DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 14, 2012

TO: Kathleen Sebelius
Secretary of Health and Human Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: U.S. Department of Health and Human Services Did Not Fully Comply With Federal Requirements for Reporting Improper Payments (A-17-12-52000)

The attached final report, entitled *U.S. Department of Health and Human Services Did Not Fully Comply With Federal Requirements for Reporting Improper Payments*, provides the results of our review of the U.S. Department of Health and Human Services' annual Agency Financial Report and accompanying material. This report fulfills the reporting requirements of the Improper Payments Information Act of 2002 (IPIA) as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

We have sent similar letters to the Honorable Joseph Lieberman; the Honorable Darrell E. Issa; the Honorable Gene L. Dodaro, Comptroller of the United States; and the Honorable Daniel I. Werfel, Controller, Office of Federal Financial Management, Office of Management and Budget.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Kay L. Daly, Assistant Inspector General for Audits, at (202) 619-1157 or through email at Kay.Daly@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-17-12-52000 in all correspondence.

Attachment

cc: Ellen G. Murray
Assistant Secretary for Financial Resources

Sheila Conley
Deputy Assistant Secretary for Financial Resources

Christine Jones
Office of Program Integrity Coordination
Office of the Assistant Secretary for Financial Resources

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES DID NOT FULLY COMPLY WITH FEDERAL REQUIREMENTS FOR REPORTING IMPROPER PAYMENTS

Daniel R. Levinson
Inspector General

March 2012
A-17-12-52000

Office of Inspector General

http://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.

EXECUTIVE SUMMARY

BACKGROUND

To improve accountability of Federal agencies' administration of funds, the Offices of Inspector General (OIG), including the OIG of the Department of Health and Human Services (the Department), are required to review and report on agencies' annual Agency Financial Report (AFR) and accompanying material to determine compliance with the Improper Payments Information Act of 2002 (IPIA) as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

To determine compliance with the IPIA, an OIG should review the AFR of the most recent fiscal year (FY) to determine whether the agency conducted a program-specific risk assessment to identify each program or activity that is susceptible to significant improper payments and reported specific information on those programs in its AFR, including whether the rate of improper payments was less than 10 percent. The OIG must also evaluate the accuracy and completeness of agency reporting and evaluate agency performance in reducing and recapturing improper payments.

OBJECTIVES

Our objectives were to (1) determine if the Department complied with the IPIA as amended by IPERA for FY 2011 in accordance with related Office of Management and Budget (OMB) guidance, (2) evaluate the accuracy and completeness of Department reporting, and (3) evaluate the Department's performance in reducing and recapturing improper payments.

SUMMARY OF FINDINGS

Nine programs were deemed by OMB to be susceptible to making significant improper payments. For five programs (i.e., Medicare Fee-for-Service, Medicare Prescription Drug Benefit, Medicaid, Foster Care, and Head Start), the Department complied with the IPIA as amended by IPERA. For four programs (i.e., Medicare Advantage, Children's Health Insurance Program, Temporary Assistance for Needy Families, and Child Care Development Fund), the Department did not meet one or more requirements. For two of the four programs, (i.e., Children's Health Insurance Program and Temporary Assistance for Needy Families), the Department did not report improper payment estimates, and thus could not meet other requirements. For the other two programs (i.e., Medicare Advantage and Child Care Development Fund), the Department reported improper payment rates that were greater than 10 percent.

Regarding the accuracy and completeness of Department reporting, for seven programs (i.e., Medicare Fee-for-Service, Medicare Prescription Drug Benefit, Medicaid, Foster Care, Head Start, Medicare Advantage, and Child Care Development Fund), we did not identify any inaccuracies or gaps in most of the information reported by the Department. However, for two programs (i.e., Children's Health Insurance Program and Temporary Assistance for Needy Families), the information reported was inconsistent or incomplete. In addition, we determined

that the Department could improve the accuracy of its improper payment estimate for the Medicare Fee-for-Service program.

With regard to the Department's performance in reducing and recapturing improper payments, the Department reported reductions in rates for five of the seven programs (i.e., Medicare Fee-for-Service, Medicaid, Head Start, Medicare Advantage, and Child Care Development Fund) for which it reported improper payment rates and developed corrective action plans for all seven programs that if implemented as designed, could be effective in further reducing improper payments.

