

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**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 2018**

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Daniel R. Levinson
Inspector General

May 2019
A-17-19-52000

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report of Independent Auditors on HHS's Compliance With the Improper Payments Information Act of 2002, as Amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012

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

We conducted a performance audit of U.S. Department of Health and Human Services' (HHS or the Department) compliance with the required calculation and disclosure of Improper Payment Rates as of and for the fiscal year ended September 30, 2018, to determine if HHS is in compliance with 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 (hereinafter, the amended IPIA is referred to as "IPIA").

We conducted this performance audit in accordance with generally accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To assess HHS compliance, we performed specific procedures to address the objectives summarized in the 2018 Statement of Work Appendix F – Improper Payment. The specific scope and methodology are summarized in Section II of this report.

In our opinion, HHS met many requirements but did not fully comply with IPIA for fiscal year (FY) 2018. Our detailed findings and recommendations are documented in Section III of this report.

This report is intended solely for the information and use of HHS and the HHS Office of Inspector General, Office of Management and Budget, Congress, and the U.S. Government Accountability Office, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

May 10, 2019
Tysons, Virginia

EXECUTIVE SUMMARY

The Improper Payments Elimination and Recovery Act of 2010 (IPERA; P.L. No. 111-204) requires Offices of Inspector General (OIGs) to review and report on agencies' annual improper payment information included in their Agency Financial Reports (AFRs) to determine compliance with the Improper Payments Information Act of 2002 (IPIA; P.L. No. 107-300), as amended by IPERA, as well as the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA; P.L. No. 112-248) (hereinafter, the amended IPIA is referred to as "IPIA").

The Department of Health and Human Services' (HHS) OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS's improper payment reporting in its annual AFR and accompanying materials to determine if HHS is in compliance with IPIA.

We conducted a performance audit to determine whether HHS complied with IPIA, as of September 30, 2018, in accordance with the related Appendix C of Office of Management and Budget (OMB) Circular A-123. As part of our performance audit, we evaluated HHS's assessment of the sampling and estimation plan designation (i.e., categorization of either Statistically Valid and Rigorous, Statistically Valid, and Non-Statistically Valid) for three of the programs that are self-certified as Statistically Valid and Rigorous (Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D)). These programs are determined to be susceptible to significant improper payments. Of these programs deemed susceptible to significant improper payments, two of the programs (Medicare FFS and Medicare Part C) are high-priority programs.

The four other programs that are susceptible to significant improper payment (Medicaid, Children's Health Insurance Program (CHIP), Foster Care, and Child Care Development Fund (CCDF)), one of which is a high-priority program (Medicaid), are considered non-statistical plans per OMB guidance due to the rolling nature of the improper payment methodologies. Generally, these programs' improper payment estimates review each state every three years and, as a result, the program is Statistically Valid for each one-year estimate but produces a Non-Statistically Valid three-year estimate since the plan does not cover the entire population each year. Based on the categorization of the sampling and estimation plans, we evaluated whether these programs are in compliance with reduction targets per OMB guidance (OMB Circular A-123, Appendix C, Part IV.A.5). We also determined the computational accuracy and disclosure of improper payment rate estimates.

BACKGROUND

To improve accountability of Federal agencies' administration of funds, IPIA requires agencies, including HHS, to annually report to Congress on the agencies' improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments) as well as other cases listed in the OMB implementing guidance. HHS issued its FY 2018 AFR, including the required IPIA disclosures, on November 14, 2018.

As required by OMB, agencies' OIGs must report on six key issues as part of their IPIA compliance reporting: (1) publishing an AFR for the most recent fiscal year and posting the report and any accompanying material required by OMB on the agency's website; (2) conducting a program-specific risk assessment for each program; (3) publishing improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessments or deemed by OMB as susceptible to significant improper payments; (4) publishing programmatic corrective action plans (CAPs); (5) publishing and meeting annual reduction targets for each program assessed to be at risk and measured for improper payments; and (6) reporting gross improper payment rates of less than 10 percent. As part of the Inspector General's review of the agency's compliance with IPIA, the Inspector General should also evaluate the accuracy and completeness of the agency's reporting and performance in reducing and recapturing improper payments.

WHAT WE FOUND

HHS met many requirements but did not fully comply with IPIA for FY 2018.

