (i.e., 7.15 percent), the FY 2017 Foster Care improper payment estimate would have fallen to 6.44 percent this year. Ten of the 12 states reviewed in the most recent cycle had improper payment estimates below 3.25 percent.

11.72 Foster Care CAP

All payment errors (100 percent) in the Title IV-E Foster Care program are administrative or process errors due to incorrect case classification and payment processing by state agencies. The Foster Care program designs CAPs to help states address the payment errors that contribute most to Title IV-E improper payments.

Corrective Actions to Address Root Cause:

Root Cause: Administrative or Process Error Made by State or Local Agency
Corrective actions have decreased the number of payment errors and altered the composition of identified payment errors. For example, following years of work with State Court Improvement Programs and outreach to raise awareness, judiciary-related errors, once the most prevalent error type, are now among the least common.

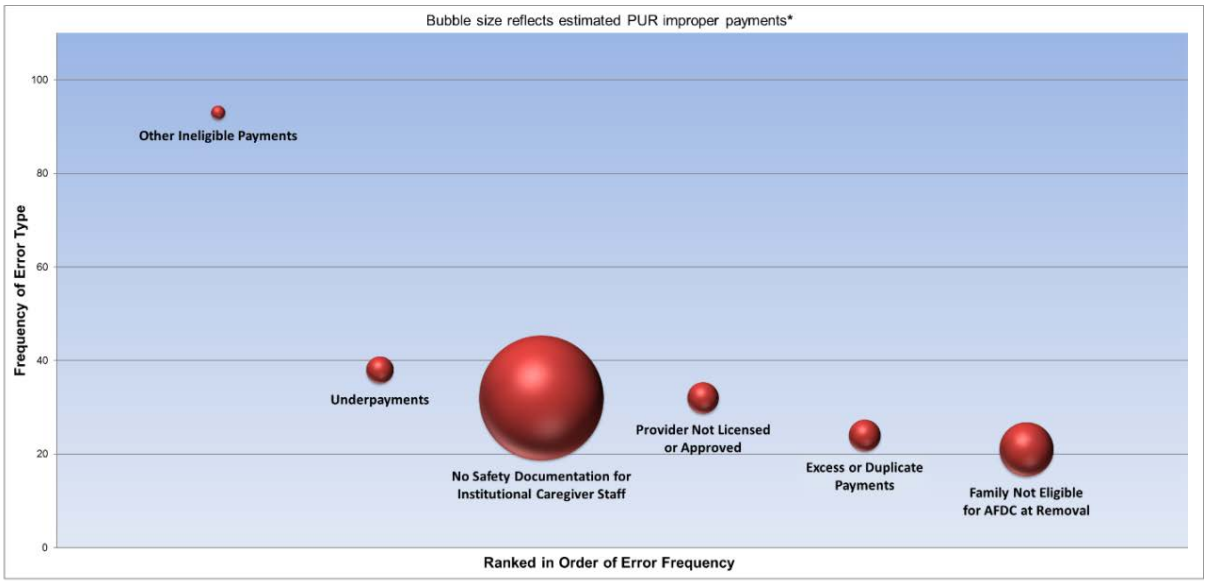
Monitoring and Analysis: HHS continues to monitor, review results, and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2017, the most common payment errors included:

- Other ineligible payments (30 percent of errors);
- Underpayments (12 percent of errors);
- No safety documentation for institutional caregiver staff (10 percent of errors);
- Provider not licensed or approved (10 percent of errors);
- Excess or duplicate payments (8 percent of errors); and
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (7 percent of errors).

Together these six items account for 77 percent of Foster Care payment errors. Although "other ineligible payments" constitute 30 percent of errors, over 70 percent of those errors come from just one small state, which, due to the size of its program, has relatively little impact on overall program improper payments. Nevertheless, this state will need to focus its Program Improvement Plan (PIP) on eliminating these claims, most of which trace to unallowable transportation costs claimed as foster care maintenance. (Some of these costs might have been allowable if claimed as foster care administration, but did not meet the definition of an allowable cost for foster care maintenance payments.) Underpayments represent 12 percent of all errors in terms of frequency; however, the dollar amount of the underpayments is quite small as underpayments contribute just 0.22 percent to the gross improper payment estimate of 7.13 percent in FY 2017. In contrast, because of the high cost of institutional care relative to other foster care placements, the dollar amount of improper payments related to cases lacking safety

documentation for institutional caregiver staff is high. Preliminary analysis suggests that cases with these payment errors contribute over 4 percent to the gross improper payment estimate of 7.13 percent. (Note: Because cases may have more than one type of overpayment error, the rate for any specific type of overpayment may involve some duplication and therefore slight overestimation.) More information on the relative contribution of these top six types of payment errors can be found in Figure 8 below.

Figure 8: Title IV-E Foster Care Program: Reasons for Improper Payments across All States – FY 2017 Frequency and Dollar Amount Across Error Types



*Improper payments for cases with more than one error type (N = 32) are counted under all applicable error types.

In FY 2017, HHS undertook the following key actions to reduce improper payments in the future:

- Emphasizing Quality Improvement: HHS engaged with title IV-E agencies to enhance the understanding of program compliance requirements and to share strategies that have proven successful in other states. Based on discussions with individual states on review preparation and compliance results, HHS worked with states to emphasize and develop strategies for continuous program improvement with an emphasis on: viewing the quality assurance process as an ongoing process, and developing sound program improvements that support systemic change and sustain the improvement effort.
- Enhancing Targeted Outreach Strategies:
  - Pre-Review Engagement of States: Since certain types of improper payments, such as those pertaining to foster care provider requirements, occur in a small number of states, HHS implemented pre-review outreach strategies (e.g., calls and site visits) tailored to particular state child welfare agencies to provide feedback about specific program performance areas needing improvement and facilitate efforts to correct them. For example, HHS conducted a series of state-specific calls with program leaders in each of the 12 states in the recent review cycle to discuss state policy and systemic factors supporting compliance with federal eligibility and payment requirements. HHS also visited five of the 12 states prior to the onsite review to examine and provide feedback on state documentation of safety checks for staff of child care institutions given the comparatively high-dollar impact of errors pertaining to institutional care. The practice of pre-review site visits began in one region 5 years ago and was instituted more broadly beginning in early 2016. The state visits focused on the federal requirements to increase state agency staff and foster care providers' knowledge of

the requirements, help the state identify missing or insufficient documentation, and help the state eliminate payment errors involving inadequate documentation of safety checks.

- Education to Address Specific Errors: In response to the FY 2017 improper payment performance, HHS will conduct two webinars in early FY 2018 to advance federal and state staff knowledge on the federal safety check requirements. The webinars will discuss challenges and solutions in meeting the requirements, and encourage effective communication of the requirements between Title IV-E agency staff and licensing agencies to further promote adequate documentation of safety check compliance.

In addition, HHS continued the following ongoing corrective actions:

- Conducting Eligibility Reviews and Providing Feedback to State Agencies: HHS conducts onsite and post-site review activities to validate the accuracy of state claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the state agency to affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the state agency including whether the state exceeded the error threshold in a review and must develop a PIP.
- Developing PIPs: HHS requires states that exceed the error threshold in a review to develop and execute state-specific PIPs that identify the specific action steps necessary to target and correct root causes of the errors. Each action strategy must be completed within one year from the date HHS approved the plan. In FY 2017, two of the 12 states reviewed were out of compliance and will complete a PIP. PIPs are an effective strategy because, since FY 2004 improper payments reporting, only one state has been found not in compliance on an eligibility review conducted following PIP completion.
- Providing Training and Technical Assistance: HHS provides training and technical assistance to states to develop and implement program improvements, even when states are not required to develop a PIP. This assistance helps states expand organizational capacity and promote more effective program operations. In FY 2017, HHS trained all of the 12 states reviewed on the federal eligibility and payment requirements and provided technical assistance prior to, during, and after the Foster Care Eligibility Reviews.
- Conducting Secondary Reviews and Disallowances: HHS conducts secondary reviews for non-compliant states and takes appropriate disallowances consistent with the review findings (HHS takes disallowances for error findings in both primary and secondary reviews). Two states reviewed in the FY 2017 cycle will undergo a secondary review. On a secondary review, if a state is found not in substantial compliance, HHS takes an extrapolated disallowance. These additional disallowances, in conjunction with the PIP development and implementation, incentivize states to improve compliance.

11.73 Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System to draw samples for the regulatory reviews. This 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. Since Foster Care payments occur at the state level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the state level. States have the option to receive federal financial participation to develop and implement a Comprehensive Child Welfare Information System in accordance with federal regulations at 45 CFR §1355.50 through §1355.59. Comprehensive Child Welfare Information System project requirements include, among others, the performance of automated program eligibility determinations and bi-directional data exchanges with systems generating the financial payments and claims to ensure the availability of needed supporting documentation.

11.74 Foster Care Statutory or Regulatory Barriers that Could Limit Corrective Actions

HHS has not identified statutory or regulatory barriers that could limit corrective actions.

11.80 CCDF

11.81 CCDF Statistical Sampling Process

The CCDF improper payments methodology uses a case-record review process to determine if child care subsidies were properly paid for services provided to eligible families. All states, and the District of Columbia and Puerto Rico, are divided into three cohorts and conduct the error rate review once every 3 years. In addition to federal rules, states have varying requirements for establishing and verifying eligibility. The methodology enables states to determine the types of errors and their sources to reflect the policies and procedures unique to each state. For the CCDF improper payments methodology, please see Improper Payments Error Rate Review Process.

The current methodology incorporates the following: (a) drawing a statistical sample from a universe of paid cases; (b) measuring improper payments; and (c) requiring states with improper payment estimates exceeding 10 percent to submit a CAP. The improper payment methodology and reporting requirements focus on administrative errors associated with client eligibility. The CCDF gross improper payment estimate for FY 2017 is 4.13 percent or $237.32 million. The FY 2017 net improper payment estimate is 3.57 percent or $204.97 million.

There were several contributing factors to the slight decrease in the improper payment estimate from 4.34 percent in FY 2016. While all states are updating their policies and procedures to ensure compliance with implementation of CCDBG), most states reporting in FY 2017 (referred to as Year One states) had not put new policies in place, which potentially kept their improper payment estimates lower. HHS anticipates that as states establish new policies in accordance with new regulations promulgated in September 2016, it will likely take some time for states and child care providers to understand, implement, and follow the new requirements. Therefore, the CCDF's program errors may increase as states implement and are evaluated against the new policies.

11.82 CCDF CAP

Insufficient documentation errors account for an estimated 66 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. The most frequently cited errors due to missing or insufficient documentation include:

- Activity schedules or hours of care needed (8 states);
- Paystubs or income verification (8 states); and
- Certifications or recertifications (2 states).

Administrative or process errors represent approximately 34 percent of errors found in the Year One reviews. These errors consist of the failure to apply policy correctly, including:

- Income calculation (15 states);
- Provider's payment rate (5 states);
- Level of care or need for care (4 states);
- Parent fee (4 states); and
- Misapplication of policy (2 states).

Corrective Actions to Address Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by State or Local Agency

HHS and states have established corrective actions targeting both error types. States are required to report on the root causes of errors once every 3 years. Each report also allows states to report on actions taken as the result of errors from the prior review. States reporting in FY 2017 plan the following actions to correct both missing or insufficient documentation and administrative or process error types:

- Conducting training with eligibility staff on CCDF policies and procedures (14 states);
- Conducting ongoing case reviews or audits (14 states);
- Making changes or updates to state eligibility policies and procedures (7 states);
- Upgrading or enhancing information technology (IT) systems (4 states); and
- Developing job aids or tools to assist eligibility staff (4 states).

HHS has limited authority to require specific actions of state grantees. As resources allow, HHS provides additional onsite and remote oversight of policy and procedure implementation to achieve compliance with the CCDBG statute and CCDF regulations. In addition, HHS has implemented other corrective actions to assist all states in their review process and error reduction including the following activities:

- Oversight: All reporting states take part in a Joint Case Review process that is part of HHS oversight. This new review process was piloted in FY 2016 with Year Three states and expanded to all reporting states in FY 2017. HHS gains insight into the implementation of the error methodology and provides additional technical assistance to states to ensure consistent reviews;
- Site Visits: HHS visits states needing assistance to address root causes of errors as resources allow;
- Technical Assistance:
  - Regulations: HHS provides technical assistance to states around policy and procedure changes to meet new requirements under the CCDBG. The Office of Child Care's National Center on Subsidy Innovation and Accountability, which was funded to specifically provide technical assistance to states and territories on program integrity and accountability, and has been targeting technical assistance to states as it relates to reauthorization;
  - IT: HHS delivers technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors; and
- Methodology Training: HHS provides training on the methodology that allows states to learn best practices from each other as they conduct the improper payment reviews.

11.83 CCDF Information Systems and Other Infrastructure

Since CCDF payments occur at the state level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the state level. In addition to the efforts outlined in prior HHS AFRs, states have taken many steps to improve their IT systems and infrastructure. In FY 2017, states reported a range of other improvements to information systems including:

- Fourteen Year One states utilize IT systems that assist in eligibility determination and authorization, with the following capabilities:
  - Data matches and syncing with other systems, including those from outside agencies (9 states);
  - Automatic determination of the payment rate (4 states);

- Automatic eligibility determination (4 states); and
- Document scanning and storage (2 states).

- Nine Year One states utilize IT systems containing information on providers or provider payments, including the following:
  - Payment management and tracking (8 states); and
  - Provider and licensing information (7 states).

- Eleven Year One states described other IT system capabilities that assist in reducing errors and improper payments, including the following:
  - Flags and blocks for avoiding eligibility errors (8 states); and
  - Flags or blocks for avoiding issuance of improper payments (5 states).

- One Year One state described limitations with an outdated system.
- Seven Year One states have plans for updates, enhancements, or new systems.

11.84 CCDF Statutory or Regulatory Barriers that Could Limit Corrective Actions

The CCDBG Act, signed into law in November 2014, reauthorized CCDF for the first time since 1996. The statute improves the quality and access to care for children across the country by requiring states to change eligibility to a minimum of 12 months, revise redetermination policies, update provider payment rates and payment practices, and increase health and safety standards for providers. States will be required to create new policies and procedures to enact the requirements of the law, which may increase errors as the changes are implemented. CCDF regulations (issued in September 2016) will also require several changes for state programs. Many states will need to pass legislative packages to enact the requirements under the regulations. Others are updating policy and procedure manuals and creating staff training and program oversight methods.

12.0 Superstorm Sandy Reporting Information

Superstorm Sandy was a major hurricane that struck the United States' eastern seaboard in October 2012 and caused extensive damage from Florida to Maine. In response to this disaster, Congress passed the *Disaster Relief Act*, which provided HHS $747 million allocated among multiple programs across five Divisions. Because funding of this type and magnitude often carries additional risk, the *Disaster Relief Act* and OMB guidance require all federal programs or activities receiving funds to calculate and report an improper payment estimate. Once a program's Superstorm Sandy funding has been spent, agencies are no longer required to report improper payment information. In FY 2017, HHS halted reporting error rate information for three programs—NIH Research, SAMHSA, and ASPR Research—that expended all *Disaster Relief Act* funding. HHS expects FY 2017 will be the last year that improper payment information will be reported for any *Disaster Relief Act* programs. Information on the remaining *Disaster Relief Act* programs' improper payment methodologies, results, and corrective actions can be found on subsequent pages.

12.10 Head Start

12.11 Head Start Statistical Sampling Process

Head Start received approximately $95 million in *Disaster Relief Act* funding to provide services, training and oversight, and construction assistance to affected grantees. Every Superstorm Sandy grantee receives an erroneous payments onsite monitoring visit in the quarter following the quarter when funds are spent, or as soon

thereafter as possible. Superstorm Sandy transactions for each quarter are reviewed using a standard onsite monitoring tool to identify potential and actual erroneous payments. Additional information on Head Start's statistical sampling process can be found on page 232 of HHS's FY 2016 AFR.

During FY 2017 grantees continued to complete significant facilities projects, primarily completing rebuilding of facilities substantially destroyed by Superstorm Sandy. A major challenge to grantees was the expenditure of funds within 2 years of award, particularly as project timelines were extended to reflect unforeseen delays (like permitting delays and scarcity of needed materials). Grantees made significant expenditures as projects concluded and grantees made final payments to contractors by August 31, 2017.

The Head Start gross and net improper payment estimate for FY 2017 is 0 percent or $0.

12.12 Head Start Root Causes and CAP

Corrective Actions to Address Root Causes

No improper payments were identified for the review period. HHS worked closely with grantees to ensure that projects finished on time and associated funds were spent within their two year expenditure period.

12.20 SSBG

12.21 SSBG Statistical Sampling Process

The SSBG program received $474.5 million in *Disaster Relief Act* funding to address necessary expenses resulting from Superstorm Sandy, including services for individuals; and repair, renovation and rebuilding of eligible facilities. HHS awarded the SSBG *Disaster Relief Act* funds to five states affected by Superstorm Sandy, and three states (Connecticut, New Jersey, and New York) were reviewed under the improper payment methodology as their allocations represented 99 percent of all SSBG *Disaster Relief Act* funds.

Because the states determine the types of services and eligibility for these services, as permitted by the SSBG law and regulations, there was considerable variation in states' use of these funds. To account for this variation, HHS developed a two-fold (bifurcated) improper payment methodology to review the use of SSBG *Disaster Relief Act* funds in three states. The two methodologies are a case record review (that examined payments or benefits provided to or on behalf of individuals, families and households based on specific eligibility criteria) and a vendor payment review (that examined payments to service vendors to assess if the vendors met the eligibility requirements for the payments).

For the FY 2017 review period (July 1, 2016 to June 30, 2017), HHS reviewed 245 records. HHS completed case record reviews in New Jersey only since it was the only state still making payments eligible for that review (HHS reviewed 98 case records in New Jersey). Also, HHS completed vendor payment reviews in Connecticut, New Jersey, and New York (HHS reviewed 147 vendor payments across the three states—15 payments in Connecticut, 48 payments in New Jersey, and 84 payments in New York). HHS consolidated its review findings and calculated a national SSBG *Disaster Relief Act* improper payment estimate from the aggregate findings across all three states.

The SSBG gross and net improper payment estimate for FY 2017 is 0.014 percent or $8,674.02.

The error rate for the case record reviews is 0.16 percent, while the error rate for the vendor payment reviews is 0 percent.

12.22 SSBG Root Causes and CAP

Two of the 245 records reviewed had an improper payment. HHS categorized both errors (representing 100 percent of the estimated improper payments) as administrative or process errors due to state or local agency. These errors included: (1) an incorrect payment to a previous landlord after a beneficiary moved to a new rental residence; and (2) an incorrect payment amount of the maximum allowable benefit for 1 month, instead of the rental amount stated on the lease.

Corrective Actions to Address Root Causes:

New Jersey completed recoupment efforts for the two overpayments identified. As the grants ended on September 20, 2017, HHS will work with New Jersey and other states to continue to gather lessons learned and apply those to any similar future efforts.

13.0 Recovery Auditing Reporting

HHS developed a risk-based strategy to implement IPERA's recovery auditing provisions. Specifically, HHS focuses on implementing—or providing a framework for states to implement—recovery audit programs in Medicare and Medicaid, which accounted for 86 percent of HHS's outlays in FY 2017. The use of RACs is one of the tools HHS uses to enforce Medicare requirements. HHS believes RACs help reduce improper payments and help educate providers on Medicare policies. HHS also believes there is a sentinel effect in the provider community with more providers billing accurately because of the possibility of a RAC audit in the future. HHS is progressing in recovering improper payments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described above and below. In addition, in FY 2017 HHS began reviewing and cataloging additional opportunities to utilize RACs outside of Medicare and Medicaid with a few programs. HHS will consider lessons learned from these experiences as it continues to implement this requirement.

