

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**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 2022**

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Deputy Inspector General
for Audit Services

May 2023
A-17-23-52000

Office of Inspector General

<https://oig.hhs.gov>

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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 (FY) ended September 30, 2022, to determine if HHS is in compliance with the Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA). We determined HHS' compliance with PIIA based on the guidance prescribed by the Office of Management and Budget's (OMB) Circular A-123, Appendix C (M-21-19, March 2021), OMB Circular A-136 (June 2022), OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources* (March 2021); OMB Memorandum M-18-14, *Implementation of Internal Controls and Grant Expenditures For the Disaster-Related Appropriations* (March 2018); OMB FY 2022 Payment Integrity Annual Data Call Instructions, and the OMB Payment Integrity Question and Answer Platform.

We conducted this performance audit in accordance with generally accepted *Government Auditing Standards* and the PIIA audit guidance established by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). 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 Contract #GS00F290CA – FY 2022 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 controls to comply with PIIA. However, this performance audit did not constitute an audit of financial statements or 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. Furthermore, the projection of any evaluations of effectiveness to future periods, or conclusions about the suitability of the design of the internal controls to achieve the related audit objectives, is subject to the risk that internal controls may



become inadequate because of changes in conditions or that the degree of compliance with such internal controls may deteriorate.

HHS met many requirements, but it did not fully comply with PIIA for FY 2022. Our detailed findings and recommendations are documented in Section III of this report.

Ernst + Young LLP

May 18, 2023

EXECUTIVE SUMMARY

The Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA) was enacted on March 2, 2020, and requires the Offices of Inspector General (OIG) to review and report on agencies' annual improper payment information to determine compliance with PIIA.

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 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 the PIIA improper payment reporting requirements. We conducted our performance audit to determine whether HHS complied with PIIA based on the improper payment reporting requirements established by: Office of Management and Budget (OMB) Circular A-123, Appendix C (M-21-19, March 2021); OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources* (March 2021); OMB Memorandum M-18-14, *Implementation of Internal Controls and Grant Expenditures For the Disaster-Related Appropriations* (March 2018); OMB Circular A-136 (June 2022); the OMB FY 2022 Payment Integrity Annual Data Call Instructions; and OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with generally accepted *Government Auditing Standards* and applicable guidance included within the Council of the Inspectors General on Integrity and Efficiency (CIGIE) guidance required under PIIA.

As part of our performance audit, we evaluated compliance with PIIA for the following programs that OMB deemed susceptible to significant improper payments¹: Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Foster Care, and Child Care and Development Fund (CCDF); one program that is deemed susceptible to significant improper payments under OMB Memorandum M-18-14: Office of Head Start (OHS) Disaster Relief; and four additional programs that HHS identified to be susceptible to significant improper payments: Head Start, Provider Relief Fund (PRF), COVID-19 Uninsured Program (UIP), and Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and CCDF are OMB-designated high-priority programs.

¹ HHS determined Head Start to be risk susceptible in FY 2021. As with other programs, developing and implementing a new improper payment estimation methodology and process can be a time-intensive process. HHS is developing an improper payment measurement and expects to report an error rate for this program in the FY 2023 reporting cycle.

As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Medicare Part C program.

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

BACKGROUND

To improve the accountability of federal agencies' administration of funds, PIIA requires agencies, including HHS, to annually report to Congress on the agencies' improper payments (IP) and unknown payments (UP). An IP is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments) under a statutory, contractual, administrative, or other legally applicable requirement. The term IP includes: (1) any payment to an ineligible recipient; (2) any payment for an ineligible good or service; (3) any duplicate payment; (4) any payment for a good or service not received, except for those payments where authorized by law; and (5) any payment that does not account for credit for applicable discounts. An UP is any payment that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation. HHS issued its FY 2022 Agency Financial Report (AFR), including the required IP disclosures, on November 14, 2022.

As required by OMB, agencies' OIGs must report on ten key issues as part of their PIIA compliance reporting:

- 1a. Publishing payment integrity information with the annual financial statement;
- 1b. Posting the annual financial statement and accompanying materials on the agency website;
- 2a. Conducting IP risk assessments for each program with annual outlays greater than \$10 million at least once in the last three years;
- 2b. Adequately concluding whether the program is likely to make IPs and UPs above or below the statutory threshold;
3. Publishing IP and UP estimates for programs susceptible to significant IPs and UPs in the accompanying materials to the annual financial statement;
4. Publishing corrective action plans for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement;
- 5a. Publishing an IP and UP reduction target for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement;

- 5b. Demonstrating improvements to payment integrity or reached a tolerable IP and UP rate;
- 5c. Developed a plan to meet the IP and UP reduction target; and
- 6. Reporting an IP and UP estimate of less than 10 percent for each program for which an estimate was published in the accompanying materials to the annual financial statement.

As part of the OIG's review of the agency's compliance with PIIA, the OIG should also: (1) evaluate and take into account the adequacy of the IP risk assessment for each program, (2) evaluate and take into account the adequacy of the sampling and estimation methodology plan for those programs that reported an improper payment error rate, and (3) review the oversight and financial controls used to identify and prevent IPs and UP.

