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 2023

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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May 2024
A-17-24-52000

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

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Report of Independent Auditors on HHS' 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, 2023, 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 (May 2023); 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 2023 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.

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, 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.

Building a better working world

HHS met many requirements, but it did not fully comply with PIIA for FY 2023. Our detailed findings and recommendations are documented in Section III of this report.

Ernst & Young LLP

May 16, 2024

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 U.S. 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 (May 2023); the OMB FY 2023 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 the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Guidance for Payment Integrity Information Act Compliance Reviews (October, 2023) 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); and four additional programs that HHS identified to be susceptible to significant improper payments: Head Start, Provider Relief Fund (PRF), COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP), and Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC and PRF were OMB-designated high-priority programs in 2023. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Medicare Part D, CHIP, and Medicaid programs.

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 2023 Agency Financial Report (AFR), including the required IP disclosures, on November 14, 2023.

As stipulated by OMB, agencies' OIGs must report on the following requirements 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 reaching a tolerable IP and UP rate;

5c. Developing 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

Additionally, 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 UPs.

WHAT WE FOUND

HHS met many requirements but did not fully comply with PIIA for FY 2023.

HHS conducted a program-specific risk assessment of 56 programs based on FY 2022 outlays and did not identify any additional programs that are susceptible to significant improper payments. 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 56 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) program in FY 2023, 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[1]

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	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	C	C	C
Medicare Advantage (Part C)	C	C	N/A (a)	N/A (a)	C	C	C	NC (b)	NC (b)	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	C
CHIP	C	C	N/A (a)	N/A (a)	C	C	C	C	C	NC (d)
APTC	C	C	N/A (a)	N/A (a)	NC (e)	C	(e)	(e)	(e)	C (e)
PRF	C	C	N/A (a)	N/A(a)	C	C	C	C	C	C
UIP	C	C	N/A (a)	N/A (a)	NC(j)	C	(f)	(f)	(f)	(j)
Foster Care	C	C	N/A (a)	N/A (a)	NC (g)	(g)	(g)	(g)	(g)	(g)
TANF	C	C	N/A (a)	N/A (a)	NC (h)	(h)	(h)	(h)	(h)	(h)
CCDF	C	C	N/A (a)	N/A (a)	C	C	(i)	(i)	(i)	C
Head Start	C	C	N/A (a)	N/A (a)	C	C	(f)	(f)	(f)	C

[1] PIIA Compliance Reporting Table, as specified by OMB guidance, for programs susceptible to significant improper payments that were assessed for compliance.

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). In FY 2023, HHS conducted program-specific risk assessments of 56 programs and adequately concluded whether the program is likely to make IPs and UPs above or below the statutory threshold. However, as described above and in Finding #1, HHS did not risk assess each program with annual outlays greater than $10 million at least once in every three years.

(b) As described in Finding #7 below, HHS has not demonstrated improvements to payment integrity for the Medicare Part C program as the FY 2023 improper payment error rate (6.01 percent) increased by 0.59 percent when compared to FY 2022 (5.42 percent). This increase represents approximately $2.6 billion in improper payments year over year. Additionally, the FY 2024 target error rate (6.38 percent) remains nearly a percentage point higher than the reported FY 2022 improper payment rate (5.42 percent).

(c) As allowed by OMB Circular A-123, Appendix C, HHS did not report an IP plus UP payment reduction target for FY 2024 due to numerous methodology changes implemented in the FY 2023 reporting period, and a baseline has not yet been established. As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an improper payment reduction target for Medicare Prescription Drug Benefit (Part D) in the FY 2023 AFR.

(d) As described in Finding #4 below, HHS did not report an IP and UP estimate of less than 10 percent in FY 2023 for the CHIP (12.81 percent) program.

(e) As described in Finding #6 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 VI.A.5a), HHS did not report an improper payment reduction target for APTC in the FY 2023 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.

(f) As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an IP plus UP reduction target for FY 2024 since FY 2023 is the first year of error rate

reporting and the program needs to establish a baseline. Appendix C allows programs up to 24 months to establish a baseline. As a result, HHS was not able to develop a plan to meet the reduction target for future IP and UP levels.

