Department of Health and Human Services

Office of Inspector General

Office of Audit Services

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Department of Health and Human Services Met Many Requirements, but It Did Not Fully Comply With the Payment Integrity Information Act of 2019 for Fiscal Year 2025

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Report of Independent Auditors on HHS's 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 have 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 for the Fiscal Year (FY) ended September 30, 2025, to determine if HHS is in compliance with the Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA). We determined HHS's 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 (July 2025); OMB FY 2025 Payment Integrity Annual Data Call Instructions; and the OMB Payment Integrity Question and Answer Platform.

We conducted this performance audit in accordance with *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 of America or *Government Auditing Standards*. Additionally, because of their nature and inherent limitations, the internal controls 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 2025. Our detailed findings and recommendations are documented in Section III of this report.

Ernst & Young LLP

July 29, 2026

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's 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 Circular A-136 (July 2025); the OMB FY 2025 Payment Integrity Annual Data Call Instructions; and OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with *Government Auditing Standards* and the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Guidance for Payment Integrity Information Act OIG Compliance Reviews (November 2025) required under PIIA.

As part of our performance audit, we evaluated compliance with PIIA for the following programs that were 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), Advance Premium Tax Credit (APTC), Temporary Assistance for Needy Families (TANF), Foster Care, Child Care and Development Fund (CCDF), and Head Start. Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC and CCDF were OMB-designated high-priority programs in 2025. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for CCDF and Medicare FFS 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.

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 2025 Agency Financial Report (AFR), including the required IP and UP disclosures, on January 14, 2026.

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 2025.

During FY 2025, HHS conducted program-specific risk assessments of 97 programs from over 200 programs within the agency whose outlays exceeded $10 million. 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 97 programs, they did not risk assess each program with annual outlays greater than $10 million at least once every three years.

Additionally, as described in Finding #9 in Section III below, HHS had not completed recovery audit activities for the identified improper payments for the Medicare Advantage (Part C) program in FY 2025, as required by PIIA.

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 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 and UPs 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	NC (c)	NC (c)	C
Medicaid	C	C	N/A (a)	N/A (a)	C	C	C	NC (d)	NC (d)	C
CHIP	C	C	N/A (a)	N/A (a)	C	C	C	NC (d)	NC (d)	C
APTC	C	C	N/A (a)	N/A (a)	NC (e)	C	(e)	(e)	(e)	C
Foster Care	C	C	N/A (a)	N/A (a)	NC (f)	C	(g)	(g)	(g)	C
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	C	C	C	C
Head Start	C	C	N/A (a)	N/A (a)	C	C	C	NC (i)	C	NC (i)

[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 2025, HHS conducted program-specific risk assessments of 97 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 (refer to Section III), HHS did not risk assess each program with annual outlays greater than $10 million at least once every three years.

b) As described in Finding #2 in Section III below, HHS has not demonstrated improvements to the payment integrity rate for the Medicare Part C program. In FY 2025, HHS published an improper payment error rate of 6.09 percent with a FY 2026 reduction target of 6.43 percent. In the prior year, the reported improper payment rate was 5.61 percent with a reduction target of 5.95 percent.

c) As described in Finding #3 in Section III below, HHS has not demonstrated improvements to the payment integrity rate for the Medicare Part D program. In FY 2025, HHS published an improper payment error rate of 4.00 percent with a FY 2026 reduction target of 4.23 percent. In the prior year, the reported improper payment rate was 3.70 percent with a reduction target of 3.91 percent.

d) As described in Finding #4 in Section III below, HHS has not demonstrated improvements to the payment integrity rates for the Medicaid and CHIP programs. In FY 2025, HHS published an improper payment error rate of 6.12 percent and 7.05 percent, respectively, with a FY 2026 reduction target of 8.99 percent and 9.52 percent, respectively. In the prior year, the reported improper payment rates were 5.09 percent and 6.11 percent, respectively, with a reduction target of 5.29 percent and 6.49 percent, respectively.

e) As described in Finding #5 in Section III below, the APTC improper payment rate reported only represents improper payments for the Federally facilitated Exchange. HHS is still in the process of implementing 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 2025 AFR and was subsequently unable to develop a plan to meet the reduction target for future IP and UP levels.