WHAT WE FOUND

HHS met many requirements but did not fully comply with PIIA for FY 2022.

HHS conducted a program-specific risk assessment of 43 programs based on FY 2021 outlays and did not identify any additional programs that are susceptible to significant improper payment. HHS is responsible for ensuring that all programs with annual outlays greater than \$10 million have been assessed for IP risk at least once every three years. While HHS conducted program-specific risk assessments of 43 programs, they did not risk assess each program with annual outlays greater than \$10 million at least once in every three years.

HHS had not fully implemented recovery audit activities for the identified improper payments for the Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D) programs in FY 2022, as required by PIIA.

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

Table 1: PIIA Compliance Reporting Table

Program Name	Published payment integrity information with the annual financial statement	Posted the annual financial statement and accompanying materials on the agency website	Conducted IP risk assessments for each program with annual outlays greater than \$10,000,000 at least once in the last three years	Adequately concluded whether the program is likely to make IPs and UPs above or below the statutory threshold	Published IP and UP estimates for programs susceptible to significant IPs in the accompanying materials to the annual financial statement	Published corrective action plans for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement	Published IP and UP reduction target for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement	Has demonstrated improvements to payment integrity or reached a tolerable IP and UP rate	Has developed a plan to meet the IP and UP reduction target	Reported an IP and UP estimate of less than 10 percent for each program for which an estimate was published in the accompanying materials to the annual financial statement
Medicare FFS	C	C	N/A (a)	N/A (a)	C	C	C	NC (b)	C	C
Medicare Advantage (Part C)	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C
Medicare Prescription Drug Benefit (Part D)	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C
Medicaid	C	C	N/A (a)	N/A (a)	C	C	C	C	C	NC (c)
Children’s Health Insurance Program (CHIP)	C	C	N/A (a)	N/A (a)	C	C	C	C	C	NC (c)
Advance Premium Tax Credit (APTC)	C	C	N/A (a)	N/A (a)	NC (d)	C	(d)	(d)	(d)	C (d)
Provider Relief Funds (PRF)	C	C	N/A (a)	C	C	C	C	C	C	C
COVID-19 Uninsured Program (UIP)	C	C	N/A (a)	C	NC (e)	(e)	(e)	(e)	(e)	(e)
Foster Care	C	C	N/A (a)	N/A (a)	NC (f)	(f)	(f)	(f)	(f)	(f)
Temporary Assistance for Needy Families (TANF)	C	C	N/A (a)	N/A (a)	NC (g)	(g)	(g)	(g)	(g)	(g)
Child Care and Development Fund (CCDF)	C	C	N/A (a)	N/A (a)	C	C	(h)	(h)	(h)	C
Head Start	C	C	N/A (a)	C	NC (i)	(i)	(i)	(i)	(i)	(i)
Head Start Disaster Relief	C	C	N/A (a)	N/A (a)	C	C	(j)	C	(j)	C

Accompanying Notes to Table 1

C – Compliant

NC – Noncompliant

N/A – Not Applicable

- (a) 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 II.A.2).
- (b) As described in Finding #8 below, HHS has not demonstrated improvements to payment integrity for the Medicare FFS program as the FY 2022 improper payment error rate (7.46 percent) increased by 1.2 percent when compared to FY 2021 (6.26 percent). This increase represents approximately \$6 billion in improper payments year over year. Additionally, the FY 2023 target error rate (7.36) remains over a percentage point higher than the reported FY 2021 improper payment rate (6.26).
- (c) As described in Finding #6 below, HHS did not report an IP and UP estimate of less than 10 in FY 2022 for the Medicaid (15.62) and CHIP (26.75) programs.
- (d) As described in Finding #9 below, the APTC improper payment rate reported only represents improper payments for the Federally-facilitated Exchange. HHS is still in the process of developing the improper payment measurement methodology for the State-based Exchanges and has not published an improper payment rate for the State-based exchanges component for APTC. As the reported rate does not include the State-based exchanges component, HHS is not in full compliance for the APTC program. As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report an improper payment reduction target for APTC in the FY 2022 AFR. The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and report a full baseline.
- (e) As described in Finding #4 below, HHS did not publish improper and unknown payment estimates for the COVID-19 UIP in the FY 2022 AFR. Due to the timing constraints of testing claims, HHS was unable to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report improper and unknown payments in FY 2022. As a result, HHS was not able to publish and develop a plan to meet the reduction target for future improper and unknown payment levels, publish corrective action plans (CAPs), and fulfill the criteria of achieving improper payment rate of less than 10 percent per OMB guidance.
- (f) As described in Finding #3 below, HHS did not publish improper and unknown payment estimates for Foster Care in the FY 2022 AFR. In response to COVID-19, HHS postponed Title IV-E reviews. HHS is planning to resume conducting onsite Title IV-E reviews in 2024. Therefore, HHS was unable to calculate and report improper and unknown payment estimates. Consequently, HHS was not able to develop and publish a plan to establish and meet a reduction target for future improper payment and unknown levels, publish CAPs,

and determine if the criteria for achieving an improper payment rate of less than 10 percent per OMB guidance was met.