Medicare FFS RACs

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 states no later than January 1, 2010. RACs are approved to review a variety of claim types, except for inpatient hospital patient status reviews, which are limited to only those providers referred by the Quality Improvement Organizations for exhibiting persistent noncompliance with Medicare policies. On October 31, 2016, HHS awarded five new Medicare FFS RAC contracts that incorporated several program enhancements developed in response to industry feedback:

- Reducing the complex review timeframe to 30 days and withholding the contingency fee if the RAC does not meet its review deadline;
- Requiring the RAC to wait 30 days to allow for a discussion request from the provider after identifying an improper payment before sending the claim to the MAC for adjustment;
- Confirming receipt of a discussion request and other written correspondence within one business day;
- Broadening review topics to all provider types and requiring reviews of topics referred by HHS; and
- Enhancing the information available on the provider web portals.

In FY 2017, the Medicare FFS RAC program identified approximately $33.78 million in overpayments and recovered $24.33 million. Policy changes regarding the payment and treatment of inpatient hospital claims and a delay in awarding new contracts resulted in fewer reviews in FY 2017 compared to previous years. Meanwhile, amounts that HHS identified in previous years continue to be collected. During FY 2017, the majority of Medicare FFS RAC collections were from Diagnosis Related Group validations and outpatient therapy reviews.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2017, HHS released quarterly Provider Compliance Newsletters that offered detailed information on seven findings identified by the Medicare FFS RACs. Also, HHS used these findings to implement local and/or national system edits to prevent improper payments. More information can be found at Medicare FFS RAC program.

Medicare Secondary Payer (MSP) RACs

The MSP RAC, known as the MSP Commercial Repayment Center (CRC), reviews information collected by HHS regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP) and situations where a Non-Group Health Plan (NGHP), such as a Workers' Compensation entity or No-Fault insurer, has or had primary payment responsibility. When GHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). At the end of FY 2016, the CRC workload expanded to include the recovery of certain conditional payments made by Medicare FFS until HHS identifies an NGHP with primary payment responsibility, when the CRC initiates recovery of these conditional payments. During FY 2017, HHS phased in the implementation of this new recovery program and fully implemented the program by March 2017.

In FY 2017, the CRC identified approximately $560.06 million and collected $160.78 million in mistaken payments. More information can be found at CRC.

Medicare Part C and Part D RACs

Section 1893(h) of the *Social Security Act* expanded the RAC program to Medicare Parts C and D. As discussed in *Section 11.22*, HHS is exploring a Medicare Part C RAC program that will fit into the larger Medicare Part C program integrity efforts.

The Part D RAC program became fully operational in FY 2012. Since its launch, the Part D RAC has recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers and improper refills of Drug Enforcement Agency scheduled drugs. The Medicare Part D RAC contract ended in December 2015, but an administrative and appeals option period allows the RAC to complete work on outstanding audit issues until the end of December 2017. Because the option period does not permit new audit work, no new improper payments were identified by the Part D RAC during FY 2017. HHS is committed to ensuring program integrity for the Part D program and is exploring options for the Part D RAC. The Part D RAC recouped approximately $0.30 million in overpayments in FY 2017 that were identified in previous years. More information can be found at Medicare Part C and Part D RAC programs.

State Medicaid RACs

Section 1902(a)(42)(B) of the *Social Security Act* required states to submit assurances by December 31, 2010 that their programs meet the statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012. Thus, FY 2017 is the fifth full federal FY of reporting State Medicaid RAC recoveries. In FY 2017, State Medicaid RAC federal-share recoveries totaled $32.52 million. State Medicaid RAC federal-share recoveries include overpayments collected, adjusted, or refunded to HHS, as reported by states on the CMS-64.

From inception of the Medicaid RAC program in FY 2012 to the end of FY 2017, 47 States and the District of Columbia had cumulatively implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments in their Medicaid programs. However, each state has the flexibility to tailor its RAC program where appropriate with guidance from HHS. For example, several states that had implemented Medicaid RAC programs ended their RAC programs when HHS approved an exception due to the high proportion of

beneficiaries enrolled in Medicaid managed care compared to FFS. As a result, 12 states currently have time-limited HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration, resulting in a total of 38 states and the District of Columbia that currently have RAC programs.

Recovery Auditing Reporting Tables

OMB Circular A-136 requires agencies to provide detailed information on their recovery auditing programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in the following tables. If HHS excluded a program from a table, it is because it does not have results in that area.

Table 3

Overpayments Recaptured with and without Recapture Audit Programs

FY 2017 (in Millions)

	Overpayments Recaptured through Payment Recapture Audits			Overpayments Recaptured Outside of Payment Recapture Audits	
Program or Activity	**Amount Identified**	**Amount Recaptured Note (1)**	**CY Recapture Rate**	**Amount Identified**	**Amount Recaptured**
CMS Error Rate Measurements Note (2)				$24.57	$19.38
Medicare FFS Recovery Auditors	$33.78	$24.33	72%		
Medicare Secondary Payer Recovery Auditor	$560.06	$160.78	29%		
Medicare Contractors Note (3)				$14,210.77	$11,410.06
Medicare Part C and Part D Note (4)				$81.54	$81.54
Medicare Part D Recovery Auditors	N/A	$0.30	N/A		
Medicaid Integrity Contractors - Federal Share Note (5)				$21.60	$10.69
State Medicaid Recovery Auditors - Federal Share Note (6)	N/A	$32.52	N/A		
ACF Error Rate Measurements and Eligibility Reviews Note (7)				$1.16	$1.26
ACF OIG Reviews				$0.305	$17.06
ACF Single Audits Note (8)				$59.29	$13.99
HRSA National Health Service Corps				$5.19	$12.24
TOTAL	$593.84	$217.93	37%	$14,404.43	$11,566.22

Notes:

1. The amount reported in the Amount Recaptured column is the amount recovered in FY 2017, regardless of the year HHS identified the overpayment.
2. The CMS Error Rate Measurements row includes recoveries from Medicare FFS (via the CERT program), Medicaid, and CHIP. The actual overpayments identified by the CERT program during the FY 2017 report period were $21,280,789.91. The identified overpayments are recovered by the MACs via standard payment recovery methods. As of the report publication date, MACs reported collecting $18,218,737.10 or 85.61 percent of the actual overpayment dollars. For Medicaid and CHIP, HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of Medicaid and CHIP improper payments are governed by the *Social Security Act* and related regulations under which states must return the federal share of overpayments. States reimburse HHS for the federal share of overpayments. Section 1903(d)(d) of the *Social Security Act* allows states up to one year from the date of discovery of an overpayment for Medicaid and CHIP services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. The actual overpayments identified by the PERM program during the FY 2017 report period were $2,528,749.13 for Medicaid and $757,063.35 for CHIP. The amounts recovered were $1,117,746.00 for Medicaid and $40,365.00 for CHIP.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS Recovery Auditors program and the Medicare FFS Error Rate Measurement program, which HHS reports separately in this table.
4. The values in the Medicare Part C and Medicare Part D row represent overpayments reported and returned by Medicare Advantage organizations and Part D sponsors. The actual overpayments identified and recovered during the FY 2017 report period were $78,705,010.00 for Medicare Part C and $2,833,663.00 for Medicare Part D.
5. For Medicaid, the Medicaid Integrity Contractors identified total overpayments that include both the federal and state shares. However, HHS reports only the actual federal share across audits.
6. For the State Medicaid Recovery Auditor row, states are only required to report the amount of recoveries, and not the amount of improper payments identified or recovery rates. The State Medicaid Recovery Auditors Amount Recaptured cell represents the federal share of the state recoveries as of the publication date of the AFR. The final amount recaptured for FY 2017 as a result of activities by State Medicaid Recovery Auditors will be reported in the Annual Medicare and Medicaid Program Integrity Report to Congress for FY 2017.
7. The ACF Error Rate Measurements and Eligibility Reviews row contains information for Foster Care, Child Care, and Superstorm Sandy SSBG identified or recovered amounts during the current reporting year. As a result of conducting Foster Care eligibility reviews in 12 states between July 2016 and June 2017, HHS recovered over $1.11 million in Title IV-E improper payments (comprised of $791,744.00 in disallowed maintenance payments and $317,018.00 in disallowed administrative payments). For Child Care, states are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error identified in the improper payments review. States reported identifying $0.048 million and recovering $0.051 million. For Superstorm Sandy SSBG, states recouped $102,892.45, which included overpayments identified in the FY 2017 sample ($1,275.00) as well as previous years. HHS will contact grantees to determine whether the funds will be allocated towards an allowable activity or repaid.
8. The ACF Single Audits row includes information for all ACF programs subject to federal audit requirements.

Table 4A

Disposition of Funds Recaptured Through Payment Recapture Audit Programs

FY 2017 (in Millions) Note (1)

Program or Activity	Amount Recaptured	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Original Purpose Note (2)	Returned to Treasury
Medicare FFS Recovery Auditors	$24.33	$49.64	$10.95	($62.44) Note (3)	N/A
Medicare Secondary Payer Recovery Auditor	$160.78	$4.02	$24.98	$131.78	N/A
Medicare Part D Recovery Auditors	$0.30	N/A	$0.08	$0.21	N/A
State Medicaid Recovery Auditors - Federal Share Note (4)	$32.52	N/A	N/A	N/A	$32.52
Total	$217.93	$53.66	$36.01	$69.55	$32.52

Notes:

1. HHS did not have any amounts that were used for financial management improvement activities or the OIG.
2. Funds included under the Original Purpose column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditor contingency fees. In addition, the Medicare FFS Recovery Auditors Original Purpose cell also takes into consideration underpayments to providers that were identified and corrected ($6.74 million) and amounts collected in prior years but overturned on appeal in FY 2017 ($19.44 million).
3. The negative original purpose amount is composed of amounts returned to the Medicare Trust Funds in previous years and does not mean the program has an overall negative return on investment.
4. The state Medicaid recovery auditors' row only includes information on the federal share of recoveries, which are returned to Treasury. States do not report information to HHS on how the state portions of recoveries are used.

Table 4B
Aging of Outstanding Overpayments Identified in the Payment Recapture Audit Programs
FY 2017 (in Millions)[Notes (1) and (2)]

Program or Activity	CY Amount Outstanding (0 to 6 months)	CY Amount Outstanding (0 to 6 months) %	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (6 months to 1 year) %	CY Amount Outstanding (over 1 year)	CY Amount Outstanding (over 1 year) %
Medicare FFS Recovery Auditors Note (3)	$0.08	<0.01%	$7.08	0.4%	$1,683.24	99.6%
Medicare Secondary Payer Recovery Auditor Notes (4) and (5)	$355.11	80.7%	$84.79	19.3%	$0.00	0%
Medicare Part D Recovery Auditor Note (6)	N/A	N/A	N/A	N/A	N/A	N/A
Total	$355.19	16.7%	$91.87	4.3%	$1,683.24	79.0%

Notes:

1. The state Medicaid recovery auditors are not included in this table since states do not report information to HHS that would allow the Department to calculate the aging of overpayment amounts that are currently outstanding.
2. HHS did not have any amounts that were determined not to be collectable.
3. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
4. The MSP recovery auditor maintains debts established under prior MSP recovery programs; consequently, collections exclusively related to mistaken payments identified by the MSP recovery auditor does not directly correlate to the amount outstanding.
5. The amount of outstanding payments identified by MSP recovery auditor included in this table reflects the outstanding balances on debts identified in FY 2017.
6. Recoupments of FY 2017 Part D overpayments will not begin until the appeals process is complete. The appeals process is ongoing, but is expected to be completed during FY 2018. However, as stated in *Section 13.0*, HHS recovered $0.30 million in overpayments that the Part D RAC identified in previous years.

FY 2017 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: Eric D. Hargan, Acting Secretary

FROM: Daniel R. Levinson, Inspector General

DATE: November 6, 2017

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2017

This memorandum transmits the Office of Inspector General's (OIG's) list of top management and performance challenges facing the Department of Health and Human Services (Department). The Reports Consolidation Act of 2000, Public Law 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

OIG's top management and performance challenges for fiscal year 2017 are:

1. Ensuring Program Integrity in Medicare
2. Ensuring Program Integrity in Medicaid
3. Curbing the Opioid Epidemic
4. Improving Care for Vulnerable Populations
5. Ensuring Integrity in Managed Care and Other Programs Delivered Through Private Insurers
6. Improving Financial and Administrative Management and Reducing Improper Payments
7. Protecting the Integrity of Public Health and Human Services Grants
8. Ensuring the Safety of Food, Drugs, and Medical Devices
9. Ensuring Program Integrity and Quality in Programs Serving American Indian and Alaska Native Populations
10. Protecting HHS Data, Systems, and Beneficiaries from Cybersecurity Threats

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or staff may contact Jason Wittemen, Director of Congressional Affairs, at (202) 708-9755 or Jason.Wittemen@oig.hhs.gov.

Top Management and Performance Challenges Facing HHS: Introduction

The Office of Inspector General (OIG) has identified 10 top management and performance challenges facing the Department of Health and Human Services (HHS) as it strives to fulfill its mission "to enhance the health and well-being of Americans by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services." These top challenges arise across HHS programs and cover critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity. The Department should be mindful of these challenges and opportunities to address them as it undertakes its efforts to reimagine HHS as part of the Federal Government's comprehensive plan to reform Government.

HHS is responsible for a $1.1 trillion portfolio, and its programs impact the lives of virtually all Americans. In this context, management and performance challenges are plentiful and consequential. To identify the 10 top challenges, we synthesized our oversight, risk analysis, data analytics, and enforcement work. The section on each challenge includes a short list of key OIG reports and other products related to that challenge; additional OIG work can be found on our webpage at https://oig.hhs.gov.

Additionally, OIG maintains a list of recommendations it has made to address vulnerabilities detected in its audits and evaluations and tracks whether these recommendations have been implemented. From among these, OIG identifies the top unimplemented recommendations that, if implemented, are likely to garner significant savings and improvements in efficiency and effectiveness.[26]

The top 10 challenges include four areas of priority for OIG:

- fighting opioid and prescription drug abuse,
- protecting the health and safety of children served by HHS programs,
- preventing improper payments and fraud in home-based services, and
- partnering with States to enhance Medicaid program integrity.

2017 Top Management and Performance Challenges

1. Ensuring Program Integrity in Medicare
2. Ensuring Program Integrity in Medicaid
3. Curbing the Opioid Epidemic
4. Improving Care for Vulnerable Populations
5. Ensuring Integrity in Managed Care and Other Programs Delivered Through Private Insurers
6. Improving Financial and Administrative Management and Reducing Improper Payments
7. Protecting the Integrity of Public Health and Human Services Grants
8. Ensuring the Safety of Food, Drugs, and Medical Devices
9. Ensuring Program Integrity and Quality in Programs Serving American Indian and Alaska Native Populations
10. Protecting HHS Data, Systems, and Beneficiaries from Cybersecurity Threats

[26] See OIG's *Compendium of Unimplemented Recommendations*, May 2017. Available at https://www.oig.hhs.gov/reports-and-publications/compendium/files/compendium2017.pdf

Top Management Challenge #1: Ensuring Program Integrity in Medicare

Why This Is a Challenge

In fiscal year (FY) 2016, Medicare spent $679 billion and provided health coverage to 56.8 million beneficiaries. Spending under Medicare is expected to increase significantly over time as a result of growth in the number of beneficiaries and increases in per capita health care costs. The 2017 Annual Report by Medicare's Board of Trustees estimates that the Trust Fund for Medicare Part A (hospital insurance) will be depleted by 2029. It also projects that spending for Medicare Part B (medical insurance) will grow by almost 7 percent over the next 5 years, outpacing the U.S. economy, which is projected to grow by 5 percent during that same time.

Key Components of the Challenge

- Reducing improper payments
- Combating fraud
- Fostering prudent payment policies
- Implementing health care reforms and the promise of health information technology (Health IT)

In addition to challenges inherent in managing a program of this size, scope, and impact, HHS faces the added challenges of navigating within a rapidly evolving health care landscape and implementing significant legislative changes to Medicare. The 21st Century Cures Act, which was signed into law in December 2016, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) incentivized changes to the ways health care is delivered and paid for and promoted the adoption and appropriate use of electronic health record (EHR) technology to share information across providers. More broadly, the Department is navigating the transformation from a volume-based health care system to a value-based, more accountable system.

To ensure that Medicare effectively serves beneficiaries well into the future, HHS must foster sound financial stewardship and program integrity. This includes protecting Medicare dollars from fraud, waste, and abuse; implementing prudent payment policies; and helping Medicare, providers, and beneficiaries achieve the goals of health care reforms and the promise of Health IT.

Key Components of the Challenge

***Reducing Improper Payments*.** Reducing improper payments to providers is a critical element in protecting Medicare's financial integrity. In FY 2016, the Centers for Medicare & Medicaid Services (CMS) reported an improper payment rate of 11 percent, corresponding to $41 billion, for Medicare Fee-for-Service, i.e., Medicare Parts A and B. *(For more information on measuring and reporting improper payment rates, see TMC #6.)* Some types of providers and suppliers pose heightened risk to the financial integrity of Medicare. For instance, OIG and CMS have identified high rates of improper payments for home health care, hospice care, and certain hospital services. Additionally, OIG estimated that Medicare improperly paid hundreds of millions of dollars for chiropractor services that did not meet Medicare requirements.

Identifying and recovering overpayments remains a critical tool for reducing improper payments. OIG has consistently found that Medicare contractors have difficulty identifying, collecting, and tracking overpayments. For example, OIG found that in 2014

OIG Focus Area: Reducing Improper Payments for Home Health Services

The Medicare home health benefit has long been recognized as vulnerable to fraud, waste, and abuse. Home health care represents a significant component of Medicare expenditures. In 2016, Medicare paid for more than 11,000 home health services, totaling approximately $18.24 billion. In FY 2018, OIG will prioritize work that identifies ways the Department can reduce improper payments for home health by reducing Medicare spending in geographic "hot spots."

Medicare Administrative Contractors collected only 20 percent of the overpayments that they sought to collect, based on referrals from benefit integrity contractors. Also, CMS is not using all tools available to recover misspent funds. For instance, Federal law requires Medicare durable medical equipment (DME) suppliers and home health agencies to obtain surety bonds. Federal law also authorizes HHS to require surety bonds for additional high-risk providers. However, CMS has implemented this requirement only for DME suppliers.

***Combating Fraud*.** Stopping fraud in Medicare is vital to safeguarding health care resources and protecting beneficiaries. OIG has identified common fraud schemes, such as billing for unnecessary services or services not provided; billing for more expensive services than needed or provided; paying kickbacks to recruiters, providers, and patients; and medical identity theft. Program areas susceptible to widespread fraud include home health, hospice services, DME, ambulance transportation, and clinical laboratory testing.

To address fraud, CMS needs accurate information about the individuals and entities with which it does business, and it must take appropriate steps to avoid doing business with—and exposing beneficiaries to—untrustworthy actors or providers who are deemed ineligible to bill Medicare. For example, shortly after CMS implemented enhanced provider enrollment screening, OIG found weaknesses in Medicare contractors' administration of this process that could leave Medicare vulnerable to enrolling unscrupulous providers.

***Fostering Prudent Payment Policies*.** Medicare should act as a prudent payer on behalf of taxpayers and beneficiaries by instituting economical payment policies. However, in certain contexts, Medicare payment policies result in Medicare and beneficiaries paying more for care provided in certain settings than for the same care provided in other settings. For example, Medicare could potentially save $4.1 billion over a 6-year period if swing-bed services at critical access hospitals were paid for at the same rates as at skilled nursing facilities (SNFs). Medicare also pays hospitals different amounts for the same care depending on whether the hospital admits beneficiaries as inpatients or treats them as outpatients. Beneficiaries' coinsurance costs and eligibility for Medicare-covered SNF costs following discharge also vary depending on their status as hospital inpatients or outpatients, even if they receive the same care during their stay.