As required, HHS conducted a program-specific risk assessment of 22 programs (representing risk assessment of programs and charge cards) that were not deemed susceptible to significant improper payments by OMB or the Department to identify those programs or activities that might have been susceptible to significant improper payments. The charge card review, consisting of purchase and travel card payments, was completed for the Administration for Children and Families (ACF), Indian Health Service, and Substance Abuse and Mental Health Services Administration. Consistent with OMB guidance, this risk review will be performed by each Staff or Operating Division on a three-year rotational basis.

Additionally, the following table displays compliance determination with IPIA requirements for HHS programs that OMB deemed to be susceptible to significant improper payments.

Table 1
IPIA Compliance Reporting Table for Programs That OMB Deemed to Be Susceptible to Significant Improper Payments

Program Name	Published an AFR or PAR	Conducted a Risk Assessment	Published an Improper Payment Estimate	Published Corrective Action Plan	Published and Met Reduction Targets	Reported an Improper Payment Rate of Less Than 10%
Medicare FFS	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Medicare Advantage (Part C) (a)	Compliant	N/A(b)	Compliant	Compliant	(c)	Compliant
Medicare Prescription Drug Benefit (Part D)	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Medicaid	Compliant	N/A(b)	Compliant	Compliant	Non-compliant	Compliant
CHIP	Compliant	N/A(b)	Compliant	Compliant	Non-compliant	Compliant
Foster Care	Compliant	N/A(b)	Compliant	Compliant	Non-compliant	Compliant
Temporary Assistance for Needy Families (TANF)	Compliant	N/A(b)	Non-compliant	Non-compliant	(d)	(d)
CCDF	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant

Accompanying Notes to Table 1

(a) HHS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as HHS did not award a Medicare Advantage (Part C) Recovery Audit Contractor (RAC) contract in FY 2018, as required by IPIA, and Section 1893 (h) of the Social Security Act to conduct recovery audits for the Medicare Part C program.

- (b) These programs are deemed susceptible to significant improper payments and are not required to perform a risk assessment (Appendix C of OMB Circular A-123, Part I.C.1).
- (c) For FY 2017, HHS reported a target error rate of 8.08percent for Medicare Advantage. In FY 2018, the reported error rate for this program was 8.10percent. HHS has had a long-standing error-rate calculation methodology that incorporates certain biases by design into their sampling approach. With the update to Appendix C of OMB Circular A-123 in June 2018, the requirement for having met the reduction target changed from plus or minus 0.1 percentage point of the target error rate set in the previous year's AFR to instead the lower bound of its confidence interval being equal or less than the reduction target, so long as the program meets the definition of Statistically Valid and Rigorous as outlined in Appendix C of OMB Circular A-123, Part I.D.1. For Statistically Valid and Non-Statistically Valid plans, in order to meet its reduction target, the estimated error rate must be lower than or equal to its target error rate. HHS should continue to work with OMB to determine if previously approved methodologies that incorporate biases into their sampling approach can be considered as Statistically Valid and Rigorous as outlined in Appendix C of OMB Circular A-123.
- (d) As described in Finding #1, an improper payment estimate was not published for TANF due to statutory limitations. As a result, HHS was not able to publish a reduction target for future improper payment levels and fulfill the criteria of achieving improper payment rate of less than 10percent per OMB guidance.

In accordance with IPIA, agencies must complete several actions based on the number of consecutive years the agencies are determined to be non-compliant by the Inspector General. These actions are described in Appendix C to OMB Circular A-123, Part IV.B.1.

During our review of prior-year reports issued by the OIG and the results of our procedures, we identified instances of non-compliance with IPIA in the TANF and Medicare Advantage (Part C RAC) programs. HHS has been non-compliant for more than four consecutive years for these programs. For the Medicaid and CHIP programs, HHS has been non-compliant for four consecutive years. For the Foster Care program, HHS has been non-compliant for three consecutive years.

WHAT WE RECOMMEND

HHS has not fully addressed recommendations from the prior years' OIG performance audits related to improper payments, including the following:

- For the Foster Care program, ACF should continue to review its process to meet its established and published reduction target rate.
- For the TANF program, ACF should develop an improper payment estimate and CAP.

