

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 2019**

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



Christi A. Grimm
Principal Deputy Inspector
General

May 2020
A-17-20-52000

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

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' 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, 2019, 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. The nature, timing, and extent of the procedures selected depend on our judgment. 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 2019 Statement of Work Appendix F – Improper Payment. The specific scope and methodology are summarized in Section II of this report. This report also addresses the extent to which HHS has identified and implemented internal control to comply with the IPIA. Because of their nature and inherent limitations, the internal control may not prevent, or detect and correct, all deficiencies that may be considered relevant to the audit objectives.

HHS met many requirements, but did not fully comply with IPIA for fiscal year 2019 (FY 2019). 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 8, 2020
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' 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, 2019, 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 compliance of eight programs that OMB deemed susceptible to significant improper payments against IPIA criteria: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Temporary Assistance for Needy Families (TANF), Foster Care, Child Care and Development Fund (CCDF) and Children's Health Insurance Program (CHIP). Four of these programs (Medicare FFS, Medicare Part C, Medicaid and CHIP) are OMB designated high-priority programs. As part of our procedures, we evaluated the improper payment methodology and estimate for two programs, Medicaid and CHIP.

Additionally, we determined that internal control within the context of the performance audit objective is significant. Accordingly, we obtained an understanding of the management process, evaluated the control environment, and determined whether HHS maintained adequate internal control over the improper payment process for the high-priority programs.

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 2019 AFR, including the required IPIA disclosures, on November 13, 2019.

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 2019.

As required, HHS conducted a program-specific risk assessment of 31 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 Food and Drug Administration (FDA). 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 Performance and Accountability Report (PAR)	Conducted a Risk Assessment	Published an Improper Payment Estimate	Published a 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	Compliant	Compliant
Medicare Prescription Drug Benefit (Part D)	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Medicaid	Compliant	N/A(b)	Compliant	Compliant	(d)	Non-compliant
CHIP	Compliant	N/A(b)	Compliant	Compliant	(d)	Non-compliant
Foster Care	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Temporary Assistance for Needy Families (TANF)	Compliant	N/A(b)	Non-compliant	Non-compliant	(c)	(c)
Child Care and Development Fund (CCDF)	Compliant	N/A(b)	Compliant	Compliant	(e)	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 had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program in FY 2019, as required by IPIA, and Section 1893 (h) of the Social Security Act.
- (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) 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 10 percent per OMB guidance.
- (d) As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report improper payment target rates for Medicaid and CHIP in FY 2019. HHS resumed the Medicaid and CHIP eligibility component measurements and is reporting the first updated national eligibility improper payment estimates in FY 2019. Since HHS uses a 17-state, 3-year rotation for measuring Medicaid and CHIP improper payments, the publication of reduction targets will occur in FY 2021 once HHS establishes and reports a full baseline, including eligibility.
- (e) As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report improper payment target rates for Child Care. CCDF state grantees are implementing large-scale changes to their child care programs in accordance with Child Care and Development Block Grant Act of 2014. Rolling implementation of the new requirements affected the FY 2019 error rate measurement and will continue to affect the error rate in the FY 2020 measurement, making it challenging to determine a target rate. As a result, the full baseline has yet to be established. HHS anticipates the publication of a reduction target in FY 2022 once HHS establishes a full baseline.

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 Medicaid, CHIP, TANF and Medicare Advantage (Part C) programs. HHS has been non-compliant for five or more consecutive years for these programs.

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 TANF program, ACF should develop an improper payment estimate and CAP;
- For the Medicare Part C program, HHS should continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2020. We also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program; and

- For Medicaid and CHIP, HHS should focus on identifying root causes for the improper payment percentage and evaluate critical and feasible action steps to reduce the improper payment percentages below 10 percent.