f) As described in Finding #6 in Section III below, the reported error rate for the Foster Care program was calculated according to the established methodology plan. However, as HHS

uses a three-year process to test all states in estimating an improper payment rate for the program and has only completed 26 Title IV-E reviews to date since resuming these reviews in FY 2024, the calculation does not currently encompass the full population of states.

g) As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an IP plus UP reduction target for the Foster Care program for FY 2026 as the program needs to establish a baseline. HHS indicated that the program will reestablish a baseline once all 50 states, the District of Colombia and Puerto Rico, have been reviewed, which is expected to be in FY27. As a result, HHS could not develop a plan to meet the reduction target for future IP and UP levels.

h) As described in Finding #7 in Section III 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 corrective action plans (CAPs), and achieve an improper payment rate of less than 10 percent.

i) As described in Finding #8 in Section III below, HHS did not report an IP and UP estimate of less than 10 percent in FY 2025 for the Head Start program (10.29 percent).

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.

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 2025 is considered year five of noncompliance for the Foster Care, APTC, and TANF programs; year two of noncompliance for Head Start; and year one of noncompliance for Medicare Part C, Medicare Part D, Medicaid, and CHIP.

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.

EFFECT

These findings may result in incomplete improper payment reporting and increase the risk that improper payments are not fully identified, which may limit HHS's ability to effectively prevent, reduce, and recover improper payments in accordance with PIIA requirements, resulting in noncompliance with applicable statutory and OMB guidance.

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 greater than $10 million at least once every three years;

- for the Medicare Part C program, HHS should perform recovery audit efforts to identify and recoup overpayments;

- for the State-based Exchanges component of the APTC program, HHS should implement an improper payment estimate and reduction target;

- for the Foster Care program, HHS should continue to follow its plan to conduct Title IV-E reviews so that all states will be included in the estimate by FY 2027;

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

- for Head Start, 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, Medicare Part D, Medicaid, and CHIP, HHS should enhance its corrective action plans that focus on the root causes of these improper payment percentages. Evaluate and document critical and feasible action steps to improve reported IP and UP rates and demonstrate sustained improvements to payment integrity.

Addressing these recommendations would improve HHS's 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's compliance with PIIA.

HHS MANAGEMENT COMMENTS

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

- Recommendation #1: HHS is committed to reducing improper payments by improving its risk assessment process. In FY 2025, the Department updated its program inventory to align with federal requirements and assessed 97 programs from 89 in FY 2024. HHS continues to enhance its assessment methods and aims to achieve full risk assessment coverage of all qualifying programs by FY 2028, while recognizing that progress will depend on available resources and staffing. Additionally, HHS is leveraging the online risk assessment portal to collect and analyze program payment risk assessments more efficiently.

- Recommendation # 2: HHS is committed to strengthening corrective action plans to address the root cause of improper payments in the Medicare Part C program, particularly those caused by diagnoses submitted by Medicare Advantage organizations that lack sufficient supporting documentation. The Department plans to continue improving oversight, documenting and implementing critical and feasible action steps to strengthen corrective actions, establishing documentation requirements through enhanced MAO outreach and education and expanding the use of data analytics to target high-risk areas.

- Recommendation #3: HHS is committed to strengthening corrective action plans to address the root cause of improper payments in the Medicare Part D program, which are primarily caused by missing or inadequate documentation supporting prescription drug event data, by continuing to work with plan sponsors to improve documentation practices and reduce payment errors.

- Recommendation #4: HHS is committed to strengthening corrective action plans to address the root cause of improper payments in the Medicaid and CHIP program. The department acknowledged higher improper rates in Medicaid and CHIP were attributed to the temporary eligibility flexibilities implemented during the COVID-19 public health emergency and the subsequent eligibility redetermination process. The Department expects payment accuracy to improve as states complete eligibility reviews and return to normal operations, while continuing to strengthen oversight and corrective action plans.

- Recommendation #5: HHS will continue its implementation of the Improper Payment Pre-Testing and Assessment (IPPTA) program through 2026 to assist states in preparing for upcoming measurement activities that will allow HHS to report an estimate for all components of the APTC program. HHS will begin the State Exchange measurement January 1, 2027 with the expectation that it will publish its first State Exchange improper payment estimate in FY 2028 Agency Financial Report.

- Recommendation #6: HHS has resumed reviews in FY2024 and expanded coverage to 26 states in FY 2025. HHS expects to complete reviews for all states by FY 2027, allowing a full baseline and reduction target to be established.