- For the Medicaid and CHIP programs, the Centers for Medicare & Medicaid Services (CMS) should review their processes to achieve the established and published reduction target rates.
- For the Medicare Part C program, CMS should actively search for a vehicle to conduct recovery audits and finalize the award in a timely manner with the intention to perform recovery audits in the current fiscal year. In addition, we also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program.

Addressing these recommendations would improve HHS's compliance with IPIA, including compliance issues identified in our current findings. We made a series of detailed recommendations as described in Section III to improve HHS's compliance with IPIA,

HHS MANAGEMENT COMMENTS

In its comments on our draft report, HHS concurred with the findings and emphasized its commitment to reduce improper payments and improve reporting. HHS's comments are included in Appendix A.

Table of Contents

INTRODUCTION	8
SECTION I – BACKGROUND	9
SECTION II – AUDIT SCOPE AND METHODOLOGY	9
SECTION III – FINDINGS AND RECOMMENDATIONS.....	11
Finding #1 – TANF improper payment estimate not published in FY 2018	11
Finding #1a – TANF corrective action plan as required by OMB not published in FY 2018.....	11
Finding #2 – Reduction target for FY 2017 not met for Foster Care program in FY 2018.....	12
Finding #3 – Reduction targets for FY 2017 not met for certain CMS programs in FY 2018.....	13
Finding #4 – No Recovery Audit Contractor (RAC) activity during FY 2018 to recover improper payments for Medicare Advantage.....	13
Appendix A: HHS MANAGEMENT COMMENTS	

INTRODUCTION

The Improper Payments Elimination and Recovery Act of 2010 (IPERA; P.L. No. 111-204) requires Offices of Inspector General (OIGs) to review and report on agencies' annual improper payment information included in their Agency Financial Reports (AFRs) to determine compliance with the Improper Payments Information Act of 2002 (IPIA; P.L. No. 107-300), as amended by IPERA, as well as the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA; P.L. No. 112-248) (herein the amended IPIA is referred as "IPIA").

The Department of Health and Human Services' (HHS or the Department) OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS's improper payment reporting in the AFR and accompanying materials to determine if HHS is in compliance with IPIA.

We conducted a performance audit to determine HHS's compliance with IPIA, as of September 30, 2018, in accordance with the related Office of Management and Budget (OMB) guidance. As part of our performance audit, we evaluated HHS's assessment of the sampling and estimation plan designation (i.e., categorization of either Statistically Valid and Rigorous, Statistically Valid, and Non-Statistically Valid) for three of the programs that are self-certified as Statistically Valid and Rigorous (Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D)). These programs are determined to be susceptible to significant improper payments. Of these programs deemed susceptible to significant improper payments, two of the programs (Medicare FFS and Medicare Part C) are high-priority programs.

The four other programs that are susceptible to significant improper payments (Medicaid, Children's Health Insurance Program (CHIP), Foster Care, and Child Care Development Fund (CCDF)), one of which is a high-priority program (Medicaid), are considered non-statistical plans per OMB guidance due to the rolling nature of the improper payment methodologies. Generally, these programs' improper payment estimates review each state every three years and, as a result, the program is Statistically Valid for each one-year estimate but produces a Non-Statistically Valid three-year estimate since the plan does not cover the entire population each year. Based on the categorization of the sampling and estimation plans, we evaluated whether these programs are in compliance with reduction targets per OMB guidance (OMB Circular A-123, Appendix C, Part IV.A.5). We also determined the computational accuracy and disclosure of improper payment rate estimates.

Objectives

The objective of our performance audit was to assess whether HHS complied with the IPIA reporting requirements and provided adequate disclosure within the annual AFR and accompanying materials.

A determination of compliance with IPIA includes whether HHS has:

- a) Published an AFR for the most recent fiscal year and posted that report and any accompanying material required by the OMB on its website

- b) Conducted a program-specific risk assessment, if required, for each program or activity to identify those that may be susceptible to significant improper payments
- c) Published improper payment estimates for all programs and activities identified in its risk assessment as susceptible to significant improper payments or deemed by OMB as susceptible to significant improper payments
- d) Published programmatic corrective action plans (CAPs) in the AFR (as required)
- e) Published and met annual reduction targets for each program assessed to be at risk and measured for improper payments (as required); and
- f) Reported a gross improper payment rate of less than 10 percent for each program or activity for which an improper payment estimate was obtained and published in the AFR