Further, some payment policies create financial incentives that may drive up Medicare costs without improving care for beneficiaries. For example, OIG found that Medicare payments to SNFs for therapy greatly exceeded SNFs' costs for that therapy, creating incentives to bill for unnecessary therapy. Indeed, OIG's work showed that SNFs have increasingly billed for the highest levels of therapy even though the characteristics of their beneficiaries did not change. In another example, OIG found that Medicare payments for hospice care to beneficiaries in assisted living facilities have risen much more quickly than payments for hospice care in other settings and that hospices have financial incentives to target beneficiaries in assisted living facilities. In 2012, Medicare paid hospices about $1,100 per week per beneficiary receiving care in assisted living facilities, yet hospices typically provided fewer than 5 hours of visits per week per beneficiary.

***Implementing Health Care Reforms and the Promise of Health IT*.** Health care delivery has been evolving in recent years, driven most recently by major legislative changes such as those in the 21st Century Cures Act and MACRA. MACRA revamped Medicare's physician reimbursement system by creating the Quality Payment Program (QPP) to replace the Sustainable Growth Rate formula and Physician Quality Reporting System for most Medicare physicians and other clinicians. The QPP

introduces into physician reimbursement two mechanisms linked to quality and efficiency: (1) a Merit-Based Incentive Payment System (MIPS) and (2) advanced alternative payment models (Advanced APMs). Within this complex program, CMS must manage clinicians' transition to MIPS and craft Advanced APMs. In so doing, CMS must be mindful of administrative burden and the specialized needs of many small and rural providers. Physicians must prepare for significant changes in reimbursement methodology, reporting, and—depending on circumstances—delivery of care and workflow.

CMS continues to manage a range of programs that address system reforms aimed at improving quality of care in Medicare and Medicaid and reduce costs. These programs include, for example, the Medicare Shared Savings Program (MSSP) and a variety of models tested under the authority of the CMS Innovation Center. Recent OIG work examining performance of the MSSP in its first 3 years concluded that accountable care organizations showed potential to improve quality and reduce costs, and that further study of successful strategies would be warranted to inform continued operation of the program. Managing a broad range of changes to Medicare poses management challenges for CMS. New payment structures, business arrangements among providers, and incentives all give rise to risk-management challenges. In pursuing innovative models to improve the health care system, CMS must take steps to prevent programs and policies from having unintended consequences, such as misaligned incentives or abusive practices.

Connecting those involved in health care, as well as in human services, is important in a value-driven health care system. Leveraging the benefits of Health IT to ensure the appropriate flow of complete, accurate, timely, and secure information and to improve patient care is also critical. HHS faces challenges in achieving a connected health system in which data flow freely, as appropriate. These challenges include ensuring that Health IT companies and providers do not inappropriately block the flow of information; preventing inappropriate payments to participants who do not meet program requirements; ensuring that EHRs are not used as tools for fraud; encouraging adoption and use of Health IT by those not eligible for existing incentive programs; ensuring that patient safety benefits are realized; and encouraging the use of exchanged data. To avoid potential gaps in policy and oversight that could undermine the promise of Health IT, HHS must ensure coordination among internal agencies and other Federal partners that have overlapping responsibility for various aspects of Health IT. *(For information on the cybersecurity challenges impacting Health IT, see TMC #10.)*

Progress in Addressing the Challenge

Reducing Improper Payments. CMS is taking action to reduce improper payments, including notifying providers and suppliers serving Medicare beneficiaries in Part A and Part B of their responsibility to report and return overpayments within 60 days of an overpayment being identified. To ensure that items and services are provided in compliance with Medicare requirements, CMS has implemented prior authorization demonstrations, models, and programs that cover power mobility devices; repetitive, scheduled nonemergent ambulance transports and nonemergent hyperbaric oxygen; and certain other DME, prosthetics, orthotics, and supplies. Additionally, CMS continues to make available and market educational products and messages about proper billing and documentation requirements to reduce improper payments.

Combating Fraud. OIG, HHS, and the U.S. Department of Justice have made substantial strides in fighting Medicare fraud. From 2014 to 2016, the joint Health Care Fraud and Abuse Control (HCFAC) program returned $5 for every $1 invested. In FY 2016, HCFAC-funded audits and investigations by OIG resulted in expected recoveries of $2.5 billion. In July 2017, OIG, along with our State and Federal law enforcement partners, participated in the largest health care fraud takedown in history. More than 400

defendants in 41 Federal districts were charged with participating in fraud schemes involving about $1.3 billion in false billings to Medicare and Medicaid. Effectively leveraging data is critical to successfully combating fraud. For example, HHS uses data to identify and prevent potential fraud via its Fraud Prevention System. OIG uses data analytics to target and support our audits and investigations and to evaluate the scope and patterns of suspected fraud across the Medicare program.

HHS has taken steps to enhance its use of program integrity tools. For example, CMS reports that it requires inspectors for national site-visit contractors to complete annual CMS-approved training and testing, terminating those inspectors who do not do so. CMS also reported that it is currently enhancing the training materials to provide specific guidance on determining whether facilities are operational. More broadly, CMS is in the process of unifying its program integrity oversight of Medicare Part A and Part B and Medicaid. The new Unified Program Integrity Contractors will oversee these programs in distinct jurisdictions across the country as the contracts continue to be awarded. Medicare billing and payments have decreased in certain services and geographic areas known for fraud risks. For example, following law enforcement activities and CMS administrative actions, billing and payments for community mental health services declined significantly from 2009 to 2016 in fraud "hot spots." In addition, Medicare payments for home health services have decreased across the country by more than $1 billion per year since CMS capped outlier payments in 2010. CMS reports that it has also continued to use its authority to suspend Medicare payments to providers during investigations based on a credible allegation of fraud or on the basis of reliable information that an overpayment exists, imposing 291 new payment suspensions during FY 2016.

Additionally, the Department has fostered relationships among Federal and State agencies as well as between government agencies and the private sector. These partnerships are valuable to the detection of fraud and to enforcement successes. For example, public- and private-sector partners in the Healthcare Fraud Prevention Partnership (the Partnership), facilitated by CMS, share data and information to detect and prevent fraud. The Partnership has completed several studies to address fraud, waste, and abuse—such as targeting false storefronts or phantom providers—that have yielded successful results for participating partners.

In addition, CMS is replacing the Social Security number on Medicare cards with a new, randomly assigned unique identifier to help prevent fraud, combat identify theft, and safeguard taxpayer dollars. CMS reports that it will begin mailing new cards to Medicare beneficiaries in April 2018 to meet the statutory deadline for replacing all existing Medicare cards by April 2019. CMS also recently started running fraud prevention advertisements that highlight the importance of safeguarding the Medicare card.

***Fostering Prudent Payment Policies*.** HHS has been instituting changes to promote more prudent payment policies in some health care settings. For example, Medicare is required by law to stop paying certain new hospital-owned, off-campus, "provider-based" departments that charge higher hospital rates than freestanding facilities that perform the same services for less. CMS projects that this will save Medicare approximately $50 million in 2017. CMS is also studying the extent to which Medicare payment rates for therapy at SNFs should be reduced by evaluating claims data and outlining potential new payment models for SNFs. CMS has solicited public comments on options to consider in their research on SNF payment rates for therapy.

The Medicare appeals process is experiencing a sustained increase in the number of appeals. For example, the number of requests for an Administrative Law Judge hearing or review increased 1,222

percent from FY 2009 through FY 2014. This increase has created a significant backlog of appeals at the third and fourth levels of appeal. The Benefits and Improvement and Protection Act of 2000 requires that Medicare appeals be adjudicated within 90 days of receipt. The average processing time for each Medicare appeal is now 1,082 days. As of June 30, 2017, HHS reported that OMHA has a backlog of approximately 580,000 Medicare appeals.

HHS has developed a three-pronged strategy to address the backlog:

1) Invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog.

2) Take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process.

3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume.

***Implementing Health Care Reforms and the Promise of Health IT*.** Through the QPP, CMS continues to make steady progress in implementing substantial payment reforms. Since January 1, 2017, CMS reports that it has engaged more than 100 stakeholder organizations and over 47,000 people to raise awareness, solicit feedback, and help clinicians prepare for participation. CMS plans to maintain its focus on the clinicians' perspective as it develops IT systems that support and streamline clinician participation, crafts flexible and transparent MIPS policies, and facilitates participation in Advanced APMs.

CMS is also developing additional Advanced APMs for the QPP, including recommendations received from the Physician-Focused Payment Model Technical Advisory Committee, which reviews and assesses stakeholder-submitted proposals for physician-focused payment models. Additionally, CMS has issued a Request for Information from the public for the development and testing of new models through the Innovation Center, including those involving State programs and managed care.

HHS continues developing programs and policies that foster the development, adoption, and effective use of Health IT to support the appropriate flow of complete, accurate, timely, and secure information, including in connection with Medicare. HHS has sought to advance the national conversation about important Health IT issues to ensure that the potential benefits of Health IT investments are realized.[27]

[27] Three years ago, the Office of the National Coordinator for Health Information Technology (ONC) issued a document entitled "*Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure*" (http://healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf). Known as the "10-Year Vision Paper," this document describes plans to expand the sharing of information for health beyond EHRs and identifies privacy and security protections for health information as a building block for a nationwide, interoperable health information infrastructure. More recently, ONC issued a document entitled "*Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap*, Draft version 1.0" (https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf), which supports the vision laid out in the 10-Year Vision Paper. ONC has also issued a report to Congress on "information blocking" (https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf); a Health IT Safety Center Roadmap (http://www.healthitsafety.org/uploads/4/3/6/4/43647387/roadmap.pdf); and an updated Federal Health IT Strategic Plan for 2015–2020 (http://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf).

As of August 2017, more than 639,000 eligible professionals and hospitals—including critical access hospitals—were actively registered in the EHR incentive programs.[28] HHS has also finalized a rule to implement the MACRA provisions that replaced the Medicare EHR Incentive Program for eligible professionals with a performance category within MIPS. Additionally, HHS has issued an array of tools to empower patients to access their electronic health information, with the goal of improving patient outcomes, health care delivery, and social services.[29] HHS is also in the process of implementing various provisions of the 21st Century Cures Act that will facilitate the appropriate flow of complete, accurate, timely, and secure data.

What Needs To Be Done

***Reducing Improper Payments*.** CMS should do more to reduce improper payments among the provider and supplier types and in the geographic locations that present a high risk to the financial integrity of Medicare. This includes focusing on provider types that OIG and CMS have found to have extremely high rates of improper payments, such as chiropractors and home health providers, as well as high-risk hospital services.

HHS should continue to address and resolve program integrity weaknesses that OIG has identified. For example, CMS should implement the requirement for home health agencies to obtain surety bonds to ensure that Medicare can recoup at least some of its overpayments and to potentially deter ill-intended providers. Additionally, CMS should prevent Medicare payments for services to incarcerated beneficiaries by developing and implementing a system that collects the information necessary to identify which beneficiaries are incarcerated.

***Combating Fraud*.** Program integrity requires vigilance and sustained focus on preventing problems from occurring, quickly detecting problems that do occur, and swiftly addressing problems by holding any wrongdoers accountable and implementing appropriate risk-mitigation tools. Although progress has been made in some vital areas, more must be done to safeguard the Medicare program from fraud, waste, and abuse. CMS should fully employ available program integrity tools to prevent payment to fraudulent providers. For example, CMS must continue improving its oversight and the performance of contractors implementing Medicare provider enrollment safeguards. CMS should also make better use of the performance results within its Fraud Prevention System to refine and enhance its predictive analytic models.

***Fostering Prudent Payment Policies*.** Certain reforms to the Medicare payment structures for hospitals, SNFs, and hospices may require legislative changes, and HHS should work with the Administration and Congress to consider policy options. However, CMS can take some actions within existing authorities to mitigate financial risks and quality-of-care risks under the current systems. For example, CMS should reform the payment policy for hospices to align payments to costs and address the financial incentives for hospices to target beneficiaries likely to have long stays. CMS should also adjust Medicare payments to SNFs to eliminate any increases in payments for therapy that is unrelated to beneficiary

[28] CMS, "State Breakdown of Registration by Medicaid and Medicare Providers through August 31, 2017," October 2017.

[29] The Office of Civil Rights (OCR) issued a factsheet (http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html); OCR and ONC released educational videos (https://www.healthit.gov/access); and ONC issued a patient engagement playbook (https://www.healthit.gov/playbook/pe/).

characteristics and use data analytics to target oversight to SNFs that may be inappropriately billing for therapy.

Health Care Reforms and the Promise of Health IT. To continue managing the transition to the QPP, CMS must address a variety of issues impacting a diverse set of stakeholders. Physician representatives have identified the following challenges: complex reporting and measurement; limited scope and availability of APMs; needs for provider education; daunting timelines; significant infrastructure investments needed to meet new business and reporting requirements; and administrative burden. CMS should allocate sufficient resources to ensure issuance of timely and clear program regulations and guidance that address physician representatives' concerns. In addition to supporting physician readiness, CMS must ensure that it has well-functioning, physician-oriented websites; fully operational back-end payment and data systems for the QPP; and robust program integrity systems to ensure the accuracy of submitted data. CMS also needs to develop quality measures as outlined in the Quality Measure Development Plan and monitor for any unintended impacts that the quality measures have on Medicare beneficiaries.

As CMS manages new Medicare models, it should continue to focus on program-integrity risks of those models and incorporate safeguards to reduce them. It should also assess the effectiveness of the safeguards it employs, promptly correcting identified issues. This is especially important for models that introduce new payment incentives, which might lead to new fraud schemes, and for models for which waivers of payment, coverage, or fraud and abuse laws may have been issued. CMS should also ensure that models achieve their intended outcomes with regard to quality of care and efficiency. Further, where applicable, CMS must clearly define actionable and meaningful quality measures, ensuring their reliability and accuracy.

New models and value-based designs rely significantly on data, EHRs, and technology. CMS must ensure that data collected and provided are complete, accurate, timely, and secure and that evolving technologies, such as telemedicine, achieve their intended results. HHS must address barriers to the appropriate flow of complete, accurate, timely, and secure data among providers, beneficiaries, and other stakeholders. To the extent that resources, cost, and quality performance are measured on the basis of Medicare Parts A and B claims data, CMS must ensure the soundness and reliability of such data. CMS should adopt sound record-retention and documentation practices for all models while being mindful of minimizing the burdens placed on those implementing the practices.

Key OIG Resources

- OIG Testimony, "Medicare and Medicaid Program Integrity: Combating Improper Payments and Ineligible Providers," May 2016. (https://oig.hhs.gov/testimony/docs/2016/maxwell-testimony05242016.pdf)
- OIG Online Portfolio: Home Health, February 2016. (https://oig.hhs.gov/reports-and-publications/portfolio/home-health/index.asp)
- OIG Report, *The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated*, September 2015. (https://www.oig.hhs.gov/oei/reports/oei-02-13-00610.pdf)
- OIG Report, *Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates*, March 2015. (https://oig.hhs.gov/oas/reports/region5/51200046.asp)
- OIG Report, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality*, August 2017. (https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp)

- OIG Report, *The Centers for Medicare & Medicaid Services Could Improve Performance Measures Associated With the Fraud Prevention System*, September 2017. (https://oig.hhs.gov/oas/reports/region1/11500509RIB.pdf)
- OIG Report, *Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements*, June 2017. (https://oig.hhs.gov/oas/reports/region5/51400047.pdf)

Top Management Challenge #2: Ensuring Program Integrity in Medicaid

Why This Is a Challenge

With almost 69 million enrolled individuals, Medicaid serves more enrollees than any other Federal health care program and represents one-sixth of the national health care economy. Medicaid is jointly administered and funded by CMS at the Federal level and by States. CMS reported that combined Federal and State Medicaid expenditures were $574 billion for FY 2016.

Key Components of the Challenge

- Ensuring compliance with fiscal controls
- Leveraging fraud prevention tools
- Improving national Medicaid data to support program integrity

Effectively overseeing Medicaid continues to be a top management challenge for HHS. Challenges include longstanding program integrity vulnerabilities, including limitations in national Medicaid data that make it more difficult to detect and address improper payments and fraud. CMS needs to partner with and support States in efficiently and effectively delivering high-quality Medicaid benefits to those who are eligible and protecting the programs and enrollees from fraud, waste, and abuse. At the same time, CMS must also oversee States' adherence to Medicaid rules governing eligibility, payment, program integrity, and Federal–State cost-sharing. In addition, the vast majority of Medicaid beneficiaries are enrolled in privately run managed care plans. OIG has identified challenges to ensuring that these beneficiaries have access to high-quality care and that Medicaid funds are expended properly. (*For information on challenges specific to Medicaid managed care, see TMC #5.)*

Key Components of the Challenge

Ensuring Compliance with Fiscal Controls. Reducing improper payments to providers is a critical element in protecting the financial integrity of the Medicaid program. In FY 2016, HHS reported an improper payment rate in the Medicaid program of 10.5 percent. *(For more information on HHS measurement and reporting of improper payments, see TMC #6.)* OIG audits have identified substantial improper payments to providers across a variety of Medicaid services, including school-based services, nonemergency medical transportation, targeted case management services, and personal care services (PCS). OIG has also uncovered improper payments made on behalf of individuals ineligible for Medicaid, deceased beneficiaries, and beneficiaries with multiple Medicaid identification numbers.

Drug manufacturers whose products are covered by Medicaid are required to report certain product and pricing information to CMS and pay rebates to States according to a statutorily defined formula. CMS and States share responsibility for ensuring that manufacturers pay all rebates to which the States and Federal Government are entitled. Ensuring that manufacturers report product and pricing information correctly is a challenge for HHS. Manufacturer misreporting can result in manufacturers' underpaying rebates, which inappropriately increases Federal and State Medicaid costs. For example, the drug manufacturer Mylan recently entered into a $465 million settlement with the United States to resolve allegations that it misclassified a drug in a way that led to underpaying Medicaid rebates. Overseeing States' collection of manufacturer rebates is also a challenge for HHS. OIG has identified instances in which States have not billed for or collected Medicaid rebates for physician-administered drugs, forgoing money owed to those States and the Federal Government.

CMS also faces challenges in ensuring that States appropriately apply criteria for Medicaid eligibility and for waiver programs. This is crucial to ensuring that CMS pays States the correct Federal share of Medicaid expenditures. For States that opted to expand Medicaid coverage, CMS faces the added

challenge of ensuring that States do not incorrectly categorize enrollees as "newly eligible," which would inappropriately shift costs from the State to the Federal Government. For example, OIG found that one State's failure to verify Medicaid eligibility data resulted in $105 million in Federal payments for potentially ineligible beneficiaries. OIG has also found that States have claimed unallowable and unsupported Federal Medicaid payments under waiver programs for home and community-based services (HCBS). While waiver programs can offer important flexibilities for States, CMS is challenged to oversee the financial integrity of these varied programs.

Further, the shared nature of Medicaid financing provides opportunities for States to shift costs to the Federal Government. OIG has identified a number of State policies that may distort the Federal share of Medicaid expenditures, causing the Federal Government to pay an increased amount of Medicaid expenditures. These include the improper use of provider taxes, intergovernmental transfers, supplemental payments, and inflated payment rates that may increase Federal funding that States receive. Such policies may distort the statutorily defined Federal share of Medicaid expenditures and undermine the Federal–State partnership.

Leveraging Fraud Prevention Tools. OIG has consistently found that there are opportunities to improve program integrity in Medicaid and better protect the program and its beneficiaries from fraud and harm by health care providers. The most effective way to prevent provider fraud is to keep bad actors from enrolling in the program. However, States are not screening high-risk providers with all of the tools at their disposal, including site visits and fingerprint-based criminal background checks. OIG has also raised concerns about the varying standards, and in some cases minimal vetting, for Medicaid PCS providers and providers in group homes that furnish care to the elderly and persons with disabilities. This leaves the Medicaid program vulnerable to financial fraud, and even more concerning, it leaves Medicaid beneficiaries vulnerable to abuse and neglect. (*For more information about quality of care and safety concerns for beneficiaries receiving personal care services, see TMC #4*.) Some States are not collecting and maintaining accurate ownership information about the Medicaid providers they are paying. Moreover, States do not currently have access to comprehensive data on providers that other States have terminated, leaving them vulnerable to enrolling unscrupulous providers already identified in another State.

