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 2015

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

May 2016
A-17-16-52000

Office of Inspector General

http://oig.hhs.gov

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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 the Department of Health and Human Services (HHS) compliance with the required improper payment reporting as of and for the fiscal year that ended September 30, 2015, to determine if HHS is in compliance with the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)(hereinafter referred to as the IPIA, as amended).

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 2015 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 the IPIA (as amended) for fiscal year (FY) 2015. 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 9, 2016

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 as IPIA, as amended).

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, as amended.

We conducted a performance audit to determine HHS's compliance with IPIA, as amended, as of September 30, 2015, in accordance with the related Office of Management and Budget (OMB) guidance, evaluate HHS's assessment of its level of risk and methodology for high-priority programs, and determine the computational accuracy and disclosure of improper payment rates estimates.

BACKGROUND

To improve accountability of federal agencies' administration of funds, the IPIA as amended requires agencies, including HHS, to annually report 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). HHS issued its Fiscal Year (FY) 2015 AFR, including the required IPIA, as amended disclosures on November 13, 2015.

As required by OMB, agencies must report on six key issues as part of their IPIA, as amended compliance reporting: (1) publishing an AFR and posting it on the agency website; (2) conducting a program-specific risk assessment; (3) developing improper payment estimates for programs and activities identified as risk-susceptible; (4) publishing corrective action plans (CAPs); (5) establishing annual reduction targets for those risk-susceptible programs; and (6) reporting gross improper payment rates of less than 10 percent. In addition to assessing compliance with the IPIA, as amended, an OIG may evaluate the accuracy and completeness of agency reporting, as well as the agency's performance in reducing and recapturing improper payments. In addition, the Disaster Relief Appropriations Act (DRAA; P.L. No. 113-2) provides that all programs and activities receiving funds under the DRAA are deemed to be "susceptible to significant improper payments" for the purposes of the IPIA, as amended (section 904(b)). The program or activities that received funding under the DRAA are required to report and calculate an improper payment estimate.

WHAT WE FOUND

HHS met many requirements, but did not fully comply with the IPIA, as amended for FY 2015.

As required, HHS:

- published an AFR for FY 2015 and posted that report and accompanying material on HHS's website;

- conducted a program-specific risk assessment of twelve programs that were not deemed susceptible to significant improper payments by OMB to identify those programs or activities that might have been susceptible to significant improper payments.

  In early FY 2015, the risk assessment was performed using an integrated risk assessment approach that has been used since FY 2012 as part of a larger, agency-wide program. In late FY 2015, HHS incorporated the improper payment risk assessment requirements into a new qualitative risk assessment tool. As a result, for FY 2015, HHS conducted its risk assessments under both approaches. Three programs were reviewed under the previous integrated risk assessment approach whilst the remaining nine programs were reviewed under the new risk assessment approach. HHS determined that all of the programs reviewed under the two risk assessment approaches were not at-risk for significant improper payments;

- published improper payment estimates for seven of the eight programs that OMB deemed to be susceptible to significant improper payments and all seven programs deemed susceptible to significant improper payments under the DRAA;

- published CAPs for eight programs that OMB deemed to be susceptible to significant improper payments. However, the CAP published for one of the programs Temporary Assistance for Needy Families (TANF) was not in accordance to OMB guidelines. HHS also published the CAPs for seven programs deemed susceptible to significant improper payments under the DRAA;

- published and met annual reduction targets for three of the seven programs for which it reported reduction targets in the FY 2014 AFR; and

- reported an improper payment rate of less than 10 percent for six of the eight programs that OMB deemed to be susceptible to significant improper payments and all seven programs deemed susceptible to significant improper payments under the DRAA.

However, HHS did not fully comply with several IPIA, as amended requirements. Specifically HHS:

- Did not fully comply with the risk assessment requirements in that they:

  - did not provide Operating Divisions (OpDivs) with a systematic method for identifying programs for improper payment risk assessment. Although HHS provides informal guidance to the OpDivs on how programs should be identified

for improper payment risk assessments, we found that the guidance was not explicitly incorporated in HHS's improper payment risk assessment methodology; and

- did not perform risk assessments of payments to employees and charge card payments.