- Recommendation #7: Despite the statutory limitations, the Department continues to support state-level efforts to improve program integrity, monitor compliance and identify the causes of improper payments while remaining committed to working with stakeholders to explore a viable pathway to full compliance for the TANF program.

- Recommendation #8: HHS acknowledged that the Head Start improper payment rate of 10.29 percent remains above the federal compliance threshold of 10 percent, although it improved from 11.98 percent in FY 2024. The Department attributes most of the payment errors to insufficient documentation and will continue to implement corrective measures including enhanced monitoring through random sampling and retroactive testing, expanded training, and issuing disallowances for insufficient documentation and stronger documentation requirements.

- Recommendation #9: HHS noted that the Risk Adjustment Data Validation (RADV) audit program is its primary tool for identifying and recovering Medicare Part C overpayments. The Department significantly expanded audit activity, initiated hundreds of new audits, and issued numerous audit findings and reconsideration decisions in response to appeals of prior period audit findings. However, HHS emphasizes that recovery of overpayments will continue to be delayed until administrative appeals and current litigation affecting the collection process for certain audit years are resolved.

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's improper payment reporting to determine if HHS is in compliance with PIIA and the applicable improper payment guidance.

We have conducted a performance audit to determine whether HHS complied with the PIIA improper payment reporting requirements. We determined HHS's compliance with PIIA based on the guidance prescribed by the OMB Circular A-123, Appendix C (M-21-19, March 2021); OMB Circular A-136 (July 2025); OMB FY 2025 Payment Integrity Annual Data Call Instructions; and the OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with *Government Auditing Standards* and the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Guidance for Payment Integrity Information Act OIG Compliance Reviews (November 2025) required under PIIA.

As part of our performance audit, we evaluated compliance with PIIA for the following programs that were 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), Advance Premium Tax Credit (APTC), Temporary Assistance for Needy Families (TANF), Foster Care, and Child Care and Development Fund (CCDF), and Head Start. Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC and CCDF were OMB-designated high-priority programs in 2025. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for CCDF and Medicare FFS 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.

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 target 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 meet 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 agency's OIG to annually report information to Congress on the agency's 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 2025, there are 10 HHS programs that are deemed or identified to be susceptible to significant IPs. HHS reported approximately $98.34 billion in gross IPs and UPs in its FY 2025 AFR.

SECTION II – AUDIT SCOPE AND METHODOLOGY

Scope

Our audit covered PIIA information that was reported in the "Payment Integrity Report" section of HHS's FY 2025 AFR and published on PaymentAccuracy.gov. HHS included information on the following 10 programs that are determined to be susceptible to significant IPs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, TANF, Foster Care, CCDF and Head Start.

Methodology

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

- reviewed applicable Federal laws and OMB Circulars;
- reviewed IP information reported in the HHS FY 2025 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 10 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 2025 and that the results were published in the HHS FY 2025 AFR;
- assessed HHS's disclosure of IP requirements in the AFR by verifying that the HHS FY 2025 AFR included required disclosures per OMB Circular A-136;
- verified that the HHS FY 2025 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 2025 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's 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.

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

- interviewed Department officials about the process for assessing the level of risk for each program and confirmed HHS's 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 revised IP sampling and estimation methodology plan for the Medicare Part D program.

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

- verified that HHS demonstrated improvements to payment integrity in FY 2025 and that the results were published in the HHS FY 2025 AFR and on PaymentAccuracy.gov;
- reviewed HHS's program-specific efforts to recapture IPs in FY 2025;
- reviewed HHS's application of the Do Not Pay Initiative at a program level in FY 2025;
- verified that the CAPs for the relevant programs were published in the HHS FY 2025 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 have conducted this performance audit per the PIIA guidance in accordance with *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 97 programs from over 200 programs within the agency whose FY 2024 outlays exceeded $10 million 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 every three years in accordance with OMB A-123, Appendix C Part VI.2a.

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 – HHS did not effectively demonstrate improvements to the payment integrity rate for the Medicare Part C program in FY 2025

HHS has not demonstrated improvements to the payment integrity rate for the Medicare Part C program as required by OMB A-123, Appendix C Part VI.5b. In FY 2025, HHS published an improper payment error rate of 6.09 percent with a FY 2026 reduction target of 6.43 percent. In the prior year, the reported improper payment rate was 5.61 percent with a reduction target of 5.95 percent. While there is an inherent element of variability due to the precision measures used in the sampling methodology, the payment integrity rate has increased overall from the established baseline in FY 2023. The primary root cause of these improper payments are medical record discrepancies where diagnoses submitted by MAOs for payment calculations were not substantiated by supporting medical record documentation.