Improving National Medicaid Data to Support Program Integrity. Data is an essential tool for detecting fraud, waste, and abuse; however, national Medicaid data have deficiencies that hinder timely and accurate fraud detection. One concern is that not all States are submitting data to the national Medicaid database known as the Transformed Medicaid Statistical Information System (T-MSIS). Despite an original deadline of July 2014, as of September 2017, CMS reported that 48 States have started submitting T-MSIS data, and 40 of these States have submitted all required data, including historical data. Getting all of the States to submit data to T-MSIS is not the only challenge. Concerns about the completeness and reliability of the data remain. Data must be complete and reliable to be of use to States, CMS, and other stakeholders in making comparisons across all States and identifying nationwide trends and vulnerabilities.

The lack of national Medicaid data hampers States, CMS, and other stakeholders' ability to quickly detect potential fraud, waste, or quality concerns at the State, multi-State, and national levels. Unscrupulous providers may commit fraud or harm beneficiaries across multiple States. Fraud schemes affecting multiple States are very difficult to detect without comprehensive national data. Localized schemes can also be harder to detect without national data. Utilization or spending patterns may not appear problematic until compared against another State's experience or national averages.

Recognizing such schemes in one State can alert other States to indicators of fraudulent or abusive practices that may be occurring in their jurisdiction. This information can lead to referrals to State law enforcement agencies like the State Medicaid Fraud Control Units (MFCUs) or joint investigations across State lines.

Progress in Addressing the Challenge

Ensuring Compliance with Fiscal Controls. With regard to improper payments to Medicaid providers, CMS has engaged with State Medicaid agencies to develop corrective action plans that address State-specific reasons for improper payments as a part of CMS's Payment Error Rate Measurement program, which measures Medicaid improper payments. CMS has facilitated national best-practices calls to share ideas across States, provided State education through the Medicaid Integrity Institute, offered ongoing technical assistance, and provided additional guidance as needed to address the root causes of improper payments. CMS has indicated that it continues to provide guidance to States on their procedures for calculating and claiming costs under waiver programs for HCBS.

CMS has also taken actions to curtail inappropriate State financing mechanisms that inflate the Federal share of Medicaid costs. For example, CMS issued guidance to State Medicaid directors and State health officials to clarify the rules for health care provider taxes.

Leveraging Fraud Prevention Tools. CMS has issued guidance, known as the Medicaid Provider Enrollment Compendium, to assist States in strengthening their provider screening and enrollment processes. In particular, CMS's guidance allows States to rely on Medicare provider screening results for providers who participate in both Medicare and Medicaid. CMS also worked with the Federal Bureau of Investigation to issue guidance to help States implement fingerprint-based criminal background checks for high-risk providers. In addition, beginning in 2018 the 21st Century Cures Act will require States, upon terminating a provider from the Medicaid program, to submit certain data to CMS's database of terminated providers, which will improve the effectiveness of this database. In 2016, CMS published a Request for Information in seeking stakeholder input on policy options to address program integrity concerns in personal care and other home and community-based services. Overall, Medicaid fraud-enforcement efforts by OIG and the MFCUs, which OIG oversees, have continued to hold wrongdoers accountable, recover stolen taxpayer dollars, and send a strong message to deter would-be fraudsters. In FY 2016, MFCUs reported more than 1,500 convictions, nearly 1,000 civil settlements and judgments, and almost $1.9 billion in criminal and civil recoveries.

OIG Focus Area: Partnering With MFCUs to Combat Medicaid Fraud

MFCUs are key partners in battling fraud, waste, and abuse in Medicaid. OIG administers grants to MFCUs, the State agencies authorized to fight waste, fraud, and abuse and to prevent patient neglect and exploitation. OIG also partners with MFCUs in joint investigations and provides them technical assistance. In FY 2018, OIG will continue to prioritize work that maximizes the effectiveness of MFCUs.

Improving National Medicaid Data to Support Program Integrity. CMS continues to work with all State Medicaid agencies to submit complete, accurate, and timely data to T-MSIS. According to CMS, as of September 2017, the number of States submitting any T-MSIS data had increased to 48, representing 94 percent of the total Medicaid population, and CMS indicated that it expects all States to submit T-MSIS data by the end of 2017. CMS also reported efforts underway to improve T-MSIS data quality, including working with States to improve the quality of their data submissions and convening a technical expert panel to make recommendations to improve T-MSIS data quality. In addition, CMS reported that it is

working to develop "research-ready" T-MSIS analytic files to make the data more consumable by a wide array of users.

What Needs To Be Done

The Medicaid program can and should be designed to minimize fraud, waste, and abuse by following core program integrity principles. Better protection of Medicaid now and in the future requires continual vigilance to keep up with changes in the environment and constantly evolving fraud schemes.

Ensuring Compliance With Fiscal Controls. CMS should continue to engage with State Medicaid agencies to develop corrective action plans and provide specific guidance to States regarding services and benefits most vulnerable to improper payments. OIG is currently assessing CMS's oversight of drug classifications and other aspects of the Medicaid drug rebate program and identifying opportunities for improvement as needed. CMS should work with States to ensure that they are applying Medicaid eligibility criteria correctly and should conduct sufficient oversight to prevent and detect any inappropriate assignment of enrollees to the higher Federal matching rate. In addition, CMS should closely review State Medicaid plans and plan amendments to identify any potentially inappropriate cost-shifting from States to the Federal Government.

Leveraging Fraud Prevention Tools. CMS should continue to work with States to leverage fraud-prevention tools. Providing guidance was an important step. CMS should also continue to work directly with those States that—despite the guidance—have not yet implemented tools like site visits or fingerprint-based criminal background checks for high-risk providers. In addition, CMS should develop a central repository or "one-stop shop" with provider information that all States and Medicare can use. This could reduce data-collection duplication and burdens on States and providers and improve the completeness and accuracy of the data available to all of these programs.

Improving National Medicaid Data to Support Program Integrity. CMS and the States need to make complete, reliable, and timely T-MSIS data a management priority. In doing so, CMS should establish and adhere to a deadline for when T-MSIS data will be available for program analysis and other management functions. CMS should monitor States' progress toward complete, reliable, and timely data submissions and use its available enforcement authorities when appropriate.

Key OIG Resources

- OIG Testimony, "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program," May 2017. (https://oig.hhs.gov/testimony/docs/2017/grimm-testimony-05022017.pdf)
- OIG Testimony, "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program," January 2017. (https://oig.hhs.gov/testimony/docs/2017/maxwell-testimony01312017.pdf)
- OIG Testimony, "Examining Medicaid and CHIP's Federal Medical Assistance Percentage," February 2016. (https://oig.hhs.gov/testimony/docs/2016/hagg-fmap-hearing-02-05-2016.pdf)
- OIG Report, *Providers Terminated from One State Medicaid Program Continued Participating in Other States*, August 2015. (https://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf)
- OIG Report, *T-MSIS Data Not Yet Available for Overseeing Medicaid*, June 2017. (https://oig.hhs.gov/oei/reports/oei-05-15-00050.pdf)

Top Management Challenge #3: Curbing the Opioid Epidemic

Why This Is a Challenge

Opioid abuse and related overdoses are a national epidemic. According to the Centers for Disease Control and Prevention (CDC), more than 33,000 people died in 2015 from overdoses involving opioids, both prescription and illicit, an increase from approximately 28,000 deaths in 2014.[30] Yet despite the increase in the number of people suffering from opioid use disorder, only about one-fifth of individuals receive specialty treatment, and even fewer receive medication-assisted treatment (MAT). [31, 32]

Key Components of the Challenge

- Addressing inappropriate prescribing of opioids
- Combating fraud and diversion of prescription opioids and potentiator drugs
- Addressing inadequate access to treatment
- Addressing misuse of grant funds
- Fighting fraud by treatment providers of opioid use disorder

Across multiple operating divisions and programs, HHS has many opportunities to help curb this epidemic. Medicare provides prescription drug coverage for 41 million Part D beneficiaries and Medicaid for almost 69 million beneficiaries. The U.S. Food and Drug Administration (FDA) oversees the approval and safe use of prescription drugs. Agencies such as the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the CDC award grants to support health care providers, researchers, and States in their efforts to combat the epidemic.

Key Components of the Challenge

Addressing Inappropriate Prescribing of Opioids. OIG found that many patients in Medicare Part D received concerning amounts of opioids in 2016. Specifically, half a million Medicare Part D beneficiaries (without a cancer diagnosis and not in hospice care) received opioids with an average daily morphine equivalent dosing (MED) greater than 120 mg for at least 3 months, exceeding the 90-mg MED level that CDC recommends staying below. While many beneficiaries receive opioids to treat legitimate health needs, these numbers raise concern that a significant number of beneficiaries may be receiving levels of prescribed opioids that are medically unnecessary and unsafe. OIG has also found that FDA lacks comprehensive data to assess whether its Risk Evaluation and Mitigation Strategies (REMS), set up to improve drug safety, are indeed meeting their goal. FDA has asked drug companies to establish a number of such programs for various drugs, including opioids; however, REMS performance remains a concern.

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[30] Rose A. Rudd, Puja Seth, Felicita David, and Lawrence Scholl, *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015, Morbidity and Mortality Weekly Report (MMWR)*, Centers for Disease Control and Prevention ePub, December 30, 2016. Available at https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm.

[31] National Institutes of Health, "Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health 2016 Detailed Tables," 2017. Available at https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm.

[32] Anjalee Sharma, et al., "Update on Barriers to Pharmacotherapy for Opioid Use Disorders," *Current Psychiatry Reports* 19(6): 35, 2017. Available at https://link.springer.com/article/10.1007%2Fs11920-017-0783-9.

Combating Fraud and Diversion of Prescription Opioids and Potentiator Drugs. Prescription opioids indicated to treat pain and those indicated to treat opioid use disorder (buprenorphine in particular) are at high risk of diversion. Also at risk for diversion are potentiator drugs, which exaggerate euphoria when combined with opioids and escalate the potential for opioid overdose. These nonopioid drugs can be prescription or over-the-counter medications and may be indicated to treat conditions very different from pain, such as HIV, psychiatric disorders, and even colds. OIG and State MFCUs have growing caseloads of Medicare and Medicaid drug-diversion investigations involving opioids and potentiator drugs.

Addressing Inadequate Access to Treatment. According to SAMHSA, 1.9 million people had disorders related to their nonmedical use of prescription pain relievers in 2015.[33] Medicare and Medicaid beneficiaries make up a large proportion of those with opioid use disorders.[34] With such high numbers of individuals in need, access to treatment of overdose and underlying opioid use disorders is a priority. Naloxone, an effective treatment for opioid overdoses, may not be readily available in an overdose emergency, and challenges exist in ensuring that people have access to quality treatment programs. In particular, an estimated 80 percent of people do not receive treatment for their underlying opioid use disorder.[35]

Addressing Misuse of Grant Funds. Through Federal grants, HHS commits substantial financial resources to combat the opioid epidemic. HHS awards grants for a range of efforts such as furthering pain management research; expanding access to opioid treatment programs; improving data access and quality to assist with prevention efforts; and providing education and training to health care practitioners. Ensuring that these funds are used for their intended purposes is paramount, and HHS faces challenges in protecting the integrity of grant programs. For instance, OIG has identified cases in which individuals falsified grant applications and used for personal gain grant funds that were intended to fight drug abuse.

Fighting Fraud by Treatment Providers of Opioid Use Disorder. Fraud committed by providers of treatment for opioid use disorder is a growing concern. Fraud schemes include the delivery of mental health services by unqualified providers and billing Medicare or Medicaid for medically unnecessary lab tests, such as urine drug screens recurring at a higher frequency than what is reasonable for that test. Such schemes may also involve billing for medically unnecessary drugs such as opioids or expensive specialty medications. Fraud in these settings can put beneficiaries at risk and diverts scarce funds needed to meet growing demand for legitimate treatment.

Progress in Addressing the Challenge

Effectively coordinating efforts across HHS programs and operating divisions and prioritizing initiatives are key to combating this complex public health emergency. To improve coordination and to focus

[33] SAMHSA, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, 2015. Available at https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

[34] According to CMS, more than 6 of every 1,000 Medicare beneficiaries and 8.7 of every 1,000 Medicaid beneficiaries have an opioid use disorder. See Centers for Medicare & Medicaid Services (CMS), Opioid Misuse Strategy 2016, January 5, 2017. Available at https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf.

[35] National Institutes of Health, National Institute on Drug Abuse, "Drug Facts: Nationwide Trends," June 2015. Available at https://www.drugabuse.gov/publications/drugfacts/nationwide-trends.

efforts, the Department established the HHS Opioid Strategy, which aims to improve access to treatment and recovery services and support alternative improvements in pain management. Many operating divisions have also established their own strategic plans to help fight the opioid crisis.

Addressing Inappropriate Prescribing of Opioids. In recognition that prescribing practices can exacerbate the misuse and abuse of prescription opioids, CDC has issued *Guideline for Prescribing Opioids for Chronic Pain* to aid providers in treating chronic pain outside of active cancer treatment, palliative care, and end-of-life care. In turn, FDA has been expanding its efforts to ensure safe use of opioids through its REMS authorities and encouraging the efforts of pharmaceutical companies to develop formulations of opioids that are more resistant to abuse. *(For more information about FDA's roles in overseeing prescription drug safety, see TMC #8.)*

OIG Focus Area: Protecting Beneficiaries From Opioid and Prescription Drug Abuse

OIG prioritizes program enforcement and oversight activities that protect beneficiaries from prescription drug abuse. Leveraging its enforcement authorities, OIG worked with other law enforcement partners to charge 120 defendants with opioid-related crimes during a national takedown in July 2017. So far this year, OIG has also issued exclusion notices to 295 providers for conduct related to opioid diversion and abuse. OIG's oversight work will continue to review issues related to opioids in HHS programs.

Combating Fraud and Diversion of Prescription Opioids and Potentiator Drugs. To identify and address suspected fraud, CMS conducts data analysis through its National Benefit Integrity Medicare Drug Integrity Contractor to identify outliers—including those related to opioid prescriptions—and to make referrals for investigation. For Medicaid, CMS compiles and publishes information that it collects from State Medicaid agencies and Medicaid MCOs about their drug utilization review program and processes, which could include employing Prescription Drug Monitoring Programs (PDMP) requirements and the use of "lock-in" programs, which restrict at-risk beneficiaries to particular pharmacies or prescribers. CMS officials reported developing a substance use disorder (SUD) tool for CMS's and State Medicaid agencies' use with T-MSIS data. This SUD tool will provide a standard method of assessing the care and treatment of Medicaid beneficiaries with SUD using a common data set. Through grants issued by CDC and SAMHSA, HHS has also been supporting States' development of PDMPs.

CMS also reported taking steps in the Part D program to address overutilization of potentiator drugs that are often abused in conjunction with opioids. These steps included encouraging Part D sponsors in its 2017 Call Letter to evaluate their claims data and use drug utilization management tools to help address the concurrent use of opioids and benzodiazepines. According to CMS, it started reporting concurrent opioid and benzodiazepine use to Part D sponsors in October 2016. CMS reported to OIG that it expects Part D sponsors to consider benzodiazepine use within their opioid overutilization review process and include this information in their discussions with prescribers.

Addressing Inadequate Access to Treatment. To improve access to the overdose treatment naloxone, FDA expedited approval of a nasal spray version of that drug. HHS has also been working to improve access to treatment for opioid use disorders. The Medication Assisted Treatment for Opioid Use Disorders final rule, published in July 2016, expands access to medication-assisted treatment services by allowing qualifying practitioners to request approval to treat up to 275 patients at a time with buprenorphine. HHS has also been implementing provisions of the Comprehensive Addiction and Recovery Act (CARA) of July 2016 that aim to increase access to addiction treatment services by expanding the buprenorphine-prescribing privileges of select providers, including nurse practitioners and physician assistants.

In addition, HHS has been supporting expansion of treatment options through a series of grant programs. Most of SAMHSA's $500 million authorized under the 21st Century Cures Act for FY 2017 has been granted to support increased access to treatment. In addition, much of HRSA's $94 million in grant funding for community health centers focused on treatment services—including medication-assisted treatment—for opioid use disorder.

Addressing Misuse of Grant Funds. Thus far, HHS efforts to address grant fraud have not been specific to opioids, but rather extend broadly to all types of grants. *(For more information on HHS efforts to prevent grant fraud, see TMC #7.)*

Fighting Fraud by Treatment Providers of Opioid Use Disorder. HHS published a final rule in September 2016 that outlined annual reporting requirements for providers with increased patient limits for medication-assisted treatment using buprenorphine, including reporting on diversion control plans. (*For more information about overall HHS efforts to prevent health care fraud in Medicare and Medicaid, see TMCs #1, #2, and #6*.)

What Needs To Be Done

In addition to deploying the grant funding for opioid use disorder treatment authorized under the 21st Century Cures Act, HHS should continue implementing new authorities under CARA that would help address the opioid epidemic. For example, CARA established new authority for Medicare Part D plan sponsors to develop lock-in programs, which help to protect beneficiaries from the harm of inappropriate utilization and protect the program from drug diversion. In addition, as discussed with OIG, CMS should continue to monitor available literature, clinical guidelines, information from other stakeholders, and internal data to proactively identify other opioid potentiators that may increase the risk of overdose when used together with opioids. Once identified, CMS should raise awareness on emerging trends and expand its policy and the Overutilization Monitoring System to include these drugs.

As access to treatment for opioid use disorders is expanded, HHS must also ensure that treatment programs and providers comply with program requirements. For example, in 2016 SAMHSA finalized regulations to increase access to providers of treatment for opioid use disorder. SAMHSA will need to oversee compliance with all these requirements. Likewise, SAMHSA will need to oversee the integrity and effectiveness of $1 billion in funding for the State Targeted Response to the Opioid Crisis Grants.

In addition, HHS should improve access to data about drug utilization and prescribing patterns. CMS should strive toward the development of complete and reliable national Medicaid data to enhance fraud-fighting efforts through better detection of questionable billing of opioids and potentiator drugs. *(For more information on challenges for Medicaid, see TMC #2.)* FDA should continue to evaluate the effectiveness of its opioids REMS programs and adjust them accordingly. Relevant HHS agencies should also continue supporting efforts to integrate PDMP data into the broader health care system, as these data enable providers to assess a patient's risk for abuse and misuse. In doing so, HHS will need to ensure appropriate safeguards to protect the privacy and security of these data. *(For more information on data security issues, see TMC #10.*)

In August 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis made a number of recommendations.[36] To the extent that these recommendations are followed, they may further expand HHS efforts to combat this crisis. OIG calls for HHS to include appropriate program integrity safeguards as it expands and implements new programs to attempt to curb the opioid epidemic.

Key OIG Resources

- OIG Data Brief, "Opioids in Medicare Part D: Concerns About Extreme Use and Questionable Prescribing," July 2017. (https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf)
- OIG Data Brief, "High Part D Spending on Opioids and Substantial Growth in Compounded Drugs Raise Concerns," June 2016. (https://oig.hhs.gov/oei/reports/oei-02-16-00290.pdf)
- OIG Data Brief, "Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D," June 2015. (https://oig.hhs.gov/oei/reports/oei-02-15-00190.pdf)
- OIG Report, *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, September 2013. (https://oig.hhs.gov/oei/reports/oei-05-12-00610.pdf)
- OIG Fact Sheet, "2017 National Health Care Fraud Takedown," July 2017. (https://oig.hhs.gov/newsroom/media-materials/2017/2017HealthCareTakedown_FactSheet.pdf
- OIG Report, *FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety*, February 2013. (https://oig.hhs.gov/oei/reports/oei-04-11-00510.pdf)

[36] Commission on Combating Drug Addiction and the Opioid Crisis, *Draft Interim Report*, July 31, 2017. Available at https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf.