SECTION I – BACKGROUND

To improve accountability of Federal agencies’ administration of funds, IPIA requires agencies, including HHS, to annually report information to the president and Congress on the agencies’ improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments) as well as other causes listed in the OMB implementing guidance. OMB circulars provide guidance on the implementation of and reporting under IPIA (OMB Circular A-123, Appendix C, Parts I, II, and III, and OMB Circular A-136, §II.5.5). OMB has deemed eight HHS programs to be susceptible to significant improper payments. Accordingly, HHS reported approximately \$86.46 billion in gross improper payments in its FY 2018 AFR.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered IPIA information that was reported in the “Payment Integrity” section of HHS’s FY 2018 AFR. HHS included information on the following eight programs that were deemed by OMB to be susceptible to significant improper payments: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, CHIP, Temporary Assistance for Needy Families (TANF), Foster Care, and CCDF.

We performed our fieldwork from December 2018 through May 2019.

Methodology

To determine whether HHS complied with IPIA and whether it had made progress on recommendations included in prior years’ OIG reports, we:

- Reviewed applicable Federal laws and OMB circulars
- Reviewed improper payment information reported in the HHS FY 2018 AFR

- Obtained and analyzed other information from HHS on the eight programs deemed susceptible to significant improper payments
- Interviewed Department staff to obtain an understanding of the processes and events related to determining improper payment rates
- Verified that the improper payment rates for the relevant programs were less than 10 percent in FY 2018 and that the results were published in the HHS FY 2018 AFR
- Assessed HHS's disclosure of IPFA requirements in the AFR by verifying that the HHS FY 2018 AFR includes required disclosures per OMB Circular A-136
- Verified that the HHS FY 2018 AFR was published on HHS.gov
- Compared amounts included on HHS-prepared supporting documentation to information included within the "Payment Integrity" section of the FY 2018 AFR for each program; and
- Performed walk-throughs to gain an understanding of management's process and assessed internal controls for the programs selected as part of our testing of HHS's processes over financial reporting

To evaluate the assessed level of risk and the quality and methodology of improper payment estimates for programs that are susceptible to significant improper payments, we:

- Interviewed Department officials about the process for assessing the level of risk for each program and confirmed HHS's approach within the context of OMB's guidance
- Made inquiries to Department officials about the quality of the improper payment estimates and the methodology for each program
- Reviewed key processes, steps, and documentation used to estimate improper payments in each program; and
- Asked program officials about the methodology for determining the estimated improper payment rate target for the subsequent year for each program

As part of our procedures, we evaluated HHS's assessment of the categorization of either Statistically Valid and Rigorous, Statistically Valid, and Non-Statistically Valid plans for three programs that are susceptible to significant improper payments (Medicare FFS, Medicare Part C, and Medicare Part D). To assess HHS's performance in reducing and recapturing improper payments, including accuracy and completeness, we:

- Verified that the improper payment reduction goals from the HHS FY 2017 AFR were met in FY 2018 and that the results were published in the HHS FY 2018 AFR

- Reviewed HHS’s program-specific efforts to recapture improper payments in FY 2018
- Reviewed HHS’s application of the Do Not Pay Initiative at a program level in FY 2018; and
- Verified that the CAPs for the relevant programs were published in the HHS FY 2018 AFR and appropriately prioritized within HHS

We discussed the results of our work with HHS and received written comments on the report and its recommendations.

We conducted this performance audit in accordance with generally accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

SECTION III – FINDINGS AND RECOMMENDATIONS

This report consolidates the instances of non-compliance with IPFA, from an overall perspective and for each of the improper payment measurement programs. Although HHS met many IPFA and other OMB reporting requirements, it did not fully comply with IPFA, as amended.

Finding #1 – TANF improper payment estimate not published in FY 2018

HHS did not calculate or report an improper payment estimate for TANF. HHS stated in its FY 2018 AFR that it did not report an improper payment estimate for TANF because statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. IPFA requires federal agencies to review all of their programs to identify those that may be susceptible to significant improper payments. OMB implementing guidance states that OMB can also designate programs as susceptible to significant improper payments regardless of risk assessment results. OMB has designated TANF as a federal program susceptible to significant improper payments. Accordingly, HHS should have estimated and reported improper payments in the AFR for TANF. A legislative proposal around TANF improper payment measurement was published in the FY 2020 President’s Budget for HHS.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF improper payments in FY 2019.

