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Report of Independent Auditors on HHS' Compliance with the Payment Integrity Information Act of 2019

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, 2020, to determine if HHS is in compliance with the Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA). PIIA was enacted on March 2, 2020, and repealed the Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper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. IPIA had been amended by IPERA and IPERIA prior to its repeal (hereinafter, the amended IPIA is referred to as "IPIA"). PIIA set forth similar improper payment reporting requirements, including an annual compliance report by Inspectors General. However, as final OMB guidance related to PIIA was not issued until March 5, 2021, and HHS issued its FY 2020 Agency Financial Report (AFR) on November 13, 2020, we conducted our FY 2020 performance audit following the requirements in OMB Circular A-123, Appendix C (M-18-20, June 2018), OMB Circular A-136 (August 2020), OMB FY 2020 Annual Data Call Instructions, OMB Payment Integrity Question and Answer Platform, and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA.

We conducted this performance audit in accordance with generally accepted *Government Auditing Standards*. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The nature, timing and extent of the procedures selected depend on our judgment. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To assess HHS compliance, we performed specific procedures to address the objectives summarized in the 2020 Statement of Work Appendix F – Improper Payment. The specific scope and methodology are summarized in Section II of this report. This report also addresses the extent to which HHS has identified and implemented internal control to comply with the improper payment regulations. However, this performance audit did not constitute an audit of internal control over financial reporting in accordance with auditing standards generally accepted in the United States. Additionally, because of their nature and inherent limitations, the internal control may not prevent, or detect and correct, all deficiencies that may be considered relevant to the audit objectives.



HHS met many requirements, but it did not fully comply with the applicable improper payment regulations for fiscal year 2020 (FY 2020). Our detailed findings and recommendations are documented in Section III of this report.

This report is intended solely for the information and use of HHS and the HHS Office of Inspector General, Office of Management and Budget, Congress, and the U.S. Government Accountability Office, and is not intended to be, and should not be, used by anyone other than these specified parties.

Ernst & Young LLP

May 10, 2021
Baltimore, MD

EXECUTIVE SUMMARY

The Payment Integrity Information Act of 2019 (PIIA: PL 116-117) requires the 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 PIIA. PIIA was enacted on March 2, 2020, and repealed the Improper Payments Information Act (IPIA) of 2002, the Improper Payments Elimination and Recovery Act (IPERA) of 2010, and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012. IPIA had been amended by IPERA and IPERIA prior to its repeal (hereinafter, the amended IPIA is referred to as "IPIA").

The Department of Health and Human Services' (HHS) OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS' improper payment reporting in its annual AFR and accompanying materials to determine if HHS is in compliance with PIIA and the applicable improper payment guidance.

We conducted a performance audit to determine whether HHS complied with PIIA improper payment reporting requirements in its fiscal year (FY) 2020 AFR. As the OMB guidance for PIIA, Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement (M-21-19), was not issued until March 5, 2021, and HHS issued its FY 2020 AFR on November 13, 2020, HHS reported improper payments in accordance with IPIA and OMB guidance for IPIA. OMB informed OIG to use the OMB Circular A-123, Appendix C (M-18-20), issued in June 2018 to review and report on agencies' annual improper payment information for fiscal year 2020. Accordingly, we conducted our performance audit using a combination of existing requirements, including OMB Circular A-123, Appendix C (M-18-20, June 2018), OMB Circular A-136 (August 2020), OMB FY 2020 Annual Data Call Instructions, OMB Payment Integrity Question and Answer Platform, and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA.

As part of our performance audit, we evaluated compliance of the following programs against PIIA criteria. Eight programs that OMB deemed susceptible to significant improper payments: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Temporary Assistance for Needy Families (TANF), Foster Care, Child Care and Development Fund (CCDF), and Children's Health Insurance Program (CHIP); four programs that are deemed susceptible to significant improper payments under Additional Supplemental Appropriations for Disaster Relief Requirement Act of 2017 (PL 115-72) and OMB Memorandum M-18-14, Implementation of Internal Controls and Grant Expenditures For the Disaster-Related Appropriations: Center for Disease Control and Prevention (CDC) Disaster Relief, Office of Assistant Secretary for Preparedness and Response (ASPR) Disaster Relief, Health Resources and Services Administration (HRSA) Disaster Relief, and Administration for Children and Families' Office of Head Start (OHS) Disaster Relief; and one additional program that HHS identified to be susceptible to significant improper payments, Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicaid and CHIP are OMB designated high-priority programs. As part of our procedures, we evaluated the improper payment methodology and estimate for two programs, Medicaid and CHIP. We also reviewed the disclosures around methodology changes for certain programs due to COVID-19.

