

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES MET MANY
REQUIREMENTS OF THE IMPROPER
PAYMENT INFORMATION ACT OF 2002
BUT DID NOT FULLY COMPLY FOR
FISCAL YEAR 2017**

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**May 2018
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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.



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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 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, 2017, 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 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 2017 Statement of Work Appendix F – Improper Payment. The specific scope and methodology are summarized in Section II of this report.

In our opinion, the HHS met many requirements but did not fully comply with the IPIA (as amended) for fiscal year (FY) 2017. 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.

May 11, 2018
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 referred to as IPIA, as amended).

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) engaged us to assist in its evaluation of the accuracy and completeness of HHS's improper payment reporting in its annual 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, 2017, in accordance with the related Appendix C of Office of Management and Budget (OMB) Circular A-123. In addition, we evaluated HHS's assessment of the level of risk for the five high-priority programs, and the quality of improper payments and methodology for two programs that are susceptible to significant improper payments, one of which is a high-priority program. We also determined the computational accuracy and disclosure of improper payment rate estimates.

BACKGROUND

To improve accountability of Federal agencies' administration of funds, the IPIA 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) as well as other cases listed in the OMB implementing guidance. HHS issued its FY 2017 AFR, including the required IPIA disclosures, on November 14, 2017.

As required by OMB, agencies' OIGs must report on six key issues as part of their IPIA compliance reporting: (1) publishing an AFR and posting it on the agency website; (2) conducting a program-specific risk assessment; (3) publishing improper payment estimates for all programs and activities identified as susceptible to significant improper payments; (4) publishing 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. In addition to assessing compliance with the IPIA, 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 (section 904(b)). The programs or activities that received funding under the DRAA are required to calculate and report an improper payment estimate until those funds are expended.

WHAT WE FOUND

HHS met many requirements, but did not fully comply with the IPIA, as amended, for FY 2017.

As required, HHS:

- Published an AFR for FY 2017 and posted that report and accompanying material on the HHS website.
- Conducted a program-specific risk assessment of 24 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.
- Conducted risk assessments of government charge cards.
 - The charge card review, consisting of purchase and travel card payments, was completed for Office of the Assistant Secretary for Preparedness and Response (ASPR) and Center for Medicare and Medicaid Services (CMS). Consistent with OMB guidance, this risk review will be done by each Staff or Operating division on a three-year rotational basis.
- Published improper payment estimates for seven of the eight programs that OMB deemed to be susceptible to significant improper payments and the two programs deemed susceptible to significant improper payments under the DRAA that had not expended all funds by FY 2017. The other programs under the DRAA that have expended all of the Disaster Relief Act funds were excluded from reporting improper payment estimates.
- Published CAPs for seven of the eight HHS programs that OMB deemed to be susceptible to significant improper payments and two programs deemed susceptible to significant improper payments under the DRAA that had not expended all funds by FY 2017. The other programs under the DRAA that have expended all of the Disaster Relief Act funds are excluded.
- Published and met annual reduction targets for four of the seven programs for which it reported reduction targets in the FY 2016 AFR.
- Reported an improper payment rate of less than 10 percent for six of the seven programs that OMB deemed to be susceptible to significant improper payments and that reported an improper payment estimate in FY 2017, and two programs deemed susceptible to significant improper payments under the DRAA that had not expended all funds by FY 2017.