Top Management Challenge #4: Improving Care for Vulnerable Populations

Why This Is a Challenge

HHS programs provide critical health and human services to many vulnerable populations, including individuals who receive nursing home care, group home care, hospice care, or home and community-based services (HCBS), as well as children from low-income families in foster care. HHS must ensure that these individuals have access to and receive high-quality services and are protected from abuse or neglect.

Key Components of the Challenge

- Addressing substandard nursing home care
- Reducing problems in hospice care
- Mitigating risks to individuals receiving home and community-based services
- Ensuring access to safe and appropriate services for children

HHS faces challenges in serving these vulnerable populations. For example, many of these services are delivered through programs—such as Medicaid, the National Aging Network, and the Child Care and Development Fund—that are not operated directly by HHS. As such, HHS has less transparency into the programs and less direct influence. *(For more information about limitations in Medicaid data, see TMC #2.)* Furthermore, even where HHS has direct oversight levers, such as through the survey and certification process for nursing homes, OIG's work shows that the Department has not always taken action to ensure that deficiencies are corrected.

Key Components of the Challenge

Addressing Substandard Nursing Home Care. Nursing facilities continue to experience problems ensuring quality of care and safety for people residing in them. OIG identified instances of substandard care causing preventable adverse events, finding that an estimated 22 percent of Medicare beneficiaries had experienced an adverse event during their nursing home stay. OIG has also raised concerns about the potentially inappropriate use of powerful antipsychotic drugs for nursing home residents. In addition, CMS has often failed to require nursing facilities to correct all deficiencies identified during the survey process, and OIG has identified nursing home staff who do not meet relevant licensure requirements.

Further, OIG continues to raise concerns about nursing home residents being at risk of abuse and neglect. In some instances, nursing home care is so substandard that providers may have liability under the False Claims Act. OIG recently alerted CMS to instances of nursing facilities' failures to identify and report abuse and neglect as required and deficiencies in procedures for enforcing these requirements. OIG alerted CMS about 134 Medicare beneficiaries treated in 2015 and 2016 for injuries that may have been caused by abuse or neglect while the beneficiary was receiving care in a nursing home.

Reducing Problems in Hospice Care. Hospice care provides comfort for terminally ill beneficiaries and supports family and other caregivers. OIG observed problems in hospice care including inadequate oversight of certification surveys and staff licensure requirements, care planning failures, inadequate medical and nursing care, and fraudulent enrollments undertaken without beneficiary consent and enrollment of beneficiaries who were not terminally ill. OIG found that some hospices billed Medicare for inappropriate general inpatient care (the second highest and most expensive level of hospice care), such as billing for care that was not provided and beneficiaries receiving care they did not need. Furthermore, OIG found that some hospice care plans lacked required information, and our review identified numerous instances of quality-of-care problems in the hospice general inpatient care setting.

Mitigating Risks to Individuals Receiving HCBS. HCBS, including personal care services (PCS), respite care, home-delivered meals, and many other services help beneficiaries stay in their communities and avoid costly and sometimes nonpreferred institutional care. PCS, a critical component of HCBS, encompass all HCBS populations, including people with mental disorders and physical, cognitive, or developmental disabilities. Without effective PCS, the goal of integrating beneficiaries into their communities may be unattainable. These programs help promote beneficiary choice and preferences, but vulnerabilities persist in the areas of payment, compliance, and quality. OIG and MFCUs have uncovered numerous instances of PCS fraud and abuse or neglect causing serious harm to HCBS recipients. Some beneficiaries may be unable to report the abuse and neglect. In some cases, a beneficiary's guardian may collude with an unscrupulous PCS attendant. In one such case, the parents of a teenage boy with disabilities accepted kickbacks from a PCS attendant who for many years billed Medicaid for thrice-weekly home visits but did not provide the boy with desperately needed services. PCS claims often do not identify the dates of service or the PCS attendant who provided the service, which creates additional challenges for effective oversight and enforcement.

OIG Focus Area: Protecting the Health and Safety of Children in HHS Programs

Protecting the health and safety of children receiving childcare through HHS programs is a top priority for OIG. Ensuring that Federal funds for these programs serve their intended purposes and are not mismanaged or stolen is also crucial. Specifically, OIG is prioritizing work that identifies ways in which HHS can improve program integrity for the Child Care Development Fund. We will focus on internal controls; program effectiveness; and prevention of fraud, waste, and abuse in this grant program. This initiative will include monitoring States' implementation of criminal background checks for childcare providers at least every 5 years.

Many Medicaid beneficiaries with developmental disabilities and older adults use group-home settings to continue living in their communities. However, reports of abuse and even death in such settings raise significant concerns. OIG has found that State agency and group-home staff lack adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect.

Ensuring Access to Safe and Appropriate Services for Children. In partnership with the States, HHS operates Medicaid and the Children's Health Insurance Program (CHIP) to provide medical care for nearly 36 million children, including children who are from financially needy families, reside in foster care, and have disabilities. The Child Care and Development Fund (CCDF) supports childcare for about 1.4 million children from low-income families while their guardians work or attend school. Ensuring that these beneficiaries enjoy access to safely delivered, high-quality services remains a longstanding challenge for HHS. OIG has identified vulnerabilities related to CCDF childcare providers who received neither a verified background check nor the necessary training.

Ensuring access to appropriate and high-quality care for children in foster care and those covered by Medicaid continues to be a challenge. OIG reviews revealed that many such children do not receive required medical or dental services. Further, OIG has raised quality-of-care concerns related to inappropriate prescribing of antipsychotic drugs for children in foster care and covered by Medicaid. Additionally, OIG found that three out of four children covered by Medicaid did not receive all required dental services, with one in four children failing to see a dentist at all.

The Department also faces challenges caring for children who enter the United States unaccompanied by a parent or guardian. The Office of Refugee Resettlement, within the Administration for Children and

Families (ACF), provides housing, medical care, and other services for unaccompanied alien children (UAC) and is responsible for placing many UAC with appropriate sponsors pending legal proceedings to resolve the UAC's immigration status.

Progress in Addressing the Challenge

HHS continues its efforts to improve the quality of nursing home, hospice, and HCBS programs, as well as services for especially vulnerable children.

Addressing Substandard Nursing Home Care. Through its Nursing Home Compare program and Five-Star Quality Rating System, HHS strives to provide residents and families accurate information about nursing home quality to enable informed care choices. Through the National Partnership to Improve Dementia Care in Nursing Homes and other initiatives, HHS continues efforts to reduce excessive use of antipsychotic drugs in nursing homes and has reported a 34 percent decrease in the use of these drugs among long-term nursing home residents since the program's inception. HHS reports progress developing the Skilled Nursing Facility Value-Based Purchasing Program, planned for launch in FY 2019, to better link payment to quality and achieve quality goals such as reducing preventable hospital admissions. HHS continues to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to promote better care for older adults and to prosecute providers that subject them to abuse or neglect.

When a False Claims Act settlement resolves allegations of poor, substandard, or worthless quality of care, OIG may impose obligations on the provider through a "quality of care" corporate integrity agreement (CIA), which requires providers to retain an independent monitor to perform clinical and quality reviews and assessments of the delivery of quality health care. OIG has entered into quality-of-care CIAs with more than 40 nursing home companies covering more than 1,000 facilities.

Reducing Problems in Hospice Care. HHS continues its efforts to help patients and families make informed hospice choices. In August 2017, it launched the Hospice Compare website to facilitate public access to hospice quality data. HHS also continues to undertake enforcement actions against hospice providers that fraudulently enroll Medicare beneficiaries.

Mitigating Risks to Patients Receiving HCBS. HHS continues to work with MFCUs and law enforcement partners to prevent, detect, and take enforcement action against fraudulent PCS providers. In July 2016, CMS issued guidance for PCS agencies and attendants on preventing improper payments. In August 2016, CMS issued an informational bulletin that discussed States' ability to implement basic training for home care workers in topics such as first aid and CPR certification. CMS also issued an informational bulletin summarizing program integrity vulnerabilities in Medicaid PCS and highlighting safeguards States can employ.

Ensuring Access to Safe and Appropriate Services for Children. In 2014, Congress reauthorized the Child Care and Development Block Grant (CCDBG) Act. The Act sets basic health and safety standards for CCDF-funded childcare and requires that staff undergo criminal background checks. These staff background checks are required as of September 30, 2017, unless the Secretary of Health and Human Services grants the State an extension. ACF is working with States to overcome various implementation challenges and operationalize the background check processes for childcare providers.

CMS is also working with States to reduce inappropriate prescribing of antipsychotic drugs for children in foster care and those covered by Medicaid and to improve access to dental care for children in

Medicaid. According to CMS, these efforts include providing technical assistance to support States in measuring, monitoring, and authorizing treatment of antipsychotic drug use in children. CMS is adding new measures related to antipsychotic drug use to the core set of children's health care quality measures for voluntary use by States. In addition, CMS reported that it engages with States that have lower reported rates of oral health services to collaborate with CMS, national oral health leaders, and other interested stakeholders through an effort called the Oral Health Initiative 2.0.

What Needs To Be Done

Addressing Substandard Nursing Home Care. OIG has recommended numerous strategies for HHS to strengthen its oversight of nursing homes and improve nursing home care. For example, HHS should monitor how often nursing home residents are hospitalized and develop additional resources to help providers avoid adverse events. In addition, HHS should improve internal controls and offer better guidance and training for surveyors to ensure that nursing homes with recorded quality and safety issues correct their deficiencies and prevent their recurrence.

Federal law requires that crimes, like abuse or neglect, against residents in federally funded nursing homes be reported to law enforcement and the Department. HHS should take the following steps to ensure that such incidents are identified and reported: (1) implement procedures to use claims for emergency room treatment of nursing home patients to identify potential abuse or neglect or other serious events, and (2) appropriately delegate and operationalize the authority to impose civil monetary penalties or exclusion from participation in Federal health care programs against individuals or entities that fail to fulfill their reporting obligations.

Reducing Problems in Hospice Care. CMS should improve hospice oversight by (1) increasing physician involvement in decisions regarding general inpatient care, (2) establishing additional remedies for poor-performing hospices, (3) educating providers and beneficiaries about hospice enrollment requirements, and (4) developing and disseminating model text for hospice election statements. HHS should also continue developing policies that effectively link payment to quality. In addition, CMS should monitor hospice providers and claims and refer suspected fraud to OIG, as appropriate.

Mitigating Risks to Patients Receiving HCBS. Ensuring high-quality HCBS and enabling beneficiaries to avoid or delay institutionalization relies heavily on appropriate PCS. OIG has recommended that HHS should (1) establish minimum Federal qualifications and screening standards for PCS workers, (2) require States to enroll or register all PCS attendants and assign them unique numbers, and (3) require that PCS claims identify the dates of service and the PCS attendant who provided the service. In addition to PCS, States and HCBS providers, including those that deliver services in group homes, must better protect beneficiaries from abuse and neglect and establish better training and more effective policies and procedures to ensure critical incidents are reported to relevant authorities as required. Specifically, States need access to relevant Medicaid data for injuries that require emergency room visits or hospital admissions in order to detect whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes. In addition, policies and procedures must be followed and results reported to State and Federal stakeholders to ensure accountability at the State and provider levels.

To assist States in developing and implementing better policies and procedures, OIG—in partnership with the Administration for Community Living and HHS Office for Civil Rights—is developing model practices for group homes. The model practices provide States with a roadmap for how to create a compliance oversight program that better protects the health and safety of individuals receiving HCBS in

group homes. The model practices focus on four critical compliance areas: (1) incident management and investigation, (2) mortality review, (3) quality assurance, and (4) auditing.

Ensuring Access to Safe and Appropriate Services for Children. ACF must fully implement its new authorities to ensure safer CCDF-funded childcare. ACF must ensure that States have the required health and safety policies and procedures in place to better protect children receiving CCDF services. HHS should also work to better ensure children's access to appropriate and high-quality Medicaid-covered medical and dental services. This includes ensuring the quality of the care provided to children receiving antipsychotic drugs.

Key OIG Resources

- OIG Report, *Early Alert: The Centers for Medicare and Medicaid Services Has Inadequate Procedures to Ensure that Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance with Applicable Requirements*, August 2017. (https://oig.hhs.gov/oas/reports/region1/11700504.pdf)
- OIG Report, *Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries*, February 2014. (http://oig.hhs.gov/oei/reports/oei-06-11-00370.asp)
- OIG Report, *Maine Did Not Comply with Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities*, August 2017. (https://oig.hhs.gov/oas/reports/region1/11600001.pdf)
- "Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services," October 2016. (https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf.)
- OIG Testimony, "Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program," May 2017. (https://oig.hhs.gov/testimony/docs/2017/grimm-testimony-05022017.pdf)
- OIG Report, Some Florida Family Childcare Homes Did Not Always Comply With State Health and Safety *Requirements*, March 2016. (https://oig.hhs.gov/oas/reports/region4/41408034.pdf)

Top Management Challenge #5: Ensuring Integrity in Managed Care and Other Programs Delivered Through Private Insurers

Why This Is a Challenge

Millions of enrollees in HHS programs receive health care coverage through private insurance companies and sponsors who contract with CMS or States to deliver benefits and services. In Medicare, approximately 18.6 million Medicare beneficiaries were enrolled in Medicare Advantage (MA) in 2016, more than a threefold increase since 2004, and 39 million beneficiaries received Part D (prescription drug) benefits through plans sponsored by private companies. The majority of Medicaid beneficiaries are enrolled in Medicaid MCOs. In addition, more than 10 million people received health insurance through private plans on health insurance marketplaces (marketplaces) in 2017.

Key Components of the Challenge

- Combating fraud, waste, and abuse by health care providers billing managed care plans
- Ensuring integrity and compliance by managed care and Part D sponsors
- Overseeing the health insurance marketplaces

HHS faces challenges in ensuring the integrity of these programs. Improper billing and fraud by health care providers is not limited to Medicare and Medicaid Fee-for-Service programs—MA organizations, Medicare Part D sponsors, and Medicaid MCOs also face these risks. An added challenge in combating health care fraud in these programs is the diffuse structure and responsibilities across HHS, private entities, and States. Further, HHS must oversee the MA organizations and Part D sponsors themselves to ensure that these entities are not inappropriately increasing the per capita payments they receive from Medicare and that they are providing beneficiaries with sufficient access to health care providers, services, and prescriptions as required. For Medicaid, HHS oversees the State's oversight of MCOs. Administering the marketplaces also requires extensive coordination among many Federal, State, and private entities.

Key Components of the Challenge

Combating Fraud, Waste, and Abuse by Health Care Providers Billing Managed Care Plans. Improper billing and fraud by health care providers is a concern. For example, CMS requires MA organizations and Part D sponsors to implement compliance plans that include measures to prevent, detect, and correct instances of fraud, waste, and abuse. However, these plans vary widely across sponsors, and so does detection of suspected fraud. For example, in 2012 several Part D sponsors reported no instances of potential fraud or abuse, while other sponsors reported identifying up to 13,000 instances of potential fraud. Furthermore, reporting this information to CMS is voluntary, and many sponsors choose not to report. Therefore, CMS lacks visibility into many MA organizations' and Part D sponsors' detection of suspected fraud and abuse incidents. In Medicaid managed care, program integrity responsibilities are even more dispersed, as they are shared among CMS, States, and MCOs, making effective oversight by HHS more complex and challenging.

Limitations in MA and Medicaid MCO encounter data (information about each service provided to beneficiaries) also hinder efficient and effective oversight to prevent fraud, waste, or abuse. OIG found that MA encounter data show promise for program oversight, but some improvements are needed. For example, CMS does not require MA organizations to include the identifiers of ordering or referring providers in their encounter data and requires identifiers for rendering providers only under certain circumstances. These provider identifiers are critical for using MA encounter data to identify patterns of

questionable billing and to pursue fraud investigations. OIG has also raised concerns about incomplete encounter data in Medicaid managed care. States have historically experienced difficulties collecting encounter data from MCOs. In 2011, OIG found that 19 of 38 States did not report some or all of their required MCO encounter data to CMS. *(For additional information on problems with national Medicaid data, see TMC #2.)*

Ensuring Integrity and Compliance by Managed Care and Part D Sponsors. HHS must be vigilant about risks posed to HHS funds and beneficiaries by the MA organizations, Part D sponsors, and Medicaid MCOs contracted to deliver health care services. These entities have incentives to maximize the capitated payments they receive from Medicare or Medicaid while minimizing their costs in providing health care services.[37] In 2016, CMS estimated a gross improper payment rate of $16 billion to MA organizations, the majority of which was attributable to unsupported diagnoses. Medicare pays higher capitated payments on behalf of sicker beneficiaries than for healthier beneficiaries. In May 2017, the Department of Justice filed a complaint against the largest MA organization alleging that it obtained inflated Medicare payments based on untruthful and inaccurate information about the health status of beneficiaries. In May 2017, an MA organization agreed to pay $32.5 million to resolve allegations related to inflated Medicare payments as well as allegations that the organization misrepresented the scope and content of its network of providers.

Ensuring that beneficiaries have sufficient access to health care providers through the provider networks of their respective MCOs is also a concern. In a study of Medicaid MCOs, OIG found that more than half of providers listed as participating in Medicaid MCOs were unable to offer appointments and more than a third were not at the location listed in the MCO's plan.

Likewise, protecting beneficiaries from inappropriate denials of services or prescriptions by private entities is also a challenge. Capitated payment models create incentives to keep health care costs low by providing fewer services or prescription drugs; in some cases, the services or drugs could be fewer than beneficiaries medically need. This presents risks to beneficiaries' health and misuses program dollars paid to those entities to provide needed health care. CMS audits have uncovered inappropriate denials of care or prescriptions by MA and Part D sponsors. These audits frequently cite entities for failing to explain to beneficiaries why they denied a request or how the beneficiary can appeal the denial.

***Overseeing the Health Insurance Marketplaces*.** The marketplaces involve complex regulatory, operational, and technological challenges for HHS. Among these are effective communication and coordination between and among internal and external parties with marketplace responsibilities, including within HHS and with contractors, issuers, and partners in State and Federal Government. As the program and its operations evolve, new oversight challenges may arise.

Sound oversight of the marketplaces needs to include the following key program integrity areas: (1) payments—ensuring that taxpayer funds are being expended correctly and for their intended purposes; (2) enrollment—making certain that the right people are getting the right benefits;

[37] For example, a Florida doctor was sentenced to 46 months in prison in 2016 for defrauding an MA organization by misdiagnosing patients to inflate payments. Combating fraud, waste, and abuse by providers in managed care differs from fee-for-service because CMS and managed care or Part D plan sponsors share responsibilities.

(3) management—ensuring that HHS administration of the program is efficient and effective; and (4) security—safeguarding consumers' personal information. OIG's work has identified management challenges and recommendations addressing these areas. These challenges include insufficient payment controls that could lead to wasteful spending; vulnerabilities in ensuring accurate eligibility determinations at the Federal and State-based marketplaces; and challenges for HHS management, including contract administration, contingency planning, and weaknesses in IT security controls.

Progress in Addressing Challenge

Combating Fraud, Waste, and Abuse by Health Care Providers Billing Managed Care Plans. CMS officials report that it is working to improve coordination, information sharing, and availability of reliable data to the Federal, State, and private entities with program integrity responsibilities. CMS has issued guidance on sharing information between CMS contractors and other program integrity stakeholders, such as State agencies, to more effectively coordinate efforts to identify and investigate fraud. CMS is also making progress in validating the completeness and accuracy of MA encounter data. Similarly, CMS continues to work with States to get complete, accurate, and timely Medicaid data. The agency issued a Medicaid managed care rule in 2016 giving States guidelines to work with MCOs on improving encounter data. CMS reports that it has also worked with States on T-MSIS to prioritize the need for complete and accurate encounter data. Further, the agency began requiring more consistent reporting of program integrity issues, such as recoupment of overpayments, from Medicaid MCOs. Finally, CMS issued requirements that MA providers enroll in Medicare through the same screening process as Medicare Fee-for-Service beginning January 1, 2019, which may help to prevent bad actors from entering the program.

