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Affordable Care Act Reviews

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Appendix A
Affordable Care Act Reviews

The reviews described in Appendix A address:

- New programs and initiatives created by the Affordable Care Act[1] that are national in scope and significantly engage the Department of Health and Human Services (HHS).
- Existing HHS programs and operations (Medicare, Medicaid, and public health) that relate directly or indirectly to Affordable Care Act provisions.

New Programs and Initiatives Created by the Affordable Care Act

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

CCIIO— CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
CLASS— COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS [PROGRAM]
CMS—CENTERS FOR MEDICARE & MEDICAID SERVICES
ERRP— EARLY RETIREE REINSURANCE PROGRAM
EXCHANGES—AFFORDABLE INSURANCE EXCHANGES
PCIP—PRE-EXISTING CONDITION INSURANCE PLANS

The Affordable Care Act created new programs and initiatives and expanded and modified a number of existing HHS programs. The Secretary of HHS is responsible for many of the new programs in the Affordable Care Act. HHS programs created by the Affordable Care Act for which the Office of Inspector General (OIG) has work in progress or plans to start reviews in fiscal year (FY) 2012 are:

- Pre-existing Condition Insurance Plans (PCIP), § 1101
- Early Retiree Reinsurance Program (ERRP), § 1102
- Health Insurance Web Portal, § 1103
- Affordable Insurance Exchanges, § 1311
- National Background Check program, § 6201
- Community Living Assistance Services and Supports (CLASS) program, § 8002

[1] Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act).

Pre-Existing Condition Insurance Plans, § 1101

WHY WAS THE PROGRAM CREATED? The PCIP program was created to provide a temporary high-risk health insurance pool program for eligible individuals with pre-existing conditions. PCIPs will operate until 2014, when individuals and small businesses will be able to purchase private health insurance through insurance exchanges called Affordable Insurance Exchanges (Exchanges). Insurance plans offered under the Exchanges may not discriminate on the basis of a pre-existing condition.

WHAT DOES THE PROGRAM DO? The law appropriates $5 billion of Federal funds to support PCIPs that offer comprehensive insurance coverage to individuals with pre-existing conditions. A State may choose to operate its own PCIP or to be covered under the Federal PCIP.

WHO IS RESPONSIBLE? The Center for Consumer Information and Insurance Oversight (CCIIO), part of the Centers for Medicare & Medicaid Services (CMS), is responsible for administering the PCIP program. HHS, through arrangements with the Office of Personnel Management and the Department of Agriculture's National Finance Center, operates a Federal PCIP for those States that choose not to operate their own PCIPs.

HOW IS THE RELATED ASSISTANCE RECEIVED AND USED? Funding for PCIPs became available on July 1, 2010, and States applied to CCIIO for funding. To ensure the integrity of the program, each PCIP is required to develop, implement, and execute procedures to prevent, detect, and recover inappropriate payments, as well as to promptly report to HHS incidences of waste, fraud, and abuse.

The objective of our initial review of the PCIP program follows.

Controls Over Pre-Existing Condition Insurance Plans and Collaborative Administration
We will review the controls HHS and States have in place to prevent and identify fraudulent health care claims for individuals covered by PCIPs. We will also examine the effectiveness of Federal agencies in working together to administer the PCIP program. (OEI; 00-00-00000; expected issue date: FY 2013; new start; Affordable Care Act)

Early Retiree Reinsurance Program, § 1102

WHY WAS THE PROGRAM CREATED? The ERRP is a temporary reinsurance program to reimburse participating employment-based plans for a portion of the cost of providing health insurance to early retirees (and to certain eligible family members). The ERRP will end on January 1, 2014, when the Affordable Insurance Exchanges under § 1311 of the Affordable Care Act are implemented.

WHAT DOES THE PROGRAM DO? The $5 billion ERRP will reimburse participating employment-based plans for a portion of health care costs incurred by the plans for certain early retirees that are not less than $15,000 nor more than $90,000.

WHO IS RESPONSIBLE? The program is being implemented by the CCIIO, a part of CMS.

HOW IS THE ASSISTANCE RECEIVED AND USED? Employment-based plans apply to CCIIO to participate in the ERRP. CCIIO made applications available until early May 2011. Employers may use ERRP payments to reduce premium costs for employment-based plans or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants.