- (g) As described in Finding #2 below, an improper payment and unknown payment estimate was not published for TANF due to statutory limitations. Consequently, HHS was not able to develop and publish a plan to establish and meet a reduction target for future improper and unknown payment levels, publish CAPs, and determine if the criteria for achieving an improper payment rate of less than 10 percent per OMB guidance was met.
- (h) 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 2022 AFR. CCDF state grantees have been implementing large-scale changes to their child-care programs in accordance with the Child Care and Development Block Grant Act of 2014. HHS anticipated re-establishing the baseline and setting a reduction target in FY 2022; however, limitations and restrictions due to COVID-19 impacted states' abilities to complete planned actions as states were granted needed flexibility. As such, HHS delayed establishment of a baseline until all cohorts have substantially completed the planned action.
- (i) As described in Finding #5 below, HHS did not publish improper and unknown payment estimates for Head Start in the FY 2022 AFR. HHS is developing and implementing a new improper payment estimation methodology. As this is a time-intensive process, HHS was unable to report improper payments in FY 2022 and anticipates reporting an error rate in FY 2023. Consequently, HHS was not able to develop and publish a plan to establish and meet a reduction target for future improper and unknown payment levels, publish CAPs, and determine if the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance was met.
- (j) HHS did not publish reduction targets for the Office of Head Start Disaster Relief program as it is below the statutory threshold for reporting estimates.

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 OIG. These actions are described in OMB Circular A-123, Appendix C, (Part VI.D).

Per OMB A-123, Appendix C (Part VI), the OIG review of the accompanying materials to the FY 2021 annual financial statement will be considered year one of a PIIA compliance review and all programs will be considered year one of noncompliance for the purpose of implementing Section VI.D. of OMB Circular A-123, Appendix C. As such, FY 2022 is considered year two of noncompliance for the Foster Care, Medicaid, CHIP, and TANF programs. FY 2022 is considered year one of noncompliance for the COVID-19 UIP, Medicare FFS, and Head Start programs.

Lastly, we obtained an understanding of management's procedures, oversight, and controls in place to identify and report improper payments and the controls surrounding the risk assessment compilation. Except for those identified below, 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:

- Perform a risk assessment over all programs with annual outlays in excess of \$10 million at least once every three years;
- For the Foster Care program, HHS should calculate an improper payment estimate, reduction targets, and CAP;
- For the TANF program, HHS should develop an improper payment estimate, reduction targets, and CAP;
- For the State-based component of the APTC program, HHS should develop an improper payment estimate, reduction targets, and CAP;
- For the Medicare Part C program, HHS should perform recovery audits to identify and recoup overpayments in FY 2023;
- For the Medicare Part D program, HHS should perform recovery audits to identify and recoup overpayments in FY 2023; 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 COVID-19 Uninsured Program (UIP), HHS should calculate an improper payment estimate, reduction targets, and CAP;
- For Head Start, HHS should calculate an improper payment estimate, reduction targets, and CAP;
- For Medicare FFS, develop and document plans to meet reduction targets and demonstrate improvements to payment integrity.

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 the draft report, HHS has outlined significant actions which the Department will take in addressing the findings in our report. Based on our review of management's response, these actions to address the findings include:

- Recommendation #1: As HHS has over two hundred programs subject to improper payment risk assessment, HHS plans to implement additional enhancements to gain efficiencies and allow for a greater number of risk assessments to be completed each year. These enhancements include modifications to the questionnaire, extending the risk assessment period, establishing a complete inventory of programs that would be covered in a three-year risk assessment cycle and developing a modified risk assessment approach for programs with outlays between \$10 million and \$100 million.
- Recommendation #2: HHS proposed new statutory authority, included in the President's FY 2024 budget, that would allow TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions.
- Recommendation #3: HHS plans to resume onsite Title IV-E reviews, that were previously postponed due to COVID-19, necessary to collect data to report Foster Care improper payment estimates in FY 2024.
- Recommendation #4: HHS expects to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report improper and unknown payments for the COVID-19 Uninsured Program in FY 2023.
- Recommendation #5: HHS expects to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report improper and unknown payments for the Head Start Program in FY 2023.
- Recommendation #6: HHS plans to continue to work with states to implement state-specific corrective action plans and ensure these corrective actions are being implemented. HHS also offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. In addition, HHS performs audits of beneficiary eligibility determinations in states identified to have higher improper payment estimates due to eligibility errors.
- Recommendation #7: In FY 2023, HHS finalized a rule to begin the recovery of overpayments under the RADV program. HHS plans to initiate recoveries later this year for completed Risk Adjustment Data Validation (RADV) audits. HHS continues to explore ways of conducting future RADV audits as soon as practicable after the close of a MA payment year and applying extrapolation to payment years 2018 and later in accordance

with the finalized rule. The Plan Program Integrity Medicare Drug Integrity Contractor (PPI-MEDIC) will continue to perform the Part D recovery audit functions.

- Recommendation #8: HHS has enhanced corrective actions related to Hospice and Skilled Nursing Facility (SNF) services in FY 2023, the largest drivers of the Medicare FFS improper payment estimates. These corrective actions included continuing to tighten provider screening and enrollment requirements and implementing new targeted education for SNF providers.
- Recommendation #9: HHS continues to develop the improper payment methodology for the State-based Exchanges in order to report an estimate for all components of the APTC program.