RECOMMENDATIONS

We recommend that the Department improve its compliance with the IPIA as amended. Specifically, the Department should:

- address payment errors in the Medicare Advantage and Child Care Development Fund programs and reduce their improper payment error rates below 10 percent;

- develop an improper payment estimate for the Temporary Assistance for Needy Families program and, if necessary, seek statutory authority to require State participation in such a measurement;

- produce a Children's Health Insurance Program error rate for FY 2012; and

- determine the feasibility of developing an estimate to adjust the Medicare Fee-for-Service Recovery Audit rate similar to the estimate used to adjust the Fee-for-Service improper payment rate.

We also recommend that the Department maintain sufficient documentation to support the amounts reported in the AFR related to recapturing improper payments, which we were unable to evaluate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES COMMENTS

The Department described the actions it is taking to address the first three recommendations. In response to our fourth recommendation, the Department pointed out that it did not believe an adjustment estimate was applicable because, unlike the improper payment estimate, the recovery audit rate is based on actual amounts identified and recovered. The Department did not comment on the recommendation to maintain sufficient supporting documentation.

OFFICE OF INSPECTOR GENERAL RESPONSE

We recognize that developing an appeals adjustment estimate for the recovery audit rate may not be the only solution for recognizing the impact of successful appeals. Nonetheless, it is important that the Department inform financial statement users about the potential impact of appeals on the recovery audit rate, particularly if such appeals have a substantial impact on the rate.

The Department's comments are included as Appendix C. The Department also provided technical comments, which we addressed as appropriate.

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INTRODUCTION

BACKGROUND

An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments).[1] To improve accountability of Federal agencies' administration of funds, 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) requires agencies, including the Department of Health and Human Services (the Department), to annually report information to the President and Congress on their improper payments. The IPERA establishes requirements for Offices of Inspector General (OIG). To implement the IPERA, the Office of Management and Budget (OMB) revised Circular A-123, Appendix C, parts I and II. Part II requires OIGs to review and report on agencies' annual Agency Financial Report (AFR) and accompanying material to determine compliance with IPIA requirements.

OMB Circular A-123, part II, section A(4), states that to determine compliance with the IPIA, an OIG should review the AFR of the most recent fiscal year (FY) to determine whether the agency has:

- published an AFR for the most recent FY and posted that report and any accompanying material required by OMB on its Web site,
- conducted a program-specific risk assessment for each program or activity to identify those programs or activities that may be susceptible to significant improper payments,
- published improper payment estimates for all programs and activities identified as susceptible to significant improper payments in its risk assessment,
- published programmatic corrective action plans in the AFR,
- published and met annual reduction targets for each program assessed to be at risk and measured for improper payments,
- 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, and
- reported information on its efforts to recapture improper payments (OMB Circular A-123, Appendix C, part II, section A(4)).

OMB Circular A-123 also requires the OIG to evaluate the accuracy and completeness of agency reporting and evaluate agency performance in reducing and recapturing improper payments.

[1] An estimate of improper payments is not an estimate of fraud. Because the improper payment estimation process is not designed to detect or measure the amount of fraud in programs such as Medicare, there may be fraud in a program that is not included in the reported improper payment estimate.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to (1) determine whether the Department complied with the IPIA as amended by IPERA for FY 2011 in accordance with related OMB guidance, (2) evaluate the accuracy and completeness of Department reporting, and (3) evaluate the Department's performance in reducing and recapturing improper payments.

Scope

Our review covered IPIA information in section III, *Other Accompanying Information* that was reported in the Department's FY 2011 AFR. The Department included information on the following nine programs, which were deemed by OMB to be susceptible to significant improper payments: Medicare Fee-for-Service, Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid, Children's Health Insurance Program, Temporary Assistance for Needy Families, Foster Care, Head Start, and Child Care Development Fund.

We were unable to evaluate the Department's performance in recapturing improper payments because it did not have sufficient supporting documentation. The Department informed us that it plans to provide such documentation in the future.

We performed our fieldwork from November 2011 through February 2012.

Methodology

To determine whether the Department complied with the IPIA, we reviewed section III of the Department's FY 2011 AFR.

