Goal 4. Objective A: Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management.

Stewardship of nearly $900 billion in federal funds involves more than ensuring that resources are allocated and expended responsibly. Managing federal healthcare related investments with integrity and vigilance will safeguard taxpayer dollars as well as benefit the public through improved health and enhanced well-being. Responsible stewardship involves allocating these resources effectively—and for activities that generate the highest benefits. HHS has placed a strong emphasis on protecting program integrity and the well-being of program beneficiaries by identifying opportunities to improve program efficiency and effectiveness. HHS is making every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time. Internal controls and risk assessment activities are evolving and being strengthened across programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP), Head Start, Temporary Assistance for Needy Families (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care, and Child Care to strengthen the integrity and accountability of payments.

HHS is strengthening efforts to identify and eliminate improper payments. Internal controls and other risk assessment activities are focused on identifying and eliminating systemic weaknesses that lead to erroneous payments. HHS investments in cutting-edge and data mining technologies, such as predictive modeling, allows for the identification of potential fraud with unprecedented speed and accuracy. HHS data tools have substantially reduced the amount of time it takes to identify fraudulent claims activity to a matter of days rather than analyses that previously took months or years. HHS efforts to combat healthcare fraud, waste, and abuse include provider and beneficiary education, data analysis, audits, investigations, and enforcement. In addition, CMS and OIG are working in collaboration with the Department of Justice in concentrated investigations in selected cities that have high fraud indicators.

All agencies and offices in HHS are focused on ensuring the efficiency and integrity of HHS programs. In the table below are performance measures which focus on HHS plans for responsible stewardship. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 4.A Table of Related Performance Measures

Unprivileged Users 2 Factor Authentication (Lead Agency - ASA; Measure ID - 3.1)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					89%	92%
Result				87%	Dec 31, 2016	Dec 31, 2017
Status				Historical Actual	Pending	Pending

Privileged Users 2-Factor Authentication (Lead Agency - ASA; Measure ID - 3.2)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					98%	98%
Result				97%	Dec 31, 2016	Dec 30, 2017
Status				Historical Actual	Pending	Pending

For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Lead Agency - ACL; Measure ID - 1.1)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	8,600 clients	8,700 clients	8,600 clients	9,250 clients	8,700 clients	9,000 clients
Result	9,206 clients	9,753 clients	8,930 clients	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Retain the average survey results from appellants reporting good customer service on a scale of 1 - 5 at the Administrative Law Judge Medicare Appeals level (Lead Agency - OMHA; Measure ID - 1.1.5)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	3.6	3.6	3.6	3.4	3.4	3.4
Result	4.1	4	3.9	3.9	Nov 8, 2016	Nov 8, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Decrease under-enrollment in Head Start programs, thereby increasing the number of children served per dollar. (Lead Agency - ACF; Measure ID – 3E)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	0.7 %	0.7 %	0.6 %	0.8 %	1.2 %	1.1 %
Result	0.8 %	0.7 %	0.9 %	1.84 %	Jan 31, 2017	Jan 31, 2018
Status	Target Not Met	Target Met	Target Not Met	Target Not Met	Pending	Pending

Decrease improper payments in the title IV-E foster care program by lowering the national error rate. (Lead Agency - ACF; Measure ID - 7S)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	4.5 %	6 %	5.1 %	5.3 %	3.6 %[76]	3.55 %[77]
Result	6.2 %	5.3 %	5.5 %	3.65 %	Oct 31, 2016	Oct 31, 2017
Status	Target Not Met	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

[76] The revised target for FY 2016 is based on the actual FY 2015 improper payment rate and was updated to reflect improved performance in this area.

[77] The revised target for FY 2017 is based on the actual FY 2015 improper payment rate and was updated to reflect improved performance in this area.