HHS also emphasized its commitment to reduce improper payments and improve reporting. HHS' comments are included in Appendix A.

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INTRODUCTION

PIIA was enacted on March 2, 2020, and requires the OIGs to review and report on the agencies' annual improper payment information compliance with PIIA.

The HHS OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS' improper payment reporting 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 the PIIA improper payment reporting requirements. We determined HHS compliance with PIIA based on the guidance prescribed by OMB Circular A-123, Appendix C (M-21-19, March 2021); OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources* (March 2021); OMB Memorandum M-18-14, *Implementation of Internal Controls and Grant Expenditures For the Disaster-Related Appropriations* (March 2018); OMB Circular A-136 (June 2022); the OMB FY 2022 Annual Data Call Instructions; and OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with generally accepted *Government Auditing Standards*, and applicable guidance included within the Council of the Inspectors General on Integrity and Efficiency (CIGIE) guidance required under PIIA.

As part of our performance audit, we evaluated compliance with PIIA for the following 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, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Foster Care, and Child Care and Development Fund (CCDF); one program that is deemed susceptible to significant improper payments under OMB Memorandum M-18-14: Office of Head Start (OHS) Disaster Relief; and four additional programs that HHS identified to be susceptible to significant improper payments: Head Start, Provider Relief Fund (PRF), COVID-19 Uninsured Program (UIP), and Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and CCDF are OMB-designated high-priority programs. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Medicare Part C program.

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

Objectives

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

A determination of compliance with PIIA includes whether HHS has:

- 1a. Published payment integrity information with the annual financial statement;
- 1b. Posted the AFR and accompanying materials on the agency website;
- 2a. Conducted an IP risk assessment for each program with annual outlays greater than \$10 million at least once every three years;
- 2b. Adequately concluded whether the program with annual outlays greater than \$10 million is likely to make improper payments and unknown payments above the statutory threshold;
3. Published improper payment (IP) and unknown payment (UP) estimates for all programs and activities identified in its risk assessment, or deemed by OMB, as susceptible to significant improper and unknown payments;
4. Published corrective action plans (CAPs) for each program for which an estimate above the statutory threshold was published in the accompanying materials to the AFR;
- 5a. Published IP and UP reduction targets for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement;
- 5b. Demonstrated improvements to payment integrity or reach a tolerable IP and UP rate;
- 5c. Developed a plan to meeting the IP and UP reduction target; and
6. Reported IP and UP estimate of less than 10 percent for each program or activity for which an estimate was obtained and published in the accompanying materials to the annual financial statement.

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' IP and UP. An IP is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments) under a statutory, contractual, administrative, or other legally applicable requirement. The term IP includes: (1) any payment to an ineligible recipient; (2) any payment for an ineligible good or service; (3) any duplicate payment; (4) any payment for a good or service not received, except for those payments where authorized by law; and (5) any payment that does not account for credit for applicable discounts. A UP is any payment that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation. OMB Circular A-123, Appendix C (M-21-19) and OMB Circular A-136 provide guidance on the implementation of and reporting under the requirement for payment integrity improvement. For FY 2022, there are 13 HHS programs that are deemed or identified to be susceptible to significant IPs. HHS reported approximately \$132.65 billion in gross IPs and UPs in its FY 2022 AFR.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered PIIA information that was reported in the “Payment Integrity Report” section of HHS’ FY 2022 AFR and published on PaymentAccuracy.gov. HHS included information on the following 13 programs that are determined to be susceptible to significant IPs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, PRF, COVID-19 UIP, TANF, Foster Care, CCDF, Head Start, and Head Start 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 IP information reported in the HHS FY 2022 AFR;
- Assessed internal control around significant processes impacting the IP process in conjunction with the audit of the consolidated financial statements;
- Obtained and analyzed other information from HHS on the 13 programs determined to be susceptible to significant IPs;
- Interviewed Department staff to obtain an understanding of the processes and events related to determining IP rates;
- Verified that the IP rates for the relevant programs were less than 10 percent in FY 2022 and that the results were published in the HHS FY 2022 AFR;
- Assessed HHS’ disclosure of IP requirements in the AFR by verifying that the HHS FY 2022 AFR included required disclosures per OMB Circular A-136;
- Verified that the HHS FY 2022 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 2022 AFR and information collected through the data call and published on PaymentAccuracy.gov 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 IP process and payment accuracy input process for the high-priority programs.

To evaluate the assessed level of risk and the quality and methodology of IP 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 IP estimates and the methodology for each program, including any changes in methodologies from the prior year;
- Reviewed key processes, steps, and documentation used to estimate IPs of programs reporting an error rate;
- Asked program officials about the methodology for determining the estimated IP rate target for the subsequent year for each program; and
- Evaluated the revised IP sampling and estimation methodology plan for the Medicare Part C program.²

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

- Verified that HHS demonstrated improvements to payment integrity in FY 2022 and that the results were published in the HHS FY 2022 AFR and on PaymentAccuracy.gov;
- Reviewed HHS' program-specific efforts to recapture IPs in FY 2022;
- Reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2022;
- Verified that the CAPs for the relevant programs were published in the HHS FY 2022 AFR and appropriately prioritized within HHS; and
- Verified that HHS submitted and published data call information to PaymentAccuracy.gov and took appropriate action to resolve any discrepancies between the annual financial statement and PaymentAccuracy.gov.