To evaluate the accuracy and completeness of the Department's reporting, we requested documentation from the Department to support the balances, amounts, percentages, and ratios reported in the AFR and reviewed the information provided. We did not evaluate the Department's methodology for estimating improper payments. We also reviewed the Department's quarterly reports on high-dollar improper payments for FYs 2010 and 2011 and the results of relevant OIG audits.

To evaluate the Department's performance in reducing improper payments, we reviewed documentation provided by the Department on its corrective actions to reduce improper payments and analyzed reported error rates.

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.

FINDINGS AND RECOMMENDATIONS

For five programs (i.e., Medicare Fee-for-Service, Medicare Prescription Drug Benefit, Medicaid, Foster Care, and Head Start), the Department complied with the IPIA as amended by IPERA. For four programs (i.e., Medicare Advantage, Children's Health Insurance Program, Temporary Assistance for Needy Families, and Child Care Development Fund), the Department did not meet one or more requirements. For two programs, (i.e., Children's Health Insurance Program and Temporary Assistance for Needy Families), the Department did not report improper payment estimates, and thus could not meet other requirements. For two programs (i.e., Medicare Advantage and Child Care Development Fund), the Department reported improper payment rates that were greater than 10 percent.

For seven programs (i.e., Medicare Fee-for-Service, Medicare Prescription Drug Benefit, Medicaid, Foster Care, and Head Start, Medicare Advantage, and Child Care Development Fund), we did not identify any inaccuracies or gaps in most of the information reported by the Department. However, for two programs (i.e., Children's Health Insurance Program and Temporary Assistance for Needy Families), the information reported was inconsistent or incomplete. In addition, we determined that the Department could improve the accuracy of its improper payment estimate for the Medicare Fee-for-Service program.

The Department reported reductions in rates for five of the seven programs (i.e., Medicare Fee-for-Service, Medicaid, Head Start, Medicare Advantage, and Child Care Development Fund) for which it reported improper payment rates and developed corrective action plans for all seven programs that, if implemented as designed, could be effective in further reducing improper payments.

DEPARTMENT COMPLIANCE WITH THE IMPROPER PAYMENTS INFORMATION ACT OF 2002

Federal Requirements

The IPERA, as implemented by OMB, defines compliance with the IPIA to mean that the agency has:

- published an AFR for the most recent FY and posted that report and any accompanying material required by OMB on its Web site,
- conducted a program-specific risk assessment for each program or activity to identify those programs or activities that may be susceptible to significant improper payments,
- published improper payment estimates for all programs and activities identified as susceptible to significant improper payments in its risk assessment,
- published programmatic corrective action plans in the AFR,

- published and met annual reduction targets for each program assessed to be at risk and measured for improper payments,

- 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, and

- reported information on its efforts to recapture improper payments (OMB Circular A-123, Appendix C, part II, section A(4)).

Requirements Met for Five Programs

The Department met all of the above requirements for the following five programs: Medicare Fee-for-Service, Medicare Prescription Drug Benefit, Medicaid, Foster Care, and Head Start. For example, for Medicaid, the Department conducted a risk assessment and published required information in the AFR, including a gross improper payment rate of less than 10 percent.

No Improper Payment Estimate Reported for Two Programs

The Department did not publish or report improper payment estimates for the Children's Health Insurance Program or the Temporary Assistance for Needy Families program. The Department did not report an improper payment estimate for the Children's Health Insurance Program because Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 prohibited it from calculating or publishing a national or State-specific error rate for the Children's Health Insurance Program until 6 months after a new Payment Error Rate Measurement final rule had taken effect.[2] The new final rule for Payment Error Rate Measurement program became effective September 10, 2010. The Department plans to publish a Children's Health Insurance Program improper payment estimate for FY 2011 in the FY 2012 AFR.

As stated in the AFR, the Department did not report an improper payment estimate for Temporary Assistance for Needy Families because it is a State-administered program and statutory limitations prohibit the Department from requiring States to participate in a Temporary Assistance for Needy Families improper payment measurement. The statutory provision does not prevent the Department from developing an improper payment estimate. As previously stated, IPIA requires Federal agencies to review all of their programs to identify those that may be susceptible to significant improper payments. Moreover, OMB has designated Temporary Assistance for Needy Families as a Federal program with a significant risk of improper payments. Accordingly, Temporary Assistance for Needy Families is required to estimate improper payments. In the FY 2011 AFR, the Department stated that it continues to explore options that will allow for a future error rate measurement. Without improper payment estimates for these programs, the Department also could not comply with other IPIA requirements.