Ensuring Integrity and Compliance by Managed Care and Part D Sponsors. CMS audits of MA organizations and Part D sponsors are an important program integrity tool. CMS has initiated dozens of audits to verify the accuracy of enrollee diagnoses (the basis for capitated payment increases or decreases) submitted by MA organizations. In addition, CMS conducts annual compliance audits of a subset of MA organizations and Part D sponsors, which include reviews of compliance program effectiveness and coverage determinations, appeals, and grievances.

CMS reports that it has made progress in reviewing Medicaid managed care rates to ensure that they are actuarially sound. These rates have been reviewed more closely since 2015, and CMS reports working with States to address issues identified in the course of these reviews.

CMS is also working to ensure that MA, Part D, and Medicaid beneficiaries have adequate access to health care providers through their plans. CMS requires State Medicaid agencies to develop and implement provisions that ensure beneficiaries have adequate access to Medicaid-covered services. State standards for provider networks are to be based on reasonable travel time and distance from enrollees' homes and provider sites, and States must monitor enrollees' access to care. CMS published a toolkit as a resource guide to assist State Medicaid staff with ensuring adequate provider networks and to highlight effective or promising practices to monitor beneficiaries' access to providers through their managed care plans. CMS has also developed a tool to help assess network adequacy in MA plans and has proposed expanding its reviews of whether beneficiaries in MA plans have sufficient access to providers.

Overseeing the Health Insurance Marketplaces. CMS has made some progress in addressing the internal controls and management challenges that OIG has identified in the marketplaces. For example, CMS has implemented an automated financial management system for the Federal Marketplace. CMS

has also improved its acquisition planning for Federal Marketplace contracts, and it has addressed some challenges in overseeing State-based marketplaces. This includes conducting annual open-enrollment readiness reviews of State-based marketplaces and creating a procedures manual for CMS employees to oversee and monitor the challenges specific to these marketplaces. CMS has developed an integrity program for the Federal Marketplace that addresses monitoring consumer complaints to identify potential fraud and abuse, conducting license verification on agents and brokers, and identifying areas of high risk that warrant further investigation and analysis.

What Needs To Be Done

Combating Fraud, Waste, and Abuse by Health Care Providers Billing Managed Care Plans. HHS should continue to partner with MA organizations, Part D sponsors, and State Medicaid agencies to ensure that payments for health care services are appropriate and to combat fraud by health care providers. This includes facilitating effective coordination and information sharing as well as maintaining accurate, complete, and timely national data to support effective oversight. For instance, CMS should require Part D sponsors and MA organizations to report on their identification of and response to potential fraud incidents. CMS should also require MA organizations to include identifiers for all ordering and referring providers and rendering providers in their encounter data to support fraud detection through data analytics.

Ensuring Integrity and Compliance by Managed Care and Part D Sponsors. CMS should continue to monitor MA organizations' and Part D sponsors' compliance with program requirements through audits and other oversight tools and take appropriate corrective and enforcement actions as needed. CMS should specifically focus on reducing and recouping overpayments resulting from MA organizations' misreporting of beneficiaries' diagnoses, which could save billions of dollars each year, and ensuring that MA plans and Part D plans are not inappropriately restricting beneficiary access to needed services, prescriptions, or providers.

Overseeing Health Insurance Marketplaces. CMS should continue to fix the internal controls and management deficiencies that OIG has identified, including working with States to address weaknesses in State marketplaces. In operating and overseeing the marketplaces, HHS should keep program integrity and sound management principles at the forefront.

Key OIG Resources

- OIG Report, *Access to Care: Provider Availability in Medicaid Managed Care*, December 2014. (https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf)
- OIG Report, *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, September 2013. (https://oig.hhs.gov/oei/reports/oei-05-12-00610.pdf)
- OIG Report, *MEDIC Benefit Integrity Activities in Medicare Parts C and D*, January 2013. (https://oig.hhs.gov/oei/reports/oei-03-11-00310.pdf)
- OIG Testimony, "Fraud, Waste, and Abuse Under the Affordable Care Act," January 2017. (https://oig.hhs.gov/testimony/docs/2017/robinson-testimony01312017.pdf)
- Inventory of OIG Reports on Health Insurance Marketplaces, 2013 to Present. (https://www.oig.hhs.gov/reports-and-publications/aca/)

Top Management Challenge #6: Improving Financial and Administrative Management and Reducing Improper Payments

Why This Is a Challenge

HHS is the largest civilian agency within the Federal Government. In FY 2016, HHS reported total budgetary resources of approximately $1.1 trillion. Responsible stewardship of HHS programs is vital, and operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and provide oversight for the protection of resources remains a challenge for HHS. HHS must also ensure the completeness, accuracy, and timeliness of any financial and program information provided to other entities, both internal and external to the Federal Government.

Key Components of the Challenge

- Addressing weaknesses in financial management systems
- Addressing Medicare trust fund issues/social insurance
- Reducing improper payments
- Addressing concerns about contracts management
- Implementing the Digital Accountability and Transparency (DATA) Act

Key Components of the Challenge

Addressing Weaknesses in Financial Management Systems. OIG continues to report a material weakness in HHS's financial management systems related to inadequate internal controls over segregation of duties in employees' job responsibilities, configuration management for approved changes to HHS financial systems, and access to HHS financial systems. OIG continues to report that HHS does not substantially comply with requirements for financial system management because of these issues. Under the Federal Financial Management Improvement Act of 1996, Federal agencies must establish and maintain financial management systems and OIGs must report on compliance by their respective agency. These systems are intended to help agencies ensure the effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations.

Addressing Medicare Trust Fund Issues/Social Insurance. The Statement of Social Insurance (SOSI) presents the actuarial present value of (1) contributions and tax income (excluding interest income), (2) scheduled expenditures, and (3) the difference between the two for all current and future participants (open group) of the Medicare program for the projection period, which covers 75 years. The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the beginning and ending open group measures and presents the components of the changes for 2 years. These statements cover the Medicare Fee-for-Service, Medicare Advantage, and Medicare Prescription Drug Benefit programs, and the amounts they disclose are based on current law. The actuarial opinion expressed in the 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds states:

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by the Medicare fee-for-service program for most health services will fall increasingly short of the costs of providing those services. The Trustees assume that the various cost-reduction measures will occur as current law requires. To achieve this outcome, healthcare providers would have to realize productivity adjustments at a faster rate than experienced historically. As a result, the Medicare Board of Trustees have included in the Annual report to Congress an alternative scenario to illustrate, where possible, the potential understatement of Medicare costs and projection results. Since 2010, OIG has

noted the inherent difficulties in projecting growth in health care costs over time and issued a disclaimer of opinion on the SOSI & SCSIA based on these uncertainties.

Reducing Improper Payments. Reducing improper payments is a critical element in protecting the financial integrity of HHS programs. Although not all improper payments constitute fraud, all improper payments pose a risk to the financial security of Federal programs. Pursuant to the Improper Payments Information Act of 2002 (IPIA), as amended, Federal agencies are required to provide uniform, annual reporting on improper payments and their efforts to reduce them. In the FY 2016 Agency Financial Report (AFR), HHS reported improper payments of nearly $100 billion for seven of the eight programs designated high risk and susceptible to improper payments. Our audit of HHS's FY 2016 AFR, published in May 2017, found that HHS did not meet all IPIA requirements. Specifically, OIG found that HHS did not report an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program, as HHS does not believe it has the statutory authority to collect from States the data necessary for calculating such a rate.

HHS has reported that the improper payment rate exceeded 10 percent for both Medicare Fee-for-Service and Medicaid. In addition, three other programs that the Office of Management and Budget (OMB) has deemed susceptible to risk of improper payments (Medicare Advantage, CHIP, and foster care programs) did not meet their FY 2016 target error rates. *(See TMC #1 for a discussion of reducing Medicare improper payments and TMC #2 for a discussion of reducing Medicaid improper payments.)*

Addressing Concerns About Contracts Management. HHS is one of the largest contracting agencies in the Federal Government. Given the high dollar amount and complexity of its contracts, it is paramount that HHS have strong monitoring and oversight. OIG has raised issues about acquisition planning and procurement, contract monitoring, and payments to contractors related to the Federal Marketplaces operated by CMS. OIG has also identified issues regarding contract closeouts. OIG found that CMS had not closed out contracts totaling $25 billion as required by the Federal Acquisition Regulation (FAR). Because the closeout process is typically the final opportunity for improper payments to be detected and recovered, delays in the closeout process pose a substantial financial risk. Additionally, OIG has identified weaknesses in CMS's oversight and performance measurement for benefit integrity contractors.

Implementing the DATA Act. The DATA Act required OMB and the Department of the Treasury to establish Government-wide data standards for reporting financial and payment information by May 2015. Broadly, the DATA Act required that HHS begin using the Government-wide data standards to enter information into USASpending.gov by May 2017 in an effort to ultimately increase transparency and accountability. OIG's readiness review of HHS's implementation of the DATA Act as of June 30, 2016, found that although HHS made progress, it had not fully met the requirements of the four initial steps of Treasury's Agency 8-Step Plan. Specifically, we found that HHS did not complete detailed project plans or determine how it will certify that the data are accurate and complete. Given the difficulty of defining and developing common data elements across multiple reporting areas and the volume of diverse programs administered by HHS, OIG determined that HHS will face challenges implementing these uniform data standards and submitting information into USASpending.gov within the required timeframe.

Progress in Addressing the Challenge

Addressing Weaknesses in Financial Management Systems. HHS has taken corrective actions to resolve the IT-related deficiencies reported in the AFR. In FY 2016, senior leadership continued to take a role in monitoring activities across all HHS IT systems. OIG noted improvements in key financial systems as a result of investments in the underlying IT infrastructure, remediation of risk over key financial systems, and the strengthening of the HHS process to develop corrective action plans, which led to the remediation of a number of prior audit findings.

Addressing Medicare Trust Fund Issues/Social Insurance. In FY 2016, HHS continued to present an illustrative alternate scenario to the current legal projections for Medicare in the footnote disclosures of the AFR to illustrate the potential magnitude on Medicare outlays if certain components of current law are not sustainable. According to the Medicare Chief Actuary, the techniques and methodology used to evaluate the financial status of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund are based on sound principles of actuarial practice. With certain caveats, the principal assumptions used and the resulting actuarial estimates are individually and in the aggregate reasonable for the purpose of evaluating the financial status of the trust funds. At this time, OIG is not aware of any projects before the Federal Accounting Standards Advisory Board to revise existing guidance related to SOSI. OIG continues to expect to issue a disclaimer of opinion on the SOSI and SCSIA until the variances between income and expenditures between current law and the illustrative alternative scenario become much less significant.

Reducing Improper Payments. In its FY 2016 AFR, HHS reported a series of actions, including working with States to analyze Single Audit material noncompliance findings and performing a detailed risk assessment of the TANF program to assist States in reducing improper payments for TANF. HHS has also stated that it recognizes the need for continual and focused effort to prevent, detect, and reduce improper payments in HHS programs. For the Medicare Fee-for-Service program, CMS continued with existing efforts to analyze and address areas of highest risk. CMS built on the Healthcare Fraud Prevention Partnership, worked with its Medicare contractors to develop medical review strategies, leveraged multiple efforts to increase provider education, clarified existing policy, and analyzed the results of the Fraud Prevention System. For Medicaid, CMS worked with the States to develop State-specific corrective action plans. CMS also shared Medicare data to assist States with meeting Medicaid screening and enrollment requirements and provided ongoing guidance, education, and outreach. CMS also offered training, technical assistance, and additional support for the States' Medicaid program integrity.

Addressing Concerns About Contracts Management. In November 2015, HHS published a final rule that updated the HHS Acquisition Regulation (HHSAR) to supplement the FAR. The HHSAR provides additional policy and procedural guidance to foster financial integrity and accountability across the acquisition lifecycle, from the concept of need through contract closeout. CMS has prioritized closing out contracts. In October 2014, CMS reported establishing a contract closeout goal of 2,250 contracts per year. Since 2013, CMS officials reported they closed out a total of 9,740 contracts, resulting in de-obligations of more than $209 million that were returned to the Department of the Treasury. CMS continues to meet this goal and closed out 2,831 contracts in FY 2016 and 4,109 contracts in FY 2017.

Implementing the DATA Act. HHS believes that the actions it has taken enabled it to meet the May 2017 due date for implementing the Government-wide data standards and submitting data in accordance with these standards into USASpending.gov. HHS established a DATA Act Project Management Office (PMO) within the Office of the Assistant Secretary for Financial Resources. The

PMO included representatives from all of HHS's Operating Divisions. The PMO has also been appointed by OMB's Office of Federal Financial Management (OFFM) as the executing agent of the financial assistance portion of the pilot required by Section V of the DATA Act. OFFM maintains strategic oversight for the pilot, while HHS is tasked with providing tactical leadership and establishing a pilot program to inform Congress of recommendations on methods to standardize reporting elements across the Federal Government, eliminate unnecessary duplication in financial reporting, and reduce compliance costs for recipients of financial awards.

What Needs To Be Done

Addressing Weaknesses in Financial Management Systems. HHS should continue to address and resolve financial management system weaknesses identified by OIG, the Government Accountability Office, and other auditors contracted by OIG or HHS.

Addressing Medicare Trust Fund Issues/Social Insurance. HHS should continue to work with the Medicare Chief Actuary to lessen the variances of income and expenses reported on the SOSI and SCSIA between current law and the illustrative alternate scenario.

Reducing Improper Payments. HHS must also continue to pursue needed legislative remedies to develop and report an improper payment estimate for TANF. In addition, HHS must meet improper payments reduction targets and reduce improper payments to less than 10 percent for all programs.

Addressing Concerns About Contracts Management. CMS should improve coordination and collaboration across departmental staff with contract closeout responsibilities. CMS must also ensure that required acquisition strategies are completed. Further, CMS must strengthen its contracts oversight and performance measurement for benefit integrity contractors.

Implementing the DATA Act. HHS must ensure it has project plans that specifically detail how it implemented the Government data standards. HHS must also ensure the items entered into USASpending.gov under these standards are accurate and complete.

Key OIG Resources

- OIG Report, *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2015*, May 2016. (https://oig.hhs.gov/oas/reports/region1/171652000.pdf)
- OIG Report on Financial Statement Audit of Health and Human Services for Fiscal Year 2016, November 2016. (https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html)
- OIG Report, *CMS Has Not Performed Required Closeouts of Contracts Worth Billions*, December 2015. (https://oig.hhs.gov/oei/reports/oei-03-12-00680.pdf)
- OIG Report, *CMS Did Not Identify All Federal Marketplace Contract Costs and Did Not Properly Validate the Amount to Withhold for Defect Resolution on the Principal Federal Marketplace Contract*, September 2015. (https://oig.hhs.gov/oas/reports/region3/31403002.pdf)
- OIG Report, *Report of Findings and Recommendations for HHS's DATA Act Implementation*, June 30, 2016. (https://oig.hhs.gov/oas/reports/region17/171602018.pdf)

Top Management Challenge #7: Protecting the Integrity of Public Health and Human Services Grants

Why This Is a Challenge

Key Components of the Challenge

- Ensuring effective grants management within the Department
- Ensuring program integrity and financial capability at the grantee level

In FY 2016, HHS awarded more grants than any other Federal entity—more than $100 billion in grants, excluding Medicaid. *(For information on challenges related to Medicaid, see TMCs #2 and #5.)* Recent legislation expands HHS's reach and increases expenditures through new grant programs. In passing the 21st Century Cures Act, Congress authorized (and subsequently appropriated) billions of dollars in new Federal spending to address national public health needs. This included $1.8 billion for cancer prevention, diagnosis, and treatment; $1.5 billion for neurological research; $1.4 billion for the Precision Medicine Initiative;[38] and $1 billion in grants to States for opioid prevention and treatment. The Act also authorized funds for smaller grants to address other public health needs. For example, it authorized $200 million over 4 years for grants for mental and behavioral health education training.

Given the increased use of grant programs to address public health needs and crises—such as the opioid epidemic and emergency preparedness and relief efforts—it is crucial to safeguard these funds so they are used efficiently, effectively, and for their intended purposes. All grant programs are susceptible to fraud, waste, and abuse, and the challenges of mitigating these risks may be heightened in public health crisis situations.

The continued growth of Federal funding to State and local governments, including block grants for health and social programs, also creates challenges for HHS in verifying that appropriate controls are present and that reporting requirements are met. HHS plays a critical role in ensuring the integrity of public health and human services programs by maintaining transparency and accountability for Federal funds. Responsible stewardship of these funds while maintaining the desired flexibility is vital to public health and well-being as well as responsible use of tax dollars.

Key Components of the Challenge

Ensuring Effective Grants Management Within the Department. Because HHS awards funds to such a diverse variety of non-Federal entities, it faces a number of challenges to ensure proper administration and program integrity of its grants. Challenges include providing an infrastructure to best oversee grants across HHS, conducting effective antifraud activities, and overseeing States' compliance with reported activities in their State plans. HHS maintains multiple grant-awarding systems that do not interface. As a result, HHS lacks the ability to readily capture a grantee's performance and financial activities related to multiple HHS grant awards. OIG has found that the existing grants management and varying grant-oversight processes within each grant-awarding agency hinder HHS's ability to effectively oversee grantees during all aspects of the grants cycle. For example, HHS lacks a systematic method to share among its awarding agencies grantee information such as problematic grantees, risks posed by new grantees, and adverse information from audits of grantees. Further, while HHS maintains the

[38] The Precision Medicine Initiative is an emerging approach for disease prevention and treatment that takes into account people's individual variations in genes, environment, and lifestyle.

Tracking Accountability in Government Grants System that awarding agencies can use to identify grantees they have in common, the system does not contain a detailed description of a grant award that might enable avoiding potential duplication and overlap of Federal funding from multiple HHS grants. OIG also found that because each HHS awarding agency uses different systems to manage their Federal grants, unintended consequences may result, such as increased administrative burden and costs and a hampered ability for HHS to effectively integrate program integrity into all aspects of its grants management activities.

HHS faces heightened challenges in overseeing grants in areas recovering from natural disasters. OIG has experience in reviewing grant oversight with the work we performed following Superstorm Sandy. For example, OIG found that after Superstorm Sandy guidance from ACF limited the effectiveness of State planning and hindered the use of funds for relief efforts. Improving ACF's guidance could enhance the response to future disasters.

Ensuring Program Integrity and Financial Capability at the Grantee Level. A common problem uncovered by our reviews of HHS grantees is a lack of accountability for Federal funds. This is often caused by inadequate financial management systems and internal controls. When these weaknesses are exploited, financial stewardship of these funds is greatly diminished or absent. Without sufficient internal controls, grants are vulnerable to financial mismanagement and fraud schemes, including embezzlement. As an example, a recent investigation found that a former chief executive officer of a HRSA grantee engaged in a fraudulent scheme to embezzle approximately $17 million in Federal funds. The intended purpose of the grant was to provide quality health care for the homeless and low-income individuals. Instead, the funds were diverted to the individual's multiple corporations for personal use. The individual was convicted on 98 counts of fraud, including conspiracy, wire fraud, bank fraud, and money laundering, and sentenced to 18 years in Federal prison. In another example, we found that a grantee unlawfully spent nearly $8 million in Head Start funds without maintaining its required enrollment level. Not only did the grantee not fulfill its program-enrollment obligations, it also misused an additional $2 million of Head Start funds. The grantee did not monitor its partner agencies' operations to ensure that children at the partners' facilities in fact received Head Start services.

