DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

July 23, 2012

TO: Ellen G. Murray
Assistant Secretary for Financial Resources

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: U.S. Department of Health and Human Services Did Not Fully Comply With Executive Order 13520 When Reporting Fiscal Year 2010 High-Dollar Improper Payments (A-02-11-01007)

The attached final report provides the results of our review of the Department of Health and Human Services' noncompliance with Executive Order 13520, "Reducing Improper Payments and Eliminating Waste in Federal Programs," when reporting fiscal year 2010 high-dollar improper payments.

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.

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 Audit Services, 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-02-11-01007 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES DID NOT FULLY COMPLY WITH EXECUTIVE ORDER 13520 WHEN REPORTING FISCAL YEAR 2010 HIGH-DOLLAR IMPROPER PAYMENTS

Daniel R. Levinson
Inspector General

July 2012
A-02-11-01007

Office of Inspector General

http://oig.hhs.gov

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

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

Executive Order 13520, "Reducing Improper Payments and Eliminating Waste in Federal Programs" (the Executive order), was signed on November 20, 2009, with the purpose of reducing improper payments by intensifying efforts to eliminate payment error, waste, fraud, and abuse in major programs. The Executive order required the Office of Management and Budget (OMB) to identify Federal programs with the highest dollar value or majority of governmentwide improper payments (high-priority programs).

OMB identified nine programs within the U.S. Department of Health and Human Services (the Department) as susceptible to significant improper payments. These programs were Medicare fee-for-service (Parts A and B), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D), which are administered by the Centers for Medicare & Medicaid Services; Head Start, which is administered by the Administration for Children and Families; and Medicaid, Children's Health Insurance Program, Foster Care, Temporary Assistance for Needy Families, and Child Care Development Fund, which are administered by State agencies (State-administered programs).

Section 3(f) of the Executive order requires the head of each Federal agency to submit a quarterly report on high-dollar improper payments identified by the agency in its high-priority programs to its Office of Inspector General (OIG). OMB Circular A-123, Appendix C, part III (the Circular), section A(1)(b), defines an improper payment as any payment that should not have been made or that was made in an incorrect amount. Section C(3)(e) of the Circular sets the thresholds for reporting high-dollar improper payments. Specifically, a high-dollar improper payment is any overpayment that is in excess of 50 percent of the correct amount of the intended payment where: (1) the payment to an individual exceeds $5,000 as a single payment or in cumulative payments for the quarter or (2) the payment to an entity exceeds $25,000 as a single payment or in cumulative payments for the quarter. Pursuant to section C(5)(n) of the Circular, the term "entity" excludes Federal, State, and local government agencies.

The Circular, section C(3)(f), states that Federal agencies should identify high-dollar improper payments by examining several sources of information. For example, agencies could identify high-dollar errors in statistical samples taken to estimate improper payments under the Improper Payments Information Act of 2002 (P.L. No. 107-300). Other sources of high-dollar improper payments include postpayment reviews, recovery audits, OIG reviews, self-reported improper payments, reports from the public through Internet and telephone hotlines, and other referrals.

Within the Department, the Assistant Secretary for Financial Resources was responsible for compiling data included in the Department's fiscal year (FY) 2010 quarterly reports to OIG on high-dollar improper payments.

OBJECTIVE

The objective of our review was to determine whether the Department complied with section 3(f) of the Executive order in its FY 2010 quarterly reports on high-dollar improper payments.

SUMMARY OF FINDINGS

The Department did not fully comply with section 3(f) of the Executive order in its FY 2010 quarterly reports on high-dollar improper payments. Specifically, the Department did not report all identified high-dollar improper payments made by Medicare Parts A and B. In addition, for Medicare Parts C and D, Head Start, and the five State-administered programs, we were unable to determine whether the Department reported all such payments. The Department's quarterly reports were incomplete and cannot be used to adequately assess the level of risk of each of the Department's programs or to determine the extent of necessary oversight.

The Department did not comply with section 3(f) of the Executive order because it did not consider available sources of information that could be applicable to its programs when compiling the high-dollar improper payment quarterly reports. In addition, it was the Department's view that overpayments for which adjustments were being made did not meet the definition of an improper payment and did not need to be reported, nor did any overpayment made by the State-administered programs need to be reported.

RECOMMENDATIONS

We recommend that the Department:

- consider developing a comprehensive list of overpayments for all of its high-priority programs that takes into account each potential source of an improper payment and that can be analyzed to determine whether the thresholds for reporting high-dollar improper payments have been met and

- determine whether there are any high-dollar improper payments for the five State-administered programs that should be reported.