Recommendation:

HHS analyzes improper payment data following each year's measurement. Root causes and potential program vulnerabilities are shared with CMS policy owners and those responsible for corrective actions. While some corrective actions may take several years for impact to be realized, we recommend that HHS continue to refine its corrective action plans that focus on the root causes of these IP percentages, specifically around medical record discrepancies, and evaluate and document critical and feasible action steps to improve reduction targets and demonstrate improvements to payment integrity.

Finding #3 – HHS did not effectively demonstrate improvements to the payment integrity rate for the Medicare Part D program in FY 2025

HHS has not demonstrated improvements to the payment integrity rate for the Medicare Part D program as required by OMB A-123, Appendix C Part VI.5b. In FY 2025, HHS published an improper payment error rate of 4.00 percent with a FY 2026 reduction target of 4.23 percent. In the prior year, the reported improper payment rate was 3.70 percent with a reduction target of 3.91 percent. While there is an inherent element of variability due to the precision measures used in the sampling methodology, the payment integrity rate has increased overall from the established baseline in FY 2024. The primary root cause of these improper payments is missing or insufficient documentation submitted by plan sponsors to support prescription drug event data.

Recommendation:

HHS analyzes improper payment data following each year's measurement. Root causes and potential program vulnerabilities are shared with CMS policy owners and those responsible for corrective actions. While some corrective actions may take several years for impact to be realized, we recommend that HHS enhance its corrective action plans that focus on the root causes of these IP percentages, specifically working with plan sponsors to improve payment accuracy and documentation, and evaluate and document critical and feasible action steps to improve reduction target and demonstrate improvements to payment integrity.

Finding #4 – HHS did not effectively demonstrate improvements to the payment integrity rate for the Medicaid and CHIP programs in FY 2025

HHS has not demonstrated improvements to the payment integrity rates for the Medicaid and CHIP programs as required by OMB A-123, Appendix C Part VI.5b. In FY 2025, HHS published an improper payment error rate of 6.12 percent and 7.05 percent, respectively, with a FY 2026 reduction target of 8.99 percent and 9.52 percent, respectively. In the prior year, the reported improper payment rates were 5.09 percent and 6.11 percent, respectively, with a reduction target of 5.29 percent and 6.49 percent, respectively. Since FY 2023, the IP and UP estimates were significantly impacted from flexibilities given to states related to COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations. The estimates reported in the current year reflect the unwinding from the COVID-19 public health emergency and phasing out of these enrollment flexibilities. As such, more errors in eligibility redeterminations and provider screenings significantly contributed to the increase in the reported rate.

Recommendation:

We recommend that HHS enhance its corrective action plans that focus on the root causes of these IP percentages, such as missing or insufficient documentation, state noncompliance with federal requirements, and improper determinations of beneficiary eligibility. Furthermore, HHS should work with states to improve payment accuracy and documentation and evaluate and document critical and feasible action steps to improve reduction target and demonstrate improvements to payment integrity.

Finding #5 – 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 APTC program, it has not calculated and reported an IP estimate for the State-based Exchanges. HHS began the Improper Payment Pretesting and Assessment program to prepare states for the upcoming measurement as they continue to develop the IP measurement methodology for the State-based Exchanges. As stated in their FY 2025 AFR, HHS intends to begin the State-based Exchange sampling and estimation measurement no earlier than January 1, 2027. Additionally, the APTC program does not report 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. OMB A-123, Appendix C Part VI.3.

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 complete and accurate IP estimate.

Finding #6 – Foster Care IP and UP estimate was calculated according to the established methodology plan, however it does not currently encompass the full population of states

HHS uses a three-year process to test all states in estimating an improper payment rate for the Foster Care program. HHS resumed conducting Title IV-E reviews in FY 2024 and reported an improper payment error rate for that year. In FY 2025, HHS continued Title IV-E reviews and calculated the Foster Care estimate based on completed review data from 26 states, however the reported IP and UP estimate does not currently encompass the full population of states and therefore Management could not develop a plan to meet the IP and UP reduction targets in accordance with OMB A-123, Appendix C Part VI.5c. Management has indicated that as the balance of states are reviewed, they will be included in future annual estimates of improper payments. Management believes that all states will be reviewed by FY 2027.

