Appendix A
Affordable Care Act Reviews

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The reviews described in Appendix A address:

- New programs and initiatives created by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act) as they relate to responsibilities of the Department of Health and Human Services (HHS).
- Existing HHS programs and operations (Medicare, Medicaid, and public health) as they relate directly or indirectly to Affordable Care Act provisions.

New Programs and Initiatives

Acronyms and Abbreviations for Selected Terms Used in This Section:

CCIIO—Center for Consumer Information and Insurance Oversight
Exchanges—Affordable Insurance Exchanges
PHI—protected health information

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 and 1413
- Consumer Operated and Oriented Plan (CO-OP) Program, § 1322 (New)

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 appropriated $5 billion of Federal funds to support PCIPs that offer comprehensive insurance coverage to individuals with pre-existing conditions. A State may 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 (OPM) 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. Funds are used to pay claims. 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; 07-12-00300; 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) with high health care costs. The ERRP will end no later than January 1, 2014, when the Affordable Insurance Exchanges under § 1311 of the Affordable Care Act are implemented.

What does the program do? Congress appropriated $5 billion for the ERRP. The ERRP reimburses participating employment-based plans for a portion of health care costs incurred by the plans for certain early retirees and family members. Reimbursable claims are those between$15,000 and $90,000 (indexed for plan years starting October 1, 2011).

Who is responsible? The program is administered by CCIIO, a part of CMS.

How is the assistance received and used? Employment-based plans applied to CCIIO to participate in the ERRP. CCIIO ceased accepting applications on May 6, 2011, and is not accepting claims incurred after December 31, 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. CMS has notified participants that they must use ERRP funds no later than December 31, 2014.

The objectives for our initial ERRP-related reviews follow.

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

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; W-00-13-59008; expected issue dates: FYs 2013-14; work in progress; 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; W-00-13-59009; expected issue dates: FYs 2013-14; 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 (PHI).
(OAS; W-00-13-59010; expected issue dates: FYs 2013-14; 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; W-00-13-59011; expected issue dates: FYs 2013-14; work in progress; 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; W-00-13-59012; expected issue dates: FYs 2013-14; work in progress; 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; W-00-13-59013; various reviews; expected issue dates: FYs 2013-14; 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 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 HealthCare.gov Plan Finder

We will assess CCIIO's oversight of the HealthCare.gov Plan Finder. Specifically, we will determine the extent to which CCIIO oversees private insurers' compliance with Plan Finder reporting requirements. We will also determine whether data displayed on the Plan Finder are complete and consistent with consumer information provided by private insurers. The Plan Finder is one of several components of the HealthCare.gov Web site. The Affordable Care Act, § 1103, required the HHS Secretary to establish a health insurance Web site portal that presents a central database of health insurance information in a standardized format and enables comparison of coverage options. The Plan Finder can be found at http://finder.healthcare.gov/. *(OEI; 03-11-00560; expected issue date: FY 2013; work in progress; Affordable Care Act)*

Affordable Insurance Exchanges, §§ 1311, 1321, 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 Affordable Care Act requires HHS and States 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 program provides funding for States for activities related to planning and establishing Exchanges. Exchanges will assist consumers with shopping for, and enrolling in, private

insurance. Exchanges will also help coordinate eligibility for premium tax credits and other subsidies. The streamlined eligibility procedures will ensure that individuals using an Exchange will be enrolled in the State Medicaid or CHIP if they qualify or will be able to purchase insurance on the Exchange and access related benefits for which they are eligible.

Who is responsible? States have flexibility in operating Exchanges for their States. HHS must establish an Exchange in States that choose not to establish one or will not have one operable by January 1, 2014. HHS's Exchange responsibilities are being implemented by CCIIO.

How is related assistance received and used? States have applied to CCIIO for 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 objectives for our initial reviews of Affordable Insurance Exchanges follow.

CCIIO Oversight of Health Insurance Exchange Establishment Grants (New)

We will review the health insurance Exchange establishment grant program and States' plans for preventing fraud, waste, and abuse in their Exchanges. We will also assess CCIIO's procedures for determining compliance with grant criteria. The Affordable Care Act, § 1311(a), requires the Secretary to award such grants, which are being administered by CCIIO. *(OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act)*

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

We will review States' progress in 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 2013; work in progress; Affordable Care Act)*

Consumer Operated and Oriented Plan Program, § 1322

Why was the program created? The program is intended to foster the creation of qualified nonprofit health insurance issuers (qualified nonprofit issuers) that will offer qualified health plans in the individual and small group markets. These issuers are known as Consumer Operated and Oriented Plans, or CO-OPs.