Reduce total amount of sub-grantee Community Services Block Grant (CSBG) administrative funds expended each year per total sub-grantee CSBG funds expended per year. (Lead Agency - ACF; Measure ID - 12B)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	17 %	16 %	16 %	16 %	16 %	16 %
Result	16.07 %	15.85 %	15.23 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Lead Agency - CMS; Measure ID - MIP1)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	5.4 %	8.3 %	9.9 %	12.5 %	11.5 %	10.4 %
Result	8.5 %	10.1 %	12.7 %[78]	12.09 %	Nov 15, 2016	Nov 15, 2017
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program (Lead Agency - CMS; Measure ID - MIP5)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	10.4 %	10.9 %	9 %	8.5 %	9.14 %	8.79 %
Result	11.4 %	9.5 %	9 %	9.5 %	Nov 15, 2016	Nov 15, 2017
Status	Target Not Met	Target Exceeded	Target Met	Target Not Met	Pending	Pending

Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program (Lead Agency - CMS; Measure ID - MIP6)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	3.2%	3.1%	3.6%	3.5%	3.4%	3.3%
Result	3.1%	3.7%	3.3%	3.6%	Nov 15, 2016	Nov 15, 2017
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	In Progress	In Progress

[78] On August 29, 2014, CMS announced that, to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS is offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68 percent of the net allowable amount). The settlement is intended to ease the administrative burden for all parties. Any claims in the sample that are included in a settlement will still be considered improper for the measurement.

Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Lead Agency - CMS; Measure ID - MIP8)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[79]	FY 2017
Target	Set Baseline	31 %	36 %	42 %	45 %[80]	TBD[81]
Result	27 %[82]	31.8 %	41.15 %	43.63 %	Nov 30, 2016	N/A[83]
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Target Not In Place

Estimate the Improper Payment Rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	7.4 %[84]	6.4 %[85]	5.6 %	6.7 %	11.53 %	10.48 %
Result	7.1 %	5.8 %	6.7 %	9.78 %	Nov 15, 2016	Nov 15, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

Estimate the Improper Payment Rate in the Children's Health Insurance Program (CHIP) (Lead Agency - CMS; Measure ID - MIP9.2)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Report national error rates in the 2012 Agency Financial Report based on 17 CHIP states	Report rolling average error rate in the 2013 Agency Financial Report based on states reported in 2012-2013	Report rolling error rate in the 2014 Agency Financial Report	6.5%	6.81%	6.23%
Result	8.2%	7.1%	6.5%	6.8%	Nov 15, 2016	Nov 15, 2017
Status	Target Met	Target Met	Target Met	Target Not Met	In Progress	Pending

Increase the number of innovative acquisitions for IT services throughout the Department in collaboration with the HHS IDEA Lab (Lead Agency - IOS; Measure ID - 1.7)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target				Set Baseline	10.0	10.0
Result				4	Sep 30, 2016	Sep 30, 2017
Status				Historical Actual	Pending	Pending

[79,80] The FY 2015 results will be available in November 2015, at which time the FY 2016 target will be determined.

[81] The FY 2016 results will be available in November 2016, at which time the FY 2017 target will be determined.

[82] 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

[83] Target and Date will be provided in November 2015.

[84] Previously as MCD1.1 in the FY 2013 HHS APP/R as 6.4%. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

[85] Previously as MCD1.1 in the FY 2013 HHS APP/R as TBD. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

Analysis of Results

HHS's enterprise-wide information security and privacy program was launched in FY 2003 to help protect HHS against potential IT threats and vulnerabilities. The HHS Cybersecurity Program ensures compliance with federal mandates and legislation, including the Federal Information Security Management Act (FISMA) and the President's Management Agenda. The Program also plays an important role in protecting HHS's ability to provide mission-critical operations, and is an enabler for e-government success. ASA leads the management and sets policy for HHS information technology systems. In conjunction with the Federal Sprint and Marathon Team initiatives, the HHS components have been focused on the implementation of two-factor authentication (LOA-4) for privileged and unprivileged users. In this case, two-factor authentication involves the use of a physical PIV card as well as a pin to access hardware and secure systems. ASA is reporting two new measures tracking the rate of two-factor authentication usage, reaching 87 percent for unprivileged network users and 97 percent for privileged network users.