Recommendation:

We recommend that HHS continue to follow its plan to conduct Title IV-E reviews so all states will be included in the estimate by FY 2027 in order to report a complete estimate.

Finding #7 – TANF IP and UP estimate not calculated nor published in FY 2025

HHS did not calculate and report an IP and UP estimate for TANF in accordance with OMB A-123, Appendix C Part VI.3. HHS stated in its FY 2025 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 is required to estimate and report 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.

Recommendation:

We recommend that HHS continue advocating for legislative changes and work with OMB and other stakeholders to develop and implement an approach to calculate and report an IP and UP estimate for TANF. This process will aid in identifying root causes of TANF IPs and allow HHS to report CAPs in the AFR.

Finding #8 – Head Start IP and UP rate percentage exceeded 10 percent for FY 2025

In accordance with OMB A-123, Appendix C Part VI.6, if a program reported an IP and UP estimate of 10 percent or more for the Fiscal Year, the program will be noncompliant. As such, the reported IP rate percentage in the HHS AFR for the Head Start program in FY 2025 was 10.298 percent, which is above the compliance threshold of 10 percent. The FY 2024 Head Start improper payment rate reported decreased by 1.69 percent when compared to FY 2025 (11.98 percent). The Administration for Children and Families (ACF) reported that the majority of the IPs and UPs were related to missing or insufficient documentation to substantiate certain payments.

Recommendation:

We recommend that HHS focus on the root causes of the IP percentage and evaluate critical and feasible action steps to assist recipients with their compliance efforts for these requirements. This would include working with the recipients 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 recipients to follow up on repeat root causes of errors and enhance the CAPs for implementation.

Finding #9 – Recovery audits and activities performed during FY 2025 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's primary action to recoup Part C overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by Medicare Advantage Organizations (MAOs) for risk-adjusted payment. Contract-level RADV audits also encourage MAOs to self-identify, report, and return overpayments. In FY 2025, HHS launched RADV audits for payment years 2018 and 2019, however, 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 2025 in the event that the RADV program cannot effectively serve as HHS's 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Office of the Assistant Secretary for
Financial Resources
Washington, D.C. 20201

July 29, 2026

Tamara J. Lilly
Acting Deputy Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Dear Ms. Lilly:

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 2025* (OAS-26-17-042). The Department of Health and Human Services (HHS) is committed to reducing improper payments across all programs to protect taxpayer resources and ensure access to essential services. While HHS has implemented a range of tools to prevent, detect, and reduce improper payments, we continue to pursue innovative solutions that address root causes without compromising beneficiary access. The Fiscal Year (FY) 2027 President's Budget includes proposals to further strengthen payment integrity and support compliance with the Payment Integrity Information Act of 2019 (PIIA). As requested, this letter provides an update on the status of actions taken in response to the draft report's recommendations.

HHS is pleased to note that, as reflected in Table 1 of the report, the Medicare Fee-for-Service program achieved full compliance with all PIIA requirements in FY 2025, and the Child Care and Development Fund program met all applicable compliance criteria. These outcomes reflect the Department's sustained commitment to payment integrity improvement.

Responses to the HHS OIG Recommendations on PIIA Compliance (OAS-26-17-042)

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 [the Office of Management and Budget] OMB to implement an approach and 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. Improper payment risk assessments are a resource-intensive process and must be balanced against resource constraints and other ongoing programmatic activities.

In FY 2025, HHS updated its program inventory for improper payments to align with the Federal Program Inventory as directed by OMB. This updated methodology for organizing programs and activities for improper payment risk assessment and reporting has identified approximately 700 programs and activities across the Department. The majority of these are subject to risk assessment on a three-year cycle under PIIA, with a subset already operating in Phase 2 and reporting annual improper payment estimates. HHS is committed to achieving full assessment coverage of all qualifying programs by FY 2028, recognizing that progress toward this goal will depend on available resources, staffing, and other operational factors.