What does the program do? The Affordable Care Act provides $3.4 billion in new funding for organizations applying to become qualified nonprofit issuers. Starting January 1, 2014, these issuers will be able to offer health plans through the Exchanges and may also offer plans outside the Exchanges.

Who is responsible? CCIIO, a part of CMS, is responsible for administering this program.

How is the related assistance received and used? The program will make loans (repayable in 5 years) to assist in funding startup costs for qualified nonprofit issuers and will award loans (repayable in 15 years) to assist such issuers in meeting State solvency requirements. The Secretary must award the loans and grants and begin funding distribution no later than July 1, 2013. (76 Fed. Reg. 5774, February 2, 2011.) HHS has made loans to 20 entities totally approximately $1.6 billion.

The objectives of our initial reviews of the CO-OP program follow.

Assessment of the CO-OP Program Award Process (New)

We will review the process CMS uses to identify and select the best qualified recipients of Consumer Operated and Oriented Plan (CO-OP) program funds in compliance with the Affordable Care Act and Federal procurement regulations. The Affordable Care Act provides $3.4 billion in new funding for the CO-OP program. The CO-OP funds are awarded to organizations applying to become qualified nonprofit health insurance issuers. The funds are to be used to establish loans to help organizations meet their startup costs and to help organizations meet any solvency requirements of States in which the organizations seek to be licensed to issue qualified health plans. The Affordable Care Act, § 1322, directs CMS to establish the CO-OP program. *(OAS; W-00-12-59025; W-00-13-59025; expected issue date: FY 2013; work in progress; Affordable Care Act)*

Affordable Care Act: Early Implementation of the Consumer Operated and Oriented Plan (CO-OP) Loan and Grant Program (New)

We will describe how early loan recipients under the CO-OP program will meet program requirements and CCIIO's oversight of the CO-OPs. Given the substantial amount of Federal funding, CCIIO must effectively monitor CO-OPs to ensure appropriate use of loans and enforce program requirements. CCIIO must implement this program in a short timeframe so that CO-OPs will be ready to enter the State Exchanges in 2014. In addition, CO-OPs are new entrants to a competitive insurance market and therefore face significant operational and financial challenges that could increase their risk of loan default. *(OEI; 01-12-00290; expected issue date: FY 2013; work in progress; Affordable Care Act)*

Existing Programs

Acronyms and Abbreviations for Selected Terms Used in This Section:

HRSA—Health Resources and Services Administration MA—Medicare Advantage

The major Parts of the OIG *Work Plan* for FY 2013 that precede the appendixes include descriptions of Affordable Care Act-related reviews in progress or planned to start in FY 2013. Below are shortened descriptions of those reviews and the major Part in which each one appears in full.

Medicare

Hospitals—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. *(OAS; W-00-13-35439; various reviews; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part I, p.2)*

HHAs—Home Health Face-to-Face Requirement (New)

We will determine the extent to which home health agencies (HHA) are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries. (*Affordable Care Act, § 6407.) (OEI; 01-12-00390; expected issue date: FY 2013; work in progress; Affordable Care Act) (Work Plan Part I, p. 11)*

Power Mobility Devices—Supplier Compliance With Payment Requirements (New)

We will conduct a series of reviews related to power mobility devices (PMD). These reviews will focus on whether Medicare payments for PMD claims submitted by medical equipment suppliers were made in accordance with requirements at 42 CFR § 410.38(c)(2) and whether savings can be achieved by Medicare for rentals rather than lump-sum purchases of certain PMDs. The Affordable Care Act, § 3136, eliminated the option of a lump-sum purchase for certain PMDs. *(OAS; W-00-13-35703; various reviews; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part I, p. 14)*

Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New)

We will determine how often onsite visits occur as part of the Medicare enrollment and reenrollment process. CMS is authorized to expand the role of unannounced preenrollment site visits. (Affordable Care Act, § 6401.) CMS implemented the Affordable Care Act provider and enrollment provisions by requiring onsite visits for provider and supplier types identified by CMS as moderate risk or high risk. (76

Fed. Reg. 5862 (February 2, 2011).) *(OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act) (Work Plan Part I, p. 18)*

State Health Insurance Assistance Programs' Provision of Medicare Fraud Information (New)