- Did not publish an improper payment estimate for one of the eight programs that OMB deemed to be susceptible to significant improper payments:
  - did not publish an improper payment estimate for the TANF program.

- Did not achieve targets or goals for certain programs:
  - did not achieve an improper payment rate of less than 10 percent for one of the eight programs who reported an improper payment estimate and was deemed susceptible to improper payments by OMB (Medicare Fee-For-Service);
  - did not meet improper payment rate reduction targets for four of the seven programs for which it reported reduction targets in the FY 2015 AFR (Medicare Advantage (Part C), Medicaid, Children's Health Insurance Program (CHIP), and Child Care Development Fund).

- Did not meet the requirements to implement a plan to reduce improper payments identified as a result of the improper payment estimate for one of the eight programs that OMB deemed to be susceptible to significant improper payments (TANF):

- Did not meet recapture and recovery requirements for one of the eight programs that OMB deemed to be susceptible to significant improper payments:
  - did not conduct recover audits for the Medicare Advantage (Part C) in FY 2015.

- Did not correctly calculate the standard error surrounding the improper payment rate for the Foster Care program. As a result of this, the confidence interval for one large state (and likely other states) does not give a true 90 percent confidence interval around the estimated error rate. Given the properly calculated sampling error is larger than originally determined, the true 90 percent confidence interval would be wider than originally calculated for both the state and federal level.

Finally, the Inspectors General must report on an agency's compliance with the IPIA, as amended (IPERA and OMB Circular A-123). If an agency is determined by an Inspector General not to be in compliance with the IPIA, as amended for three consecutive fiscal years for the same program or activity, the head of the agency must, not later than 30 days after the determination, submit to Congress either reauthorization proposals for each program or activity that has not been in compliance for three or more consecutive FYs or proposed statutory changes necessary to bring the program or activity into compliance. During our review of prior year reports issued by the Office of Inspector General and the results of our procedures, we identified

noncompliances with the IPIA, as amended in TANF and Medicare FFS for three or more consecutive years.

WHAT WE RECOMMEND

HHS has not fully addressed recommendations from the prior years' OIG Performance Audits related to improper payments, including the need to provide an improper payment estimate and corrective action plan for TANF, meet certain improper payment rate reduction targets, and reduce improper payment error rates to below 10 percent. Addressing these recommendations would improve HHS's compliance with the IPIA, as amended, 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 the IPIA, as amended.

HHS MANAGEMENT COMMENTS

In its comments on our draft report, HHS emphasized its commitment to becoming compliant with the IPIA Act, as amended, by working to reduce improper payment error rates, meeting reduction targets, reviewing its methodologies, and establishing recovery audit activities in all required programs. It provided information on the status of actions it has taken in response to our recommendations and previous recommendations provided by the HHS Office of Inspector General. In addition, HHS advised us that it will perform risk assessments of payments to employees and charge card payments in FY 2016 and publish the results in the FY 2016 AFR.

HHS's comments, excluding technical comments (which we addressed appropriately), are included in Appendix A.

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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 referred to as IPIA, as amended).

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 Agency Financial Report (AFR) and accompanying materials to determine if HHS is in compliance with IPIA, as amended.

We conducted a performance audit to determine HHS compliance with IPIA, as amended, as of September 30, 2015, in accordance with the related Office of Management and Budget (OMB) guidance, evaluate HHS's assessment of its level of risk and methodology for high-priority programs[1] and determine the computational accuracy and disclosure of improper payment rates estimates.

Objectives

Specifically, our objective is to provide audit support to the OIG with respect to HHS's improper payment reporting in the Agency Financial Report (AFR) and accompanying materials to determine if HHS is in compliance with IPIA, as amended.