HHS continues to leverage the online Risk Assessment Portal to collect and analyze program improper payment risk assessments more efficiently than under previous processes. In FY 2025, HHS conducted risk assessments of 97 programs based on FY 2024 outlays, an increase from 89 programs assessed in FY 2024, and notable given the significant staff turnover experienced across the Department during the year. HHS will continue to implement process enhancements to support its assessment cycle, including: 1) extending the risk assessment period to allow for a greater number of risk assessments to be completed each year; 2) maintaining a complete inventory of programs and their three-year risk assessment cycle status; 3) utilizing a streamlined questionnaire to improve the effectiveness and usefulness of the data; and 4) applying a modified risk assessment approach for programs with outlays between $10 million and $100 million. HHS will continue to work with OMB to implement an approach that meets the intent of PIIA.

Recommendation #2: HHS should "continue to refine its corrective action plans that focus on the root causes of these IP percentages, specifically around medical record discrepancies, and evaluate and document critical and feasible action steps to improve reduction targets and demonstrate improvements to payment integrity" for the Medicare Part C program.

HHS Response: HHS is committed to strengthening corrective action plans to address the root causes of improper payments in the Medicare Part C program, particularly those related to medical record discrepancies where diagnoses submitted by Medicare Advantage Organizations (MAOs) for payment calculations were not substantiated by supporting medical record documentation.

HHS notes that the FY 2025 reported improper payment rate of 6.09 percent, when viewed within the context of the sampling methodology's precision, is not statistically distinguishable from the FY 2024 rate of 5.61 percent. At a 95 percent confidence level with a margin of error of ±0.69 percent, the FY 2024 confidence interval ranges from 4.92 percent to 6.30 percent and the FY 2025 confidence interval ranges from 5.40 percent to 6.78 percent. These intervals overlap significantly, meaning the observed difference in point estimates does not constitute a statistically meaningful change in the payment integrity rate. The draft report itself acknowledges the inherent element of variability due to the precision measures used in the sampling methodology.

HHS analyzes improper payment data following each year's measurement, and root causes and program vulnerabilities are shared with CMS policy owners and those responsible for corrective actions. HHS notes that certain corrective actions, particularly those requiring changes to MAO behavior, medical record documentation practices, and data submission processes, require time to implement and for their impact to be realized in measured rates. HHS will continue evaluating and documenting critical and feasible action steps to strengthen corrective action plans, improve reduction targets, and demonstrate measurable improvements in payment integrity, including through enhanced MAO outreach and education and expanded use of data analytics to target high-risk areas.

Recommendation #3: HHS should "enhance its corrective action plans that focus on the root causes of these IP percentages, specifically working with plan sponsors to improve payment accuracy and documentation, and evaluate and document critical and feasible action steps to improve reduction target and demonstrate improvements to payment integrity" for the Medicare Part D program.

HHS Response: HHS is committed to strengthening corrective action plans to address the root causes of improper payments in the Medicare Part D program. The primary root cause of Medicare Part D improper payments is missing or insufficient documentation submitted by plan sponsors to support prescription drug event data.

HHS notes that the FY 2025 reported improper payment rate of 4.00 percent, when viewed within the context of the sampling methodology's precision, is not statistically distinguishable from the FY 2024 rate of 3.70 percent. At a 95 percent confidence level with a margin of error of ±0.45 percent, the FY 2024 confidence interval ranges from 3.25 percent to 4.15 percent and the FY 2025 confidence interval ranges from 3.55 percent to 4.45 percent. These intervals overlap, meaning the observed difference in point estimates does not constitute a statistically meaningful change in the payment integrity rate. The draft report itself acknowledges the inherent element of variability due to the precision measures used in the sampling methodology.

HHS analyzes improper payment data following each year's measurement and shares root cause findings and program vulnerabilities with CMS policy owners and those responsible for corrective actions. HHS will continue to work with plan sponsors to improve payment accuracy and documentation practices and will evaluate and document critical and feasible action steps to strengthen corrective action plans, improve reduction targets, and demonstrate measurable improvements to payment integrity in future reporting periods.

Recommendation #4: HHS should "enhance its corrective action plans that focus on the root causes of these IP percentages, such as missing or insufficient documentation, state noncompliance with federal requirements, and improper determinations of beneficiary eligibility. Furthermore, HHS should work with states to improve payment accuracy and documentation and evaluate and document critical and feasible action steps to improve reduction target and demonstrate improvements to payment integrity" for the Medicaid and CHIP programs.

HHS Response: HHS is committed to strengthening corrective action plans to address the root causes of improper payments in the Medicaid and CHIP programs. HHS acknowledges that the FY 2025 reported improper payment rates of 6.12 percent for Medicaid and 7.05 percent for CHIP reflect increases from FY 2024 rates of 5.09 percent and 6.11 percent, respectively.