Addressing these recommendations would improve HHS' 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' 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' 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 2019	11
Finding #1a – TANF corrective action plan as required by OMB not published in FY 2019	11
Finding #2 – Medicaid and CHIP improper payment rate percentages exceed 10 percent for FY 2019	12
Finding #3 – No Recovery Audit Contract (RAC) activity completed during FY 2019 to recover improper payments for Medicare Advantage	13
APPENDIX A: HHS MANAGEMENT COMMENTS	14

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' 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' compliance with IPIA, as of September 30, 2019, in accordance with the related Office of Management and Budget (OMB) guidance. As part of our performance audit, we evaluated compliance of eight programs that OMB deemed susceptible to significant improper payments against: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Temporary Assistance for Needy Families (TANF), Foster Care, Child Care and Development Fund (CCDF), and Children's Health Insurance Program (CHIP). Four of these programs (Medicare FFS, Medicare Part C, Medicaid and CHIP) are OMB designated high-priority programs. In addition, we evaluated the quality of improper payment methodology and estimate of two programs, Medicaid and CHIP.

Additionally, we determined that internal control within the context of the performance audit objective is significant. Accordingly, we obtained an understanding of the management process, evaluated the control environment, and determined whether HHS maintained adequate internal controls over the improper payment process for the high-priority programs.

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, 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 the accountability of federal agencies' administration of funds, IPIA requires the 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.4.5). OMB has deemed eight HHS programs to be susceptible to significant improper payments. Accordingly, HHS reported approximately \$106.67 billion in gross improper payments in its FY 2019 AFR.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered IPIA information that was reported in the "Payment Integrity Report" section of HHS' FY 2019 AFR. HHS included information on the following eight programs that OMB deemed susceptible to significant improper payments: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, TANF, Foster Care, and CCDF.

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 2019 AFR;
- Assessed internal control around significant processes impacting the improper payment process in conjunction with the audit of the consolidated financial statements;
- 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 2019 and that the results were published in the HHS FY 2019 AFR;

- Assessed HHS' disclosure of IPIA requirements in the AFR by verifying that the HHS FY 2019 AFR includes required disclosures per OMB Circular A-136;
- Verified that the HHS FY 2019 AFR was published on HHS.gov;
- Compared amounts included on HHS-prepared supporting documentation to information included within the "Payment Integrity Report" section of the FY 2019 AFR for each program;
- 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' processes over financial reporting; and
- Evaluated the control environment to determine if HHS maintained adequate internal controls over the improper payment process for the high priority programs.

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' 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 the improper payment methodology and estimate for two programs, Medicaid and CHIP. To assess HHS' performance in reducing and recapturing improper payments, including accuracy and completeness, we:

- Verified that the improper payment reduction goals from the HHS FY 2018 AFR were met in FY 2019 and that the results were published in the HHS FY 2019 AFR;
- Reviewed HHS' program-specific efforts to recapture improper payments in FY 2019;
- Reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2019; and
- Verified that the CAPs for the relevant programs were published in the HHS FY 2019 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 IPIA, from an overall perspective and for each of the improper payment measurement programs. Although HHS met many IPIA and other OMB reporting requirements, it did not fully comply with IPIA, as amended.

Finding #1 – TANF improper payment estimate not published in FY 2019

HHS did not calculate or report an improper payment estimate for TANF. HHS stated in its FY 2019 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. IPIA 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.

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 2020. A legislative proposal around TANF improper payment measurement published in FY 2020 President's Budget was not enacted by Congress and HHS submitted a new proposal for the FY 2021 President's Budget. We recommend that HHS continue to seek legislative proposals submitted through the President's Budget related to the program's measurement of improper payments.