A determination of compliance with IPIA, as amended 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) developed improper payment estimates for all programs and activities identified in its risk assessment as susceptible to significant improper payment;

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

[1] High-priority programs include: Medicare Fee-for-Service, Medicaid, Medicare Advantage (part C), Medicare Prescription Drug Benefit (Part D), Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF) program, Foster Care, and Child Care Development Funds. Of these eight programs, OMB has classified Medicare Fee-for-Service, Medicaid, Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), and Children's Health Insurance Program (CHIP) as High Error Programs.

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.

In addition, we evaluated HHS's assessment of the level of risk and quality of improper payments estimates and methodology for high-priority programs.

SECTION I – BACKGROUND

In its FY 2015 AFR, HHS reported approximately $89.7 billion in 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). To improve accountability of federal agencies' administration of funds, the IPIA, as amended requires agencies, including HHS, to annually report information to the President and Congress on the agencies' improper payments. OMB Circulars provide guidance on the implementation of and reporting under the IPIA, as amended (OMB Circular A-123, Appendix C, parts I and II, and OMB Circular A-136, § II.5.8). Further, OMB has deemed eight programs to be susceptible to significant improper payments.

On January 29, 2013, the President signed into law the Disaster Relief Appropriations Act (DRAA; P.L. No. 113-2), which provides aid to Superstorm Sandy disaster victims and their communities. All programs and activities receiving funds under the DRAA are deemed to be "susceptible to significant improper payments" for the purposes of IPIA, as amended (section 904(b)), so the DRAA requires agencies to calculate and report an improper payment estimate for these programs and activities.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our review covered the IPIA, as amended and DRAA information that was reported in the "Other Information" section of HHS's FY 2015 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, Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D), Medicaid, CHIP, TANF, Foster Care, and CCDF. As required by DRAA, HHS also included information on seven programs that received Superstorm Sandy funds.

We performed our fieldwork from November 2015 through April 2016.

Methodology

To determine whether HHS complied with the IPIA, as amended 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 HHS FY 2015 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 2015 and the results were published in the HHS FY 2015 AFR;

- assessed HHS's disclosure of IPIA, as amended requirements in the AFR by verifying that the HHS FY 2015 AFR includes required disclosures;

- verified that the HHS FY 2015 AFR was published on HHS.gov; and

- compared amounts included on HHS prepared supporting documentation to information included within the Other Information section of the FY 2015 AFR for each program.

To evaluate the assessed level of risk and the quality and methodology of improper payment estimates for high-priority programs, we:

- interviewed Department officials about the process for assessing the level of risk for the high-priority programs 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 methodology for the high-priority programs;

- reviewed key processes, steps, and documentation used to estimate improper payments in high-priority programs;

- asked program officials about the methodology for determining the estimated error rate targets for the subsequent three years for the high-priority programs; and

- for two programs (Medicare Advantage Part C and Foster Care), performed reviews of HHS methodologies used in the calculation of error rates.

To assess HHS's performance in reducing and recapturing improper payments, including accuracy and completeness, we:

- verified that the improper payment reduction goals from HHS FY 2014 AFR were met in FY 2015 and the results were published in HHS FY 2015 AFR;

- reviewed HHS's efforts to recapture improper payments at a program level in FY 2015;

- reviewed HHS's application of the Do Not Pay Initiative at a program level in FY 2015; and

- verified that the corrective action plans (CAPs) for the relevant programs were published in the HHS FY 2015 AFR and appropriately prioritized within HHS.

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

We conducted this performance audit in accordance with generally accepted *Government Auditing Standards* (GAGAS). 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 objective.

SECTION III – FINDINGS AND RECOMMENDATIONS

This report consolidates the instances of noncompliance with IPIA, as amended from an overall perspective and for each of the improper payment error rate programs. Although HHS met many IPIA, as amended and other OMB reporting requirements, it did not fully comply with the IPIA, as amended.

Finding #1 – TANF improper payment estimate not published in FY 2015

HHS did not calculate or report an improper payment estimate for TANF. HHS stated in its FY 2015 AFR that it did not report an improper payment estimate for TANF because it is a state-administered program and statutory limitations prohibit HHS from requiring states to participate in a TANF improper payment measurement. The IPIA, as amended 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 for TANF.