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

² The implemented policy contributed to a decrease in the projected Part C IP rate, representing a new baseline IP rate for Part C and is not directly comparable with prior reporting years.

We conducted this performance audit per the PIIA guidance 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 IP measurement programs. Although HHS met many PIIA and other OMB reporting requirements, it did not fully comply with PIIA. This report also addresses the extent to which HHS has identified and implemented internal controls to comply with PIIA. Except for those identified below, we did not identify internal control findings during the performance of the audit.

Finding #1 – HHS did not conduct improper payment risk assessments for each program with annual outlays greater than \$10 million at least once every three years

HHS conducted a program-specific risk assessment of 43 programs based on FY 2021 outlays and did not identify any additional programs that are susceptible to significant IP. PIIA and OMB guidance states that the Department must conduct an IP risk assessment at least once every three years for each program with annual outlays greater than \$10 million to determine whether the program is likely to make IPs plus UPs that would be in total above the statutory threshold. The agency is responsible for ensuring that all programs with annual outlays greater than \$10 million have been assessed at least once every three years. While management has a process to identify programs with over \$10 million in annual outlays and developed criteria to determine which programs need to be risk assessed, not all programs considered for risk assessment were risk assessed. HHS did not risk assess all such programs at least once every three years. HHS' management indicated that due to the number of programs that met the \$10 million threshold, adequate resources are not available to complete the risk assessments for all programs meeting the threshold. HHS is developing an approach to increase the capacity for additional risk assessment submission and review. The development of the approach would facilitate an increase in the number of risk assessments completed and enable programs to be risk assessed in the three-year cycle.

Recommendation:

We recommend that HHS either: (1) finalize the development of an approach that would facilitate a risk assessment and review of all programs with annual outlays greater than \$10 million at least once every three years or (2) work with OMB to develop an approach and obtain concurrence to perform risk assessments at a level that meets the intent of PIIA. As HHS has over 200 programs that exceed the \$10 million threshold in FY 2022, HHS should consider what additional resources are needed to perform these risk assessments for an organization as large and complex as HHS, or what enhancements can be made to the current process to reduce the time and effort to risk assess each program.

Finding #2 – TANF improper payment and unknown payment estimate not published in FY 2022

HHS did not calculate and report an IP and UP estimate for TANF. HHS stated in its FY 2022 AFR that it did not report an IP estimate for TANF because statutory limitations preclude HHS from requiring states to participate in a TANF IP measurement. PIIA requires federal agencies to review all of their programs to identify those that may be susceptible to significant IPs. OMB implementing guidance states that OMB can also designate programs as susceptible to significant IPs regardless of the risk assessment results. OMB has designated TANF as a federal program susceptible to significant IPs. Accordingly, HHS should have estimated and reported IPs in the AFR for TANF. Since HHS did not calculate and report an IP estimate for the TANF program, HHS could not publish a corrective action plan for TANF addressing the root causes for TANF's IPs.

HHS continues to work on a multifaceted approach to support states in improving TANF program integrity and preventing improper payments. In FY 2019, HHS also 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 showed that over 90 percent of state respondents are using at least one of the HHS recommended strategies to minimize initial errors and at least one of the HHS recommended strategies to identify and correct existing errors. In FY 2022, HHS completed a risk assessment of TANF and will use the results of the assessment to identify areas for risk mitigation.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF IPs going forward. This process will aid in identifying root causes of TANF IPs and allow HHS to report CAPs in the AFR.

Finding #3 – Foster Care improper payment and unknown payment estimate not published in FY 2022

HHS is not reporting a Foster Care error rate for FY 2022 or an IP, plus an UP target for FY 2023. In response to COVID-19, HHS postponed Title IV-E reviews. HHS is planning to resume conducting on-site Title IV-E reviews in FY 2024. Therefore, HHS was unable to develop IP and UP estimates and could not develop a reduction target for FY 2023.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Foster Care in FY 2023.

Finding #4 – COVID-19 Uninsured Program (UIP) improper payment and unknown payment estimate not published in FY 2022

HHS did not publish an IP and UP estimate for the COVID-19 Uninsured Program (UIP). Due to timing constraints of testing claims, HHS was unable to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report IPs and UPs in FY 2022.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on COVID-19 UIP in FY 2023.

Finding #5 – Head Start improper payment and unknown payment estimate not published in FY 2022

HHS did not publish an IP and UP for Head Start due to the timing constraint of developing and implementing a new IP estimation methodology. In FY 2021, HHS conducted a risk assessment of Head Start and determined it to be risk susceptible. As with other programs, developing and implementing a new methodology is a time-intensive process. As such, HHS was unable to develop IP and UP estimates and, therefore, could not develop a reduction target for FY 2023.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Head Start in FY 2023.