Finding #1a – TANF corrective action plan as required by OMB not published in FY 2018

The process of reporting an improper payment estimate helps programs identify the root causes of improper payments. Since HHS did not report an improper payment estimate for the TANF program, HHS did not publish a corrective action plan for TANF addressing the root causes for

TANF's improper payments. In the FY 2018 AFR, HHS reported a series of actions, including promoting and supporting innovation in TANF data, and working with states to mitigate potential payment risk identified as part of a detailed risk assessment of the program performed in FY 2016. However, according to OMB guidance, programs for which OMB designates as susceptible to significant improper payments are required to report CAPs that address the root causes of the program's improper payments.

Recommendation:

We recommend that HHS first focus on developing and implementing an approach to reporting on TANF improper payments, as this process will aid in identifying root causes of TANF improper payments. In addition, we recommend that HHS develop and publish corrective action plans after implementing an approach.

Finding #2 – Reduction target for FY 2017 not met for Foster Care program in FY 2018

In accordance with IPERA of 2010 (Section 3(a)(E)), an agency is in compliance with IPERA if it has published improper payment reduction targets and has met such targets. Foster Care did not meet its FY 2018 reduction goal (target from FY 2017 AFR – 7.0percent; actual – 7.56 percent). As discussed in the FY 2018 AFR and Foster Care's FY 2018 OMB Improper Payment Report, there was no single factor that drove the program's slight increase from the prior year's estimate. The national error rate was affected by the interaction of the state error rate with its program size. One state with a large program (third nationally in terms of dollars) experienced a modest increase in its error rate and was the most influential of the 10 newly reviewed states in raising the national error rate due to the size of its program. Two other states' programs also experienced a significant increase in error rates, which offset improvements in performance in other states.

Additionally, errors due to lack of sufficient safety documentation for institutional caregiver staff (10percent of all errors) continued to drive up the error rate due to the high cost of institutional care. Cases with these payment errors may have contributed to more than two-thirds of the gross improper payment estimate of 7.56percent. While these types of errors were identified in states reviewed in the most recent cycle, the majority were identified in states reviewed in previous years.

Other error types that had less impact on the error rate included the following: other ineligible payments (43 percent), underpayments (6 percent), provider not licensed or approved (8 percent), excess or duplicate payments (8percent), and family not eligible for Aid to Families with Dependent Children program at time of removal (5 percent).

Recommendation:

We recommend that HHS and ACF continue working with states to (1) provide technical assistance and training related to policy updates and (2) support the Foster Care program in reaching its overall reduction target through appropriate implementation of CAPs at the state level.

Finding #3 – Reduction targets for FY 2017 not met for certain CMS programs in FY 2018

In accordance with IPERA of 2010 (Section 3(a)(E)), an agency is in compliance with IPERA if it has published improper payment reduction targets and has met such targets. The following programs did not meet the FY 2018 reduction targets:

CMS Program	Reduction Target From FY 2017 AFR	Actual Rate From FY 2018 AFR
Medicaid	7.93%	9.79%
CHIP	8.20%	8.57%

As detailed in the HHS FY 2018 AFR, Medicaid and CHIP did not achieve the reduction targets mainly due to insufficient documentation or process errors by third parties and administrative or process errors made by the state or local agencies. HHS identified that insufficient documentation to determine errors mainly consists of errors resulting from insufficient or no medical documentation submitted by providers. Administrative and process errors made by states or local agencies mainly consist of errors resulting from non-compliance with provider enrollment, provider screening, and National Provider Identifier (NPI) requirements (described further below).

Recommendation:

We recommend that HHS proactively take action throughout the fiscal year to achieve its established improper payment reduction targets.

Both Medicaid and CHIP did not achieve the reduction targets due to insufficient documentation or process errors by third parties and administrative or process errors made by state or local agencies, and therefore we recommend, for example, that HHS continue to work with the state Medicaid program and CHIP, as well as providers, to communicate the documentation requirements and monitor the adherence to such requirements throughout the year. In addition, both Medicaid and CHIP did not achieve their reduction targets in FY 2018 due to administrative or process errors made by the state or local agencies, and as a result, we recommend, for example, that HHS work with the states to bring their respective systems into compliance to fully implement provider enrollment, provider screening, and NPI requirements.