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

BACKGROUND

To improve accountability of federal agencies' administration of funds, PIIA requires agencies, including HHS, to annually report to Congress on the agencies' improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments), as well as other cases listed in the OMB implementing guidance. HHS issued its FY 2020 AFR, including the required improper payment disclosures, on November 13, 2020.

As required by OMB, agencies' OIGs must report on six¹ key issues as part of their PIIA compliance reporting: (1) publishing an AFR for the most recent fiscal year and posting the report and any accompanying material required by OMB on the agency's website; (2) conducting a program-specific risk assessment for each program; (3) publishing improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessments or deemed by OMB as susceptible to significant improper payments; (4) publishing programmatic corrective action plans (CAPs); (5) publishing and meeting annual reduction targets for each program assessed to be at risk and measured for improper payments; and (6) reporting gross improper payment rates of less than 10 percent. As part of the Inspector General's review of the agency's compliance with PIIA, the Inspector General should also evaluate the accuracy and completeness of the agency's reporting and performance in reducing and recapturing improper payments.

WHAT WE FOUND

HHS met many requirements but did not fully comply with PIIA for FY 2020.

As required, HHS conducted a program-specific risk assessment of 23 programs (representing risk assessment of programs and charge cards) that were not deemed susceptible to significant improper payments by OMB or the Department to identify those programs or activities that might have been susceptible to significant improper payments. The charge card review, consisting of purchase card payments, was completed for the National Institutes of Health (NIH). Additionally, HHS incorporated charge card risk assessment within each program's risk assessment to the extent it is applicable to the program being risk assessed. Consistent with OMB guidance, this risk review will be performed by each Staff or Operating Division on a three-year rotational basis.

¹ These six compliance criteria were established by IPERA, which was repealed by PIIA on March 2, 2020. PIIA retained the compliance criteria of IPERA with some refinements. The OMB guidance for PIIA (M-21-19) was not issued until March 5, 2021. OMB informed OIG to use the OMB Circular A-123, Appendix C (M-18-20), issued in June 2018, and we followed that OMB, which was for IPIA.

Additionally, the following table (Table 1) displays compliance determination with PIIA requirements for HHS programs that are susceptible to significant improper payments.

Table 1: PIIA Compliance Reporting Table for Programs That Are Susceptible to Significant Improper Payments

Program Name	Published an AFR or Performance and Accountability Report (PAR)	Conducted a Risk Assessment	Published an Improper Payment Estimate For CY	Published a Corrective Action Plan	Published Reduction Targets in CY AFR and Met Reduction Targets Set in PY AFR	Reported an Improper Payment Rate of Less Than 10%
Medicare FFS	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Medicare Advantage (Part C) (a)	Compliant	N/A(b)	Compliant	Compliant	Partially compliant (h)	Compliant
Medicare Prescription Drug Benefit (Part D)	Compliant	N/A(b)	Compliant	Compliant	Compliant	Compliant
Medicaid	Compliant	N/A(b)	Compliant	Compliant	(d)	Noncompliant
CHIP	Compliant	N/A(b)	Compliant	Compliant	(d)	Noncompliant
Advance Premium Tax Credit (APTC)	Compliant	N/A(b)	Noncompliant (g)	(g)	(g)	(g)
Foster Care	Compliant	N/A(b)	Compliant	Compliant	Partially compliant (j)	Compliant
Temporary Assistance for Needy Families (TANF)	Compliant	N/A(b)	Noncompliant (c)	(c)	(c)	(c)
Child Care and Development Fund (CCDF)	Compliant	N/A(b)	Compliant	Compliant	(e)	Compliant
ASPR Disaster Relief	Compliant	N/A(b)	Compliant	Compliant	(f)	Compliant
CDC Disaster Relief	Compliant	N/A(b)	Noncompliant (i)	(i)	(i)	(i)
HRSA Disaster Relief	Compliant	N/A(b)	Compliant	Compliant	(f)	Compliant
OHS Disaster Relief	Compliant	N/A(b)	Noncompliant (k)	(k)	(k)	(k)

