

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 2021**

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for Audit Services**

**May 2022
A-17-22-52000**

Office of Inspector General

<https://oig.hhs.gov>

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

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We conducted a performance audit of the U.S. Department of Health and Human Services' (HHS or the Department) compliance with the required calculation and disclosure of improper payment rates as of and for the fiscal year ended September 30, 2021, to determine if HHS is in compliance with the Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA). We conducted our Fiscal Year 2021 performance audit following the requirements in the Office of Management and Budget's (OMB) Circular A-123, Appendix C (M-21-19, March 2021), OMB Circular A-136 (August 2021), OMB FY 2021 Annual Data Call Instructions, OMB Payment Integrity Question and Answer Platform, and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA. HHS management is responsible for compliance with PIIA.

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

To assess HHS compliance, we performed specific procedures to address the objectives summarized in the Contract #GS00F290CA - 2021 Statement of Work Appendix F – Improper Payment. The specific scope and methodology are summarized in Section II of this report. This report also addresses the extent to which HHS has identified and implemented internal controls to comply with PIIA. However, this performance audit did not constitute an audit of financial statements or internal control over financial reporting in accordance with auditing standards generally accepted in the United States. Additionally, because of their nature and inherent limitations, the internal control may not prevent, or detect and correct, all deficiencies that may be considered relevant to the audit objectives. Furthermore, the projection of any evaluations of effectiveness to future periods, or conclusions about the suitability of the design of the internal controls to achieve the related audit objectives, is subject to the risk that internal controls may become inadequate because of changes in conditions or that the degree of compliance with such internal controls may deteriorate.

HHS met many requirements, but it did not fully comply with PIIA for FY 2021. Our detailed findings and recommendations are documented in Section III of this report.



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

Ernst & Young LLP

May 2, 2022

EXECUTIVE SUMMARY

The Payment Integrity Information Act of 2019 (PIIA: PL 116-117) was enacted on March 2, 2020 and requires the Offices of Inspector General (OIGs) to review and report on agencies' annual improper payment information included in their Agency Financial Reports (AFRs) to determine compliance with PIIA.

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

We conducted a performance audit to determine whether HHS complied with the PIIA improper payment reporting requirements in its fiscal year (FY) 2021 AFR. We conducted our performance audit using a combination of requirements, including: 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 (August 2021); the OMB FY 2021 Annual Data Call Instructions; OMB Payment Integrity Question and Answer Platform; and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA.

As part of our performance audit, we evaluated compliance 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, Child Care, and Development Fund (CCDF); two programs that are deemed susceptible to significant improper payments under OMB Memorandum M-18-14: Center for Disease Control and Prevention (CDC) and Administration for Children and Families' Office of Head Start (OHS) Disaster Relief; and one additional program that HHS identified to be susceptible to significant improper payments, Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and CCDF are OMB-designated high-priority programs. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Medicare Part C program. We also reviewed the disclosures around methodology changes for certain programs due to COVID-19.

Additionally, we determined that internal control within the context of the performance audit objective is significant. Accordingly, we obtained an understanding of 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 improper payment 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 improper payment 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 unknown payment 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 2021 AFR, including the required improper payment disclosures, on November 12, 2021.

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

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

As part of the Inspector General's review of the agency's compliance with PIIA, the Inspector General 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; and (3) review the oversight and/or financial controls used to identify and prevent IPs and UP.

WHAT WE FOUND

HHS met many requirements but did not fully comply with PIIA for FY 2021.

As required, HHS conducted a program-specific risk assessment of 38 programs and determined that three new programs were susceptible to 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 38 programs, they did not risk assess each program with annual outlays greater than \$10 million at least once in every three years. The three programs that were identified as susceptible to IP are (1) Head Start; (2) COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured Program (Uninsured Program); and (3) Provider Relief Fund General and Targeted Payments. As such, HHS will be required to publish improper payments for these programs in FY 2022.

HHS had not fully implemented recovery audit activities for the identified improper payments for the Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D) programs in FY 2021, as required by PIIA.