DEPARTMENT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Department disagreed with our findings and explained why it believed it had complied with the Executive order's reporting requirements. The Department stated, however, that it would carefully consider our recommendations.

After reviewing the Department's comments, we maintain that our findings and recommendations are valid. The Department's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Executive Order 13520

Executive Order 13520, "Reducing Improper Payments and Eliminating Waste in Federal Programs" (the Executive order) was signed November 20, 2009, with the purpose of reducing improper payments by intensifying efforts to eliminate payment error, waste, fraud, and abuse in major programs. The Executive order required the Office of Management and Budget (OMB) to identify Federal programs with the highest dollar value or majority of governmentwide improper payments (high-priority programs).

OMB identified nine programs within the U.S. Department of Health and Human Services (the Department) as susceptible to significant improper payments. These programs were Medicare fee-for-service (Parts A and B), Medicare Advantage (Part C), and Medicare Prescription Drug Benefit (Part D), which are administered by the Centers for Medicare & Medicaid Services (CMS); Head Start, which is administered by the Administration for Children and Families (ACF); and Medicaid, Children's Health Insurance Program, Foster Care, Temporary Assistance for Needy Families, and Child Care Development Fund, which are administered by State agencies (State-administered programs).

Section 3(f) of the Executive order requires the head of each Federal agency to submit a quarterly report on high-dollar improper payments identified by the agency in its high-priority programs to its Office of Inspector General (OIG). The reports describe any actions the agency has taken or plans to take to recover improper payments and to prevent them.

Office of Management and Budget Circular A-123

OMB Circular A-123, Appendix C, part III (the Circular), section A(1)(b), defines an improper payment as any payment that should not have been made or that was made in an incorrect amount. Section C(3)(e) of the Circular sets the thresholds for reporting high-dollar improper payments. Specifically, a high-dollar improper payment is any overpayment that is in excess of 50 percent of the correct amount of the intended payment where: (1) the payment to an individual exceeds $5,000 as a single payment or in cumulative payments for the quarter or (2) the payment to an entity exceeds $25,000 as a single payment or in cumulative payments for the quarter. Pursuant to section C(5)(n) of the Circular, the term "entity" excludes Federal, State, and local government agencies.

The Circular, section C(3)(f), states that Federal agencies should identify high-dollar improper payments by examining several sources of information. For example, agencies could identify high-dollar errors in statistical samples taken to estimate improper payments under the Improper Payments Information Act of 2002 (P.L. No. 107-300). Other sources of high-dollar improper payments include postpayment reviews, recovery audits, agency OIG reviews, self-reported improper payments, reports from the public through Internet and telephone hotlines, and other referrals.

Office of the Assistant Secretary for Financial Resources

Within the Department, the Assistant Secretary for Financial Resources was responsible for compiling data included in the Department's fiscal year (FY) 2010 quarterly reports to OIG on high-dollar improper payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the Department complied with section 3(f) of the Executive order in its FY 2010 quarterly reports on high-dollar improper payments.

Scope

Our review covered the four quarterly reports on high-dollar improper payments that the Department submitted to OIG for FY 2010 (October 1, 2009, through September 30, 2010).

We did not assess the Department's overall internal control structure. Rather, we limited our review to obtaining an understanding of how the Department developed its quarterly reports on high-dollar improper payments.

We performed fieldwork from November 2010 through May 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal requirements and OMB guidance;
- obtained and reviewed the Department's quarterly reports on high-dollar improper payments for FY 2010;
- interviewed Department officials to gain an understanding of how the quarterly reports on high-dollar improper payments are developed;
- interviewed CMS officials about procedures for developing information that CMS reports to the Department on high-dollar improper payments for Medicare Parts A, B, C, and D; and
- obtained information from Department officials on Head Start procedures for developing information that ACF reports to the Department on high-dollar improper payments.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The Department did not fully comply with section 3(f) of the Executive order in its FY 2010 quarterly reports on high-dollar improper payments. Specifically, the Department did not report all identified high-dollar improper payments made by Medicare Parts A and B. In addition, for Medicare Parts C and D, Head Start, and the five State-administered programs, we were unable to determine whether the Department reported all such payments. The Department's quarterly reports were incomplete and cannot be used to adequately assess the level of risk of each of the Department's programs or to determine the extent of necessary oversight.

The Department did not comply with section 3(f) of the Executive order because it did not consider available sources of information that could be applicable to its programs when compiling the high-dollar improper payment quarterly reports. In addition, it was the Department's view that overpayments for which adjustments were being made did not meet the definition of an improper payment and did not need to be reported, nor did any overpayment made by the State-administered programs need to be reported.