Accompanying Notes to Table 1

- (a) HHS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as HHS had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program in FY 2020, as required by PIIA, and Section 1893 (h) of the Social Security Act.
- (b) These programs are determined to be susceptible to significant improper payments and are not required to perform a risk assessment (Appendix C of OMB Circular A-123, Part I.C.1).²
- (c) As described in Finding #1, an improper payment estimate was not published for TANF due to statutory limitations. As a result, HHS was not able to publish a reduction target for future improper payment levels, publish corrective action plans and fulfill the criteria of achieving improper payment rate of less than 10 percent per OMB guidance.
- (d) As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report improper payment target rates for Medicaid and CHIP in FY 2020. HHS resumed the Medicaid and CHIP eligibility component measurements in 2019 and reported the second updated national eligibility improper payment estimates in FY 2020. Since HHS uses a 17-state, 3-year rotation for measuring Medicaid and CHIP improper payments, the publication of reduction targets will occur in FY 2021 once HHS establishes and reports a full baseline, including eligibility.
- (e) As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report improper payment target rates for Child Care in the FY 2020 AFR. CCDF state grantees are implementing large-scale changes to their child care programs in accordance with the Child Care and Development Block Grant Act of 2014. Rolling implementation of the new requirements affected the FY 2020 error rate measurement and will continue to affect the error rate in the FY 2021 measurement, making it a challenge to determine a target rate. As a result, the full baseline has yet to be established. Further, as a result of uncertainties due to the COVID-19 Public Health Emergency (PHE), states' abilities to complete planned actions were impacted.
- (f) This is the first year HHS reported improper payment estimates for these programs; as such, the criteria to meet the reduction target set in the prior year is not applicable. However, these programs have established reduction targets for the subsequent year.
- (g) As described in Finding #4, while a FY 2016 risk assessment concluded that the APTC program is susceptible to significant improper payments, the program is not yet reporting improper payment estimates for FY 2020. As a result, HHS was not able to publish a reduction target for future improper payment levels, publish corrective action plans and fulfill the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance.

² All references in the Notes to Appendix C of OMB Circular A-123 are the version transmitted in M-18-20.

- (h) HHS met the reduction target set in the FY 2019 AFR. However, HHS did not fulfill the criteria of publishing a reduction target in the FY 2020 AFR. Due to HHS's temporary policy to stop documentation requests to providers as a result of the PHE for the COVID-19 pandemic, the Medicare Part C Improper Payment Measurement medical record submission did not follow the same pattern as in previous years. As a result, HHS had to make significant changes to the sampling and estimation plan for FY 2020 Medicare Part C improper payment reporting. This impacted HHS's ability to set target rates for FY 2021. OMB allows for this exception for not reporting out year targets in OMB Circular A-123, Appendix C. Although HHS did not report a new Medicare Part C reduction target in the FY 2020 AFR for FY 2021, the Medicare Part C program did meet the FY 2020 reduction target set in the FY 2019 AFR.
- (i) HHS did not publish an improper payment rate for the CDC Disaster Relief program. The COVID-19 PHE delayed HHS's effort to test the CDC Disaster Relief funds in FY 2020. As a result, HHS was not able to publish a reduction target for future improper payment levels, publish corrective action plans and fulfill the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance.
- (j) HHS met the reduction targets set in the FY 2019 AFR. However, HHS did not fulfill the criteria of publishing a reduction target in FY 2020. In the FY 2020 AFR, HHS noted that given the ongoing COVID-19 PHE, HHS is uncertain of when it will be safe to resume onsite Title IV-E Reviews and how many states will be newly reviewed in time. In light of this uncertainty, as well as the unknown impact of the recent programmatic changes on the improper payment rate, HHS has chosen not to set an improper payment reduction target for FY 2021, which is in accordance with OMB Circular A-123, Appendix C.
- (k) HHS did not publish an improper payment rate for OHS Disaster Relief program. HHS management noted that due to a change in expected reporting timelines, combined with the impact of COVID-19, HHS was unable to report improper payment estimates in FY 2020. HHS expects to begin reporting improper payment estimates in FY 2021, which will also allow OHS and its grantees additional time to gather and review documentation. As a result, HHS was not able to publish a reduction target for future improper payment levels, publish corrective action plans and fulfill the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance.

In accordance with PIIA, agencies must complete several actions based on the number of consecutive years the agencies are determined to be noncompliant by the Inspector General. These actions are described in Appendix C to OMB Circular A-123, Part IV.B.1.

During our review of prior-year reports issued by the OIG and the results of our procedures, we identified instances of noncompliance with PIIA in the Medicaid, CHIP, TANF and Medicare Advantage (Part C) programs. HHS has been noncompliant for six or more consecutive years for these programs.

Lastly, we obtained an understanding of management procedures, oversight and controls in place to identify and report improper payments and controls surrounding the risk assessment compilation. We determined that HHS maintained adequate internal controls over these processes.

WHAT WE RECOMMEND

HHS has not fully addressed recommendations from the prior years' performance audits related to improper payments, including the following:

- For the TANF program, ACF should develop an improper payment estimate, reduction targets and CAP;
- For the Medicare Part C program, HHS should continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2021. We also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program; and
- For Medicaid and CHIP, HHS should focus on identifying root causes for the improper payment percentage and evaluate critical and feasible action steps to reduce the improper payment percentages below 10 percent.