Recommendation:

We recommend that HHS continue to work with the OMB to implement one of the potential alternative approaches to reporting on TANF improper payments in FY 2016, as recommended by OMB.

Finding #1a – TANF corrective action plan as required by OMB not published in FY 2015

Since it 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. The process of reporting an improper payment estimate helps programs identify the root causes of their improper payments. In the FY 15 AFR, HHS reported a series of actions, including monitoring a TANF Program Integrity Innovation Grant and working with states to analyze single audit material noncompliance findings, to assist the states in reducing improper payments for TANF. However, according to OMB guidance, programs, for which OMB designates as susceptible to significant improper payments, are required to report corrective action plans that address the root causes of the program's improper payments.

Recommendation:

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

Finding #2 – HHS did not perform risk assessments of payments to employees and charge card payments

HHS did not perform a risk assessment of employee pay and charge card payments as required by IPERA/IPERIA. HHS did not request nor did they receive an approved waiver from OMB to not perform the risk assessment in FY 2015.

Recommendation:

During FY 2015, HHS reviewed processes in place that could be leveraged to meet the requirement and planned qualitative risk assessments of employee pay and charge cards that would be conducted in FY 16. We recommend that HHS, along with its OPDIVs, continue its efforts and perform risk assessments for employee pay and charge cards and report in the FY 2016 AFR.

Finding #3 – HHS did not properly identify programs for improper payment risk assessment

HHS's FY 2015 risk assessment process for identifying programs at risk for significant improper payment is not in compliance with OMB A-123, Appendix C guidance as HHS does not provide OpDivs with a systematic method for identifying programs for improper payment risk assessments. Although HHS provides informal guidance to the OpDivs on how programs should be identified for improper payment risk assessments, we found that the guidance was not explicitly incorporated in HHS's improper payment risk assessment methodology.

Recommendation:

We recommend that HHS provide OpDivs with formal guidance on identifying programs for improper payment risk assessments in compliance with OMB A-123 Appendix C and incorporate this guidance in its overall improper payment risk assessment methodology.

Finding #4 – Reduction goals for FY 2014 not met for Child Care program in FY 2015

According to the IPERA of 2010 (section 3.3.E), an agency is in compliance with IPERA if they have published improper payment reduction targets and is meeting such targets. Child Care did not meet its FY 2015 reduction goal (target from FY 2014 AFR – 5.60 percent, actual – 5.74 percent). Management indicated that targets in FY 2015 were missed due to the failure of states to apply certain policies correctly and missing or insufficient documentation in the case record files.

Recommendation:

We recommend that HHS and Administration for Children and Families (ACF) continue working with the states to (1) provide technical assistance and training related to policy updates and (2) support Child Care and Development Fund programs in reaching reduction goal targets through implementing corrective action plans at the state level, if appropriate.

Finding #5 – Foster Care program did not correctly calculate the standard error for improper payment estimation, which impacts the confidence interval

To test the sampling methodologies used by HHS to calculate the improper payment rates of applicable programs, we performed a review of the statistical sampling and estimation methods used for the Title IV-E Foster Care program improper payment reporting process.

The Foster Care program developed the FY 2015 improper payments estimates that follow the OMB-approved sampling and estimation methodology described in the improper payments section of the annual (2015) HHS AFR. Title IV-E Foster Care eligibility reviews are conducted systematically in each state (the 50 states, the District of Columbia, and Puerto Rico) about every three years, with the timing depending on the state's performance in prior reviews. During these reviews, a team comprised of federal and state staff review 80 cases for primary reviews and 150 cases for secondary reviews (plus at least a 10 percent oversample if additional cases are needed) selected from the state's Title IV-E Foster Care population to determine whether the state is compliant in meeting the federal eligibility requirements for the Foster Care program and to validate the accuracy of a state's claim for federal reimbursement of Foster Care maintenance payments. The state samples are selected based on a simple random sampling approach. Each regulatory review identifies the number of error cases and amount of payment errors, as determined from the review of a sample drawn from the state's overall Title IV-E caseload for its six-month period under review (PUR).