Weak program integrity and internal controls may also result in nonmonetary vulnerabilities. For example, audits of State agency oversight of childcare providers funded by the CCDF program highlighted the need to strengthen compliance with requirements for background screenings of individuals caring for children. We also found that States receiving CCDF grants sometimes failed to perform important program integrity and antifraud activities, such as reviewing provider records for potential fraud, identifying potential duplicate payments, performing verification checks (such as verifying addresses) of childcare providers, and conducting onsite visits.

Progress in Addressing the Challenge

HHS has worked to strengthen some program integrity efforts. To facilitate better information sharing about grantees, guidance has been issued to HHS awarding agencies that facilitates a review of prospective grantees prior to awarding grants. This information enhances HHS's assessment of prospective grant recipients' integrity and potential performance.

In addition, information provided via the Federal Awardee Performance and Integrity Information System (FAPIIS) database will improve HHS's access to information pertaining to entities applying for or receiving Federal funds. FAPIIS tracks contractor misconduct and performance by including information

on contractor criminal, civil, and administrative proceedings in connection with Federal awards, suspensions and debarments, contracts terminated for fault, and past performance evaluations.

Further, HHS awarding agencies have begun to reach out to OIG regarding allegations of fraud. For example, HRSA officials referred allegations to OIG that resulted in significant criminal convictions and recoveries on behalf of HRSA's grant program and shut down a fraud scheme in which Federal funds were being stolen and diverted for personal use.

To combat fraud, waste, and abuse in its grant programs, HHS continues to pursue suspension and debarment actions (in addition to other administrative remedies). In addition, HHS has collaborated with OIG in presenting training on suspension and debarment and training for employees of HHS and Tribal facilities on how to identify and report potential fraud, waste, and abuse.

What Needs To Be Done

Effective grants administration depends on strengthening the use of data and technology to allow HHS to assess risk prior to making grants and to track grantee compliance and performance after an award. Specifically, HHS should develop interoperable grants management systems to share information across grant programs. HHS should also continue to work with States and other grantees to assess and strengthen their program integrity and fraud-fighting activities. When the Department identifies mismanagement, waste, or abuse, it must continue to pursue appropriate administrative remedies, such as suspension and debarment, as well as continue to refer suspected fraud to OIG. To fight fraud, OIG will continue to use all of our enforcement remedies, including a new enforcement tool authorized by the 21st Century Cures Act that empowers OIG to impose civil monetary penalties for fraudulent conduct in HHS grants, contracts, or other agreements.

Key OIG Resources

- OIG Report, *Newark Preschool Council, Inc., Did Not Always Comply With Head Start Requirements*, February 2017. (https://oig.hhs.gov/oas/reports/region2/21402024.asp)
- OIG Report, *HHS Oversight of Grantees Could Be Improved Through Better Information Sharing*, September 2015. (https://oig.hhs.gov/oei/reports/oei-07-12-00110.asp)
- OIG Report, *More Effort Is Needed to Protect the Integrity of the Child Care and Development Fund Block Grant Program*, July 2016. (https://oig.hhs.gov/oei/reports/oei-03-16-00150.pdf)
- OIG Report, *Cleveland Clinic Lerner College of Medicine Inappropriately Drew Down Hurricane Sandy Disaster Relief Act Funds and Did Not Always Implement Effective Internal Controls,* March 2017. (https://oig.hhs.gov/oas/reports/region2/21502011.asp)
- OIG Report, *Superstorm Sandy Block Grants: Funds Benefited States' Reconstruction and Social Service Efforts, Though ACF's Guidance Could Be Improved*, September 2016. (https://oig.hhs.gov/oei/reports/oei-09-15-00200.asp)

Top Management Challenge #8: Ensuring the Safety of Food, Drugs, and Medical Devices

Why This Is a Challenge

The FDA has a broad statutory mandate, and its responsibilities continue to grow. FDA protects the public health by ensuring the safety, efficacy, quality, and security of human and veterinary drugs, biological products, and medical devices, and by ensuring the safety of our Nation's food supply, cosmetics, and electronic products that emit radiation. FDA also regulates the manufacture, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors.[39] FDA regulates products accounting for approximately 20 percent of all U.S. consumer spending. FDA has the continuing challenge of ensuring the safety and security of our Nation's foods and medical products (including drugs, biological products, and medical devices), which directly affect the health of every American. The expansion of FDA's authorities through legislation, including the 21st Century Cures Act in 2016, the Drug Quality and Security Act in 2013, and the Food Safety Modernization Act in 2010, add to the agency's mandate to protect the public health.

Key Components of the Challenge

- Ensuring food safety
- Ensuring the safety, efficacy, and quality of medical products
- Overseeing the complex drug and medical device supply chain

Key Components of the Challenge

Ensuring Food Safety. Each year roughly 48 million people get sick from a foodborne illness, 128,000 are hospitalized, and 3,000 die.[40] FDA is responsible for ensuring the safety of almost all food products sold in the United States, with the exception of catfish, meat, poultry, and some egg products, which are regulated by the U.S. Department of Agriculture. Oversight is complicated by the immense diversity of the global food supply: 20 percent of vegetables consumed in the United States come from abroad, as does 50 percent of fresh fruit and more than 80 percent of seafood.[41]

FDA inspects food facilities to ensure food safety and compliance with regulations and may use various administrative tools and enforcement authorities as necessary to protect the public from unsafe or potentially unsafe food. However, OIG has consistently found that FDA does not always take action after it discovers significant inspection violations at food facilities. Additionally, OIG has found that FDA's actions are not always timely nor do they always result in the correction of these violations. For example, in 2016 OIG issued an Early Alert based on a review of a judgmental sample of 30 food recalls with a preliminary finding that FDA lacked an efficient and effective process to ensure that firms initiate prompt, voluntary food recalls.

Ensuring the Safety, Efficacy, and Quality of Medical Products. FDA's responsibility to ensure safe, effective, and quality medical products begins long before a product is brought to market and continues after FDA approval. FDA oversees more than 13,000 drug facilities and 25,000 medical device facilities.

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[39] See https://www.fda.gov/aboutfda/whatwedo/

[40] Centers for Disease Control and Prevention, Food Safety, "Foodborne Germs and Illnesses." Available at https://www.cdc.gov/foodsafety/foodborne-germs.html

[41] U.S. Food and Drug Administration, Global Engagement. Available at https://www.fda.gov/downloads/aboutfda/reportsmanualsforms/reports/ucm298578.pdf

FDA is also responsible for authorizing the use of investigational medical products as well as ensuring the safety and efficacy of all prescription medical products before marketing in the United States. In 2016, FDA approved 22 novel drugs, 73 first-time generic drugs, and 91 novel medical devices. FDA also oversees compounded drugs, which are not subject to FDA's premarket approval process, and continues to identify issues with the development of compounded products.

FDA must also ensure that medical products remain safe and of acceptable quality once on the market. In 2016, OIG released a report concerning FDA's oversight of drug sponsors' compliance with postmarketing requirements. Some drug sponsors may be required to carry out postmarketing studies or clinical trials to assess known or potential serious risk. OIG found that most sponsors are completing their studies according to schedule, although some studies were delayed at the time of our study. OIG recommended that FDA address limitations in its data management system that can hinder FDA's ability to track studies.

Overseeing the Complex Drug and Medical Device Supply Chain. The drug and medical device supply chain is growing increasingly complex, not only domestically but globally. Intricate global supply chains present FDA with many challenges as medical products move through the supply chain and are at risk of diversion, theft, counterfeiting, and adulteration. To enhance the security of the drug supply chain, the Drug Supply Chain Security Act (DSCSA) requires trading partners in the drug supply chain to exchange certain information with each other in each drug product transaction and to identify and investigate suspect and illegitimate drug products.[42] FDA can then use such tracing and investigational information to further investigate suspect and illegitimate drug products and potential diversion. In 2017, OIG found that selected wholesalers were exchanging drug product tracing information and that about half of them—including the three largest wholesalers that account for more than 80 percent of drug distribution revenues—exchange all information required under the DSCSA. However, some wholesalers were missing a few of the required tracing information elements.

Progress in Addressing the Challenge

Ensuring Food Safety. In response to OIG's June 2016 Early Alert on FDA's food-recall initiation process, FDA announced the establishment of the Strategic Coordinated Oversight of Recall Execution, a team of FDA senior leaders that examines cases that present a significant hazard to human health and makes decisions during the most challenging high-risk food-recall cases. FDA also designed and implemented a plan to audit and monitor FDA's recall program across all regulated product areas. Lastly, FDA implemented a strategic plan to identify priorities that optimize FDA's policies and procedures for recall of FDA-regulated products that pose a public health risk.

In 2017, FDA also implemented many longstanding OIG recommendations targeted at ensuring that structure and function claims made by dietary supplements are truthful and not misleading. FDA educated the dietary supplement industry about registration and labeling and improved the accuracy of the information in the dietary supplement registry by publishing updates to three guidance documents and developing additional resources. FDA improved its notification system for dietary supplement structure/function claims by developing an e-portal system that allows for an organized, complete, and accurate accounting of health benefit claims. FDA also expanded its market surveillance of dietary supplements to enforce the use of disclaimers.

[42] Drug Quality and Security Act, P.L. No.113-54, Title II.

Ensuring the Safety, Efficacy, and Quality of Medical Products. In response to recommendations OIG made related to postmarketing requirements for drug sponsors, FDA followed up with sponsors to ensure they are carrying out these requirements. Through this followup, FDA enhances public safety and quality of care as well as compliance and accountability.

Overseeing the Complex Drug and Medical Device Supply Chain. FDA continually engages in efforts to enhance drug and device traceability. For example, FDA published guidance that outlines general parameters for the interoperable exchange of drug product tracing information, issued revised guidance on product tracing requirements for dispensers, and issued draft guidance on identifying trading partners pursuant to requirements of the DSCSA.

FDA also continues to implement the unique device identification (UDI) system for medical devices. FDA's UDI system for medical devices should facilitate better detection of adverse events, improve product recalls, and enable robust postmarket surveillance.[43] In 2013, FDA promulgated a final rule establishing a UDI system designed to adequately identify medical devices through distribution and use.[44] In 2016, FDA supported capturing certain UDI information on Medicare claim forms to help identify safety concerns with medical devices.

What Needs To Be Done

Ensuring Food Safety. FDA must ensure the safety of the Nation's food supply by continuing to monitor food facilities and effectively using its administrative and enforcement tools. FDA must establish timeframes to discuss with a firm the possibility of a voluntary recall of its violative products. In addition, FDA must finalize its mandatory recall procedures and agency guidance to include the factors that staff should consider when determining whether there is a reasonable probability that a food could cause serious adverse health consequence or death.

Ensuring the Safety, Efficacy, and Quality of Medical Products. In addition to continuing its implementation of DSCSA, FDA must also implement the 21st Century Cures Act, which requires FDA to, among other things, establish new programs to accelerate innovation and increase access to medical products, increase patient involvement in the research and medical product development process, and operationalize its new hiring authority for scientific staff. FDA must also continue its commitment to improving both its postmarket reporting processes and its technical oversight capacity.

Overseeing the Complex Drug and Medical Device Supply Chain. FDA must continue to implement requirements of the DSCSA to enhance drug and device traceability. To ensure that all trading partners comply with this law, OIG recommends that FDA offer technical assistance where appropriate.

Key OIG Resources

- OIG Report, *Challenges Remain in FDA's Inspections of Domestic Food Facilities*, September 2017. (https://oig.hhs.gov/oei/reports/oei-02-14-00420.pdf)
- OIG Report, *Early Alert: The Food and Drug Administration Does Not Have an Efficient and Effective Food Recall Initiation Process*, June 2016. (http://oig.hhs.gov/oas/reports/region1/11501500.asp)

[43] Food and Drug Administration Amendments Act of 2007, P.L. No. 110-85 (enacted Sept. 27, 2007).
[44] 78 Fed. Reg. 58786 (Sept. 24, 2013) and 21 CFR part 803.

- OIG Report, *FDA Is Issuing More Postmarketing Requirements, but Challenges With Oversight Persist*, July 2016. (https://oig.hhs.gov/oei/reports/oei-01-14-00390.asp)
- OIG Report, *Drug Supply Chain Security: Wholesalers Exchange Most Tracing Information*, August 2017. (https://oig.hhs.gov/oei/reports/oei-05-14-00640.pdf)

Top Management Challenge #9: Ensuring Program Integrity and Quality in Programs Serving American Indian and Alaska Native Populations

Why This Is a Challenge

In FY 2016, HHS administered 45 percent of all Federal funds that serve American Indian and Alaska Native (AI/AN) communities—a total of $7 billion. A number of HHS agencies administer programs for AI/ANs throughout the United States. With an annual budget of approximately $6 billion, the Indian Health Service (IHS) is the largest of these programs and, in partnership with Tribes, provides or funds health care to approximately 2.2 million AI/ANs who are members of the 567 federally recognized Tribes located in 36 States served by 662 health care facilities. Other HHS agencies provide grants to Tribes for human services programs, ranging from Head Start to the Low Income Home Energy Assistance Program (LIHEAP). HHS faces significant challenges to ensuring effective delivery of crucial services to AI/ANs and protecting funds from fraud, waste, and abuse.

Key Components of the Challenge

- Improving IHS quality of care, management, and infrastructure
- Combating fraud and misuse of funds
- Ensuring adequate internal controls and staff training for HHS grant programs in Indian Country

Key Components of the Challenge

Improving IHS Quality of Care, Management, and Infrastructure. AI/ANs often face health disparities in comparison to the national population. For example, the infant mortality rate for AI/ANs is about 25 percent higher than the national rate, and AI/ANs are almost twice as likely as the overall population to have diabetes. Additionally, AI/ANs have disproportionately high rates of suicide and death from unintentional injuries. IHS operates health care facilities to help meet these needs, including 26 Federal acute-care hospitals, many of which are in remote locations. However, some IHS hospitals face longstanding challenges that affect their ability to provide quality care and comply with Medicare standards. These challenges include recruiting and retaining essential staff, ensuring access to needed care and training resources, maintaining the clinical proficiency of professional staff serving a diverse caseload, and maintaining and upgrading outdated buildings and equipment. Further, OIG has found that IHS has few systematic sources of information on its hospitals' performance and a limited capacity to provide clinical support. As a result, IHS may be missing opportunities to improve the quality of care at its hospitals. In addition, we found that IHS monitors hospitals through its Area Offices, which have varying access to information about the quality of care and degree of oversight at hospitals. Shortages of staffing and funding at Area Offices also limit the clinical support and guidance they can provide. Hospitals with limited resources struggle to implement IT improvements and update EHR systems. In addition, IHS faces challenges in combating the opioid abuse epidemic. *(For more information about curbing the opioid epidemic, see TMC #3.)*

Combating Fraud and Misuse of Funds. OIG has identified instances of fraud that put Federal funds and AI/AN communities at risk. OIG investigations have revealed that some Tribes and Tribal organizations have not adequately protected funds provided under the Indian Self-Determination and Education Assistance Act (ISDEAA). (ISDEAA provides Tribes with the option to assume IHS program funds to administer programs, services, functions, and activities themselves rather than having them be administered by IHS.) In some cases, the funds were misappropriated or misused by individuals. In the most egregious cases, funds had been converted to personal use, leaving the Tribes with dangerous shortages in health care funding for their members.

In the resolution to one alarming case of fraud, in 2017 a business owner in Montana was sentenced in Federal court to 2 years in prison for multiple criminal offenses related to HHS and IHS programs. The business owner was convicted of conspiracy, wire fraud, and bribery, all of which were associated with "pay to play" kickback schemes related to HHS and other Federal programs on a Montana Indian reservation. The business owner was ordered to pay $4.58 million in criminal restitution and fines.

OIG investigations have also found that some IHS pharmacies are particularly vulnerable to fraud and abuse related to controlled substances, including diversion and trafficking by employees, contract providers, and patients. For example, in 2016 one IHS employee in Montana was sentenced to 3 years of Federal probation after admitting to stealing controlled substances from two IHS pharmacies as well as tampering with a consumer product by replacing the controlled substance the employee had stolen with tablets containing other substances.

In addition, OIG has pursued cases against Tribes and Tribal organizations for submitting false claims and violating the civil monetary penalties law. For example, in 2017 a Washington State Tribe entered into a settlement to resolve allegations that it had submitted false claims to Medicaid for mental health counseling services that the Tribe's behavioral health unit did not actually provide.

Ensuring Adequate Internal Controls and Staff Training for HHS Grant Programs in Indian Country. Insufficient internal controls and inadequate staff training create vulnerabilities for agencies, grantees, and beneficiaries. OIG has uncovered insufficient internal controls, lack of documentation relating to employee misconduct, and prohibited personnel practices, including the hiring of excluded individuals to provide items or services to Federal program beneficiaries. For example, we found that of the $5.7 million in LIHEAP grant funds that the ACF awarded to one North Dakota Tribal organization for Federal FYs 2010 through 2014, $1.2 million was not administered by the Tribal organization in compliance with Federal laws, regulations, and guidance. The errors occurred because the Tribal organization did not have sufficient internal controls in place to prevent the errors and because their staff circumvented existing internal controls. These funds could have been used to provide additional benefits to eligible LIHEAP beneficiaries. *(For more information about protecting the integrity of public health and human services grants, see TMC #7.)*

Progress in Addressing the Challenge

Improving IHS Quality of Care, Management, and Infrastructure. IHS recently reported to OIG a broad range of efforts toward improvement. IHS noted that it revised leadership and staffing for implementing its new Quality Framework and Office of Quality, with the goal of tracking compliance and quality efforts through a new accountability dashboard under development. IHS has awarded a national hospital accreditation contract and is developing a formal governance structure within the IHS Director's office to oversee compliance throughout the agency. With regard to internal oversight, IHS has made strides in establishing standards and expectations for how Area Offices and governing boards oversee and monitor hospitals and monitor adherence to those standards. The agency now requires a standardized governance process for use by IHS hospital governing boards. In addition, IHS has finalized agency-wide standards for patient wait times and is developing plans for system-wide monitoring by the end of 2017. In addition, IHS has increased its focus on addressing the opioid epidemic, including carrying out activities related to the following priorities: provide treatment and recovery services, promote broader use of overdose reversal drugs, monitor opioid prescribing data, and support appropriate pain management.

IHS is also providing opportunities for leadership training internally and through coordination with the Partnership to Advance Tribal Health, the Quality Improvement Organization (QIO) for IHS. Additionally, IHS awarded a contract for a national provider credentialing system in 2017 and is updating its credentialing policy to reflect current standards and use of the new system. IHS also implemented a global recruitment strategy that allows applications to be considered for multiple locations. IHS is coordinating with CMS to implement the IHS and CMS Quality Improvement Network, QIO, and Hospital Engagement Network programs. Further, IHS has begun planning for an agency-wide needs assessment for quality of care and compliance. Finally, HHS created an Executive Council on Quality Care in 2016, led by the Deputy Secretary to identify opportunities from across the department that could be leveraged to support IHS in improving quality and safety. The Council includes health quality experts from across HHS and is working collaboratively to identify opportunities to assist IHS in its improvement efforts.

***Protecting the Integrity of Programs Serving AI/ANs*.** OIG is engaging in ongoing efforts to provide technical assistance to Tribal recipients of HHS funds. For instance, OIG negotiated in 2017 the first-ever Voluntary Tribal Compliance Agreement with the Washington State Tribe mentioned earlier as part of the Tribe's efforts to resolve allegations that it had submitted false claims to Medicaid for children's mental health services. With this type of agreement, OIG is helping the Tribe to implement a compliance program that includes retaining a compliance officer, establishing a compliance committee and relevant policies and procedures, providing pertinent training to employees, and appropriately screening employees upon hiring and then regularly thereafter. Also, OIG conducted a training program for IHS and Tribal officials on health care and grants management compliance in South Dakota, with a focus on quality of care and service delivery, compliance programs and other tools for combating fraud and abuse, and internal controls and single audits. In addition, in August 2017 OIG provided IHS headquarters managers training to mitigate grant fraud. OIG is also working with Offices of Inspector General from other Federal departments to identify common risks and opportunities to strengthen program integrity across Federal programs serving AI/ANs.