In addition, we recommend the following based on current year findings:

- For the APTC program, HHS should develop an improper payment estimate, reduction targets and CAP; and
- For the CDC and OHS Disaster Relief program, HHS should develop an improper payment estimate, reduction targets and CAP.

Addressing these recommendations would improve HHS' compliance with PIIA, including compliance issues identified in our current findings. We made a series of detailed recommendations as described in Section III to improve HHS' compliance with PIIA.

HHS MANAGEMENT COMMENTS

In its comments on our draft report, HHS has outlined significant actions for which the agency will take in addressing the findings in our report. HHS also emphasized its commitment to reduce improper payments and improve reporting. HHS' comments are included in Appendix A.

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INTRODUCTION

The Payment Integrity Information Act of 2019 (PIIA: PL 116-117) requires the Offices of Inspector General (OIGs) to review and report on agencies' annual improper payment information included in their AFRs to determine compliance with PIIA. PIIA was enacted on March 2, 2020, and repealed the Improper Payments Information Act (IPIA) of 2002, the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012. IPIA had been amended by IPERA and IPERIA prior to its repeal (hereinafter, the amended IPIA is referred to as "IPIA").

The Department of Health and Human Services' (HHS) OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS' improper payment reporting in its annual AFR and accompanying materials to determine if HHS is in compliance with PIIA and the applicable improper payment guidelines.

We conducted a performance audit to determine whether HHS complied with PIIA improper payment reporting requirements in its fiscal year (FY) 2020 AFR. As the OMB guidance for PIIA, Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement (M-21-19), was not issued until March 5, 2021, and HHS issued its FY 2020 AFR on November 13, 2020, HHS reported improper payments in accordance with IPIA and OMB guidance for IPIA, OMB informed OIG to use the OMB Circular A-123, Appendix C (M-18-20), issued in June 2018 to review and report on agencies' annual improper payment information for fiscal year 2020. Accordingly, we conducted our performance audit using a combination of existing requirements, including OMB Circular A-123, Appendix C (M-18-20, June 2018), OMB Circular A-136 (August 2020), OMB FY 2020 Annual Data Call Instructions, OMB Payment Integrity Question and Answer Platform, and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA.

As part of our performance audit, we evaluated compliance of the following programs against PIIA criteria. Eight programs that OMB deemed susceptible to significant improper payments: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Temporary Assistance for Needy Families (TANF), Foster Care, Child Care and Development Fund (CCDF), and Children's Health Insurance Program (CHIP); four programs that are deemed susceptible to significant improper payments under Additional Supplemental Appropriations for Disaster Relief Requirement Act of 2017 (PL 115-72) and OMB memorandum (M 18-14), Implementation of Internal Controls and Grant Expenditures For Disaster Related Appropriations: Centers for Disease Control and Prevention (CDC) Disaster Relief, Office of Assistant Secretary for Preparedness and Response (ASPR) Disaster Relief, and Health Resources and Services Administration (HRSA) Disaster Relief and Office of Head Start (OHS) Disaster Relief; and one additional program HHS identified to be susceptible to significant improper payments: Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicaid and CHIP are OMB designated high-priority programs. As part of our procedures, we evaluated the improper payment methodology and estimate for two programs, Medicaid and CHIP. We also reviewed the disclosures around methodology changes for certain programs due to COVID-19.

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

Objectives

The objective of our performance audit was to assess whether HHS complied with the PIIA reporting requirements and provided adequate disclosure within the annual AFR and accompanying materials.

A determination of compliance with PIIA³ includes whether HHS has:

- a) Published an AFR for the most recent fiscal year and posted that report and any accompanying material required by the OMB on its website;
- b) Conducted a program-specific risk assessment, if required, for each program or activity to identify those that may be susceptible to significant improper payments;
- c) Published improper payment estimates for all programs and activities identified in its risk assessment, or deemed by OMB, as susceptible to significant improper payments;
- d) Published programmatic corrective action plans (CAPs) in the AFR (as required);
- e) Published and met annual reduction targets for each program assessed to be at risk and measured for improper payments (as required); and
- f) Reported a gross improper payment rate of less than 10 percent for each program or activity for which an improper payment estimate was obtained and published in the AFR.

SECTION I – BACKGROUND

To improve the accountability of federal agencies' administration of funds, PIIA requires the agencies, including HHS, to annually report information to the President and Congress on the agencies' improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments), as well as other causes listed in the OMB implementing guidance. OMB circular, A-123, Appendix C (M-18-20), Parts I, II, and III, and OMB Circular A-136, §II.4.5, provides guidance on the implementation of and reporting under the requirement for payment integrity improvement. There are thirteen programs that are deemed or identified to be susceptible to significant improper payments. Accordingly, HHS reported approximately \$134.65 billion in gross improper payments in its FY 2020 AFR.