We will review the extent to which State Health Insurance Assistance Programs (SHIP) provide Medicare fraud information. CMS provides grants to States so they can provide information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage to Medicare beneficiaries. (42 USC § 1395b-4.) Additional funding for SHIPs was provided by the Affordable Care Act, § 3306. For FYs 2011 and 2012, CMS included objectives related to increasing the awareness about Medicare fraud in the Basic Program Announcement and Grant Renewal Application. *(OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act)*

Recovery Audit Contractors—Identification and Recoupment of Improper and Potentially Fraudulent Payments and CMS's Oversight and Response

We will determine the extent that Recovery Audit Contractors (RAC) identified improper payments, identified vulnerabilities, and made potential fraud referrals in 2010 and 2011. We will also review the activities that CMS performed to resolve RAC-identified vulnerabilities, address potential fraud referrals, and evaluate RAC performance in 2010 and 2011. (Affordable Care Act, § 6411.) *(OEI; 04-11-00680; expected issue date: FY 2013; work in progress; Affordable Care Act) (Work Plan Part I, p. 34)*

Part C: Special-Needs Plans—CMS Oversight of Enrollment and 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. (Affordable Care Act, § 3205.) *(OEI; 07-12-00170; expected issue date: FY 2013; work in progress; Affordable Care Act) (Work Plan Part II, p. 42)*

Parat D: Coverage Gap—Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts

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. The Affordable Care Act, § 3301, established the coverage gap discount program. *(OAS; W-00-13-35611; various reviews; expected issue date: FY 2013; Affordable Care Act) (Work Plan Part II, p. 47)*

Medicaid

Manufacturer Rebates—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. The Affordable Care Act, § 2501, amended the Medicaid rebate requirements. *(OAS; W-00-13-31450; various reviews; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part III, p. 54)*

Manufacturer Rebates—New Formulations of Existing Drugs

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. The Affordable Care Act, § 2501, amended the Medicaid rebate requirements. *(OAS; W-00-13-31451; various reviews; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part III, p. 54)*

Health-Care-Acquired Conditions—Prohibition on Federal Reimbursements

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. The Affordable Care Act, § 2701, changed Medicaid requirements to preclude Federal payments related to health-care-acquired conditions. *(OAS; W-00-13-31452; various reviews; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part III, p. 60)*

State Terminations of Providers Terminated by 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 terminated 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. (Affordable Care Act, § 6401(b)(2).) *(OEI; 06-12-00030; expected issue date: FY 2014; work in progress; Affordable Care Act) (Work Plan Part III, p. 66)*

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. The Affordable Care Act, § 6504, requires submission of data elements necessary for program integrity, program oversight, and administration. *(OEI; 00-00-00000; expected issue date: FY 2014; new start; Affordable Care Act) (Work Plan Part III, p. 71)*

State Enrollment and Monitoring of Medicaid Medical Equipment Suppliers (New)

We will review State Medicaid agencies' processes for enrolling and monitoring medical equipment suppliers. We will conduct site visits to determine whether such suppliers complied with their State Medicaid agencies' enrollment standards. In a recent OIG report on Medicaid suppliers, more than 15 percent of the suppliers failed to meet at least one enrollment standard. *(OAS; W-00-12-31468; various reviews; expected issue date: FY 2014; work in progress; Affordable Care Act) (Work Plan Part III, p. 65)*

Public Health

HRSA—Community Health Centers' Compliance With Grant Requirements of the Affordable Care Act

We will determine whether community health centers that received Affordable Care Act funds though the Health Resources and Services Administration (HRSA) are complying with Federal laws and regulations. (Affordable Care Act, § 10503) The review will include determining the allowability of expenditures and the adequacy of accounting systems and assessing the accounting for program income. *(OAS; W-00-13-58303; various reviews, expected issue dates: FY 2013; new start; Affordable Care Act) (Work Plan Part V, p. 85)*

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

We will determine the effectiveness of HRSA's monitoring of recipients to ensure timely fulfillment of their National Health Service Corps contract obligations and the timeliness of HRSA's 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, § 10503, and the Recovery Act provided increased funding for National Health Service Corps Loan Repayment and Scholarship Programs. *(OAS; W-00-13-58205; expected issue date: FY 2013; new start; Affordable Care Act) (Work Plan Part V, p. 85)*

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

We will review Substance Abuse and Mental Health Services Administration (SAMHSA) 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. The Prevention and Public Health Fund was established pursuant to the Affordable Care Act, § 4002. *(OAS; W-00-12-59005; W-00-13-59005; expected issue date: FY 2013; work in progress and new start; Affordable Care Act) (Work Plan Part V, p. 90)*