(g) As described in Finding #3 below, HHS did not publish an IP and UP estimate for Foster Care in the FY 2023 AFR. In response to COVID-19, HHS postponed Title IV-E reviews. In preparation to resume the reviews, HHS finalized the Title IV-E Foster Care Eligibility Review instrument to reflect changes in Title IV-E eligibility requirements enacted through the Family First Prevention Service Act, enacted as Title VII of the Bipartisan Budget Act of 2018. HHS needed to train and provide technical assistance prior to resuming Title IV-E reviews. HHS plans to resume conducting on-site Title IV-E reviews in FY 2024. Therefore, HHS was unable to calculate and report IP and UP estimates. Consequently, HHS was not able to develop and publish a plan to establish and meet a reduction target for future IP and UP levels, publish corrective action plans (CAPs), and achieve an improper payment rate of less than 10 percent.

(h) As described in Finding #2 below, an IP and UP 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 IP and UP levels, publish CAPs, and achieve an improper payment rate of less than 10 percent.

(i) As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an IP plus UP reduction target for CCDF in FY 2024. CCDF state grantees have been implementing large-scale changes to their childcare 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 2023; 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 actions.

(j) In its FY 2023 AFR, HHS published an IP and UP estimate of 0.73 percent, representing $39.0 million in IP and UP. However, as described in Finding No. 8, HHS's Sampling and Estimation Methodology Plan (S&EMP) did not completely measure all key characteristics of the UIP program. Due to limitations in data available, management was unable to adequately perform insurance verification checks to determine if patients had existing health insurance coverage.

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). In response, HHS published information on paymentaccuracy.gov describing the actions that the agency is taking to come into compliance. For any programs that were in the second year of noncompliance as of FY 2022, HHS incorporated a program integrity proposal in the FY 2025 President's Budget that would help the program come into compliance, with the exception of Foster Care, for which the noncompliance was not due to funding or legislative hurdles as further explained below.

Per OMB A-123, Appendix C (Part VI), the OIG's 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 2023 is considered year three of noncompliance for the Foster Care, APTC, CHIP, and TANF programs. FY 2023 is considered year one of noncompliance for Medicare Part C and UIP.

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 CAPs;

- For the TANF program, HHS should develop an improper payment estimate, reduction targets, and CAPs;

- For the State-based component of the APTC program, HHS should develop an improper payment estimate, reduction targets, and CAPs;

- For the Medicare Part C program, HHS should perform recovery audits to identify and recoup overpayments in FY 2023; and

- For the CHIP program, HHS should focus on identifying root causes of the improper payment percentage and evaluate critical and feasible action steps to reduce the improper payment percentage below 10 percent.

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

- For Medicare Part C, enhance corrective action plans that focus on the root causes of the improper payment percentage, such as medical record discrepancies, which make up nearly 88 percent of the Medicare Part C improper payment percentage. Evaluate and document critical and feasible action steps to improve reduction targets and demonstrate improvements to payment integrity.

- For the UIP program, HHS should enhance its methodology to include an evaluation of patient eligibility and consider alternative methods to perform this evaluation if data limitations exist .

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 that 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 250 programs subject to improper payment risk assessment, HHS continues to implement additional enhancements to gain efficiencies and allow for a greater number of risk assessments to be completed each year. These enhancements included 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. Leveraging these enhancements to the risk assessment process, HHS is on track 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 proposed new statutory authority, included in the President's FY 2024 and FY 2025 budgets, 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. With the resumption of these reviews, HHS will again have the data needed to calculate and report Foster Care improper payment estimates, beginning in FY 2024.

- Recommendation #4: HHS plans to continue working with states to implement state-specific corrective action plans and ensure that these corrective actions are being implemented. HHS also offers training, technical assistance, and support to state CHIP program integrity officials. In addition, HHS performs audits of beneficiary eligibility determinations in states identified to have higher improper payment estimates due to eligibility errors.

- Recommendation #5: In FY 2023, HHS finalized a rule to begin the recovery of overpayments under the Risk Adjustment Data Validation (RADV) program. Also, in April 2024, HHS finalized a rule to clarify the RADV appeals regulation and process. HHS plans to initiate recoveries later this year for completed RADV audits. HHS continues to explore ways of accelerating the pace and effectiveness of future RADV audits. This includes focusing future audits on areas at highest risk for improper payments, applying extrapolations to payment years (PYs) 2018 and later, using advanced data analytics to select audit samples, and automating to a greater degree the intake and initial screening of medical records submitted by Medicare Advantage (MA) organizations.

- Recommendation #6: 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.