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

- Did not achieve goals or targets for certain programs:
 - Did not publish an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program, which is one of the eight programs that OMB deemed susceptible to significant improper payments.
 - Did not achieve an improper payment rate of less than 10 percent for one of the seven programs deemed susceptible to significant improper payments by OMB (Medicaid) and that reported an improper payment estimate in FY 2017.
 - Did not meet improper payment rate reduction targets for three of the seven programs for which it reported reduction targets in the FY 2016 AFR (Medicaid, Children's Health Insurance Program (CHIP), and Foster Care.)
 - Did not award a Medicare Advantage (Part C) Recovery Audit Contractor (RAC) contract in FY 2017, as required by Section 1893 (h) of the Social Security Act to conduct recovery audits for the Medicare Part C Program.
- Did not correctly calculate the standard error surrounding the improper payment rate at the state level for the Foster Care program. As a result of this, the confidence interval for the federal estimate does not state a correct 90 percent confidence interval around the estimated error rate. Given that the properly calculated sampling errors for the states of Louisiana (FY 2017) and Texas (FY 2015) are larger than originally determined, the correct 90 percent confidence interval could be wider than originally calculated for the 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 propose statutory changes necessary to bring the program or activity into compliance. If an agency is determined by an Inspector General not to be in compliance with the IPIA, as amended, for two consecutive fiscal years for the same program or activity, the OMB will review the program and determine if additional funding would help the agency come into compliance. This process will unfold as part of the annual development of the President's Budget. If the Director of OMB determines that additional funding would help the agency become compliant, the agency shall obligate an amount of additional funding determined by the Director of OMB to intensify compliance efforts. When providing additional funding for compliance efforts, the agency shall exercise reprogramming or transfer authority to provide additional funding to meet the level determined by the Director of OMB and submit a request to Congress for additional reprogramming or transfer authority if additional funding is needed to meet the full level of funding determined by the Director of OMB. During our review of prior-year reports issued by the Office of Inspector General and the results of our procedures, we identified

instances of noncompliance with the IPIA, as amended, in the TANF, Medicaid, Medicare Part C and CHIP programs for three or more consecutive years. We also identified instances of noncompliance with the IPIA, as amended, in the Foster Care program for two 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 correct the method for calculating the standard error to estimate the improper payments at the state level. In addition, ACF may need to increase the sample size at the state level to refine its calculation to meet OMB precision requirements at the national level. Finally, 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 corrective action plan.
- For the Medicaid program, CMS should focus on identifying root causes for the improper payment percentage and evaluate critical and feasible action steps to decrease the improper payment percentage below 10 percent.
- For the CHIP program, CMS should review its processes to achieve the established and published reduction target rate.
- 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 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 concurred with the findings and emphasized its commitment to reduce improper payments and improve reporting. 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's compliance with IPIA, as amended, as of September 30, 2017, in accordance with the related Office of Management and Budget (OMB) guidance. In addition, we evaluated HHS's assessment of the level of risk and quality of improper payments and methodology for two programs that are susceptible to significant improper payments (Foster Care and Medicaid), one of which is a high-priority program¹. We also determined the computational accuracy and disclosure of improper payment rate estimates.

Objectives

Specifically, our objective is to provide audit support to the OIG with respect to HHS's improper payment reporting in the annual 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) Published improper payment estimates for all programs and activities identified in its risk assessment 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)

¹ OMB deemed the following HHS programs as susceptible to significant improper payments: Medicare Fee-for-Service (FFS), Medicaid, Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Foster Care, and Child Care Development Fund (CCDF). The following programs are considered high-priority: Medicare Fee-for-Service (FFS), Medicaid, Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), and Children's Health Insurance Program (CHIP).

- 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 for the five high-priority programs, and the quality of improper payments estimates and methodologies for two programs that are susceptible to significant improper payments, one of which is a high-priority program.

SECTION I – BACKGROUND

In its FY 2017 AFR, HHS reported approximately \$90.1 billion in gross 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. To improve accountability of Federal agencies’ administration of funds, the IPIA 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 (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 (section 904(b)), so the DRAA requires agencies to calculate and report an improper payment estimate for these programs and activities until all funding has been expended.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered the IPIA and DRAA information that was reported in the “Payment Integrity” section of HHS’s FY 2017 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 the Child Care Development Fund (CCDF). As required by DRAA, HHS also included information on two programs that received Superstorm Sandy funds.

We performed our fieldwork from November 2017 through May 2018.