The sample selection and extrapolation methodology for one large state was selected and reviewed in detail. The same methodologies are applied for each state thus a detailed review of a single state was considered to be adequate to evaluate the state level methodology.

EY found the overall sampling approach and estimation methodology for the selected state, for the most part, to be reasonable and valid. However, EY found that the method for estimating the standard error of the estimated PUR for the selected state's improper payment rate was incorrect. The proper calculations were run, and EY found that the current method underestimates the standard error of the estimated improper payments at the state level. Although this error would not impact the estimated national improper payment rate, the use of the incorrect formula may result in a significant underestimation of the reported sampling error surrounding the improper payment rate estimate at both the state and national level.

HHS management indicated that the OMB-approved methodology uses data collected through title IV-E Foster Care eligibility reviews in which samples of either 80 or 150 cases are reviewed. The review protocol was established in federal regulations published in 2000. OMB has encouraged agencies, to the extent possible, to utilize existing processes to reduce the burden on the states in calculating their error rates. To conform to OMB's guidance to use existing data sources and processes, HHS developed an error rate methodology that makes use of the data collected through title IV-E Foster Care eligibility reviews.

Recommendation:

The OMB requirement for program-level sampling plans is that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a

90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments.

We recommend that the estimation method for the standard error of the estimated improper payments at the state level be updated to reflect that a ratio estimate has been used to estimate the improper payments at the state level. As a result, it may be necessary to increase the sample sizes at the state level to achieve a standard error of the estimated improper payments that projects to the national level with precision that is in compliance with the OMB requirement for a 90 percent confidence interval.

Additionally, we recommend that HHS management review its descriptions of the Foster Care improper payment calculation within its HHS Agency Financial Report to ensure the process and amount for determining precision is representative of the process being utilized.

Finding #6 – Medicare fee-for-service error rate percentage exceeds 10 percent for FY 2015

In accordance with IPERA of 2010 (section 3.3.F), an agency is in compliance with IPERA if they have "reported an improper payment rate of less than 10 percent for each program and activity for which an estimate was published under section 2(b) of the Improper Payment Information Act of 2002." The reported error rate percentage in the HHS AFR for the Medicare Fee-For-Service program in FY 2015 was 12.09 percent, which is above the compliance threshold of 10 percent. HHS identified the primary causes of the Medicare Fee-For-Service improper payments as insufficient documentation and medical necessity errors. In addition, HHS documented that insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased 7.57 percent in FY 2015 (compared to FY 2014) due to the documentation requirements to support the medical necessity of the services. In addition, insufficient documentation was also common for Skilled Nursing Facility (SNF) claims where the improper payment rate for SNF claims increased by 4.10 percent in FY 2015 (compared to FY 2014).

Recommendation:

We recommend that HHS focus on the root causes for the improper error rate percentage and evaluate critical and feasible action steps to decrease the improper error rate percentage below 10 percent.

Finding #7 – Reduction goals for FY 2014 not met for CMS programs in FY 2015

In accordance with IPERA of 2010 (section 3.3.E), an agency is in compliance with IPERA if it has published improper payment reduction targets and is meeting such targets. The following programs did not meet the published target percentages from the published HHS FY 2014 AFR:

CMS Program	Target Rate From FY 2014 AFR	Actual Rate From FY 2015 AFR
Medicare Advantage (Part C)	8.50 percent	9.50 percent
Medicaid	6.70 percent	9.78 percent
CHIP	6.50 percent	6.80 percent

Recommendation:

We recommend HHS proactively take action throughout the fiscal year to achieve its established improper payment target rates. Medicare Advantage did not achieve the target rate mainly due to insufficient documentation by third parties, and therefore, we recommend, for example, that HHS continue to work with the Medicare Advantage plans and providers to communicate the documentation requirements and monitor the adherence to such requirements throughout the year. In addition, Medicaid and CHIP did not achieve their respective target rates due to administrative 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 implement new requirements.

Finding #8 – No Recovery Audit Contract (RAC) activity during FY 2015 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 (excluding financial management improvement programs) and activity of the agency that expends $1,000,000 or more annually if conducting such audits would be cost-effective.