- Recommendation #7: HHS continues its efforts to address the root causes of significant improper payments in Medicare Part C by educating Part C sponsors regarding incomplete or invalid medical record documentation in an effort to prevent potential improper payments and MA organizations on specific medical record coding examples and the impact to the Part C improper payment estimate, as well as the latest schemes, trends, data analysis, and investigations to better protect their networks against fraud and abuse. Additionally, in January 2024, HHS released two fact sheets aimed at assisting MA organizations with appropriate medical record coding, as well as improper payment processes and reporting.

- Recommendation #8: HHS is aware that, retrospectively, auditors have used different methodologies and additional data sets that were not available to UIP claims processors during the COVID-19 pandemic when maintaining access to timely testing, treatment, and vaccinations was paramount. However, with the subsequent rescission of funds by the Fiscal Responsibility Act, there are very limited resources left available to the program, and these resources are being prioritized for critical accountability functions like audits, financial assessments, and collection of improper payments, consistent with the charge in the PIIA and OMB Memorandum M-21-19, *Requirements for Payment Integrity Improvement*.

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

Contents

INTRODUCTION

PIIA was enacted on March 2, 2020, and requires the Office of the Inspector General (OIG) of each agency to review and report on the agency's 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 (May 2023); the OMB FY 2023 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 the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Guidance for Payment Integrity Information Act Compliance Reviews (October, 2023) 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); and four additional programs that HHS identified to be susceptible to significant improper payments: Head Start, Provider Relief Fund (PRF), COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP), and Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC and PRF were OMB-designated high-priority programs in 2023. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Part D, CHIP, and Medicaid programs.

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 IPs and UPs above the statutory threshold;

3. Published IP and UP estimates for all programs and activities identified in its risk assessment, or deemed by OMB, as susceptible to significant IPs and UPs;

4. Published 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 statements

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 2023, there are 12 HHS programs that are deemed or identified to be susceptible to significant IPs. HHS reported approximately $104.79 billion in gross IPs and UPs in its FY 2023 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 2023 AFR and published on PaymentAccuracy.gov. HHS included information on the following 12 programs that are determined to be susceptible to significant IPs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, PRF, UIP, TANF, Foster Care, CCDF and Head Start.

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 2023 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 12 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 2023 and that the results were published in the HHS FY 2023 AFR;
- Assessed HHS' disclosure of IP requirements in the AFR by verifying that the HHS FY 2023 AFR included required disclosures per OMB Circular A-136;
- Verified that the HHS FY 2023 AFR was published on HHS.gov;
- Compared amounts included in HHS-prepared supporting documentation to information included within the "Payment Integrity Report" section of the FY 2023 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 of 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;

- Evaluated the IP sampling and estimation methodology plan for the Medicaid and CHIP programs; and

- Evaluated the revised IP sampling and estimation methodology plan for the Medicare Part D program.

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

- Verified that HHS demonstrated improvements to payment integrity in FY 2023 and that the results were published in the HHS FY 2023 AFR and on PaymentAccuracy.gov;

- Reviewed HHS' program-specific efforts to recapture IPs in FY 2023;

- Reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2023;

- Verified that the CAPs for the relevant programs were published in the HHS FY 2023 AFR and appropriately prioritized within HHS; and

- Verified that HHS submitted and published data call information to PaymentAccruacy.gov and took appropriate action to resolve any discrepancies between the annual financial statement and PaymentAccruacy.gov.

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

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 56 programs based on FY 2022 outlays and did not identify any additional programs that are susceptible to significant IPs. 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 continued to develop policies, procedures, and tools to facilitate coverage of all programs over $10 million in accordance with PIIA, HHS did not meet the requirement to assess each program with annual outlays greater than $10 million at least once in every three years. Management indicated that HHS began implementing additional enhancements in FY 2023 to capture all programs in its three-year assessment cycles (2023 – 2025). The enhancements included: 1) extending the risk assessment period and utilizing the Risk Assessment Portal (RAP), 2) restructuring the risk assessment questionnaire, and 3) establishing a complete inventory of programs and a three-year risk assessment cycle to facilitate the review of all programs with annual outlays greater than $10 million.

Recommendation:

We recommend that HHS continue to enhance and implement the developed policies and procedures in place to fulfill the requirement of assessing all programs with annual outlays greater than $10 million at least once every three years. Additionally, we recommend that HHS continue to work with OMB to implement an approach and perform risk assessments at a level that meets the intent of PIIA.