³ These compliance criteria were prescribed under IPERA, which was repealed by PIIA on March 2, 2020. PIIA retained the six-compliance criteria of IPERA with some refinements. Since the OMB guidance (M-21-19 Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement) was pending and was issued later on March 5, 2021, we followed the OMB guidance under PIIA: OMB Circular A-123, Appendix C (M-18-20, June 2018).

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered PIIA information that was reported in the “Payment Integrity Report” section of HHS’ FY 2020 AFR. HHS included information on the following thirteen programs that are determined to be susceptible to significant improper payments: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, TANF, Foster Care, CCDF, CDC Disaster Relief, ASPR Disaster Relief, OHS Disaster Relief and HRSA Disaster Relief.

Methodology

To determine whether HHS complied with PIIA and whether it had made progress on recommendations included in prior years’ reports, we:

- Reviewed applicable federal laws and OMB circulars;
- Reviewed improper payment information reported in the HHS FY 2020 AFR;
- Assessed internal control around significant processes impacting the improper payment process in conjunction with the audit of the consolidated financial statements;
- Obtained and analyzed other information from HHS on the thirteen programs determined to be 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 2020 and that the results were published in the HHS FY 2020 AFR;
- Assessed HHS’ disclosure of improper payment requirements in the AFR by verifying that the HHS FY 2020 AFR includes required disclosures per OMB Circular A-136;
- Verified that the HHS FY 2020 AFR was published on HHS.gov;
- Compared amounts included on HHS-prepared supporting documentation to information included within the “Payment Integrity Report” section of the FY 2020 AFR for each program;
- Performed walk-throughs to gain an understanding of management’s process and assessed internal controls for the programs selected as part of our testing of HHS’ processes over financial reporting; and
- Evaluated the control environment to determine if HHS maintained adequate internal controls over the improper payment process for the high priority programs.

To evaluate the assessed level of risk and the quality and methodology of improper payment estimates for programs that are susceptible to significant improper payments, we:

- Interviewed Department officials about the process for assessing the level of risk for each program and confirmed HHS' approach within the context of OMB's guidance;
- Made inquiries to Department officials about the quality of the improper payment estimates and the methodology for each program;
- Reviewed key processes, steps, and documentation used to estimate improper payments in each program;
- Asked program officials about the methodology for determining the estimated improper payment rate target for the subsequent year for each program; and
- We evaluated the improper payment methodology and estimate for two programs, Medicaid and CHIP.

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

- Verified that the improper payment reduction goals from the HHS FY 2019 AFR were met in FY 2020 and that the results were published in the HHS FY 2020 AFR;
- Reviewed HHS' program-specific efforts to recapture improper payments in FY 2020;
- Reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2020; and
- Verified that the CAPs for the relevant programs were published in the HHS FY 2020 AFR and appropriately prioritized within HHS.

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

We conducted this performance audit in accordance with generally accepted *Government Auditing Standards*. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

SECTION III – FINDINGS AND RECOMMENDATIONS

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

Finding #1 – TANF improper payment estimate not published in FY 2020

HHS did not calculate or report an improper payment estimate for TANF. HHS stated in its FY 2020 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. PIIA 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. 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.

We acknowledge that HHS continues to work on a multi-faceted approach to support states in improving TANF program integrity and preventing improper payments. In the FY 2020 AFR, HHS continued to report on a series of actions, including awarding a contract to promote and support innovation in TANF data, and working with states to mitigate potential payment risk identified as part of a detailed risk assessment of the program performed in FY 2016. In FY 2019, HHS conducted a comprehensive needs assessment of all TANF states, territories and the District of Columbia, including information about payment integrity efforts to understand existing state approaches and alternative methods for measuring TANF improper payments. This assessment is helping HHS understand existing state approaches and alternative methods for measuring TANF improper payments, including the feasibility and cost-benefit analysis of different approaches. In FY 2019, HHS also performed a detailed risk assessment of the TANF program to determine susceptibility to significant improper payments and identified potential payment risks at the federal level.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF improper payments in FY 2021. This process will aid in identifying root causes of TANF improper payments and allow HHS to report CAPs in the AFR. To this effort, we acknowledge that HHS conducted a comprehensive needs assessment to help understand existing state approaches and alternative methods for measuring TANF improper payments. We also understand that a legislative proposal around TANF improper payment measurement published in the FY 2020 President's Budget was not enacted by Congress and HHS submitted a new proposal for the FY 2021 President's Budget that was also not enacted. We recommend that HHS continue to seek legislative proposals submitted through the President's Budget related to the program's measurement of improper payments.