[2] The Payment Error Rate Measurement program measures improper payments in Medicaid and Children's Health Insurance Program and produces error rates for them. The error rates are based on reviews of the fee-for-service, managed care, and eligibility components of Medicaid and Children's Health Insurance Program in the FY under review.

Gross Improper Payment Rates for Two Programs Were Greater Than 10 Percent

The Department's reported gross improper payment rate for the Medicare Advantage Program in the FY 2011 AFR was 11.0 percent. Its reported gross improper payment rate for the Child Care and Development Fund was 11.2 percent. In its 2010 AFR, the Department reported a 14.1-percent gross improper payment rate for the Medicare Advantage Program and a 13.3-percent gross improper payment rate for the Child Care and Development Fund. The FY 2011 rates indicate that the Department has reduced the gross improper payment rates for these programs, but it must reduce these rates further to comply with the IPIA requirement of having an error rate of less than 10 percent. The Department complied with the remaining IPIA requirements for these programs.

ACCURACY AND COMPLETENESS OF INFORMATION IN THE AGENCY FINANCIAL REPORT

For seven programs, we did not identify any inaccuracies or gaps in most of the information reported by the Department. However, we were unable to evaluate the accuracy of the Department's reporting on recapturing improper payments because it did not have sufficient supporting documentation. The Department informed us that it plans to provide such documentation in the future. In addition, there were inconsistencies in the Department's reporting, the Department may have overstated some amounts, and the Department did not report some overpayments. We also determined that the Department could improve the accuracy of its improper payment estimate for the Medicare Fee-for-Service program.

Inconsistencies in Reporting Certain Overpayments

Section III.12 of the AFR covers recovery auditing and includes tables with details of overpayments and recaptured funds (Appendix A). Tables 3 and 5 in section III.12 should include outstanding overpayments identified by recovery auditors. However, the total outstanding overpayments identified in these two tables are different. In Table 3, the total is $163.9 million, and in Table 5, the total is $213.9 million ($59.9 million + $154.0 million). (See Appendix B.) We were unable to verify the accuracy of either number, and the Department was unable to provide an explanation for the discrepancy.

Pursuant to section 2(d)(5) of IPIA as amended, the Department is required to summarize in the AFR how amounts recovered have been disposed of. In the AFR (Table 3, column "Amount Recovered (CY)."), the Department reported $797.4 million in current-year recaptured funds. In Table 6, the Department reported a total of $129.4 million ($47.5 million in the column "Agency Expenses to Administer the Program" and $81.9 million in the column "Payment Recapture Auditor Fees"). The remaining $668.0 million in recaptured funds, which was returned to the Medicare Trust fund, was not accounted for in Table 6.

Reporting for Certain Overpayments and Recoveries May Have Been Overstated

In the AFR (Table 7, "Overpayments Recaptured Outside of Payment Recapture Audits," Appendix C), the Department reported $14.0 billion in identified overpayments and $10.3 billion

in recoveries. However, these amounts may have been overstated because they could include identified and recovered amounts that the Department does not consider and has never reported as improper payments. For example, the Department may have included amounts resulting from reconciliation of items, such as periodic interim payments[3] and cost reports,[4] that are unrelated to improper payments. Because the Department did not have sufficient supporting documentation for this section of the AFR, we could not determine the amount of the potential overstatement.

Some Medicare Advantage Overpayments Not Reported

In the AFR (Table 7, "Overpayments Recaptured Outside of Payment Recapture Audits,"), the Department did not report any amounts for the Medicare Advantage program. However, in its *Quarterly High Dollar Overpayment Report* for quarter ending December 31, 2009, it identified $1.9 million in actual overpayments for this program. In addition, the Department did not report any identified overpayments or recoveries associated with OIG reviews for the Medicare or Medicaid programs.