Finding #6 – Medicaid and CHIP improper payment and unknown payment rate percentages exceed 10 percent for FY 2022

In accordance with PIIA, if the program reported an IP and UP estimate of 10 percent or more for the FY, the program will be noncompliant. The reported IP rate percentage in the HHS AFR for the Medicaid and CHIP programs in FY 2022 was 15.62 percent and 26.75 percent, respectively, which are above the compliance threshold of 10.00 percent.

HHS identified that a majority of Medicaid and CHIP IPs were due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility.

Recommendation:

We recommend that HHS focus on the root causes of the IP percentage and evaluate critical and feasible action steps to assist states with their compliance efforts for these requirements. This would include working with the states to bring their respective systems into full compliance with the requirements to decrease the IP rate percentage below 10 percent. HHS should work with the

states to follow up on repeat root causes of errors and enhance the CAPs for implementation. In addition, as HHS reviews only 17 states each year for the Medicaid and CHIP IP rate, HHS should continue to follow up with states during the interim period to verify that corrective actions identified after the Payment Error Rate Measurement (PERM) review are being implemented. HHS should also consider sharing corrective action best practices across states to help address these issues.

Finding #7 – Recovery audits and activities performed during FY 2022 to recoup improper payments for Medicare Advantage and Medicare Part D programs are delayed or missing cost-effectiveness documentation

In accordance with PIIA (that part codified at 31 U.S.C. § 3352(i)(a)(A)), the Department shall conduct recovery audits with respect to each program and activity of the Department that expends \$1 million or more annually if conducting such audits would be cost-effective.

Contract-level Risk Adjustment Data Validation (RADV) audits are HHS’ primary action to recoup Part C overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by Medicare Advantage organizations for risk-adjusted payment. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. However, RADV audit results have not been finalized for several years as HHS was in the process of finalizing a rule that codifies in regulation that, as part of the RADV audit methodology, HHS will extrapolate RADV audit findings beginning with payment year 2018. As reported in the FY 2022 AFR, HHS continues RADV audit activities, most recently related to the PYs 2014 and 2015 RADV audits, although recoveries have yet to be made or reported in the AFR.

HHS believes that the Plan Program Integrity Medicare Drug Integrity Contract (PPI-MEDIC) performs the Part D recovery audit function. The PPI-MEDIC primarily assists HHS with outreach and education support, audits of plan sponsors, and data analysis. In FY 2022, the PPI-MEDIC continued previously contracted audits that identified potential IPs and conducted education and outreach for Part D plan sponsors. In addition, HHS conducted 13 plan sponsor self-audits in FY 2022. In addition, HHS has not documented how the PPI-MEDIC, which resulted in recovery of IPs and reported in the AFR, is cost-effective compared to the use of a recovery audit contractor. Therefore, HHS is not in full compliance with this specific section of the law and regulations.

Recommendation:

We recommend that HHS improve its recovery audit efforts as required under PIIA Section 2(i) to identify and recoup overpayments for Medicare Part C and Medicare Part D. HHS should also continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C and Medicare Part D programs in FY 2022 in the event that the RADV and PPI-MEDIC programs cannot effectively serve as HHS’ sole recovery audit strategies. If using a recovery audit contractor approach is determined to not be cost-effective, HHS should document how existing programs are cost-effective when compared to the use of a recovery audit contractor.

Finding #8 – HHS did not effectively demonstrate improvements to payment integrity for the Medicare FFS program in FY 2022

HHS has not demonstrated improvements to payment integrity for the Medicare FFS program as the FY 2022 IP error rate (7.46 percent) increased 1.2 percent when compared to FY 2021 (6.26 percent). HHS outlined the two drivers of the increase, which are: 1) Skilled Nursing Facilities (SNF) implemented a new payment policy that resulted in insufficient documentation errors, and 2) Hospice saw an increase in medical necessity errors from not meeting coverage criteria. Additionally, the FY 2023 target error rate (7.36 percent) remains over a percentage point higher than the reported FY 2021 improper payment rate (6.26 percent).

Recommendation:

While HHS continues to make improvements in certain areas of the Medicare FFS program that have reduced IP, the impact of IP stemming from the two drivers mentioned above outweighed this progress in FY 2022. We recommend that HHS continue to focus on the root causes of the IP percentage, especially the new drivers related to SNF and Hospice, and evaluate and document critical and feasible action steps to meet the Medicare FFS reduction target.

Finding #9 – HHS has not calculated and reported an improper payment estimate for the State-based Exchanges of the APTC program

Although HHS has calculated and reported an improper payment estimate for the Federally facilitated exchange of the Advance Premium Tax Credit (APTC) program, it has not calculated and reported an IP estimate for the State-based Exchanges. HHS stated in their AFR that they continue to develop the IP measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status. Additionally, the APTC program is not reporting an IP target. The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and report a full baseline.

Recommendation:

We recommend that HHS continue to work with OMB and other relevant stakeholders to complete the IP measurement program for the State-based Exchanges to report a full and accurate IP estimate.