HIGH-DOLLAR IMPROPER PAYMENTS NOT REPORTED

Federal Requirements

Pursuant to section 3(f) of the Executive order, the Department must report quarterly all high-dollar improper payments that it identifies. OMB correspondence to Department officials in response to questions raised by CMS officials on what to include in the quarterly reports stated that "… if an adjustment is made in the next payment cycle, then it should not be reported as an overpayment. However, if a provider submits new documentation and an adjustment has not been made at the time of quarterly reporting (therefore the payment is currently incorrect), then it should be included as an improper payment."[1]

Medicare Parts A and B

The Department did not report Medicare Parts A and B high-dollar improper payments, as defined by the Circular, in accordance with section 3(f) of the Executive order. Specifically, for Medicare Parts A and B, the Department reported only high-dollar overpayments identified (1) by recovery audit contractors,[2] (2) in data from CMS's annual fee-for-service error rate measurement, and (3) by Medicare administrative contractors for which no recoveries had been made and that were referred to the U.S. Department of the Treasury for collection. The

[1] OMB, "OMB Responses to HHS [Health and Human Services] Questions on Quarterly High-Dollar Overpayment Reports," email message, April 27, 2010.

[2] Established under the authority of section 1893(h) of the Social Security Act, the Medicare recovery audit contractor program is administered by CMS to identify underpayments and overpayments and recoup overpayments.

Department did not report Medicare Parts A and B high-dollar improper payments that were being recovered.

For Medicare Parts A and B, the Department did not comply with section 3(f) of the Executive order because it did not consider available sources of information that could be applicable to its programs when compiling the high-dollar improper payment quarterly reports. While the Implementing Guidance for section 3(f) does not explicitly call for all sources of information to be considered, an agency cannot comply with the Executive Order to identify and report high-dollar improper payments without considering data sources that are applicable and readily available. The Department did not follow the April 2010 OMB correspondence that clarified the reporting requirements of the Executive order, i.e., that overpayments for which an adjustment has not been made at the time of quarterly reporting are incorrect and should be included as improper payments.

Medicare Parts C and D and Head Start

We were unable to determine whether the Department reported all high-dollar improper payments for Medicare Parts C and D and Head Start in accordance with section 3(f) of the Executive order. Pursuant to the Circular, section C(3)(f), Federal agencies should identify such payments by examining several sources of information, including improper payments identified under the Improper Payments Information Act of 2002, postpayment reviews, recovery audits, agency OIG reviews, self-reported improper payments, reports from the public through Internet and telephone hotlines, and other referrals.

For Medicare Parts C and D and Head Start, the Department did not comply with section 3(f) of the Executive order because it did not consider available sources of information that could be applicable to its programs when compiling the high-dollar improper payment quarterly reports. Medicare Parts C and D officials at CMS analyzed only overpayments made to terminated plans to identify high-dollar improper payments. Head Start officials at ACF analyzed only data from the annual error measurement's statistical sample. The officials relied on these data because none of the programs had an all-inclusive list of overpayments that could be reviewed each reporting period to identify high-dollar improper payments. Without such an all-inclusive list, the Department could not ensure that it reported all high-dollar payments for these programs.

State-Administered Programs

We could not assess whether the Department reported all high-dollar improper payments made by the five State-administered programs because the Department did not report data for these programs. The Department stated that it did not report data for these programs because the term "entity" as defined in part III of the Circular, section C(5)(n), excludes Federal, State, and local governments. However, according to OMB officials, the Department should report any high-dollar overpayments made by these five programs to any nongovernmental entity, i.e., any entity that is not a Federal, State, or local government. Department officials stated that these programs did not make payments to nongovernmental entities to carry out essential and basic program functions. However, many of the programs set aside money to pay for training and

technical assistance, which may go to nongovernmental entities and could result in an improper payment.

RECOMMENDATIONS

We recommend that the Department:

- consider developing a comprehensive list of overpayments for all of its high-priority programs that takes into account each potential source of an improper payment and that can be analyzed to determine whether the thresholds for reporting high-dollar improper payments have been met and

- determine whether there are any high-dollar improper payments for the five State-administered programs that should be reported.

DEPARTMENT COMMENTS

In written comments on our draft report, the Department disagreed with our findings and explained why it believed it had complied with the Executive order's reporting requirements. The Department stated, however, that it would carefully consider our recommendations because it is "always looking for ways to improve." The Department also made two technical comments on our draft report. We addressed those comments, as appropriate, in the "Office of Inspector General Response" section below.