Finding #2 – TANF IP and UP estimate not calculated nor published in FY 2023

HHS did not calculate and report an IP and UP estimate for TANF. HHS stated in its FY 2023 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 of TANF's IPs.

HHS continues to support state-level efforts to enhance the TANF program's integrity and prevent improper payment. HHS conducts regular improper payment risk assessments, with the most recently completed in FY 2022. HHS utilizes the information from the assessments to inform refinement of the multifaceted approach to support states in improving the TANF program's integrity and preventing improper payments. Additionally, in the FY 2024 and FY 2025 President's Budget request, HHS proposed new statutory authority to gather more comprehensive data on TANF and maintenance-of-effort expenditures for nongovernmental subrecipients to enhance the monitoring of TANF spending and activities and establish improper payment rate.

Recommendation:

We recommend that HHS continue advocating for legislative changes and work with OMB and other stakeholders to develop and implement an approach to calculating and 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 IP and UP estimate not published in FY 2023

HHS did not report a Foster Care error rate for FY 2023 or an IP, plus an UP target for FY 2024. In response to COVID-19, HHS postponed Title IV-E reviews. As part of the resumption of the review process, HHS updated the Title IV-E Foster Care Eligibility Review instrument to reflect changes in Title IV-E eligibility requirements enacted through the Family First Prevention Services Act, enacted as Title VII of the Bipartisan Budget Act of 2018. HHS needed to train HHS' regional staff, Title IV-E agencies, and other stakeholders on the Title IV-E review instrument and provide technical assistance prior to resuming the Title IV-E reviews. Therefore, HHS was unable to develop IP and UP estimates for FY 2023 and could not develop a reduction target for FY 2024. In March 2023, HHS released the program instruction, which included the updated Title IV-E Review Guide. HHS is planning to resume conducting on-site Title IV-E reviews in FY 2024.

Recommendation:

We recommend that HHS continue to train HHS' regional staff, Title IV-E agencies, and other stakeholders on the updated Title IV-E Review Guide and resume reporting an IP and UP estimate in FY 2024.

Finding #4 – CHIP IP and UP rate percentage exceed 10 percent for FY 2023

Flexibilities afforded by the COVID-19 Public Health Emergency (PHE), such as postponed eligibility determinations and eased requirements around provider enrollment and validations, significantly impacted the eligibility component of the reported Medicaid and CHIP improper payment rates in FY 2023. These flexibilities contributed to a decrease in the Medicaid IP rate reported in FY 2022 from 15.6 percent to 8.6 percent in FY 2023 and from 26.8 percent in FY 2022 to 12.8 percent for CHIP. 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. As such, the reported IP rate percentage in the HHS AFR for the CHIP program in FY 2023 was 12.81 percent, which is above the compliance threshold of 10 percent.

HHS identified that a majority of 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 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.

Additionally, HHS should continue to focus on corrective actions around eligibility as there is an increased risk that the rates for Medicaid and CHIP will significantly increase as the flexibilities afforded by the PHE expire.

Finding #5 – Recovery audits and activities performed during FY 2023 to recoup improper payments for the Medicare Advantage program are delayed

In accordance with PIIA (that part codified at 31 U.S.C. § 3352(i)(1)(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 (MA) organizations for risk-adjusted payment. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. As reported in the FY 2023 AFR, HHS finalized CMS-4185-F2, a regulation that codifies HHS's practice of extrapolating RADV audit findings starting from payment year (PY) 2018 as part of the RADV audit methodology, although recoveries have yet to be made or reported in the AFR. 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 (that part codified at 31 U.S.C. § 3352(i)(1)(A)) to identify and recoup overpayments for Medicare Part C. HHS should also continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2024 in the event that the RADV program cannot effectively serve as HHS' sole recovery audit strategy. If using a recovery audit contractor approach is determined not to be cost-effective, HHS should document how existing programs are cost-effective when compared to the use of a recovery audit contractor.

Finding #6 – 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 will begin the Improper Payment Pretesting and Assessment program in 2024 to prepare states for the upcoming measurement as 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.

Finding #7 – HHS did not effectively demonstrate improvements to payment integrity for the Medicare Part C program in FY 2023

HHS has not demonstrated improvements to payment integrity for the Medicare Part C program as the FY 2023 improper payment error rate (6.01 percent) increased by 0.59 percent when compared to FY 2022 (5.42 percent). The FY 2023 improper rate calculation follows the policy changes implemented in FY 2022 and, as such, FY 2023 and FY 2022 are comparable. This

increase represents approximately $2.6 billion in improper payments year over year. Additionally, the FY 2024 target error rate (6.38 percent) remains nearly a percentage point higher than the reported FY 2022 improper payment rate (5.42 percent).