What Needs To Be Done

***Improving IHS Quality of Care, Management, and Infrastructure*.** IHS should continue its efforts to improve oversight and quality of care at IHS hospitals. This includes implementing a compliance program that provides internal controls to govern IHS's ethics and business policies and helps create a culture that promotes prevention, detection, and resolution of unlawful or unethical conduct. Also, IHS should implement OIG's recommendation to conduct a needs assessment and continue its recent efforts to develop an agency-wide strategic plan with actionable initiatives and target dates. In addition, IHS should establish standards for oversight activities by Area Offices and governing boards and should continue maturing its hospital performance metrics for the accountability dashboard. IHS's plans for improvement are extensive, but these plans are early in implementation and contingent on the agency's ability to establish and staff new executive-level national oversight functions, including the new Office of Quality and Office of Strategic Workforce Development. In addition, IHS should continue to take actions to curb opioid abuse, including periodically analyzing and reporting on purchasing and prescribing data for controlled substances within IHS facilities.

Further, HHS must continue to harness expertise from across its agencies and stakeholder community to address IHS's challenges. The HHS Executive Council on Quality Care should lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's longstanding challenges. In addition, CMS should conduct more frequent

surveys of nonaccredited IHS hospitals.

Protecting the Integrity of Programs Serving AI/ANs. To ensure that HHS funds are protected and that AI/AN communities receive maximum value and benefit from services, Tribes and Tribal organizations should develop and implement policies, procedures, and internal controls to detect and prevent fraud, mismanagement of funds, and improper billing. HHS reported that it is using annual audits to assess these issues. In addition, programs serving AI/ANs should ensure that their staffs are adequately trained to comply with Federal requirements and Tribal policies and controls.

Key OIG Resources

- OIG Report, *The Three Affiliated Tribes Improperly Administered Low-Income Home Energy Assistance Program Funds for Fiscal Years 2010 Through 2014*, July 2017. (https://oig.hhs.gov/oas/reports/region7/71604230.asp)
- OIG Training Session, "Protecting Indian Health and Human Services Programs and their Beneficiaries: The Basics of Health Care and Grants Management Compliance," Crazy Horse, South Dakota, April 2017. (https://oig.hhs.gov/conference/)
- OIG Companion Reports, *Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care in Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care*, October 2016. (https://oig.hhs.gov/oei/reports/oei-06-14-00010.asp and https://oig.hhs.gov/oei/reports/oei-06-14-00011.asp)
- OIG Report, *Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported*, March 2016. (https://oig.hhs.gov/oas/reports/region7/71504221.asp)
- OIG Alert to Tribes and Tribal Organizations To Exercise Caution in Using Indian Self-Determination and Education Assistance Act Funds, November 2014. (https://oig.hhs.gov/compliance/alerts/guidance/20141124.pdf)
- Podcasts, "Voluntary Tribal Compliance Agreement," February 2017, and "What Is OIG's Work in Indian Country?", August 2016. (https://oig.hhs.gov/newsroom/podcasts/)

Top Management Challenge #10: Protecting HHS Data, Systems, and Beneficiaries From Cybersecurity Threats

Why This Is a Challenge

Key Components of the Challenge

- Protecting HHS's data and systems
- Fostering a culture of cybersecurity beyond HHS

Data management, use, and security are essential to the effective and efficient operation of HHS and its programs. As HHS works to leverage the power of data, the Department will maintain and use expanding amounts of sensitive data. So, too, will individuals and entities—such as States, contractors, providers, grant recipients, and beneficiaries—involved in delivering or receiving benefits from the many HHS programs. Cybersecurity incidents and breaches pose a significant risk to the confidentiality, integrity, and availability of sensitive data. This could cause a myriad of problems including impeding HHS's ability to offer essential programs and services, threatening major elements of our country's critical infrastructure, and placing the health and safety of patients at risk. The Department must ensure that it takes appropriate actions to protect all HHS data and systems from cybersecurity threats. Similarly, HHS must protect its beneficiaries by fostering a culture of cybersecurity among its partners and stakeholders.

The environment in which the Department must achieve these imperatives is complex. For example, the sheer volume of data grows at an extremely rapid rate, which means there are significant and ever-increasing amounts of data to protect. Relatedly, data reside in many places and in the possession of private individuals and organizations who have a wide range of cybersecurity knowledge, experience, and resources. The continuing expansion of the Internet of Things, including networked medical devices, further increases potential attack vectors. These factors all impact the threat ecosystem.

Additionally, data—particularly health care data—are extremely valuable to cyber criminals. Media reports have identified the value of electronic health records (EHRs) to be as much as 10 times that of a credit card number. The threat facing the Department comes not just from individual actors, but also from organized groups representing or acting on behalf of criminal organizations and foreign nation states with sophisticated tools and resources. Furthermore, many public and private individuals, organizations, and agencies operate aging equipment and outdated software, which can create challenges in terms of keeping up with technological advances and evolving cybersecurity threats. For example, the WannaCry ransomware that critically impacted the United Kingdom's National Health Service in May 2017 and the NotPetya malware that halted a pharmaceutical company's production of some of its drugs in June 2017 offer cautionary warnings. The Department and its public and private partners and stakeholders have taken some steps to address coordination and information sharing concerning cybersecurity threats, but they must continue to work to enhance capabilities.

Key Components of the Challenge

Protecting HHS's Data and Systems. HHS must continually undertake efforts to protect its data and information systems and make certain that the Department is prepared to respond in the event of an incident. Meanwhile, the Department is under constant attack as criminals attempt to infiltrate or disrupt HHS systems.[45] OIG has identified cybersecurity vulnerabilities in multiple HHS systems and State Medicaid systems, including inadequacies in access controls, patch management, configuration management, encryption of data, and website security. Such weaknesses could affect the Department's ability to protect against unauthorized access to sensitive information. HHS is also responsible for complying with Executive Order 13800 (Strengthening the Cybersecurity of Federal Networks and Critical Infrastructure) as well as implementing the Continuous Diagnostics and Mitigation program in conjunction with the U.S. Department of Homeland Security (DHS). When implementing technology, HHS must use modern IT practices, such as those highlighted by the Digital Services Playbook. Additionally, more and more of the Department's programs, such as the All of Us Research Program, are becoming technology dependent. Ensuring the protection of the confidentiality, integrity, and availability of participants' personal information—and the systems the initiatives rely on—is paramount.

Fostering a Culture of Cybersecurity Beyond HHS. To protect the privacy and safety of those served by HHS programs, the Department must foster a culture that prioritizes cybersecurity among its partners and stakeholders.[46] The Department can encourage such a culture through policy and partnerships. With respect to policy, the Department must determine when and how to appropriately use existing policy levers—such as regulations, contract or grant requirements, financial incentives, or guidance—to encourage cybersecurity efforts without creating undue burden. For example, FDA has opportunities to promote cybersecurity in fulfilling its responsibility to ensure the safety and effectiveness of medical devices. Similarly, CMS has opportunities in the design and operation of its programs to further cybersecurity among participants.

The Department must collaborate with public and private partners and stakeholders to further cybersecurity goals. HHS is the Sector-Specific Agency for the Healthcare and Public Health Sector (HPH) and the Co-Sector-Specific Agency for the Food and Agriculture Sector. In those roles, HHS is tasked with, among other things, coordinating with Federal partners, collaborating with critical infrastructure owners and operators, and offering support in identifying vulnerabilities and mitigating incidents.[47] These sectors face many cybersecurity-related issues, including those identified in the Health Care Industry Cybersecurity Task Force Report (the Task Force Report), released in June 2017. The Department must determine how best to support partners' and stakeholders' efforts to enhance cybersecurity while being mindful of the wide diversity in the infrastructure and resources available to prepare for, detect, and respond to cybersecurity threats.

[45] See, for example, Chase Gunter, *Federal Computer Week (FCW),* "CIO: HHS faces 500 million hack attempts per week," June 20, 2017. Available at https://fcw.com/articles/2017/06/20/hhs-cio-cyber-attacks.aspx.
[46] Executive Order 13636, Improving Critical Infrastructure Cybersecurity, and Presidential Policy Directive (PPD) 21, Critical Infrastructure Security and Resilience.
[47] Ibid.

Progress in Addressing the Challenge

Protecting HHS's Data and Systems. HHS has made progress in strengthening the privacy safeguards and security of its systems and information. For example, HHS adopted DHS's Continuous Diagnostics and Mitigation program and is currently working on final implementation of Phase Two. Additionally, HHS has taken steps to address vulnerabilities identified in OIG cybersecurity reports, including those referenced above.

Fostering a Culture of Cybersecurity Beyond HHS. Similarly, HHS made progress in fostering a culture of cybersecurity among public and private partners and stakeholders. In 2016, FDA published final guidance addressing postmarket cybersecurity vulnerabilities for medical devices. In addition, in 2016 FDA entered into a new Memorandum of Understanding with the National Health Information Sharing and Analysis Center (NH-ISAC) and the Medical Device Innovation, Safety, and Security Consortium to share information on cybersecurity threats and foster the development of risk assessment frameworks. Further, HHS has undertaken efforts to increase communication within the Department and across the HPH Sector by developing its new Healthcare Cybersecurity and Communications Integration Center (HCCIC). According to the Department, the HCCIC is a necessary resource for health care providers and a sector-specific response to cybersecurity threats that will supplement DHS's National Cybersecurity and Communications Integration Center and provide direct benefits for health care cybersecurity. Additionally, HHS awarded cooperative agreements to the NH-ISAC totaling $350,000 to support cybersecurity efforts by HPH Sector partners through the sharing of information and threat indicators. Finally, the Department continued its efforts as a Sector-Specific Agency to improve sector-specific communication by, among other things, sharing important information with health care providers and associations during the May 2017 WannaCry incidents.

What Needs To Be Done

Protecting HHS's Data and Systems. Cybersecurity threats are evolving, as evidenced by the recent rise of ransomware, and HHS must remain vigilant. While HHS continues to undertake efforts to protect its own data and systems, more remains to be done. To protect its data and systems, the Department must continue to take steps to address vulnerabilities previously identified by OIG and others. OIG's work will continue to focus on HHS systems' privacy and security to support HHS's efforts to mitigate the risk of unauthorized access or changes to or theft of its sensitive information. In addition, across HHS, several key mission areas rely on aging or outdated technology. These systems pose a risk to the successful execution of the HHS mission if they fail or are compromised. As the Department updates or acquires new technology, HHS must also ensure that it aligns with technology priorities defined in legislation and administration policy. This includes the full implementation of the Federal Information Technology Acquisition Reform Act, modernization of legacy systems, and adoption of modern IT management practices.

Fostering a Culture of Cybersecurity Beyond HHS. To further foster a culture of cybersecurity among partners and stakeholders to protect beneficiaries, HHS must use available policy levers to address Health IT security issues. Ongoing work will continue to consider security issues related to networked medical devices, and future work may consider additional security issues that arise from the continuing expansion of the Internet of Things. Furthermore, the Department must complete its review of recommendations included in the Task Force Report and determine how best to address those recommendations.

Key OIG Resources

- OIG Report, *HealthCare.gov: Case Study of CMS Management of the Federal Marketplace*, February 2016. (https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf)
- OIG Report, *Hospitals Largely Reported Addressing Requirements for EHR Contingency Plans*, July 2016. (https://oig.hhs.gov/oei/reports/oei-01-14-00570.asp)
- OIG Summary Report, *Wireless Penetration Test of Centers for Medicare & Medicaid Services' Data Centers*, August 2016. (https://oig.hhs.gov/oas/reports/region18/181530400.asp)
- OIG Summary Report, *Information Technology Control Weaknesses Found at the Commonwealth of Massachusetts' Medicaid Management Information System*, March 2017. (https://oig.hhs.gov/oas/reports/region6/61500057.asp)
- OIG Summary Report, *Virginia Did Not Adequately Secure Its Medicaid Data*, May 2017. (https://oig.hhs.gov/oas/reports/region4/41505066.asp)
- OIG Summary Report, *Information Technology Control Weaknesses Found in the New Mexico Human Services Department's Medicaid Eligibility Systems*, August 2017. (https://oig.hhs.gov/oas/reports/region6/61605000.asp)
- OIG Summary Report, *The State of North Carolina Did Not Ensure That Federal Information System Security Requirements Were Met for Safeguarding Its Medicaid Claims Processing Systems and Data*, August 2017. (https://oig.hhs.gov/oas/reports/region7/71600469.asp)

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Appendices

A

In This Section

- Acronyms
- Connect with HHS

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APPENDIX A: ACRONYMS

A	
ACF	Administration for Children and Families
ACO	Accountable Care Organization
ACL	Administration for Community Living
ADA	*Anti-Deficiency Act*
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
APG	Agency Priority Goal
APM	Alternative Payment Model
APTC	Advance Premium Tax Credit
AR	Antibiotic Resistant
ARRT	Advanced Rehabilitation Research and Training
ASA	Office of the Assistant Secretary for Administration
ASFR	Office of the Assistant Secretary for Financial Resources
ASL	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
B	
BBA	*Bipartisan Budget Act of 2015*
BHP	Basic Health Program
BHW	Bureau of Health Workforce
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
BUP	Buprenorphine
C	
CAPs	Corrective Action Plans
CARA	*Comprehensive Addiction and Recovery Act*
CBR	Comparative Billing Reports
CCDBG	*Child Care and Development Block Grant Act of 2014*
CCDF	Child Care and Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CCR	Center for Cancer Research
CDC	Centers for Disease Control and Prevention
CEAR	Certificate of Excellence in Accountability Reporting
CERT	Comprehensive Error Rate Testing
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIA	Corporate Integrity Agreement
CIO	Chief Information Officer
CL	Current Law
CLASS	Classroom Assessment Scoring System
CMA	Computer Matching Agreement
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of Living Adjustment
CO-OP	Consumer Operated and Oriented Plan
COTS	Commercial Off-the-Shelf
CPI	Consumer Price Index
CPIM	Consumer Price Index-Medical
CRC	Commercial Repayment Center
CSR	Cost-sharing Reduction
CSRS	Civil Service Retirement System
CTO	Office of the Chief Technology Officer
Cures Act	*21st Century Cures Act*
CY	Current Year
D	
DAB	Departmental Appeals Board
DACA	Deferred Action for Childhood Arrivals
DAP	DATA Act Program Management Office
DATA Act	*Digital Accountability and Transparency Act of 2014*
DHS	Department of Homeland Security
DME	Durable Medical Equipment
DMF	Death Master File
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNP	Do Not Pay
DOD	Department of Defense
DOI	Department of the Interior
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*

DSCSA	*Drug Supply Chain Security Act*
E	
EHR	Electronic Health Record
ES	The Executive Secretariat
ESRD	End-stage Renal Disease
F	
FACES	Family and Child Experience Survey
FAPIIS	Federal Awardee Performance and Integrity Information System
FAR	Federal Acquisition Regulation
FASAB	Federal Accounting Standards Advisory Board
FBIP	Financial Business Intelligence Program
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees Retirement System
FETP	Field Epidemiology Training Programs
FFATA	*Federal Funding Accountability and Transparency Act of 2006*
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FICA	*Federal Insurance Contributions Act*
FIFO	First-In/First-Out
FISCAM	Federal Information System Controls Audit Manual
FITARA	*Federal Information Technology Acquisition Reform Act*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FPS	Fraud Prevention System
FRDAA	*Fraud Reduction and Data Analytics Act of 2015*
FSIP	Financial Systems Improvement Program
FY	Fiscal Year
G	
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GONE Act	*Grants Oversight and New Efficiency Act*
GPRA	*Government Performance and Results Act of 1993*
GSA	General Services Administration
H	
H5N1	Avian Influenza
HCBS	Home and Community-based Services
HCCIC	Healthcare Cybersecurity and Communications Integration Center
HCFAC	Health Care Fraud and Abuse Control
HEW	Department of Health, Education, and Welfare
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
HHS	Department of Health and Human Services
HHSAR	HHS Acquisition Regulation
HI	Hospital Insurance
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HIV	Human Immunodeficiency Virus
HPH	Healthcare and Public Health Sector
HPMS	Health Plan Management System
HRSA	Health Resources and Services Administration
I	
IBNR	Incurred But Not Reported
IEA	Office of Intergovernmental and External Affairs
IHS	Indian Health Service
IM	Information Memorandum
IOS	Immediate Office of the Secretary
IP	Improper Payment
IPAB	Independent Payment Advisory Board
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IPERIA	*Improper Payments Elimination and Recovery Improvement Act of 2012*
IPIA	*Improper Payments Information Act of 2002*
IPPS	Inpatient Prospective Payment System
IPT	Integrated Project Team
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
ISDEAA	*Indian Self-Determination and Education Assistance Act*
IT	Information Technology

L	
LIHEAP	Low Income Home Energy Assistance Program
LTCH	Long-Term Care Hospital
M	
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACRA	*Medicare Access and CHIP Reauthorization Act of 2015*
MARx	Medicare Advantage Prescription Drug
MAT	Medication-assisted Treatment
MBD	Medicare Beneficiary Database
MCH	Maternal and Child Health
MED	Morphine Equivalent Dosing
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Units
MIPS	Merit-based Incentive Payment System
MLN	Medicare Learning Network
MMEs	Morphine Milligram Equivalents
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Savings Program
MWWG	Material Weakness Working Group
N	
NAL	Naltrexone
NBI	National Benefit Integrity
NBS	NIH Business System
NCCI	National Correct Coding Initiative
NCI	National Cancer Institute
NGHP	Non-Group Health Plan
NH-ISAC	National Health Information Sharing and Analysis Center
NHSC	National Health Service Corps
NIDILRR	National Institute for Disability, Independent Living, and Rehabilitation Research
NIH	National Institutes of Health
NPI	National Provider Identifier
O	
OASDI	Old-Age, Survivors, and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCR	Office for Civil Rights
OFFM	Office of Federal Financial Management
OGA	Office of Global Affairs
OGC	Office of the General Counsel
OHR	Office of Health Reform
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OpDiv	Operating Division
OPM	Office of Personnel Management
OS	Office of the Secretary
OWH	Office of Women's Health
P	
PARIS	Public Assistance Reporting Information System
PCS	Personal Care Services
PDE	Prescription Drug Event
PDMP	Prescription Drug Monitoring Programs
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PI	Program Integrity
PIP	Program Improvement Plan
Plan	HHS Strategic Plan FY 2018 – 2022
PMD	Power Mobility Device
PMO	Project Management Office
PMS	Payment Management System
PP	Paid Properly
PPACA	*Patient Protection and Affordable Care Act*
PRRB	Provider Reimbursement Review Board
PSC	Program Support Center
PTC	Premium Tax Credit
PY	Prior Year
Q	
QHP	Qualified Health Plans
QIO	Quality Improvement Organization
QPP	Quality Payment Program
R	
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
RAPS	Risk Adjustment Processing System
REMS	Risk Evaluation and Mitigation Strategies
RSI	Required Supplementary Information
S	
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	*Self Employment Contributions Act of 1954*

Section 601	*Bipartisan Budget Act of 2015*
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSBG	Social Services Block Grant
StaffDiv	Staff Division
SUD	Substance Use Disorder
T	
T-MSIS	Transformed Medicaid Statistical Information System
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
TMC	Top Management Challenge
Treasury	U.S. Department of the Treasury
U	
UAC	Unaccompanied Alien Children
UDI	Unique Device Identification
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	United States Code
USSGL	United States Standard General Ledger
V	
VA	Department of Veterans Affairs
VFC	Vaccines for Children

APPENDIX B: CONNECT WITH HHS

The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.

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