The Department stated that the OMB implementing guidance does not require agencies to review "every available source of potential overpayments." The Department stated that it utilized several sources to identify high-dollar overpayments in the Medicare Fee-for-Service program. In addition, for Medicare Parts C and D, the Department stated that it reviewed "payments to terminated plans, which, because of the programs' structure, are one of the only potential sources of high-dollar overpayments." The Department further stated that it had followed OMB direction regarding examining adjusted payments. According to the Department, in April 2010, OMB directed it to report overpayments for which adjustments had not been made and said that it should not focus on payments for which adjustments had been made. Finally, the Department stated that the OMB implementing guidance excludes reporting overpayments to "entities," including Federal, State, and local government agencies. The Department indicated that the overwhelming majority of overpayments made by the Federal Government for the five State-administered programs are to State and local governments and that these overpayments are, therefore, excluded from the Executive order's reporting requirements.

The Department stated that it would study our first recommendation to develop a comprehensive list of overpayments for each program to determine whether it is feasible and cost effective to implement. In response to our second recommendation, the Department stated that it would work with the applicable State-administered programs to determine whether there are any high-dollar overpayments to nongovernmental entities that should be included in future high-dollar overpayment quarterly reports.

The Department's comments appear in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Department's comments, we maintain that our findings and recommendations are valid.

We acknowledge that the OMB implementing guidance does not require agencies to review every available source of potential overpayments. However, pursuant to section C(3)(f) of the Circular, Federal agencies should examine several sources of available information, including, where applicable, statistical sample reviews conducted under the Improper Payments Information Act, agency postpayment reviews, recovery audits, agency OIG reviews, self-reports or reports from the public through Internet and telephone hotlines, and other referrals. The Department did not examine available sources that could be applicable to its programs. Specifically, for Medicare Parts A and B, the Department did not examine any high-dollar improper payments that were in the process of being recovered to determine whether they met the Executive order's reporting requirements.

The April 2010 OMB correspondence that the Department refers to in its comments did not instruct the Department to report only those overpayments where adjustments had not been made, nor did it state that the Department should not focus on overpayments for which adjustments had been made. The OMB correspondence stated that "… if an adjustment is made in the next payment cycle, then it should not be reported as an overpayment. However, if a provider submits new documentation and an adjustment has not been made at the time of quarterly reporting (therefore the payment is currently incorrect), then it should be included as an improper payment." The Department acknowledged that there were high-dollar improper payments that had not been adjusted at the time of the Department's quarterly reporting and that, according to the OMB correspondence, should have been reported.

For Medicare Parts C and D, the Department stated that, to identify high-dollar improper payments, it reviewed only overpayments made to terminated plans because it determined that this source was likely to be the most useful, inclusive, and cost-effective source of high-dollar overpayments. The Department stated that it also believed that overpayments made to terminated plans included most errors that would not be identified through the programs' reconciliation processes.[3] The Executive order, however, requires that all—not most—high-dollar improper payments be reported. Since the Department reviewed only overpayments made to terminated plans and did not consider any of the other sources listed in section C(3)(f) of the Circular, we were unable to determine whether the Department reported all high-dollar improper payments for Medicare Parts C and D.

For the five State-administered programs, we agree that overpayments made by these programs to State and local governments are excluded from the Executive order's reporting requirements. However, as the Department acknowledged in its comments, these programs make payments to nongovernmental agencies (e.g., vendors) for services such as training and technical assistance.

[3] Medicare Parts C and D are prospective payment systems in which payments are adjusted to reflect better information about enrollees or plans during a yearend reconciliation process.

Accordingly, we are pleased that the Department will work with the State-administered programs to determine whether there are any high-dollar improper payments made to nongovernmental entities that should be reported.

APPENDIX

APPENDIX: DEPARTMENT COMMENTS

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

MAY 10 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' (HHS) compliance with Executive Order (EO) 13520 when reporting Fiscal Year (FY) 2010 high-dollar improper payments. The Department appreciates the opportunity to review this draft report prior to publication.

As the draft report notes, one of the EO's requirements is to complete quarterly reports that identify high-dollar improper payments that meet thresholds set by the Office of Management and Budget's (OMB) implementing guidance. HHS respectfully disagrees with the draft report's findings that we did not comply with the EO's quarterly high-dollar overpayment reporting requirement. We believe that the Department complied with the EO's quarterly high-dollar overpayment reporting requirement for the following reasons:

1) The OMB implementing guidance does not require agencies to review every available source of potential overpayments. Rather, the guidance states "High-dollar overpayments should be identified by examining *several* [italics added] sources of information available to agencies. For instance, agencies *could* [italics added] identify high-value errors, *where applicable* [italics added], through" statistical samples, post-payment reviews, recovery audits, IG reviews, self-reports, or public referrals. The Department utilizes several sources to identify high-dollar overpayments in the Medicare Fee-For-Service program, such as the error measurement process, overpayments referred to the Treasury Department for collection, and the recovery audit program; and, for Medicare Part C and Part D, the Department reviews payments to terminated plans, which, because of the programs' structure, are one of the only potential sources of high-dollar overpayments.