Finding #4 – No Recovery Audit Contractor (RAC) activity during FY 2018 to recover improper payments for Medicare Advantage

According to IPERA of 2010 (Section 2(h)), the agency shall conduct recovery audits with respect to each program and activity of the agency that expends \$1 million or more annually if conducting such audits would be cost-effective.

As reported in the HHS FY 2018 AFR, Section 1893 (h) of the Social Security Act expanded the RAC program to Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D).

In 2015, HHS issued a Request for Information on the proposal to place Risk Adjustment Data Validation (RADV) under the purview of a Part C RAC. In response, the Medicare Advantage

(MA) industry expressed concerns of burden related to the high overturn rate in the early experience of the FFS RAC program. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process. In light of these challenges, HHS believes Part C RAC functions are currently being performed by the contract-level RADV program. Contract-level RADV audits for payment years 2011 through 2013 have completed several stages of the audit process, and payment year 2014 audits will begin in FY 2019. However, the contract-level RADV audits did not recover any overpayments in FY 2018. Hence, in FY 2018, there was no Part C RAC awarded nor were recovery audits in place, although the annual expenditures exceed \$1 million. Therefore, CMS is not in compliance with this specific section of the law/regulations. A legislative proposal around Medicare Part C RAC efforts was published in the FY 2020 President's Budget for HHS.

Recommendation:

We recommend that HHS continue to explore a vehicle to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2019. We also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program.

APPENDIX A: HHS MANAGEMENT COMMENTS



MAY 06 2019

Gloria L. Jarmon
Deputy Inspector General for Audit Services
Department of Health and Human Services
Cohen Building, Room 5700A
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Jarmon:

Thank you for the opportunity to review the Office of Inspector General's (OIG) draft 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 2018*" (A-17-19-52000). The Department of Health and Human Services (HHS) takes seriously its responsibility to meet the Improper Payments Information Act of 2002 (IPIA; P.L. No. 107-300), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA; P.L. No. 111-204), as well as the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA; P.L. No. 112-248) (hereinafter referred to as IPIA, as amended).

We concur with the following recommendations in the draft report. For the Administration for Children and Families (ACF) high-risk programs, HHS is not in full compliance with the IPIA, as amended, due to a) the Foster Care program not meeting the improper payment reduction target for FY 2018 and b) the Temporary Assistance for Needy Families (TANF) program not reporting an improper payment estimate and not publishing a corrective action plan. For the Centers for Medicare & Medicaid Services (CMS) high-risk programs, HHS is not in full compliance with the IPIA, as amended, due to a) reporting program improper payment rates that did not meet the improper payment reduction targets for FY 2018 (Medicaid and Children's Health Insurance Program (CHIP)). With regard to CMS conducting a Medicare Part C recovery audit program, we note that CMS does conduct contract-level Risk Adjustment Data Validation audits, which meet IPERA's recovery audit requirements and advance corrective actions for the Medicare Part C program.

Although HHS has implemented a number of important steps in the past several years to reduce improper payments and improve reporting, many of which are outlined in the draft report, we recognize the need for continuous and focused efforts to further prevent, detect, and reduce improper payments in our programs.

Office of Management and Budget (OMB) guidance requires agencies to establish a plan for bringing each cited noncompliant program into compliance (including specific actions for programs that have been out of compliance for three or more years). Accordingly, HHS will develop and submit a plan to address the compliance findings to the Senate Committee on Homeland Security and Governmental Affairs, the House Committee on Oversight and Government Reform, and OMB.

While we have previously identified many tools and resources to prevent, detect, and reduce improper payments, we look forward to continuing our efforts to find innovative ways to address the root causes of improper payments and achieve compliance for the Department's programs. Reducing improper payments across HHS programs will strengthen our stewardship of taxpayer funds and accomplish HHS's mission.

We would like to thank the OIG and our independent auditors, Ernst & Young LLP, for your efforts and continued collaboration in support of the Department's programs.

Sincerely,

A handwritten signature in blue ink, appearing to read "J Moughalian", with a long horizontal flourish extending to the right.

Jen Moughalian

Acting Assistant Secretary for Financial Resources