Recommendation:

We recommend that HHS enhance its corrective action plans that focus on the root causes of the IP percentage, such as medical record discrepancies, which make up nearly 88 percent of Medicare Part C IP. Evaluate and document critical and feasible action steps to improve reduction targets and demonstrate improvements to payment integrity.

Finding #8 – UIP Sampling and Estimation Methodology Plan did not adequately measure all key characteristics of the UIP program

In its FY 2023 AFR, HHS published an IP and UP estimate of 0.73 percent, representing $39.0 million in IP and UP. However, HHS' Sampling and Estimation Methodology Plan (S&EMP) did not adequately measure all key characteristics of the UIP program. Due to limitations in data available, management was unable to adequately perform insurance verification checks to determine if patients had existing health insurance coverage. By not appropriately measuring the patient eligibility component, the IP rate reported may be understated.

Recommendation:

We recommend that HHS should include in its UIP estimation methodology an evaluation of patient eligibility and consider alternative methods to perform this evaluation if data limitations exist.

APPENDIX A: HHS MANAGEMENT COMMENTS

U.S. Department of Health and Human Services

Office of the Secretary

Washington, DC 20201

Office of the Assistant Secretary
for Financial Resources

May 14, 2024

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 2023 (*A-17-24-52000). 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 2025 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-17-24-52000)

Recommendation #1: HHS should "continue to enhance and implement the developed policies and procedures in place to fulfill the requirement of assessing all programs with annual outlays greater than $10 million at least once every three years. Additionally, we recommend that HHS continue to work with OMB to develop an approach and obtain concurrence to perform risk assessments at a level that meets the intent of PIIA."

HHS Response: HHS is dedicated to assessing and minimizing the risk of improper payments made by its programs. HHS has over 250 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 online Risk Assessment Portal (RAP) to collect and analyze program improper payment risk assessments more efficiently than under previous processes.

HHS has increased the number of programs that are risk assessed in recent years. In addition, HHS implemented enhancements in FY 2023 and will continue to do so in FY 2024 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) streamlining the questionnaire to improve the effectiveness and usefulness of the data; ; 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 is on track 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 advocating for legislative changes and work with OMB and other stakeholders to develop and implement an approach to calculating and 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."

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 2025 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 train HHS regional staff, IV-E agencies and other stakeholders on the updated Title IV-E review guide and resume reporting an improper payment and unknown payment estimate in FY 2024."

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 remained focused on mission-critical activities. These Title IV-E reviews generate data used to calculate Foster Care's improper payment estimate. While preparing to resume the Title IV-E review process, HHS updated the Title IV-E Foster Care Eligibility Review instrument to reflect changes in Title IV-E eligibility requirements enacted through the Family First Prevention Service Act , enacted as Title VII of Bipartisan Budget Act of 2018. Prior to resuming these reviews, HHS trained regional staff, IV-E agencies, and other stakeholders on the updated Title IV-E review instrument and released training and informational materials. HHS will report Foster Care improper payment estimates beginning in FY 2024 using the updated Title IV-E review guide. Due to the length of time that has passed, Foster Care will establish a new baseline measurement for improper payments once all cycles of states have been measured.

Recommendation #4: For the Children's Health Insurance Program (CHIP), HHS should: "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 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… Additionally, HHS should continue to focus on corrective actions around eligibility as there is an increased risk that the rates for Medicaid and CHIP will significantly increase as the flexibilities afforded by the PHE [Public Health Emergency] expire."

HHS Response: HHS continues to work with states to implement state-specific corrective action plans. HHS provides enhanced technical assistance and guidance to states 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 CHIP. HHS established a new CHIP improper payment baseline with all three cycles measured under new eligibility requirements in FY 2021 and reduced the estimate by over 50 percent over the past two years.