Accuracy in Reporting Improper Payment and Recovery Rates in the Agency Financial Report Can Be Improved

In the FY 2011 AFR, the Department reported an estimated gross improper payment rate for the Medicare Fee-for-Service program of 8.6 percent. The Department used estimates of claims that might be overturned on appeal in future periods. These estimates were based on the results of Comprehensive Error Rate Testing appeals related to FY 2010 claims.[5] However, an adjustment based on data from a single year may not be as reliable as an adjustment based on multiple years of activity. In a previous report, we recommended that the Centers for Medicare & Medicaid Services develop a reliable methodology for adjusting the Medicare Fee-for-Service error rate, incorporating the outcome of appeal decisions for Comprehensive Error Rate Testing claim payment denials, to make the Centers for Medicare & Medicaid Services' estimate of the value of reported errors more accurate.[6] Accordingly, we are not making any recommendation on this issue in this report.

[3] Periodic interim payments are biweekly payments made to a provider enrolled in the periodic interim payment program and are based on the provider's estimate of applicable Medicare reimbursement for the current cost report period.

[4] Providers of services participating in Medicare are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries (section 1815(a) of the Social Security Act; 42 U.S.C. § 1395g(a)). Regulations state that cost reports "… are required from providers on an annual basis..." (42 CFR § 413.20(b)).

[5] The Centers for Medicare & Medicaid Services implemented the Comprehensive Error Rate Testing program to measure improper payments in the Medicare Fee-for-Service program. The Comprehensive Error Rate Testing program is designed to comply with the IPERA.

[6] OIG, *Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010*, A-01-11-00504, March 9, 2012.

The Department also reported a recovery rate for improper payments identified by the Medicare Fee-for-Service Recovery Audit program. Providers may also appeal improper payment determinations made as a result of this program. Without an adjustment for appeals similar to that made to the Fee-for-Service improper payment rate, the recovery rate for the Medicare Fee-for-Service Recovery Audit program is likely overstated.

PERFORMANCE IN REDUCING IMPROPER PAYMENTS

In the AFR, the Department reported reductions in rates for five of the seven programs for which it reported improper payment rates. The Department reported an improper payment rate for the Medicare Prescription Drug Benefit for the first time in FY 2011. The Department reported an increase in the Foster Care program's improper payment rate from 4.9 percent in 2010 to 5.3 percent in 2011. The Department has developed corrective action plans for all seven programs that, if implemented as designed, could be effective in further reducing improper payments.

The Department attributed the increase in the Foster Care program improper payment rate to higher error rates in three of the States reviewed for the FY 2011 improper payment rate. According to the Department, those three States were in the top third of States in terms of program size and error rates and had a substantial impact on the overall program rate.

RECOMMENDATIONS

We recommend that the Department improve its compliance with the IPIA as amended. Specifically, the Department should:

- address payment errors in the Medicare Advantage and Child Care Development Fund programs and reduce their improper payment error rates below 10 percent;

- develop an improper payment estimate for the Temporary Assistance for Needy Families program and, if necessary, seek statutory authority to require State participation in such a measurement;

- produce a Children's Health Insurance Program error rate for FY 2012; and

- determine the feasibility of developing an estimate to adjust the Medicare Fee-for-Service Recovery Audit rate similar to the estimate used to adjust the Fee-for-Service improper payment rate.

We also recommend that the Department maintain sufficient documentation to support the amounts reported in the AFR related to recapturing improper payments, which we were unable to evaluate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES COMMENTS

The Department described the actions it is taking to address the first three recommendations. In response to our fourth recommendation, the Department pointed out that it did not believe an adjustment estimate was applicable because, unlike the improper payment estimate, the recovery audit rate is based on actual amounts identified and recovered. The Department did not comment on the recommendation to maintain sufficient supporting documentation.

OFFICE OF INSPECTOR GENERAL RESPONSE

We recognize that developing an appeals adjustment estimate for the recovery audit rate may not be the only solution for recognizing the impact of successful appeals. Nonetheless, it is important that the Department inform financial statement users about the potential impact of appeals on the recovery audit rate, particularly if such appeals have a substantial impact on the rate.

The Department's comments are included as Appendix C. The Department also provided technical comments, which we addressed as appropriate.