Methodology

To determine whether HHS complied with the 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 2017 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 2017 and the results were published in the HHS FY 2017 AFR
- Assessed HHS's disclosure of IPFA requirements in the AFR by verifying that the HHS FY 2017 AFR includes required disclosures
- Verified that the HHS FY 2017 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 2017 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'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 methodology for each program
- Reviewed key processes, steps and documentation used to estimate improper payments in each program
- Asked program officials about the methodology for determining the estimated improper payment rate target for the subsequent year for each program
- Agreed amounts included on HHS's prepared supporting documentation to information included within the "Payment Integrity" section of the FY 2017 AFR for each program
- Performed reviews of HHS's methodologies used in the calculation of improper payment rates for two programs that are susceptible to significant improper payments (Foster Care and Medicaid), one of which is a high-priority program

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 2016 AFR were met in FY 2017 and the results were published in the HHS FY 2017 AFR
- Reviewed HHS's efforts to recapture improper payments at a program level in FY 2017
- Reviewed HHS's application of the Do Not Pay Initiative at a program level in FY 2017
- Verified that the corrective action plans CAPs for the relevant programs were published in the HHS FY 2017 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. 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 noncompliance 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 the IPIA, as amended.

Finding #1 – TANF improper payment estimate not published in FY 2017

HHS did not calculate or report an improper payment estimate for TANF. HHS stated in its FY 2017 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. The 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 the OMB to develop and implement an approach to reporting on TANF improper payments in FY 2018.

Finding #1a – TANF corrective action plan as required by OMB not published in FY 2017

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 2017 AFR, HHS reported a series of actions, including working with states to analyze Single Audit material noncompliance findings, 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 CAPs after implementing an approach.

Finding #2 – Reduction target for FY 2016 not met for Foster Care program in FY 2017

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. Foster Care did not meet its FY 2017 reduction goal (target from FY 2016 AFR – 6.60 percent; actual – 7.13 percent). As discussed in the FY 2017 AFR and Foster Care's FY 2017 OMB Improper Payment Report, the primary factor that drove the program's slight increase from the prior year's estimate of 6.89 percent was the performance of one state with a relatively large program (sixth largest in terms of Title IV-E payments) that HHS reviewed this cycle. This state, which has a comparatively large influence on overall program performance due to its program size, had an improper payment estimate of over 18 percent. Had performance in this state remained at its previous level (i.e., 7.15 percent), the FY 2017 Foster Care improper payment estimate would have fallen to 6.44 percent this year.

Additionally, errors due to lack of sufficient safety documentation for institutional caregiver staff (10 percent 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 over 4 percent to the gross improper payment estimate of 7.13 percent. (Note: Because cases may have more than one type of overpayment error, the rate for any specific type of overpayment may involve some duplication and therefore slight overestimation.)

Other error types that had less impact on the error rate included: other ineligible payments (30 percent), underpayments (12 percent), provider not licensed or approved (10 percent), excess or duplicate payments (8 percent), and child not eligible for Aid to Families with Dependent Children at time of removal (i.e., financial need or parental deprivation requirement not met) (7 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 2016 not met for certain CMS programs in FY 2017

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 has met such targets. The following programs did not meet the FY 2017 reduction targets:

CMS Program	Reduction Target from FY 2016 AFR	Actual Rate from FY 2017 AFR
Medicaid	9.57%	10.10%
CHIP	7.38%	8.64%

As detailed in the HHS FY 2017 AFR, Medicaid and CHIP did not achieve the reduction target 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 noncompliance with provider enrollment, screening and National Provider Identifier (NPI) requirements (described further below).

Recommendation:

We recommend 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 Medicaid and CHIP plans and 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 2017 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 screening and NPI requirements.

Finding #4 – Medicaid improper payment rate percentage exceeds 10 percent for FY 2017

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 improper payment rate percentage in the HHS AFR for the Medicaid program in FY 2017 was 10.10 percent, which is above the compliance threshold of 10.00 percent. HHS identified that the primary causes of the Medicaid improper payments were driven by errors due to state noncompliance with provider screening, enrollment and NPI requirements. The requirements include: 1) all ordering and referring providers are required to be enrolled in Medicaid and claims are required to be submitted with the ordering and referring provider’s NPI, 2) states are required to screen providers under a risk-based screening process prior to enrollment, and 3) attending provider NPI is required to be submitted on all electronically filed institutional claims. HHS began reviewing based on these requirements for the FY 2014 improper payment reporting. As HHS only reviews 17 states each year for the Medicaid improper payment rate, FY 2016 represents the first “baseline” improper payment rate reflecting the new requirements because all 50 states and the District of Columbia were measured under the same requirement. FY 2017 represents the first cycle of states that has been measured a second time.