ACL addresses performance efficiency at all levels of the National Aging Services Network in the provision of home and community-based services, including caregiver services. Access to and quality of these home and community-based services is foundational to the success of AoA's programs. In FY 2014, the Aging Services Network served 8,930 clients per million dollars of OAA funding exceeding the target of 8,600. While results for FY 2014 declined from FY 2013's exceptionally high performance, the results are more consistent with performance prior to FY 2013 and may also reflect a delayed effect of sequester. Performance has trended upward over the last ten years and performance targets have been consistently achieved. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs) and increased commitments and partnerships at the state and local levels have all had a positive impact on program efficiency.

As part of its program assessment, OMHA is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience. This measure will assure appellants and related parties are satisfied with their Level III appeals experience based on beneficiary survey results. OMHA is specifically seeking to assess the appellants experiences that characterize the administrative law judge hearing process, including: being informed of the hearing process and applicable rules; being informed of the status of their case; feeling there was a full opportunity to be heard and present their position; believing the decision was fair, regardless of whether they agree with the outcome. In FY 2015, OMHA achieved a 3.9 level of appellant satisfaction nationwide, exceeding the 3.4 performance target level. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with the hearing formats used to adjudicate their cases. Despite a growing backlog of cases, OMHA will continue to strive to meet customer expectations and maintain customer satisfaction levels.

ACF continues to focus on improvements to reduce Head Start under-enrollment. Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as state pre-kindergarten programs have grown, parents may choose to send their children to those programs. The most recent data available indicate that, during the 2014-2015 program year, Head Start grantees had, on average, not enrolled 1.84 percent of the children they were funded to serve, missing the FY 2015

target of 0.8 percent. This represents approximately 16,700 children who could have been served using the Head Start funds appropriated and awarded to grantees.

ACF seeks to reduce erroneous payments in the title IV-E foster care program by estimating the national payment error rate and developing an improvement plan to strategically reduce, or eliminate where possible, improper payments. The national error rate is estimated using data collected in the most recent foster care eligibility review for each state. The FY 2015 Foster Care estimated national payment error rate is 3.65 percent, exceeding the target of 5.3 percent.

ACF also strives to provide services to low income individuals and families through an efficient and cost effective delivery system through the Community Service Block Grant network. While states have an administrative cap of 5 percent, which limits the amount of funds that the state may retain for expenses, this ACF measure focuses on the administrative spending by sub-grantees. Historical trend data for this measure have fluctuated, with sub-grantees spending between 15 and 22 percent on administrative expenses. In FY 2014, 15.23 percent of CSBG sub-grantee funds were used for administrative costs, a slight decrease from the previous year's result and exceeding the FY 2014 target of 16 percent.

HHS employs a number of measures to track the performance of efforts to fight fraud and reduce improper payments. One of CMS's key goals is to pay claims properly the first time. The primary cause of improper payments is administrative and documentation errors, in large part due to insufficient documentation. CMS continues to develop new data analysis strategies and engage in provider and supplier education to prevent improper payments in Medicare Fee-for-Service. The Medicare Fee-for-Service improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program. The FY 2015 result, an error rate of 12.09 percent, was below the targeted level of 12.5 percent.

Medicare Advantage (MA) plans (Medicare Part C) are managed care plans that provide Medicare-covered services for beneficiaries who select to participate in the program. All Part C plans are paid a monthly per capita premium, and errors can occur in the transfer and interpretation of source data and in payment calculations. CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions that required that MA organizations must report and return overpayments that they identify and a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by an MA organization. In FY 2015 results show that CMS fell short of the measure target with an improper payment rate of 9.5 percent. CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions. Additional information about these initiatives is available in the "Plans for the Future" section below and in the 2015 HHS AFR.