The Medicare Advantage (Part C) program had no recovery audit amounts reported in FY 2015. As reported in the HHS FY 2015 AFR, Section 6411(b) of the ACA expanded the RAC) program to Medicare Advantage (Part C) and Medicare Prescription Drug (Part D). As part of the procurement process to secure a Medicare Advantage (Part C) RAC, HHS posted a Request for Quote in June 2014; however, no responses were received as a result of that solicitation. HHS continues its implementation efforts and anticipates awarding a Part C RAC contract in 2016; but there was not one awarded in FY 2015 and there were no recovery audits conducted for Part C although the annual expenditures exceed $1 million. Therefore, CMS is not in compliance with this specific section of the law/regulations.

Recommendation:

We recommend that HHS continue to take steps to implement a Medicare Advantage (Part C) RAC program and finalize the award in a timely manner with the intention to perform RAC audits in FY 2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary
Washington, DC 20201

MAY 0 9 2016

Daniel R. Levinson
Inspector General
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Dear Mr. Levinson:

Thank you for the opportunity to review the Office of Inspector General's 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 2015" (A-17-16-52000). The Department of Health and Human Services (HHS) takes 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)*, 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) requirements seriously. As requested, this letter includes information on the status of actions we are taking in response to the recommendations in the report. In addition, our technical comments are attached for your consideration.

Responses to the HHS OIG Recommendations on IPERA Compliance (A-17-16-52000)[1]

Recommendation #1[2]: The Department should "continue to work with the OMB to implement one of the potential alternative approaches to reporting on Temporary Assistance for Needy Families (TANF) improper payments in Fiscal Year (FY) 2016, as recommended by OMB." After implementing an approach, the Department should "publish corrective action plans" in response to the root causes identified through the alternative approach to reporting on TANF improper payments.

HHS Response: As disclosed in the FY 2015 Agency Financial Report (AFR)[3] and previous AFRs, statutory limitations prohibit HHS from developing a TANF improper payment estimate—that is, HHS cannot require States to participate in, calculate, or report an improper payment measurement. When legislation is considered to reauthorize TANF we want to work with Congress to address a set of issues related to accountability and how funds are used, and to craft statutory changes that would allow for reliable error rate measurement, if appropriate. In the meantime, HHS is engaging with stakeholders, such as OMB, to explore potential options to develop an alternative approach that could bring TANF into compliance with IPIA, as amended, and meet reporting requirements. Lastly, although HHS did not publish corrective action plans addressing the specific root cause(s) identified through a TANF improper payment

[1] The Department consolidated the HHS OIG recommendations on IPERA Compliance for the purpose of responding to the recommendations and noted, where appropriate, which recommendations and responses correspond to the findings and recommendations as presented in A-17-16-52000.
[2] This recommendation and response corresponds to Finding #1 and Finding #1a.
[3] More information is available at http://www.hhs.gov/afr.

measurement process (since HHS did not report an error rate for TANF), HHS took, and continues to take, corrective actions listed in the FY 2015 AFR to assist States in strengthening program integrity.

Recommendation #2[4]: The Department should "focus on root causes for the improper error rate percentage and evaluate critical and feasible action steps to decrease the improper error rate percentage below 10 percent" for the Medicare Fee-For-Service (FFS) program.

HHS Response: HHS is committed to reducing all program error rates below the 10 percent threshold, and has made progress in recent years. As the draft report notes, in FY 2015, six of the seven programs that OMB deemed susceptible to significant improper payments and all of the seven programs deemed susceptible to significant improper payments under the *Disaster Relief Appropriations Act* reported error rates below the 10 percent level (the exceptions was the Medicare FFS program). HHS has taken, and continues to take, a number of actions to address root causes, outlined in the FY 2015 AFR (please see http://www.hhs.gov/afr/ for HHS' AFR, released November 13, 2015) to reduce error rates in all of its programs, including Medicare FFS. While the Medicare FFS improper payment rate decreased from FY 2014 to FY 2015, we believe these actions, as well as new corrective actions, will allow HHS to achieve compliance with the 10 percent goal in the future.