The objectives for our initial ERRP-related reviews follow.

CCIIO's Internal Control Structure for the Early Retiree Reinsurance Program (New)

We will determine whether CCIIO's internal controls for the ERRP provide reasonable assurance that the program is in compliance with the requirements of the Affordable Care Act.
(OAS; W-00-12-59008; expected issue dates: FYs 2012-14; new start Affordable Care Act)

CCIIO's Certification Procedures for Employment-Based Plans and Plan Sponsor's Use of Federal Funds

We will determine whether CCIIO's procedures for certifying employment-based plans for participation in the ERRP and plans use of ERRP reimbursements are in compliance with the requirements of the Affordable Care Act. (OAS; W-00-12-59009; expected issue dates: FYs 2012-14; new start; Affordable Care Act)

CCIIO's System Security Controls Over Protected Health Information

We will review CCIIO's system security controls over claims that employment-based plans submit for reimbursement to determine whether CCIIO's claims system contains vulnerabilities that could affect the confidentiality, integrity, and availability of the claims' protected health information.
(OAS; W-00-12-59010; expected issue dates: FYs 2012-14; new start; Affordable Care Act)

CCIIO's Reimbursements to Plans

We will review CCIIO's ERRP reimbursements to participating employment-based plans to determine whether CCIIO's payments for the costs of health benefits for early retirees complied with Federal requirements. A plan receives reimbursement for 80 percent of the costs net of negotiated price concessions for health benefits within certain cost thresholds. (OAS; W-00-12-59011; expected issue dates: FYs 2012-14; new start; Affordable Care Act)

Employment-Based Plans' Costs for Items and Services Reimbursed

We will determine whether the costs for items and services that employment-based plans reported on their claims for reimbursement complied with Federal requirements. Claims are to be based on the actual amount expended by the plans for the health benefits provided to early retirees and eligible spouses, surviving spouses, and dependents. (OAS; W-00-12-59012; various reviews; expected issue dates: FYs 2012-14; new start; Affordable Care Act)

Employment-Based Plan Sponsors' Use of Early Retiree Reinsurance Program Funds

We will determine whether employment-based plans sponsors' use of ERRP Federal funds complied with Federal requirements. (OAS; W-00-12-59013; various reviews; expected issue dates: FYs 2012-14; new start; Affordable Care Act)

Health Insurance Web Portal, § 1103

WHY WAS THE PROGRAM CREATED? The portal provides a mechanism through which residents of, and small businesses in, any State may identify affordable health insurance coverage options in that State and receive information about coverage options. The Affordable Care Act required the portal to be available not later than July 1, 2010.

WHAT DOES THE PROGRAM DO? The program enables individuals and consumers to access information on coverage options, including private health insurance, Medicaid coverage, State high-risk pools, and other types of insurance.

WHO IS RESPONSIBLE? CCIIO, a part of CMS, is responsible for operating the portal.

The objective of our initial review of the Health Insurance Web Portal follows.

Oversight of Private Health Insurance Submissions to the Health Insurance Web Portal
We will assess CCIIO's oversight of the health insurance Web portal (portal). We will also review the procedures CCIIO has established to determine and protect the integrity of data submitted by private insurers for the portal and will assess private insurer compliance with reporting requirements. The portal can be found at http://www.healthcare.gov/. (OEI; 03-11-00560; expected issue date: FY 2012; work in progress)

Affordable Insurance Exchanges, § 1311 and 1413

WHY WAS THE PROGRAM CREATED? Starting in 2014, individuals and small businesses will be able to purchase qualified health plans through State-based insurance Exchanges. The Afforable Care Act requires HHS to streamline the procedures for enrolling through an Exchange and State Medicaid, Children's Health Insurance Program (CHIP), and health insurance subsidy programs.

WHAT WILL THE PROGRAM DO? The streamlined eligibility procedures will ensure that an individual applying to an Exchange who is found to be eligible for enrollment under a State Medicaid program or CHIP will be enrolled under such plan or program.

WHO IS RESPONSIBLE? HHS's Exchange responsibilities (including funding, regulations, and other guidance to States) are being implemented by CCIIO with the assistance of the National Coordinator for Health Information Technology.