The Medicare Part D Prescription Drug Program established an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A and Part B and for beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles). The program also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and other qualified low-income beneficiaries. The payment error rate for the Medicare Part D Prescription Drug Program was 3.6 percent in FY 2015, falling just short of the target of 3.5 percent. The root cause of many improper payments in the Part D program reported in FY 2015 is administrative and documentation errors, particularly related to long term care facility medication orders. CMS continues to pursue enhancements to address this issue and has national training sessions for Part D plan sponsors covering comprehensive information for Part D payment and data submission requirements.

CMS's Fraud Prevention System (FPS) uses sophisticated algorithms and computer modeling to identify providers whose behavior is aberrant and potentially fraudulent. This program seeks to increase the percentage of Medicare providers and suppliers identified as high risk that receive administrative action. CMS measures performance in this area by instances where a high risk provider had at least one administrative action (numerator) compared to the universe of high risk providers and suppliers (denominator). In FY 2015, the FPS exceeded its target, with 43.63 percent of high risk Medicare providers and suppliers receiving an administrative action. This approach reduces the burden on legitimate providers, while focusing the majority of the resources on those posing a high risk of fraud.

State Medicaid and CHIP programs, working with CMS, also have developed systems to identify, examine, track, and reduce the Medicaid and CHIP payment error rates. The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for service, managed care, and eligibility components of both Medicaid and CHIP. In FY 2013 CMS made enhancements to the rate calculation methodology to improve the accuracy of the Medicaid improper payment rate estimate. These improvements included replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and incorporating prior year state-level improper payment rate recalculations. The Medicaid Program did not meet its performance target with 9.78 percent payment error rate estimated, an increase from the previous year. CHIP also did not meet its target for the CHIP performance indicator, with 6.8 percent estimate of payment errors, missing the 6.5 percent target. These increases were due to state difficulties getting systems into compliance with new requirements that were put in place to strengthen program integrity.

Plans for the Future

There are three factors that contributed to the increased rate of under-enrollment in Head Start in FY 2015: a period of under-enrollment as more programs become Birth-to-Five through competition and renovate facilities, train staff and recruit infants and toddlers; 2) competitive transitions which can result in a period of under-enrollment as programs become fully operational; and 3) under-enrollment within some very large grantees. The ACF Office of Head Start (OHS) is following up and providing technical assistance to ensure these grantees become fully enrolled as soon as possible. Per the 2007 reauthorization of the Head Start Act, ACF now collects online enrollment data on a monthly basis from all Head Start grantees through the Head Start Enterprise System (HSES). HSES provides a system-generated alert when grantees are under-enrolled, and Regional Offices have procedures in place, consistent with the Head Start Act, to begin technical assistance and to establish improvement plans with clear timetables if the under-enrollment persists. In such cases, Regional Offices have worked with grantees to address under-enrollment by considering, for example, conversion of Head Start slots to Early Head Start slots if it support community need or enrollment reductions depending on the circumstances. Very few Head Start grantees trigger the designation of chronically under-enrolled in the Head Start Act, which requires being at 97 percent of funded enrollment after receiving 12 months of technical assistance, but in a small subset of cases, ACF has reduced the grantee's base funding.

ACF is developing strategies to implement Enterprise Risk Management (ERM) throughout the agency; currently, ACF is developing a planning and scoping document that will facilitate implementation of the key principles of ERM. The intent of this program, in part, is reducing erroneous payments in the title IV-E Foster Care program.

ACL expects the targeted number of clients served for home and community-based services to vary in the future as delayed effects of sequestration may occur. Recent performance improvements reflect the success of ongoing initiatives to improve program management and expand options for home and

community-based care. Aging and Disability Resource Centers (ADRCs) and increased commitments and partnerships at the state and local levels have all had a positive impact on program efficiency.