APPENDIX A: HHS MANAGEMENT COMMENTS



May 17, 2023

Amy J. Frontz
Deputy Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Dear Ms. Frontz:

Thank you for the opportunity to review the Office of Inspector General's (OIG) draft report, *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 2022 (A-17-23-52000)*. The Department of Health and Human Services (HHS) is committed to reducing improper payments in all programs to better serve recipients and protect taxpayer resources. While we have previously identified many tools and resources to prevent, detect, and reduce improper payments, we are continuing efforts to find innovative solutions to address the root causes of improper payments, while protecting beneficiaries' access to health and human services. As a result of these efforts, the FY 2024 President's Budget request included several proposals to enhance HHS's compliance with the *Payment Integrity Information Act of 2019* (PIIA) and strengthen payment integrity. 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-17-23-52000)

Recommendation #1: HHS should "either (1) finalize the development of an approach that would facilitate a risk assessment and review of all programs with annual outlays greater than \$10 million at least once every three years or (2) work with OMB [Office of Management and Budget] to develop an approach and obtain concurrence to perform risk assessments at a level that meets the intent of PIIA." HHS should also "consider what additional resources are needed to perform these risk assessments...or what enhancements can be made to the current process to reduce the time and effort to risk assess each program."

HHS Response: HHS is dedicated to assessing and minimizing the risk of improper payments made by its programs. HHS has over two hundred programs that expend more than \$10 million annually and thus are subject to an improper payment risk assessment. Improper payment risk assessments are a resource-intensive process and must be balanced against resource constraints and other ongoing programmatic activities. HHS developed the Risk Assessment Portal (RAP) to collect and analyze program improper payment risk assessments. RAP is an online tool that allows programs to complete improper payment risk assessments more efficiently than under previous processes. While HHS has increased the number of programs that are risk assessed in recent years, HHS will implement additional enhancements in FY 2023 and beyond to capture all programs in its three-year assessment cycles. These enhancements include: 1) extending the risk assessment period to allow for a greater number of risk assessments to be completed each year; 2) establishing a complete inventory of programs and three-year risk assessment cycle; 3) restructuring the risk assessment questionnaire to gain efficiency; and 4) developing a modified risk assessment

approach for programs with outlays between \$10 million and \$100 million. Leveraging these enhancements to the risk assessment process, HHS aims to complete a full risk assessment cycle that captures all programs and activities with more than \$10 million in annual outlays by the end of FY 2025.

Recommendation #2: HHS should “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF [Temporary Assistance for Needy Families] improper payments going forward. This process will aid in identifying root causes of TANF improper payments and allow HHS to report [corrective action plans] in the AFR.”

HHS Response: Statutory limitations preclude HHS from collecting required information needed to develop a TANF improper payment measurement or corrective action plans. Section 411 of the Social Security Act lists the exact data elements that HHS can collect from TANF agencies, and therefore limits the agency’s ability to measure and oversee payment integrity. Under section 417 of the Social Security Act, HHS cannot collect data elements other than those listed. HHS proposed new statutory authority, included in the President’s FY 2024 budget, that would allow TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions.

Recommendation #3: HHS should “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Foster Care in FY 2023.”

HHS Response: In response to the COVID-19 pandemic, HHS postponed onsite Title IV-E reviews to protect the health and safety of state and federal reviewers, ensuring that state child welfare officials remain focused on mission-critical activities. These Title IV-E reviews generate data used to calculate Foster Care’s improper payment estimate. Due to the postponement of reviews, HHS had no new data for FY 2022 and did not report an improper payment estimate. HHS will resume Title IV-E reviews and report Foster Care improper payment estimates beginning in FY 2024. Due to the length of time that has passed, Foster Care will need to establish a new baseline measurement for improper payments using the same methodology.

Recommendation #4: HHS should “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on COVID-19 [Uninsured Program] in FY 2023.”

HHS Response: HHS determined COVID-19 Uninsured Program to be risk-susceptible in FY2021 and it is required to develop and implement an improper payment estimate. As with other programs, developing and implementing a new improper payment estimation methodology and process can be a time-intensive process. Due to the timing constraints of developing a statistical methodology and testing claims in the same year, HHS was unable to complete the statistical sampling methodology and subsequent extrapolation procedures to identify and report improper and unknown payments for the COVID-19 Uninsured Program in FY 2022. HHS expects to report improper payment estimates for this program in FY 2023.

Recommendation #5: HHS should “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Head Start in FY 2023.”

HHS Response: HHS determined the Head Start program to be risk-susceptible in FY 2021 and it is required to develop and implement an improper payment estimate. As with other programs,

developing and implementing a new improper payment estimation methodology and process is a time-intensive process. Due to the timing constraints of developing and implementing a new improper payment methodology, HHS was unable to complete the statistical sampling methodology needed to calculate improper and unknown payments for the Head Start program in FY 2022. HHS expects to report an improper payment estimate for this program in FY 2023.

Recommendation #6: For Medicaid and the Children’s Health Insurance Program (CHIP), HHS 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 requirements;... work with the states to follow up on repeat root causes for errors and enhance the [corrective action plans] for implementation;... continue to follow up with states during the interim period to verify that corrective actions identified after the Payment Error Rate Measurement review are being implemented; [and]... also consider sharing corrective action best practices across states to help address these issues.”