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. For states that are being measured a second time, 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 only reviews 17 states each year for the Medicaid 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.

Finding #5 – No Recovery Audit Contract (RAC) activity during FY 2017 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 2017 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). 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. In 2015, HHS posted a Request for Information and reviewed comments received. Currently HHS is exploring how to fit the Medicare Part C RAC program into the larger Medicare Part C program integrity efforts, and examining refinements that can be made to the operation of RACs such that their activities do not excessively burden plans. Hence, in FY 2017 there was no Part C RAC awarded, 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 actively explore a vehicle to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2018. We also recommend HHS analyze the viability of issuing a contract that is cost-beneficial to the program.

Finding #6 – Foster Care program did not correctly calculate the state-level standard error for improper payment estimation, which could impact the confidence interval

To test the sampling methodology used by HHS to calculate the improper payment rate, 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 2017 Improper Payments estimates which follow the OMB previously approved sampling and estimation methodology described in “the Payment Integrity” section of the annual 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 selected from the state's Title IV-E Foster Care population. Based on their review, they determine whether the state is compliant in meeting the federal eligibility requirements for the Foster Care program and 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 the state of Louisiana 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 that the Foster Care Program Improper Payments Reporting follows the OMB previously approved sampling methodology, and the overall sampling approach and estimation methodology for the state of Louisiana, for the most part, to be reasonable and valid. However, similar to the finding reported in the FY 2015 OIG performance audit report, EY found that the method for estimating the standard error of the PUR Louisiana 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. Therefore, aggregating correct standard errors from all states may potentially result in the margin of error for the national estimate exceeding the threshold of 2.5 percent required by OMB. EY found that the margin of error for the national estimate is higher for FY 2017 as compared to the margin of error for FY 2015 (0.25 percent vs. 0.09 percent), increasing the risk of not meeting the OMB precision requirement for FY 2017.

In response to the FY 2015 OIG performance audit report, HHS evaluated the formula recommended by EY for calculating state-level confidence intervals (based on calculations from one state in the FY 2015 review cycle) and recalculated all FY 2015 and FY 2016 review cycle states (and the national program estimate). HHS then compared the recalculated state confidence

intervals to the current methodology and against OMB statistical requirements. Through this examination, HHS concluded that the confidence intervals around the FY 2015 and FY 2016 estimates—though wider—conform to the current precision requirements specified in OMB guidance for improper payments, and the national improper payment estimate would not change. HHS has not performed a similar analysis for FY 2017 as of the date of this report.

Under OMB requirements for sampling plans, all estimates should 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.

Recommendation:

Consistent with our FY 2015 performance audit, we recommend HHS correct the method for calculating the standard error to estimate the improper payments at the state level. In addition, HHS may need to increase the sample size at the state level to refine its calculation to meet OMB precision requirements at the national level.



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MAY 11 2018

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 2017*" (A-17-18-52000). 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).

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 2017 and the appropriateness surrounding the calculation of the standard error at the state-level 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 2017 (Medicaid and Children's Health Insurance Program (CHIP)) and b) reporting an improper payment rate that is greater than 10 percent (Medicaid). With regard to CMS conducting a Medicare Part C recovery audit contractor (RAC) program, HHS acknowledges that CMS has not implemented an expansion of the RAC program to Medicare Advantage (Part C). We note, however, that CMS does conduct Risk Adjustment Data Validation audits that are consistent with 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, many of which are outlined in the draft report, to reduce improper payments and improve reporting, 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. 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,



Jen Moughalian
Acting Assistant Secretary for Financial Resources