Finding #1a – TANF corrective action plan as required by OMB not published in FY 2019

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 2019 AFR, HHS reported a series of actions, including awarding a contract to promote and support 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. In FY 2019, through the contract, HHS conducted a comprehensive needs assessment of all TANF states, territories, and the District of Columbia, including information

about payment integrity efforts to understand existing state approaches and alternative methods for measuring TANF improper payments. HHS also performed a detailed risk assessment of the TANF program to determine susceptibility to significant improper payments and identified potential payment risks at the federal level. However, according to OMB guidance, programs that 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 continue to 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 – Medicaid and CHIP improper payment rate percentages exceed 10 percent for FY 2019

In accordance with IPERA of 2010 (section 3(a)(3)(F)), an agency is in compliance with IPERA if it has “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 improper payment rate percentage in the HHS AFR for the Medicaid and CHIP programs in FY 2019 was 14.90 percent and 15.83 percent, respectively, which are above the compliance threshold of 10.00 percent.

One area driving the FY 2019 Medicaid and CHIP improper payment estimates is the reintegration of the PERM eligibility component. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously, states conducted the measurement and self-reported results to HHS for reporting the national rate. This allows for consistent insight into the accuracy of Medicaid and CHIP eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income or resource verification.

HHS also identified that the primary causes of the Medicaid improper payments were driven by errors due to state noncompliance with provider screening, enrollment and National Provider Identifier (NPI) requirements. Most improper payments cited on claims are those where a newly enrolled provider had not been appropriately screened by the state; a provider did not have the required NPI on the claim; or a provider was not enrolled. States also must revalidate the enrollment and rescreen all providers at least every five years. In FY 2019, HHS measured the second cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate.

Recommendation:

We recommend that HHS focus on the root causes of the improper payment percentage and evaluate critical and feasible action steps to assist states with their compliance efforts for these new requirements. This would include working with the states to bring their respective systems into full compliance with the requirements to decrease the improper payment rate percentage below 10 percent. HHS should work with the states to follow up on repeat root causes for errors and enhance the CAPs for implementation. In addition, as HHS reviews only 17 states each year for the Medicaid and CHIP improper payment rate, HHS should continue to follow up with states during the interim period to verify that corrective actions identified after the improper payment error rate measurement review are being implemented. HHS should also consider sharing corrective action best practices across states to help address these issues.

Finding #3 – No Recovery Audit Contract (RAC) activity completed during FY 2019 to recover improper payments for Medicare Advantage

In accordance with 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 2019 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. In April 2019, HHS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits. The purpose of the training was to prepare the MA industry for the selection of audited MA organizations for RADV audits. The payment year 2014 RADV audit is currently underway but has not yet concluded. Hence, in FY 2019, there was no Part C RAC awarded, nor were recovery audits yet completed, although the annual expenditures exceed \$1 million. Therefore, HHS is not in compliance with this specific section of the law/regulations.

To more efficiently use program integrity resources, the FY 2020 budget included a proposal to remove the requirement for HHS to expand the RAC program to Medicare Part C. The FY 2020 proposal was not enacted by Congress and HHS submitted a new proposal for the FY 2021 President's Budget. The proposal also requires plan sponsors to report Part C fraud and abuse incidents and corrective actions. Given that functions of the Part C RAC program are being performed through other program integrity mechanisms, the proposal explores programmatic and administrative efficiencies while strengthening fraud and abuse reporting.

Recommendation:

We recommend that HHS continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2020. We also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program.

APPENDIX A: HHS MANAGEMENT COMMENTS



Amy J. Frontz
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. Frontz:

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 2019*" (A-17-20-52000). 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 by 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 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 reporting program improper payment rates exceeding the 10 percent threshold for FY 2019 (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. As part of these continuous efforts, the President's FY 2020 and FY 2021 Budgets included legislative solutions to help TANF and Medicare Part C achieve compliance with the IPIA, as amended.

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 HHS'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 HHS's programs.

Sincerely,

Jennifer C.
Moughalian -A

Digitally signed by Jennifer C. Moughalian -A
DN: c=US, o=U.S. Government, ou=HHS, ou=OS,
ou=People,
0.9.2342.19200300.100.1.1=2002135815,
cn=Jennifer C. Moughalian -A
Date: 2020.05.06 21:14:23 -04'00'

Jen Moughalian
Principal Deputy Assistant Secretary for Financial
Resources