HOW IS RELATED ASSISTANCE RECEIVED AND USED? Although Exchanges are not required to be operational until 2014, States have applied to CCIIO for initial grants that can be used in a variety of initial planning activities, including planning the coordination of eligibility and enrollment systems across Medicaid, CHIP, and the Exchanges.

The objective for our initial review of Affordable Insurance Exchanges follows.

States' Readiness To Comply With Exchange and Medicaid Eligibility and Enrollment System Requirements

We will review States' progress toward complying with new eligibility and enrollment requirements for the Exchanges, Medicaid, CHIP, and health subsidy programs. We will also identify what steps States have already taken to meet these requirements, what additional steps States plan to take, and challenges or barriers that States report regarding the implementation of eligibility and enrollment systems. We will also determine the extent to which CMS has provided guidance and technical assistance to States to meet the streamlined eligibility and enrollment requirements.
(OEI; 07-10-00530; expected issue date: FY 2012; work in progress; Affordable Care Act)

National Background Check Program, § 6201

WHY WAS THE PROGRAM CREATED? The program is designed to address continued problems of patient abuse and neglect and misappropriation of patient funds in long-term-care facilities through background checks of employees with direct access to patients.

WHAT WILL THE PROGRAM DO? Under the program, the Secretary is required to identify, on a nationwide basis, efficient, effective, and economical procedures for long-term-care facilities or providers to conduct background checks on prospective employees and providers that would have direct access to patients. The program authorizes matching funds to participating States that have a plan to implement a section 6201 compliant program statewide in all specified types of long-term-care entities.

WHO IS RESPONSIBLE? The program will be administered by CMS, in consultation with the Department of Justice and the Federal Bureau of Investigation. The program will be evaluated by OIG.

HOW IS RELATED ASSISTANCE RECEIVED AND USED? Federal 3-to-1 matching funds are available to all States and territories that apply to CMS and meet all the program requirements. Although CMS will fully fund grant awards under this program, CMS will impose drawdown restrictions as necessary to ensure that State program preapproved milestones are met.

The objective of our initial review of the National Background Check Program follows.

Program for National Background Checks for Long-Term-Care Employees

We will review the procedures implemented by participating States for long-term-care facilities or providers to conduct background checks on prospective employees and providers who would have direct access to patients and determine the costs of conducting background checks.
(OEI; 07-10-00420; expected issue date: FY 2013; work in progress; Affordable Care Act)

Community Living Assistance Services and Supports Program, § 8002

WHY WAS THE PROGRAM CREATED? The Community Living Assistence and Supports Program (CLASS) is a national voluntary insurance program for purchasing community living assistance services and supports to provide individuals having functional limitations with tools that will enable them to maintain their personal and financial independence and live in the community.

WHAT WILL THE PROGRAM DO? Those who are eligible and who enroll will receive benefits to purchase long-term services and supports.

WHO IS RESPONSIBLE? CLASS will be administered by the Administration on Aging (AoA) through the Office of Community Living Assistance Services and Supports (CLASS Office).

The objective for our initial review of CLASS follows.

Development of the Community Living Assistance Services and Supports Program
We will describe AoA's progress in developing the CLASS program requirements of the Affordable Care Act. The law requires OIG to annually report on the CLASS program with regard to eligibility determination; provision of cash benefits; quality assurance and protection against waste, fraud, and abuse; and recouping of unpaid and accrued benefits. (OEI; 04-11-00450; multiple reports; expected issue date: FY 2012; work in progress; Affordable Care Act)

Existing Programs Related to Affordable Care Act Provisions

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

CDC—CENTERS FOR DISEASE CONTROL AND PREVENTION
HRSA—HEALTH RESOURCES AND SERVICES ADMINISTRATION
MA—MEDICARE ADVANTAGE

The major parts of the OIG *Work Plan* for FY 2012 that precede the appendixes include descriptions of Affordable Care Act-related reviews in progress or planned to start in FY 2012. Below are shortened descriptions of those reviews and the the major Part in which each one appears in full.