Recommendation #3[5]**:** The Department should assess the need for additional actions to meet error rate reduction targets.

HHS Response: HHS is committed to meeting its error rate reduction targets, and has made progress. As the draft report notes, in FY 2015, three programs met the reduction targets that were published in the FY 2014 AFR (Medicare FFS, Medicare Part D, and Foster Care), which is an increase compared to FY 2014 when only two programs met the reduction targets that were published in the FY 2013 AFR. Four programs (Medicare Part C, Medicaid, Children's Health Insurance Program (CHIP), and Child Care) did not meet the reduction targets in FY 2015.

HHS sets aggressive reduction targets in an effort to drive improvement in payment accuracy levels in conjunction with changes to strengthen program integrity. The downside of setting aggressive targets is that they may not always be met. For example, efforts to strengthen program integrity may lead to short term increases in improper payment estimates since it takes time for stakeholders to meet and implement new, and oftentimes more stringent, requirements. As mentioned previously, HHS has taken a number of actions to reduce error rates in all of our programs, including Medicare Part C, Medicaid, CHIP, and Child Care. We believe these actions will allow HHS to achieve error rates at or below the established targets in the future.

Recommendation #4[6]: As part of its risk assessment process for FY 2016, the Department should "conduct risk assessments of payments to employees and charge card payments" and issue formal guidance for "identifying programs for improper payment risk assessments."

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[4] This recommendation and response corresponds to Finding #6.
[5] This recommendation and response corresponds to Finding #4 and Finding #7.
[6] This recommendation and response corresponds to Finding #2 and Finding #3.

HHS Response: Prior to the passage of IPERIA and issuance of OMB's updated Appendix C to OMB Circular A-123 in October 2014, agencies were allowed to exclude payments to employees and charge card payments from their ongoing risk assessment process. In FY 2015, HHS reviewed this requirement and other guidance (including Appendix B of OMB Circular A-123 and OMB Memorandum M-13-21 – *Implementation of the Government Charge Card Abuse Prevention Act of 2012*) and HHS activities to determine how to meet this requirement. HHS will perform risk assessments of payments to employees and charge card payments in FY 2016 and publish the results in the FY 2016 AFR. Lastly, HHS will transmit formal guidance on how programs should be identified for improper payment risk assessments and incorporate this guidance in the improper payment risk assessment methodology for FY 2016.

Recommendation #5[7]: The Department should "review the process for determining precision to estimate improper payments at the State level" and "ensure that its descriptions of the Foster Care improper payment calculation within its AFR is representative of the process being utilized."

HHS Response: HHS is committed to ensuring accurate reporting of improper payment information. HHS will review the Foster Care program's methodology that is used to estimate the standard error for improper payment estimation at the State level and its impact on the national precision level in accordance with OMB statistical requirements to determine if any changes are needed. HHS will also review Foster Care's reporting in the annual AFR to ensure that the description of this process is complete and accurate in the FY 2016 AFR.

Recommendation #6[8]: The Department should "conduct recovery audits for the Medicare Advantage (Part C) program."

HHS Response: HHS is committed to establishing Recovery Audit Contractor (RAC) programs in all required programs per Section 6411 of the *Affordable Care Act*—Medicare Part C, Medicare Part D, and Medicaid. While HHS has implemented the Medicare Part D and Medicaid RAC programs, HHS has not yet implemented a Medicare Part C RAC program. Since the *Affordable Care Act* was enacted, HHS has taken steps to implement a Medicare Part C RAC program by: publishing a solicitation of comments, posting a Request for Quote, and most recently releasing a Request for Information and a proposed statement of work. HHS anticipates awarding a Medicare Part C RAC contract in FY 2016.

Thank you again for your ongoing efforts to assist the Department. We look forward to continuing to partner with your office to prevent and reduce improper payments.

Sincerely,

Ellen G. Murray
Assistant Secretary for Financial Resources

[7] This recommendation and response corresponds to Finding #5.
[8] This recommendation and response corresponds to Finding #8.