Historical trend data for the ACF Community Services Block Grant (CSBG) administrative funds expended performance measure have fluctuated, with sub-grantees spending between 15 and 22 percent on administrative expenses. To accomplish future targets, the ACF Office of Community Services (OCS) will continue to monitor and to provide training and technical assistance to CSBG grantees in the areas of cost effective program administration and organizational efficiency. In addition, OCS is supporting two Centers of Excellence that support organizational standards and performance management efforts.

In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that the correct Medicare payments are made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. CMS will enhance its efforts to reduce improper payments for Medicare FFS and Medicare Parts C and D and continue to use predictive analytics to focus on areas where incidence or opportunity for improper payments and/or fraud is greatest. CMS is continuing to apply the risk-based approach to payment and provider oversight, which increases contractors' efficiency. This approach also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. CMS's goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

The factors contributing to improper payments are complex and vary from year to year, and CMS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources isI.A.1 used to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation.

Of particular importance are five corrective actions that CMS believes will have a considerable effect in preventing and reducing improper payments: 1) HHS implemented corrective actions to address program payment vulnerabilities related to home health services; 2) proposed an update to the "Two Midnight" rule CMS-1633-P regarding when hospital admissions are appropriate for payment under Medicare Part A; 3) issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially could be subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that would be subject to a prior authorization process, 4) expanded the use of prior authorization in the Medicare FFS program by instituting a prior authorization demonstration program with the expectation of reducing improper payments for power mobility devices; and 5) implemented two demonstration projects to test whether prior authorization in Medicare FFS reduces expenditures while maintaining quality of care for certain non-emergent services. Detailed information on corrective actions can be found on pages 184 and 185 of the 2015 HHS AFR. Future targets are 11.50 percent for FY 2016 and 10.40 percent for FY 2017.

CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions. Contract-level audits are conducted to recover over-payments and to verify the accuracy of enrollee diagnoses submitted by (MA) organizations for risk adjusted payments. In new regulatory provisions, CMS codified the Affordable Care Act requirement that MA organizations must report and return overpayments that they identify. CMS also established a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data

submitted by an MA organization. Accordingly, in FY 2015, approximately $650 million in overpayments have been reported and returned. This recovery appears to be the result of the sentinel effect of the RADV audits, as well as the 'report and pay' requirement.

To improve program integrity in the Part D program, CMS conducts national training sessions for Part D plan sponsors on Part D payment and data submission. In addition, CMS continues to provide additional guidance to Part D sponsors to improve data accuracy and validity. HHS also codified the Affordable Care Act requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor. Accordingly, in FY 2015, approximately $11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the "report and return" requirement.

In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit corrective action plans (CAPs) to CMS. CAPs will focus on helping states comply with new system requirements, provider communication and education to reduce errors related to missing or insufficient documentation and also target eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the state-specific CAPs, CMS has implemented additional efforts to lower improper payments rates including provider outreach, mini-PERM audits, best practice calls, and various other methods of state outreach. For more information on corrective actions see the FY 2015 HHS AFR.

The IDEA Lab supports innovative approaches to achieving the HHS mission by assisting all 11 Operating Divisions in addition to Staff Divisions within the Office of the Secretary. An area of focus for the IDEA Lab is the acquisition of IT services. IT acquisition can be ineffective and inefficient, resulting in high failure rates[86] that are attributable to many factors, including but not limited to lack of stakeholder collaboration with acquisitions; miscommunication and failure to identify needs, gaps, and problems; poor project management; and the lack of end user involvement with frequent feedback loops throughout implementation. Given the $50 billion annual spend on IT services government-wide[87], and the growing complexity of IT and health IT needs, it is important for HHS to address this high-impact area by investing in and experimenting with solutions to mitigate risk of failure through new approaches.