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

Table 1: PIIA Compliance Reporting Table

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

Accompanying Notes to Table 1

C – Compliant

NC – Noncompliant

N/A – Not Applicable

- (a) These programs are determined to be susceptible to significant improper payments and are not required to perform a risk assessment (Appendix C of OMB Circular A-123, Part II.A.2).
- (b) As described in Finding #6, refinements to the denominator methodology implemented in FY 2021 led to the increase in the FY 2021 error estimate. Prior to FY 2021, the Part C denominator methodology reflected total MA payments and included some payments that were non-risk adjusted or were based on a different model resulting in a reported error biased downward. Therefore, the FY 2021 reporting year is a baseline and should not be compared with prior reporting years.
- (c) As described in Finding #3, while a previous risk assessment concluded that the APTC program is susceptible to significant improper payments, the program is not yet reporting improper payment and unknown payment estimates for FY 2021. As a result, HHS was not able to publish and develop a plan to meet the reduction target for future improper payment and unknown levels, publish corrective action plans (CAPs) and fulfill the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance.
- (d) As described in Finding #4, HHS did not publish improper and unknown payment estimates for Foster Care in the FY 2021 AFR. HHS is uncertain of when it will be safe to resume onsite Title IV-E Reviews and how many states will be newly reviewed in time. In light of this uncertainty, as well as the unknown impact of the recent programmatic changes on the improper payment rate, HHS was unable to report improper and unknown payment estimates. As a result, HHS was not able to publish and develop a plan to meet the reduction target for future improper payment and unknown levels, publish CAPs and fulfill the criteria of achieving an improper payment rate of less than 10 percent per OMB guidance.
- (e) As described in Finding #2, an improper payment and unknown payment estimate was not published for TANF due to statutory limitations. As a result, HHS was not able to publish and develop a plan to meet the reduction target for future improper and unknown payment levels, publish corrective action plans, and fulfill the criteria of achieving improper payment rate of less than 10percent per OMB guidance.
- (f) As permitted by OMB Circular A-123, Appendix C (Part III.A.3), HHS did not report improper payment target rates for Child Care in the FY 2021 AFR. CCDF state grantees are implementing large-scale changes to their child-care programs in accordance with the Child Care and Development Block Grant Act of 2014. Rolling implementation of the new requirements affected the FY 2021 error rate measurement, making it a challenge to determine a target rate. Further, as a result of uncertainties due to the COVID-19 Public Health Emergency (PHE), states' abilities to complete planned actions were impacted. As a result, HHS delayed the establishment of a full baseline.
- (g) HHS did not publish reduction targets for the CDC Disaster Relief program and OHS Disaster Relief program, as they are below the statutory threshold for reporting estimates.

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

During our review of prior-year reports issued by the OIG and the results of our procedures, we identified instances of noncompliance with PIIA in the Medicaid, CHIP, TANF, and Medicare Advantage (Part C) programs. HHS has been noncompliant for six or more consecutive years for these programs. In addition, HHS has not reported an error rate for the APTC program since it was first risk assessed as susceptible to significant improper payments in FY 2016.

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. We determined that HHS maintained adequate internal controls over these processes.

WHAT WE RECOMMEND

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

- For the TANF program, ACF should develop an improper payment estimate, reduction targets and CAP;
- For the APTC program, HHS should develop an improper payment estimate, reduction targets and CAP;
- For the Medicare Part C program, HHS should perform recovery audits to identify and recoup overpayments for the Medicare Part C program in FY 2022; and
- For Medicaid and CHIP, HHS should focus on identifying root causes for the improper payment percentage and evaluate critical and feasible action steps to reduce the improper payment percentages below 10 percent.

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

- Perform a risk assessment over all programs with annual outlays in excess of \$10 million at least once every three years;
- For the Foster Care program, HHS should calculate an improper payment estimate, reduction targets, and CAP;
- For Medicare Part C, HHS should focus on identifying root causes for the improper payment percentage and evaluate critical and feasible action steps to reduce the improper payment percentages below 10 percent; and

- For the Medicare Part D program, HHS should perform recovery audits to identify and recoup overpayments for the Medicare Part D program in FY 2022.

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

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INTRODUCTION

The Payment Integrity Information Act of 2019 (PIIA: PL 116-117) was enacted on March 2, 2020 and requires the Offices of Inspector General (OIGs) to review and report on agencies' annual improper payment information included in their AFRs to determine compliance with PIIA.

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

We conducted a performance audit to determine whether HHS complied with the PIIA improper payment reporting requirements in FY 2021 AFR. We conducted our performance audit using a combination of requirements, including 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 (August 2021); the OMB FY 2021 Annual Data Call Instructions; OMB Payment Integrity Question and Answer Platform; and the Council of the Inspectors General on Integrity and Efficiency guidance required under PIIA.