Finding #2 – Medicaid and CHIP improper payment rate percentages exceed 10 percent for FY 2020

In accordance with IPERA of 2010, an executive agency is in compliance if it has reported an improper payment rate of less than 10 percent for each program and activity for which an estimate was published. The reported improper payment rate percentage in the HHS AFR for the Medicaid and CHIP programs in FY 2020 was 21.36 percent and 27.00 percent, respectively, which are above the compliance threshold of 10.00 percent.

One area driving the FY 2020 Medicaid and CHIP improper payment estimates is the continued reintegration of the Payment Error Rate Measurement (PERM) eligibility component, which was revamped to incorporate the Patient Protection and Affordable Care Act (PPACA) requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of the Medicaid and CHIP eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated, but the state provided no documentation to validate the verification process was completed.

HHS also identified that the Medicaid and CHIP improper payment estimates were driven by errors due to state noncompliance with provider screening, enrollment and National Provider Identifier (NPI) requirements. Most improper payments cited on claims were a newly enrolled provider not appropriately screened by the state; a provider without the required NPI on the claim; or a provider not enrolled.

Lastly, improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate.

Recommendation:

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

Finding #3 – No Recovery Audit Contract (RAC) activity completed during FY 2020 to recover improper payments for Medicare Advantage

In accordance with IPERA of 2010 (Section 2(h)), the agency shall conduct recovery audits with respect to each program and activity of the agency that expends \$1 million or more annually if conducting such audits would be cost-effective.

As reported in the HHS FY 2020 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 noted in the HHS FY 2020 AFR, in 2015, HHS issued a Request for Information on the proposal to place Risk Adjustment Data Validation (RADV) under the purview of a Part C RAC. In response, the Medicare Advantage (MA) industry expressed concerns of burden related to the high overturn appeal rate in the early experience of the FFS RAC program. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process. In light of these challenges, HHS believes the Part C RAC functions are currently being performed by the contract-level RADV program. In April 2019, HHS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits. The purpose of the training was to prepare the MA industry for the selection of audited MA organizations for RADV audits. The payment year 2014 RADV audit is currently underway but has not yet concluded. Hence, in FY 2020, a Part C RAC contract was not awarded, nor were any recovery audits completed, although the annual expenditures exceed \$1 million. Therefore, HHS is not in compliance with this specific section of the law/regulations.

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

Recommendation:

We recommend that HHS continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2021. We also recommend that HHS analyze the viability of issuing a contract that is cost-beneficial to the program.

Finding #4 – APTC improper payment estimate not published in FY 2020

HHS did not calculate or report an improper payment estimate for APTC. HHS stated in its FY 2020 AFR that while a FY 2016 risk assessment concluded that the APTC program is susceptible to significant improper payments, the program is not yet reporting improper payment estimates for FY 2020. HHS also stated that, as with similar HHS programs, developing an effective and efficient improper payment measurement program requires multiple, time-intensive steps, including contractor procurement, developing measurement policies, procedures and tools, and extensive pilot testing to ensure an accurate improper payment estimate. HHS will continue to monitor and assess the program for changes and adapt accordingly. In FYs 2017 through 2020, HHS conducted development and piloting activities for the APTC improper payment measurement program and will continue these activities in FY 2021. Accordingly, HHS should have estimated and reported improper payments in the AFR for APTC. Since HHS did not report an improper payment estimate for the APTC program, HHS did not publish a corrective action plan for APTC addressing the root causes for APTC's improper payments.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders, including considering recommendations from recent OIG audits, to develop and implement an approach to reporting on APTC improper payments in FY 2021.

Finding #5 – Disaster Relief Programs (CDC and OHS) improper payment estimate not published in FY 2020

HHS did not publish an improper payment rate either for CDC Disaster Relief program or OHS Disaster Relief program. These programs are required to report improper payment rate under the Additional Supplemental Appropriations for Disaster Relief Requirement Act of 2017 (PL 115-72) and an OMB memorandum (Implementation of Internal Controls and Grant Expenditures for Disaster-Related Appropriations, M 18-14). Per the legislation and OMB guidance, disaster programs with an annual outlay exceeding \$10 million are deemed susceptible to significant improper payments and are required to report improper payment estimate. Both the CDC and OHS Disaster Relief programs had outlays exceeding \$10 million in FY 2020. However, HHS did not report an improper payment estimate for these programs, and as a result, HHS was not able to publish a corrective action plan addressing the root causes for these programs' improper payments.