APPENDIXES

APPENDIX A: TABLES FROM THE FISCAL YEAR 2011 ANNUAL FINANCIAL REPORT

Table 3
Payment Recapture Audit Reporting, FY 2011 (in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY)	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$961.3	$797.4	83	$163.9	17.1	N/A	N/A	$135.7	$75.4	$1,097.0	$872.8	$224.2	N/A
HHS-Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.5	$0.074	$1.5	$0.074	N/A	N/A

Table 5
Aging of Outstanding Overpayments, FY 2011 (in Millions)

Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)
Medicare FFS Recovery Auditors	$59.9	$154	N/A*

*Currently, HHS does not separately track over-payments identified by the Medicare FFS Recovery Auditors after they are one year old. HHS is exploring a mechanism to meet this requirement..

Table 6
Disposition of Recaptured Funds, FY 2011 (in Millions)

Type of Payment	Agency Expenses to Administer the Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury
Medicare FFS Recovery Auditors	$47.5	$81.9	N/A	N/A*	N/A	N/A

*Currently, HHS does not separately track over-payments identified by the Medicare FFS Recovery Auditors after they are one year old. HHS is exploring a mechanism to meet this requirement..

Table 7
Overpayments Recaptured Outside of Payment Recapture Audits, FY 2011 (in Millions)

Agency Source	Amount Identified (CY)	Amount Recovered (CY)	Amount Identified (PY)	Amount Recovered (PY)	Cumulative Amount Identified (CY+PYs)	Cumulative Amount Recovered (CY+PYs)
Medicare FFS Error Rate Measurement	$5.8	$5.4	$5.1	$3.8	$10.9	$9.2
Medicare Contractors	$14,019.7	$10,256.4	$10,682.9	$9,149.0	$24,702.7	19,405.4
Medicare Part C	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Part D	N/A	N/A	N/A	N/A	N/A	N/A
Medicaid Error Rate Measurement	$1.7	$0.1	$0.8	$0.6	$2.5	$0.7
Foster Care Eligibility Reviews = Post-Payment Reviews	$2.3	$2.3	$12.2	$ 12.2	$14.5	$14.5
Foster Care OIG Reviews	$115.9	$0.7	$182.0	$102.0	$297.9	$102.7
Foster Care Single Audits	$1.4	$0.2	$26.1	$26.1	$27.5	$26.3
Child Care-Single Audit	$2.4	-	$0.174	N/A	$0.802	N/A
Child Care-Error Rate Measurement	$0.2	-	$0.384	N/A	$0.552	N/A
Head Start- OIG Reviews	$0.3	$0.3	N/A	N/A	$0.3	$0.3
Head Start- Single Audits	$1.4	$0.7	N/A	N/A	$1.4	$0.7

Source: Department of Health and Human Services, FY 2011 Agency Financial Report, Section III, Section 12, November 15, 2011.

FY = fiscal year
CY = current year
PY = prior year
HHS = Department of Health and Human Services
FFS = fee-for-service

APPENDIX B: TABLE 3 AND TABLE 5 FROM THE ANNUAL FINANCIAL REPORT SHOWING DIFFERENT TOTALS FOR OUTSTANDING OVERPAYMENTS IDENTIFIED IN FISCAL YEAR 2011

Table 3
Payment Recapture Audit Reporting, FY 2011 (in Millions)

Type of Payment	Amount Subject to Review for CY Reporting	Actual Amount Reviewed and Reported (CY)	Amount Identified for Recovery (CY)	Amount Recovered (CY)	% of Amount Recovered out of Amount Identified (CY)	Amount Outstanding (CY)	% of Amount Outstanding out of Amount Identified (CY)	Amount Determined Not to be Collectable (CY)	% of Amount Determined Not to be Collectable out of Amount Identified (CY)	Amounts Identified for Recovery (PYs)	Amounts Recovered (PYs)	Cumulative Amounts Identified for Recovery (CY + PYs)	Cumulative Amounts Recovered (CY + PYs)	Cumulative Amounts Outstanding (CY+PYs)	Cumulative Amounts Determined Not to be Collectable (CY+PYs)
Medicare FFS Recovery Auditors	N/A	N/A	$961.3	$797.4	83	$163.9	17.1	N/A	N/A	$135.7	$75.4	$1,097.0	$872.8	$224.2	N/A
HHS-Contracts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.5	$0.074	$1.5	$0.074	N/A	N/A

$163.9M ≠ $59.9M + $154M

Table 5
Aging of Outstanding Overpayments, FY 2011 (in Millions)

Type of Payment	CY Amount Outstanding (0 – 6 months)	CY Amount Outstanding (6 months to 1 year)	CY Amount Outstanding (over 1 year)
Medicare FFS Recovery Auditors	$59.9	$154	N/A*

*Currently, HHS does not separately track over-payments identified by the Medicare FFS Recovery Auditors after they are one year old. HHS is exploring a mechanism to meet this requirement..