Medicare

Reliability of Hospital-Reported Quality Measure Data

We will review hospitals' controls for ensuring the accuracy and validity of data related to quality of care that they submit to CMS for Medicare reimbursement. The Affordable Care Act expands Medicare's existing quality initiative. *(Work Plan Part I.)*

Accuracy of Present-on-Admission Indicators Submitted on Medicare Claims

We will determine the accuracy of present on admission (POA) indicators on inpatient claims submitted by hospitals nationally in October 2008. The Affordable Care Act provides that hospitals with high rates of hospital-acquired conditions receive reduced payments. Accurate POA indicators are needed for CMS to implement requirements in the Deficit Reduction Act of 2005 (DRA) and the Affordable Care Act. *(Work Plan Part I.)*

Hospital Same-Day Readmissions

We will review Medicare claims to determine trends in the number of same-day hospital readmissions. This work, which pertains to an existing system edit, may also be helpful to CMS in implementing provisions of the Affordable Care Act. *(Work Plan Part I.)*

Nursing Home Compliance Plans

We will review Medicare- and Medicaid-certified nursing homes' incorporation of compliance plans into their day-to-day operations and determine whether the plans contain elements identified in OIG's compliance program guidance. Starting in 2013, we will determine whether CMS has incorporated compliance requirements into Requirements of Participation and oversees provider implementation of plans. *(Work Plan Part I.)*

Recovery Audit Contractors' Performance and Identification and Recoupment of Improper Payments

We will review the performance of the Recovery Audit Contractor (RAC) program and CMS's oversight of the program. Congress expanded the RAC program, giving it additional responsibilities

to address improper payments in Medicare (including Part C and Part D), and Medicaid. *(Work Plan Part I.)*

Enhanced Payments to Plans for Certain Beneficiary Types

We will determine the appropriateness of Medicare Part C reimbursement for beneficiaries classified as institutionalized, as having end stage renal disease, or as Medicaid eligible. We will also determine the impact of inaccurate or invalid classification of beneficiaries on Medicare payments to Medicare Advantage (MA) plans. *(Work Plan Part II.)*

Enrollment of Medicare Beneficiaries With Chronic Conditions in Special-Needs Plans

We will review Special-Needs Plans' compliance with chronic condition enrollment requirements and will assess CMS's oversight of the enrollment practices. *(Work Plan Part II.)*

Quality-Based Bonus Payments to Unrated Plans in 2011 and 2012

We will determine the amounts of quality-based bonus payments made to unrated MA plans in 2011 and 2012and will determine the extent to which CMS collects data for MA plans that are unrated. *(Work Plan Part II.)*

Part D and Medicaid Payments for High-Volume Prescription Drugs

We will review prices paid by Medicare Part D plans and State Medicaid agencies for 200 high-volume prescription drugs, compare prices paid under the programs (including discounts and rebates), and assess the impact of any price discrepancies on the Federal Government and beneficiaries. *(Work Plan Part II.)*

Quality of Sponsor Data Used in Calculating Coverage-Gap Rebates

We will review data submitted by Part D sponsors used in calculating coverage-gap rebates to ensure that beneficiary payments were correct. *(Work Plan Part II.)*

Quality of Sponsor Data Used in Calculating Coverage-Gap Disounts

We will review data submitted by Part D sponsors used in calculating the coverage gap discount. We will determine the accuracy of the sponsor-submitted data to ensure that beneficiary payments are correct and amounts paid to sponsors are supported. *(Work Plan Part II.)*

Medicaid

Appropriateness of Federal Upper Limit Amounts

We will compare Federal Upper Limit (FUL) amounts under the 2010 Affordable Care Act methodology (which changed the FUL calculation to no less than 175 percent of the designated pricing point) to estimates of pharmacy acquisition costs for selected drugs. *(Work Plan Part III.)*

States' Collection of Rebates for Drugs Paid by Managed Care Organizations

We will determine whether Medicaid Managed Care Organizations ((MCO) are providing State Medicaid agencies with the utilization data needed to collect rebates for drugs used by Medicaid MCO enrollees. The Affordable Care Act, § 2501, expanded Medicaid rebate requirements to include

drugs dispensed to MCO enrollees and required Medicaid MCOs to report enrollees' drug utilization data to the State for the purpose of collecting rebates from manufacturers. *(Work Plan Part III.)*

Federal Share of Rebates

We will review States' reporting of the Federal share of Medicaid rebate collections to determine whether States are correctly identifying and reporting the increases in rebate collections. *(Work Plan Part III.)*