In the FY 2020 AFR, HHS disclosed that improper payments information will be reported in the FY 2021 AFR. HHS reported that the COVID-19 PHE delayed HHS's effort to test the CDC disaster relief funds in FY 2020. However, for FY 2021, HHS stated results of the special emphasis review that focused on internal control related to the funding of Hurricanes Harvey, Irma and Maria will be leveraged to ensure the improper payment requirement is satisfied for the CDC disaster funding. The effort to test the OHS disaster relief fund was also delayed due to the COVID-19 PHE, for which funding to the grantees was provided under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136). To allow OHS and its grantees additional time to gather and review documentation, HHS determined not to estimate improper payments and report in the

FY 2020 AFR but, rather, to estimate and report improper payment based on expenditures from the prior year in FY 2021 AFR. However, in FY 2020, we took note that as part of the effort toward reporting an improper payment estimate, HHS has developed an improper payment and estimation plan and submitted it to OMB for both programs.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on CDC and OHS Disaster Relief improper payments in FY 2021. We acknowledge that the OMB guidance states that disaster programs deemed susceptible to improper payments shall produce and report improper payment estimate to the extent possible. We also understand that HHS developed improper payment and estimation plan as part of the effort toward reporting improper payment estimates for these programs.

APPENDIX A: HHS MANAGEMENT COMMENTS



Amy J. Frontz
Deputy Inspector General for Audit Services
Department of Health and Human Services
Cohen Building, Room 5700A
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Frontz:

Thank you for the opportunity to review the Office of Inspector General's (OIG) draft report "*U.S. Department of Health and Human Services Met Many Requirements, but It Did Not Fully Comply With the Payment Integrity Information Act of 2019 and Applicable Improper Payment Guidance for Fiscal Year 2020*" (A-17-21-52000). The Department of Health and Human Services (HHS) takes seriously its responsibility to meet the Payment Integrity Information Act (PIIA, P.L. No. 116-117), which repealed and replaced previous improper payment legislation. HHS's new leadership will be re-examining the existing corrective actions and exploring new and innovative approaches to reduce improper payments. This re-evaluation of efforts may lead to additional administration options as well as legislative proposals in future budget submissions. As requested, this letter includes information on the status of actions we are taking in response to the recommendations in the draft report.

Responses to the HHS OIG Recommendations on PIIA Compliance (A-17-21-52000)

Recommendation #1: The Department should "continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF improper payments in FY 2021. This process will aid in identifying root causes of TANF improper payments and allow HHS to report CAPs in the AFR". The Department should also "continue to seek legislative proposals submitted through the President's Budget related to the program's measurement of improper payments".

HHS Response: As disclosed in the FY 2020 Agency Financial Report (AFR) and previous AFRs, statutory limitations prohibit HHS from developing a TANF improper payment measurement, or collecting the required information to develop corrective action plans. HHS continues to explore options with relevant stakeholders for developing an approach to measure improper payments in TANF. In the meantime, the Department uses a multi-faceted approach to support states in improving TANF program integrity and to prevent improper payments in the program, including awarding a five-year contract for Promoting and Supporting Innovation in TANF Data in FY 2017.

Recommendation #2: For Medicaid and CHIP, the Department should "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... HHS should work with the states to follow up on repeat root causes for errors and enhance the CAPs for implementation. In addition... HHS should continue to follow up with states during the interim period to verify that corrective actions identified after the improper payment error

rate measurement review are being implemented. HHS should also consider sharing corrective action best practices across states to help address these issues”.

HHS Response: HHS continues to implement a multi-faceted approach to Medicaid and CHIP corrective actions, with multiple efforts underway concurrently. The Department will continue to emphasize to states the need to come into compliance with HHS requirements and to work with providers and plans, as needed, to reduce improper payments in Medicaid and CHIP. In addition, HHS will collect promising practices states have implemented and share them with all states. The following are some of HHS’s key efforts to prevent and reduce improper payments in the Medicaid program. Due to the similarities between Medicaid and CHIP improper payments, the Medicaid corrective actions listed here also largely apply to CHIP.

- State Medicaid Provider Screening and Enrollment;
- Technical Assistance and Education on Beneficiary Eligibility and Enrollment;
- Medicaid Integrity Institute;
- Audits of State Beneficiary Eligibility Determinations;
- Enhanced State-Specific Payment Error Rate Measurement Corrective Action Plans;
- and
- Medicaid Eligibility Quality Control Program

Additional information on these and other corrective actions can be found in HHS’s FY 2020 AFR and will be updated in the FY 2021 AFR.

Recommendation #3: The Department should “continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2021”. The Department should also “analyze the viability of issuing a contract that is cost-beneficial to the program”.