HHS notes, however, that these rate increases are directly and substantially attributable to a specific, identifiable, and time-limited structural cause: the unwinding of COVID-19 public health emergency (PHE) flexibilities. During the PHE, states were permitted to suspend eligibility redeterminations and operate under reduced requirements for provider enrollment and revalidation. The expiration of these flexibilities required states to resume full eligibility redetermination processes for tens of millions of Medicaid and CHIP beneficiaries simultaneously, a volume and operational burden without precedent in the programs' histories. The resulting increases in documentation errors, processing errors, and eligibility determination errors are a direct and foreseeable consequence of this unwinding process, not an indication that existing corrective actions have failed or that the underlying integrity of program operations has deteriorated.

HHS's FY 2026 reduction targets of 8.99 percent for Medicaid and 9.52 percent for CHIP reflect this transitional period and were established conservatively to account for continued unwinding impacts. HHS anticipates that as states complete eligibility redetermination cycles and their systems and processes normalize to pre-pandemic operating conditions, improper payment rates

will stabilize and trend downward. HHS is actively working with states to strengthen eligibility determination processes, improve documentation practices, and enhance provider enrollment and screening controls. HHS will continue to evaluate and document critical and feasible corrective action steps and will update its corrective action plans as the unwinding process concludes and the root cause profile of Medicaid and CHIP improper payments evolves accordingly.

Recommendation #5: HHS should "continue to work with OMB and other relevant stakeholders to complete the IP measurement program for the State-based Exchanges to report a complete and accurate IP 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 2025, HHS continued reporting an improper payment measurement for the Federally-facilitated Exchange. HHS implemented the Improper Payment Pre-Testing and Assessment (IPPTA) program from 2024 through 2026 to assist states in preparing for upcoming measurement activities. On May 15, 2026, HHS published the State Exchange Improper Payment Measurement (SEIPM) Final Rule and will begin the State Exchange measurement January 1, 2027. HHS intends to publish its first improper payment (IP) estimate in its FY 2028 AFR. HHS remains committed to working with OMB and relevant stakeholders to report a complete and accurate IP estimate for all components of the APTC program.

Recommendation #6: HHS should "continue to follow its plan to conduct Title IV-E reviews so all states will be included in the estimate by FY 2027 in order to report a complete estimate."

HHS Response: HHS is committed to completing the full cycle of Title IV-E reviews and has made substantial progress since resuming these reviews in FY 2024 following the COVID-19 pandemic pause. In FY 2024, HHS reported an improper payment estimate based on reviews of six states. In FY 2025, HHS expanded coverage to 26 states, reflecting continued and significant progress toward a complete population estimate.

HHS respectfully notes that the report acknowledges the Foster Care estimate "was calculated according to the established methodology plan." The noncompliance determination rests on the fact that the three-year review cycle is not yet complete, a condition that is structural and expected given that reviews only resumed in FY 2024. OMB Circular A-123, Appendix C, Section VI.A.5a, provides that OMB does not expect a program to publish a reduction target until a baseline has been established and reported. Because a complete baseline cannot be established until all jurisdictions have been reviewed, the inability to set the reduction target at this stage reflects the phased nature of the review process. HHS has consistently communicated this trajectory and has published the Title IV-E Foster Care Eligibility Review schedules for FY 2026 online at https://acf.gov/cb/policy-guidance/title-iv-e-foster-care-eligibility-reviews-schedule. The full cycle of reviews, encompassing all 50 states, the District of Columbia, and Puerto Rico, is on track for completion in FY 2027, at which point a complete baseline and reduction target will be established and reported.

Recommendation #7: HHS should "continue advocating for legislative changes and work with OMB and other stakeholders to develop and implement an approach to calculate and report an IP and UP estimate for TANF. This process will aid in identifying root causes of TANF IPs and allow HHS to report [corrective action plans] CAPs in the Agency Financial Report (AFR)."

HHS Response: Statutory limitations continue to preclude HHS from collecting the 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 Section 417 of the Social Security Act prohibits HHS from collecting data elements other than those listed. These statutory constraints limit the agency's ability to measure and oversee payment integrity for the TANF program.