HHS Response: HHS continues to work with states to implement state-specific corrective action plans. HHS provides enhanced technical assistance and guidance to states during the development process to address each error and deficiency identified during the measurement cycle. HHS monitors the states’ progress in implementing corrective actions. HHS continues to emphasize to states the need to comply with requirements and to work with providers and plans to reduce improper payments in Medicaid and CHIP. HHS established a new Medicaid and CHIP baseline with all three cycles measured under new eligibility requirements in FY 2021 and saw a decrease in the estimates for both programs in FY 2022.

HHS continues to follow up with states during the 2-year period between Payment Error Rate Measurement (PERM) reviews to ensure corrective actions are being implemented. During these off years, under the Medicaid Eligibility Quality Control (MEQC) program, states design and conduct pilots to evaluate the processes that determine an individual’s eligibility for Medicaid and CHIP benefits. States have flexibility in designing pilots to focus on vulnerable or error-prone areas identified by the PERM program and state. The MEQC program also reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. In addition, HHS performs audits of beneficiary eligibility determinations in states identified to have higher improper payment estimates due to eligibility errors, issues identified by states through the MEQC program, or issues identified through HHS’s oversight of state corrective actions.

HHS also offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. In FY 2022, HHS continued a robust training program that provided training opportunities, including a Medicaid Risk Assessment Webinar, a Corrective Action Symposium, and a Provider Enrollment and Terminations Webinar, among others. In addition, HHS provides venues for states to share promising practices states have implemented, including various state Technical Advisory Groups focused on fraud, waste and abuse issues, data analytics, and provider enrollment.

Recommendation #7: HHS should “improve its recovery audit efforts as required under PIIA Section 2(i) to identify and recoup overpayments for Medicare Part C and Medicare Part D.” HHS should also, “continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C and Medicare part D programs in FY 2022 in the event that the RADV [Risk Adjustment Data Validation] and PPI-MEDIC [Plan Program Integrity Medicare Drug

Integrity Contractor] programs cannot effectively serve as HHS' sole recovery audit strategies. If using a recovery audit contractor approach is determined to not be cost effective, HHS should document how existing programs are cost-effective when compared to the use of a recovery audit contractor.”

HHS Response: The RADV audit program, which is the primary corrective action regarding Part C improper payments, performs Part C recovery audit functions. RADV verifies that diagnoses submitted by Medicare Advantage (MA) organizations for risk-adjusted payment are supported by medical record documentation. The RADV program is consistent with PIIA's recovery audit requirements and advances corrective actions for the Medicare Part C program.

In January 2023, HHS finalized a rule to begin the recovery of overpayments under the RADV program. HHS plans to initiate recoveries later this year for completed RADV audits, as results are finalized, starting with payment year (PY) 2011. HHS continues to explore ways of conducting future RADV audits as soon as practicable after the close of a MA payment year. These efforts include focusing future audits on areas at highest risk for improper payments, only applying extrapolation to PYs 2018 and later, and using artificial intelligence to make activities like enrollee sampling and medical record intake processing more efficient and effective.

The Plan Program Integrity Medicare Drug Integrity Contractor (PPI-MEDIC) performs the Part D recovery audit functions. The PPI-MEDIC has a robust program to identify improper payments. HHS recovered nearly \$640,833 from Part D sponsors in FY 2022 because of the PPI-MEDIC projects and Part D plan sponsor self-audits.

Recommendation #8: HHS should “continue to focus on the root causes of the improper payment percentage, especially these new drivers related to SNF [Skilled Nursing Facility] and Hospice, and evaluate and document critical and feasible action steps to meet the Medicare FFS [Fee-For-Service] reduction target.”

HHS Response: For FY 2022, the Medicare FFS estimated improper payment rate was below 10 percent for the sixth consecutive year. Although the improper payment estimate increased compared to the prior year, HHS has many activities underway to further reduce improper payments in Medicare FFS. For example, HHS expanded, or enhanced, corrective actions related to Hospice and Skilled Nursing Facility (SNF) services in FY 2023, the largest drivers of the Medicare FFS improper payment estimates. This includes continuing RAC post-payment review and medical review initiatives, tightening provider screening and enrollment requirements, and implementing new targeted education for SNF providers. These corrective actions are being developed and implemented as a direct result of the increase in improper payments reported.

Recommendation #9: HHS should “continue to work with OMB and other relevant stakeholders, to complete the improper payment measurement program for the State-based Exchanges to report a full and accurate [improper payment] estimate.”

HHS Response: HHS is committed to fully implementing an improper payment measurement for the Advance Premium Tax Credit (APTC) program, as required by PIIA. In FY 2022, HHS reported its first improper payment measurement of the Federally-facilitated Exchange. HHS continues to develop the improper payment methodology for the State-based Exchanges and will

continue to update its annual agency financial reports with the measurement development and implementation status.

Conclusion

Although HHS has made progress 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 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 each year for bringing non-compliant programs into compliance. Accordingly, HHS will develop a plan to address compliance findings and submit that to OMB as part of the FY 2023 PaymentAccuracy.gov data call. For programs that are not compliant for the second consecutive year, HHS will submit program integrity proposals to OMB in the development of the next President's Budget.

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. 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,

Robert M.
Gordon -S

Digitally signed by Robert
M. Gordon -S
Date: 2023.05.18
07:37:29 -04'00'

Robert Gordon
Assistant Secretary for Financial Resources