2) HHS has followed OMB direction regarding examining adjusted payments. Due to the unique nature of our programs, we met with OMB after the implementing guidance was released to discuss several HHS-specific issues related to producing the quarterly high-dollar overpayment reports and complying with the EO. As a result of these discussions, in April 2010, OMB directed HHS to report on overpayments for which adjustments had not been made, and not to focus on payments for which adjustments had been made.

3) The OMB implementing guidance excludes reporting overpayments to entities. The OMB implementing guidance defines the term "entity" as "exclude[ing] an individual acting in either a personal or commercial capacity (that is, a sole proprietor) and Federal, state, and local government agencies". For HHS' five state-administered programs, the overwhelming majority of the payments made by the Federal government are to state and local governments; thus they are excluded from EO reporting requirements. In addition, we notified OMB of our implementation approach for state-administered programs and they did not direct the Department to change its approach.

With respect to the recommendations within the draft report, we are always looking for ways to improve our efforts and will carefully consider the recommendations. Specifically, HHS will study the recommendation to develop a more comprehensive list of overpayments for each program to determine if it is feasible and cost-effective to implement. In addition, we believe that the likelihood of any high-dollar overpayments in the state-administered programs that pay for services like training and technical assistance is very small due to limited outlays; well-established payment procedures, including contract monitoring; and strong internal controls. However, we will work with the applicable programs to determine if there are any high-dollar overpayments to non-governmental entities that should be included in future high-dollar overpayment quarterly reports. Lastly, HHS will meet with OMB to ensure OMB continues to approve our implementation of the EO, and we will notify your office of the results of these discussions.

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 Compliance with EO 13520 When Reporting FY 2010 High-Dollar Improper Payments (A-02-11-01007)

Attachment: Technical Comments on the HHS OIG Draft Report on Compliance with EO 13520 When Reporting FY 2010 High-Dollar Improper Payments (A-02-11-01007)

Below are our technical comments on the draft report.

- In several sections of the report (Pages ii and 3), the draft report notes that "In addition, it was the Department's opinion that overpayments for which adjustments were being made did not meet the definition of an improper payment and did not need to be reported, nor did any overpayments made by the State-administered programs need to be reported."

  Not including adjustments was not based on "the Department's opinion", but was implemented after consultation with OMB in which OMB directed HHS in April 2010 not to focus on overpayments for which adjustments had been made.

  Also, the EO does not require high-dollar overpayments made to states to be reported because the EO guidance excludes states from the definition of an entity, thereby excluding payments to states from the high-dollar overpayment quarterly report. In addition, neither the EO nor the implementing guidance requires the agency to report high-dollar overpayments made by states to its recipients. Therefore, HHS notified OMB that we would not be reporting information for the state-administered programs, and OMB did not direct HHS to change its reporting efforts.

  Accordingly, we recommend that this sentence be deleted throughout the document.

- In the Medicare Parts C and D section on Page 4, the draft report notes that Part C and D officials only analyzed overpayments made to terminated plans to identify high-dollar improper payments, and this source was not all-inclusive of potential errors. However, HHS believes this source includes most errors that would be identified outside of the reconciliation process.

  Specifically, Medicare Part C and Part D are prospective payment systems with reconciliation occurring multiple times following the close of the payment year. During reconciliation, payments are adjusted to reflect better information about the enrollees or plan that impact payment (for example, offsetting any remaining payments to account for improper overpayments made earlier in the year), which are very similar to the ongoing adjustments that are made in the Medicare Fee-For-Service program.

  However, terminated plans sometimes receive payment inappropriately due to delays in termination notifications. For example, the terminated plans should no longer be receiving payments from the payment system, but due to the delays in the termination

notification they may receive payment. In these cases, payments to terminated plans are the only entities for which specific overpayments can be routinely identified. As a result, HHS now routinely checks for the inappropriate payment of terminated plans and has taken steps to facilitate payment recovery under this circumstance.

Accordingly, we recommend that this sentence should be revised to say "Medicare Parts C and D officials at CMS analyzed only overpayments made to terminated plants to identify high-dollar improper payments, which HHS determined was likely to be the most useful, inclusive, and cost-effective source of high-dollar overpayment information for the programs."