HHS Response: The primary corrective action regarding Part C improper payments has been the contract-level Risk Adjustment Data Validation (RADV) audits. RADV verifies that diagnoses submitted by Medicare Advantage (MA) organizations for risk-adjusted payment are supported by medical record documentation. Despite efforts to effectively implement a successful Part C Recovery Audit Contractor (RAC) program, such as issuing a Request for Information on the proposal to include RADV audits under the purview of a Part C RAC in 2015 and receiving significant feedback from the public against the proposal, HHS has never entered into a contract with a Part C RAC. RACs have found Medicare Part C to be an unattractive business model because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes.

As discussed in Section 11 of the FY 2020 AFR, HHS completed several stages of the contract-level RADV audits for payment years 2011 through 2013. HHS initiated payment year 2014 and 2015 audits in 2019, incorporating an updated methodology. HHS has implemented a RADV program for many years with the support of contractors. The RADV program is consistent with PIIA’s recovery audit requirements and advances corrective actions for the Medicare Part C program.

Recommendation #4: The Department should “continue to work with OMB and other stakeholders... to develop and implement an approach to reporting on APTC improper payments in FY 2021”.

HHS Response: The Department is committed to implementing an improper payment measurement program for the Advance Premium Tax Credit (APTC) program as required by PIIA. As disclosed in the FY 2020 AFR, developing an effective and efficient improper payment measurement program requires multiple, time-intensive steps including contractor procurement, developing measurement policies, procedures, and tools, and extensive pilot testing to ensure an accurate improper payment estimate. HHS will continue to monitor and assess the program for changes and adapt accordingly. In FYs 2017 through 2020, HHS conducted development and piloting activities for the APTC improper payment measurement program and will continue these activities in FY 2021. The Department will continue to update its annual AFRs with the measurement program development status until reporting an improper payment estimate.

Recommendation #5: The Department should, “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on CDC and OHS Disaster Relief improper payments in FY 2021”.

HHS Response: Under the Bipartisan Budget Act of 2018 and OMB memorandum M-16-14, *Implementation of Internal Controls and Grant Expenditures for the Disaster-Related Appropriations*, programs that have outlays above \$10 million must produce and report an improper payment estimate “to the extent possible”. Further, under an OMB memorandum issued on June 17, 2020, *Risk-Based Financial Audits and Reporting Activities in Response to COVID-19*, agencies and auditors were provided with greater flexibility to prioritize audits, and reports, given the impact of COVID-19 on agency operations. The Centers for Disease Control and Prevention’s (CDC) plans to produce and report an improper payment estimate and relevant corrective action plans (CAPs) in FY 2020 were substantially delayed due to the impact of the COVID-19 public health emergency. The Department believes the flexibility permitted in OMB’s guidance in the two documents mentioned above (OMB memorandum M-16-14 and the June 17, 2020 memorandum) allows for the unique circumstances of not reporting a CDC or Office of Head Start (OHS) disaster relief program error rate estimate. The Department anticipates reporting an improper payment estimate and corrective action plans for the CDC and OHS disaster relief programs in FY 2021, as stated in the FY 2020 AFR.

Although HHS has implemented a number of important steps in the past several years to reduce improper payments and improve reporting, many of which are outlined in the draft report, we recognize the need for continuous and focused efforts to further prevent, detect, and reduce improper payments in our programs. The Administration is exploring cutting-edge methods (e.g., artificial intelligence) for program integrity purposes, as part of its efforts to ensure the government is a good steward of these programs and of the taxpayer dollars which fund them. The new Administration is eager to work with Congress, states, and other important stakeholders to make sure that HHS’s programs achieve compliance with PIIA.

Office of Management and Budget (OMB) guidance requires agencies to establish a plan for bringing each cited noncompliant program into compliance (including specific actions for programs that have been out of compliance for three or more years). Accordingly, HHS will


develop and submit a plan to address the compliance findings to the Senate Committee on Homeland Security and Governmental Affairs, the House Committee on Oversight and Government Reform, and OMB.

While we have previously identified many tools and resources to prevent, detect, and reduce improper payments, we look forward to continuing our efforts to find innovative ways to address the root causes of improper payments and achieve compliance for HHS's programs. Reducing improper payments across HHS's programs will strengthen our stewardship of taxpayer funds and accomplish HHS's mission.

We would like to thank the OIG and our independent auditors, Ernst & Young LLP, for your efforts and continued collaboration in support of HHS's programs.

Sincerely,

Norris W.
Cochran IV -S



Digitally signed by Norris W.
Cochran IV -S
Date: 2021.05.07 15:25:05 -04'00'

Norris Cochran
Acting Assistant Secretary for Financial Resources