Source: Department of Health and Human Services, FY 2011 Agency Financial Report, Section III, Section 12, November 15, 2011.

APPENDIX C: DEPARTMENT OF HEALTH AND HUMAN SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington DC 20201

MAR 12 2012

Daniel R. Levinson
Inspector General
Department of Health and Human Services
Cohen Building, Room 5250
330 Independence Ave, S.W.
Washington, D.C. 20201

Dear Mr. Levinson:

Thank you for sharing the draft report on the results of your review of the Department of Health and Human Services' compliance with Federal requirements for reporting improper payments. The Department appreciates the opportunity to review this draft report prior to publication.

As requested, this response includes information on the status of any actions that we are taking in response to the draft recommendations, as well as any planned actions. In addition, our technical comments are attached for your consideration.

Responses to the HHS OIG Recommendations on IPERA Compliance (A-17-12-52000)

Recommendation #1: The Department should "address payment errors in the Medicare Advantage and Child Care Development Fund programs and reduce their improper payment error rates below 10 percent."

> **HHS Response:** HHS is committed to reducing improper payments in all of its programs. As the draft report notes, in Fiscal Year (FY) 2011 the Department reduced the improper payment rate for the Medicare Advantage program from 14.1 percent to 11 percent, and the Child Care Development Fund program from 13.3 percent to 11.2 percent. Despite this marked improvement, the programs continued to report improper payment estimates above 10 percent in FY 2011.
>
> HHS recognizes the importance of reducing the error rate in these two programs. We have taken a number of actions, outlined in the FY 2011 Agency Financial Report (AFR), to reduce the Medicare Advantage and Child Care Development Fund program error rates (see http://www.hhs.gov/afr/ for HHS' AFR, released November 15, 2011). We believe these actions will allow HHS to achieve error rates below 10 percent for these programs in future reporting cycles.

Recommendation #2: The Department should "develop an improper payment estimate for the Temporary Assistance for Needy Families program and, if necessary, seek statutory authority to require State participation in such a measurement."

HHS Response: As noted in HHS' FY 2011 AFR, statutory limitations prohibit the Department from requiring states to participate in a Temporary Assistance for Needy Families (TANF) program error rate methodology. Under the TANF statute, HHS lacks authority to require states to calculate or report improper payment rates. HHS will work to include a legislative proposal that will allow for a TANF error rate measurement when Congress considers TANF reauthorization. Until the law can be changed, the Department continues to work with states on reducing improper payments in the TANF program.

Recommendation #3: The Department should "produce a Children's Health Insurance Program error rate for FY 2012."

HHS Response: As noted in the FY 2011 AFR and the draft OIG report, HHS was prohibited by statute from calculating or publishing an error rate for the Children's Health Insurance Program (CHIP) until 6 months after a new Payment Error Rate Measurement (PERM) final rule had taken effect. The PERM final rule that was published on August 11, 2010, identified FY 2011 as the first fiscal year for which PERM will measure a CHIP error rate and defined the methodology for the measurement. The PERM measurement is underway, and HHS is on track to report a CHIP improper payment estimate in the FY 2012 AFR that is based on a review of FY 2011 payments.

Recommendation #4: The Department should "determine the feasibility of developing an estimate to adjust the Medicare Fee-For-Service Recovery Audit rate similar to the estimate used to adjust the Fee-For-Service improper payment rate."

HHS Response: We do not believe that developing an adjustment estimate, similar to the one used in adjusting the Medicare FFS improper payment rate, is applicable to the Medicare FFS Recovery Audit rate because the reported Recovery Audit information is based on actual amounts identified and recovered through the end of the fiscal year (September 30th). It is not an estimate or projection, and thus unlike the improper payment rate estimate. In addition, any changes (i.e., collections or appeals) that occur after the end of the fiscal year are included in the annual Recovery Audit Report to Congress.

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

Attachment: Technical Comments on the HHS OIG Draft Report on IPERA Compliance (A-17-12-52000)