HHS continues to follow up with states during the 2-year period between 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 CHIP program integrity officials. In FY 2023, HHS continued a robust training program that provided training opportunities, including 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 #5: HHS should "improve its recovery audit efforts as required under PIIA (that part codified at 31 U.S.C. § 3352(i)(1)(A)) to identify and recoup overpayments for Medicare Part C. HHS should also continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C programs in FY 2024 in the event that the RADV program cannot effectively serve as HHS' sole recovery audit strategy. 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 Risk Adjustment Data Validation (RADV) audit program serves as the primary corrective action regarding Part C improper payments and is responsible for performing 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. Also, in April 2024, HHS finalized a rule to clarify the RADV appeals regulation and process. 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 accelerating

the pace and effectiveness of future RADV audits. This includes focusing future audits on areas at highest risk for improper payments, applying extrapolations to PYs 2018 and later, using advanced data analytics to select audit samples, and automating to a greater degree the intake and initial screening of medical records submitted by MA organizations.

Recommendation #6: 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 IP [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 2023, HHS reported its second 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 Report (AFR) with the measurement development and implementation status.

Recommendation #7: HHS should "enhance its corrective action plans that focus on the root causes of the IP percentage, such as medical record discrepancies that make up nearly 88 percent of Medicare Part C IP. Evaluate and document critical and feasible action steps to improve reduction targets and demonstrate improvements to payment integrity."

HHS Response: HHS continues efforts to address the root causes of significant improper payments in Medicare Part C. In addition, HHS refined the Medicare Part C methodology and established a new baseline for the program in FY 2023. Furthermore, HHS sent Final Findings Reports to all Part C sponsors that participated in the improper payment measurement, which included feedback on their submissions and validation results compared to all participating sponsors. HHS also formally reached out to plan sponsors regarding incomplete or invalid medical record documentation to prevent potential improper payments during the sample submission period. HHS takes numerous actions throughout the year to educate MA organizations on specific medical record coding examples and the impact to the Part C improper payment estimate. In January 2024, HHS released two fact sheets aimed at assisting MA organizations with appropriate medical record coding as well as improper payment process and reporting.

HHS has a number of corrective actions underway to prevent and reduce improper payments in Medicare Part C. As noted above, the RADV audit program is the primary corrective action regarding Part C improper payments. HHS plans to initiate recoveries later this year for completed RADV audits and initiate the PY 2018 audit. HHS also conducts trainings for MA organizations and MA-Prescription Drug Plan sponsors (MA-PDs) on topics related to improper payments. For example, in March 2023, HHS held a Medicare Part C Fraud, Waste, and Abuse training covering the latest schemes, trends, data analysis, and investigations. The training featured presentations by law enforcement, plan sponsors, and program integrity contractors. HHS also conducted four program integrity reviews of MA-PD plans' efforts in FY 2023, focusing on best practices and areas of improvement to better protect their networks against fraud and abuse. HHS expects that all of these activities will continue to help Part C meet its improper payment reduction target. target.

Recommendation #8: HHS should "include in its [UIP] methodology to include an evaluation of patient eligibility and consider alternative methods to perform this evaluation if data limitations exist."

HHS Response: In FY 2023, HHS developed and executed a statistically valid and appropriate methodology to measure and report on the UIP. As a result, HHS produced the first improper payment estimate for UIP and publicly reported this information in the FY 2023 HHS AFR. HHS is aware that, retrospectively, auditors have used different methodologies and additional data sets that were not available to UIP claims processors during the COVID-19 pandemic when maintaining access to timely testing, treatment, and vaccinations was paramount. Program policies established in the earliest days of the UIP in 2020 were intended to maximize access to services during times of critical need using reasonable data collection processes while employing a number of pre-payment risk mitigation safeguards. In fact, HHS used various measures to evaluate claims, including evaluating patient eligibility, and rejected 15 percent of claims as inappropriate. The UIP stopped accepting claims in April 2022 and completed making payments.

With the subsequent rescission of funds by the Fiscal Responsibility Act, there are very limited resources left available to the program, and these resources are being prioritized for critical accountability functions like audits, financial assessments, and collection of improper payments, consistent with the charge in the PIIA and OMB Memorandum M-21-19, *Requirements for Payment Integrity Improvement*. With very limited administrative dollars remaining in a program that is no longer operational, pursuing potential recoveries offers a more productive use of resources than designing new approaches to an existing and valid methodology.

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 full 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 2024 PaymentAccuracy.gov data call. For programs out of compliance for three consecutive years, HHS will submit a separate report to Congress describing proposals to help the programs achieve compliance with PIIA.

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,

Lisa Molyneux

Lisa Molyneux
Acting Assistant Secretary for Financial Resources