Rebates on New Formulations

We will review drug manufacturers' compliance with Medicaid drug rebate requirements for drugs that are new formulations of existing drugs. We will also determine whether manufacturers have correctly identified all their drugs that are subject to a new provision in law. *(Work Plan Part III.)*

Payments for Health-Care-Acquired Conditions

We will determine whether selected State agencies made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and will quantify the amount of Medicaid payments for such conditions. *(Work Plan Part III.)*

State Agencies' Terminations of Providers Terminated Under Medicare or by Other States

We will review States' compliance with a new requirement that State Medicaid agencies terminate providers that have been terminated under Medicare or by another State. We will also determine whether such providers are teminated by all States, assess the status of the supporting information-sharing system, determine how CMS is ensuring that States share complete and accurate information, and identify obstacles States face in complying with the termination requirement. *(Work Plan Part III.)*

Medicaid National Correct Coding Initiative Effectiveness

We will review selected States' implementation of National Correct Coding Initiative (NCCI) edits for Medicaid claims. Pursuant to the Affordable Care Act, State Medicaid programs were required to incorporate "NCCI methodologies" into their claims processing systems by October 1, 2010. *(Work Plan Part III.)*

Completeness and Accuracy of Managed Care Encounter Data

We will determine the extent to which Medicaid managed care encounter data included in Medicaid Statistical Information System (MSIS) submissions to CMS accurately represent all services provided to beneficiaries. We will also determine the extent to which CMS acted to enforce Federal requirements that mandate the inclusion of Medicaid managed care encounter data in MSIS. *(Work Plan Part III.)*

Public Health

Prevention and Public Health Fund Recipient Capability Audits

We will perform limited-scope reviews to determine whether Centers for Disease Control and Prevention (CDC) grantees can manage and account for Federal funds, including Affordable Care Act

funds, in accordance with Federal regulations. We will also determine whether Prevention and Public Health Fund grantees can fulfill program requirements. *(Work Plan Part V.)*

CDC Grantees' Use of Funds From the Prevention and Public Health Fund

We will determine whether CDC grantees' use of funds from the Prevention and Public Health Fund were properly used for the purposes outlined in Federal laws and directives. *(Work Plan Part V.)*

Internal Controls for Awarding Affordable Care Act Grants

We will review and test CDC's internal controls for awarding Affordable Care Act grants. We will also determine whether selected CDC Affordable Care Act grantees complied with grants administration requirements and terms and conditions of the funding opportunity announcements. *(Work Plan Part V.)*

Payment of Invoices for Affordable Care Act Purchases

We will review and test CDC's controls over payments for goods and services, including Affordable Care Act-related purchases. We will also determine whether CDC's Financial Management Office obtains proper validation that goods or services were received before payment of invoices and whether a previously identified control deficiency has been corrected. *(Work Plan Part V.)*

Community Health Centers' Compliance With Affordable Care Act Grant Requirements

We will determine whether community health centers that received Affordable Care Act funds though the Health Resources and Sercvices Administration (HRSA) are complying with Federal laws and regulations. The review will include determining the allowability of expenditures and the adequacy of accounting systems and assessing the accounting for program income. *(Work Plan Part V.)*

Community Health Center Limited-Scope Capability Audits

We will determine the capacities of community health centers receiving Affordable Care Act funds through HRSA to manage and account for Federal funds and to operate community health service delivery sites in compliance with Federal requirements. *(Work Plan Part V.)*

HRSA's Monitoring of Recipients' Fulfillment of National Health Services Corps's Obligations

We will review the effectiveness of National Health Service Corps monitoring of recipients to ensure timely fulfillment of their contract obligations or timely recognition and referral of defaults to a Treasury-designated Debt Collection Center (HHS Program Support Center) if the recipients breach their obligations. We will determine the accuracy of HRSA's default rate (2 percent) and the adequacy of its followup with health care professionals who default on their service commitments. The Affordable Care Act and the Recovery Act provided increased funding for National Health Service Corps Loan and Scholarship Programs. *(Work Plan Part V.)*

SAMHSA Grantees' Use of Funds From the Prevention and Public Health Fund

We will review Substance Abuse and Mental Health Services Administration grantees' use of funds from the Prevention and Public Health Fund to determine whether such funds were properly used for the purposes outlined in Federal laws and directives. *(Work Plan Part V.)*