The goal is to create a more effective and efficient government by transforming how HHS acquires information technology and digital services in order to improve stakeholder outcomes. This HHS-wide approach involves creating awareness of potential issues with IT acquisitions, introduction of more effective methods as well as extensive training to master them, and broadening the evidence base to iteratively improve, learn, and share best practices. Established baseline and target measures will yield important information to help acquire IT in a more effective and efficient way, resulting in better systems and reduced costs.

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[86] 2013 Chaos Manifesto by The Standish Group

[87] General Services Administration. Based on category management data analysis derived from certain Product Service Codes (PSCs) from the Federal Procurement Data System (FPDS).

An innovative IT services acquisition is one that utilizes any of the following approaches to mitigate risk, deliver required end-user outcomes, and increase stakeholder collaboration by aligning incentives. The below approaches tend to lead to on-time or early delivery, increased end user satisfaction, and reduction in total cost of ownership:

- Early and frequent collaboration between acquisition stakeholders;
- Use of agile, iterative, modular implementation methods;
- Frequent feedback loops with end users and stakeholders;
- Utilization of new or rarely-used acquisition approaches, such as incentive prize tools, multi-stage acquisitions (down-selects), rapid-prototyping, and prototype-based proposals that more effectively prove contractor capability.

Innovative acquisitions also include evaluating contractor capabilities based on the established requirements in order to yield better value to the government by mitigating risk of failure. For example, evaluating IT service contractors through submission of coding, prototypes, and/or other associated work product as opposed to strictly text-based proposal submissions mitigates risk of failure because the requisite contractors are evaluated based on their capability to perform the government's requirements. The IDEA Lab has created a new measure to track the number of innovative acquisitions and set a target of 10 for FY 2016 and FY 2017.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: HHS has made progress in addressing improper payments. HHS has established new risk-based screening requirements to ensure that only legitimate providers are enrolling in and billing the Medicare program. The Department has instituted a number of new policies and demonstrations to strengthen program integrity within (FFS), such as requiring physicians to document face-to face-encounters with a patient prior to certifying eligibility for the home health benefit and instituting a prior authorization demonstration program for power mobility devices. This demonstration has reduced improper payments and overall Medicare expenditures and was expanded in FY 2015 from the initial seven states to include an additional 12 states.

Other areas of progress include the implementation of revisions to the financial reporting form in the Temporary Assistance for Needy Families (TANF) program, which will require states to provide more accurate information about the ways they are using their TANF block grants and meeting Maintenance-of-Effort obligations, as well as the continuation of the Senior Medicare Patrol program to empower Medicare beneficiaries, their families, and caregivers to prevent Medicare fraud, waste, and abuse through outreach, counseling and education.

HHS still faces challenges in reducing improper payments, as the FY 2014 improper payment rates for both the Medicare FFS and Medicaid programs increased from previous years. The factors contributing to improper payments are complex and vary from year to year. Insufficient documentation for home health claims was the major driver of the increase in the Medicare Fee-For-Service improper payment rate, increasing from 17 percent in FY 2013 to 51 percent in FY 2014 due to the implementation of new

face-to-face encounter requirements to support the medical necessity of the billed services. Another contributing factor was medical necessity errors that are common for inpatient hospital claims, particularly short stays found to not be medically necessary because services should have been billed as outpatient (i.e., patient status errors).

During the review, a weakness identified was the statutory limitations in the TANF program, which prohibit HHS from requiring states to participate in a TANF improper payment measure. As a result, the TANF program has not reported an improper payment error rate. In addition, Medicare Advantage and state Medicaid programs face challenges with managed care due to the program integrity responsibilities largely being delegated to the managed care organizations as part of the capitated payment. The Department is seeking to take a more active role in program integrity oversight and guidance.

HHS is working to revisit and revise performance measures to track new developments, specifically related to cybersecurity. HHS and its individual Operating and Staff Divisions are developing and implementing Enterprise Risk Management principles to better address risk. In addition, the Department is looking at integrating the Medicare and Medicaid program integrity work to provide cooperative benefits in fraud, waste, and abuse oversight.