HHS continues to support state-level efforts to enhance TANF program integrity and prevent improper payments. HHS is also reviewing single audit findings, conducting monitoring of state compliance, and assessing penalties according to statutory guidelines. HHS will continue examining options 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 corrective actions. HHS remains committed to working with OMB and other stakeholders to identify viable pathways to full PIIA compliance for the TANF program.

Recommendation #8: HHS should "focus on the root causes of the IP percentage and evaluate critical and feasible action steps to assist recipients with their compliance efforts for these requirements. This would include working with the recipients 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 recipients to follow up on repeat root causes of errors and enhance the CAPs for implementation [for the Head Start program]."

HHS Response: HHS recognizes that the Head Start improper payment rate of 10.29 percent in FY 2025 remains above the 10 percent compliance threshold, and the Department is committed to bringing the program into full compliance. HHS notes, however, that the FY 2025 rate represents a reduction of approximately 1.68 percentage points from the FY 2024 rate of 11.98 percent, reflecting meaningful progress resulting from corrective actions implemented during the year. Missing or insufficient documentation errors continue to account for many improper payments identified in the program.

Starting in FY 2025, HHS implemented a series of corrective actions consistent with commitments made in its FY 2024 management response, including: issuing disallowances for insufficient documentation; enhancing monitoring through random sampling and retroactive testing; refining the Improper Payment Review process; and developing and expanding training and technical assistance for recipients through resources, event summits and individual recipient support. HHS will continue to pursue these and additional corrective actions, working directly with recipients to address repeat root causes of errors and strengthen documentation practices, with the goal of bringing the Head Start improper payment rate below 10 percent.

Recommendation #9: 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 program in FY 2025 in the event that the RADV program cannot effectively serve as HHS's 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."

HHS Response: The Risk Adjustment Data Validation (RADV) audit program serves as the primary corrective action and recovery audit mechanism for Medicare Part C improper payments. RADV uses medical record review to verify that diagnoses submitted by Medicare Advantage Organizations (MAOs) for risk-adjusted payment are supported by medical record documentation. The RADV program is consistent with PIIA's recovery audit requirements and effectively serves as HHS's sole recovery audit strategy for the Medicare Part C program.

HHS has made significant progress in implementing its strategy to accelerate and expand RADV audit activities and is committed to completing audits for payment years 2018 through 2024 on an expedited basis. Specific accomplishments in FY 2025 included:

- Initiated Payment Year (PY) 2018 audits of 58 Medicare Advantage (MA) contracts;
- Initiated expanded PY 2019 contract-specific RADV audits of 355 MA contracts; and
- Issued audit findings to 90 MA contracts for PYs 2011–2013.

HHS has continued this momentum into FY 2026 and has:

- Initiated PY 2020 RADV audits of 471 MA contracts;
- Initiated PY 2021 RADV audits of 492 MA contracts;
- Issued more than 200 reconsideration decisions in response to appeals of PY 2011, 2012, and 2013 RADV audit findings;
- Issued audit findings to more than 400 MA contracts for PY 2014 and PY 2015 RADV audits;
- Begun processing appeals of PY 2014 and PY 2015 RADV audit findings; and
- Posted an audit schedule on the CMS website for the remaining payment year audits.

HHS cannot recover overpayments under the RADV program until all administrative appeals are exhausted. In addition, on September 25, 2025, the U.S. District Court for the Northern District of Texas vacated certain portions of HHS's 2023 RADV Final Rule. HHS appealed this decision on November 21, 2025; nonetheless, HHS will fully comply with the district court's order as long as it remains in effect, while continuing to pursue upcoming RADV payment year audits.

Conclusion

Although HHS has made progress to reduce improper payments and improve reporting, including achieving full compliance for the Medicare Fee-for-Service program and Child Care and Development Fund program in FY 2025, we recognize the need for continuous and focused efforts to further prevent, detect, and reduce improper payments in our programs. The Administration is committed to leveraging innovative methods, including advanced data analytics and technology-driven oversight tools, for program integrity purposes, as part of its efforts to ensure the government is a responsible steward of taxpayer resources. 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.

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 2026 PaymentAccuracy.gov data call. For programs out of compliance for three or more consecutive years, HHS will submit separate reports to Congress

as required under PIIA and OMB Circular A-123, Appendix C, describing actions being taken and timelines for achieving compliance.

We look forward to finding 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,

Gustav Chiarello
Assistant Secretary for Financial Resources

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