As part of our performance audit, we evaluated compliance 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, Child Care and Development Fund (CCDF); two programs that are deemed susceptible to significant improper payments under OMB Memorandum M-18-14: Center for Disease Control and Prevention (CDC) and Administration for Children and Families' Office of Head Start (OHS) Disaster Relief; and one additional program that HHS identified to be susceptible to significant improper payments, Advance Premium Tax Credit (APTC). Of these programs, Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and CCDF are OMB designated high-priority programs. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for the Medicare Part C program. We also reviewed the disclosures around methodology changes for certain programs due to COVID-19.

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

Objectives

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

A determination of compliance with PIIA includes whether HHS has:

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

SECTION I – BACKGROUND

To improve the accountability of federal agencies' administration of funds, PIIA requires the agencies, including HHS, to annually report information to the President and Congress on the agencies' IP and UP. An improper payment 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 improper payment 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 unknown payment 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, provides guidance on the implementation of and reporting under the requirement for payment integrity improvement. There are eleven programs that are deemed or identified to be susceptible to significant improper payments. HHS reported approximately \$153.87 billion in gross improper payments in its FY 2021 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 2021 AFR. HHS included information on the following eleven programs that are determined to be susceptible to significant improper payments: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, TANF, Foster Care, CCDF, CDC Disaster Relief, and OHS Disaster Relief.

Methodology

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

- Reviewed applicable federal laws and OMB circulars;
- Reviewed improper payment information reported in the HHS FY 2021 AFR;
- Assessed internal control around significant processes impacting the improper payment process in conjunction with the audit of the consolidated financial statements;
- Obtained and analyzed other information from HHS on the eleven programs determined to be susceptible to significant improper payments;
- Interviewed Department staff to obtain an understanding of the processes and events related to determining improper payment rates;
- Verified that the improper payment rates for the relevant programs were less than 10 percent in FY 2021 and that the results were published in the HHS FY 2021 AFR;
- Assessed HHS’ disclosure of improper payment requirements in the AFR by verifying that the HHS FY 2021 AFR included required disclosures per OMB Circular A-136;
- Verified that the HHS FY 2021 AFR was published on HHS.gov;
- Compared amounts included on HHS-prepared supporting documentation to information included within the “Payment Integrity Report” section of the FY 2021 AFR for each program;
- Performed walk-throughs to gain an understanding of management’s process and assessed internal controls for the programs selected as part of our testing of HHS’ processes over financial reporting; and

- Evaluated the control environment to determine if HHS maintained adequate internal controls over the improper payment process and payment accuracy input process for the high priority programs.

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

- Interviewed Department officials about the process for assessing the level of risk for each program and confirmed HHS' approach within the context of OMB's guidance;
- Made inquiries to Department officials about the quality of the improper payment estimates and the methodology for each program;
- Reviewed key processes, steps, and documentation used to estimate improper payments in each program;
- Asked program officials about the methodology for determining the estimated improper payment rate target for the subsequent year for each program; and
- Evaluated the revised improper payment sampling and estimation methodology plan for the Medicare Part C program.

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

- Verified that HHS demonstrated improvements to payment integrity in FY 2021 and that the results were published in the HHS FY 2021 AFR;
- Reviewed HHS' program-specific efforts to recapture improper payments in FY 2021;
- Reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2021;
- Verified that the CAPs for the relevant programs were published in the HHS FY 2021 AFR and appropriately prioritized within HHS; and
- Verified that HHS submitted and published data call information to PaymentAccuracy.gov and took appropriate action to resolve any discrepancies between the annual financial statement and PaymentAccuracy.gov.

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

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

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

SECTION III – FINDINGS AND RECOMMENDATIONS

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

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

PIIA states that the Department must conduct an IP risk assessment at least once every three years, for each program with annual outlays greater than \$10 million to determine whether the program is likely to make IPs plus UPs that would be in total above the statutory threshold. The agency is responsible for ensuring that all programs with annual outlays greater than \$10 million have been assessed at least once every three years. While management has a process to identify programs with over \$10 million in annual outlays, HHS did not risk assess all such programs at least once every three years, and instead maintained their previous risk assessment threshold of \$100 million for FY 2021. HHS management indicated that due to the number of programs that met the \$10 million threshold, adequate resources are not available to complete the risk assessments for all programs meeting the threshold. Additionally, from the programs over \$100 million, not all programs considered for risk assessment were risk assessed due to resource constraints.

Recommendation:

We recommend that HHS either (1) implement a risk assessment strategy that ensures that all programs with annual outlays greater than \$10 million are risk assessed at least once every three years or (2) work with OMB to develop an approach and obtain concurrence to perform risk assessments at a level that meets the intent of PIIA. As HHS has 236 programs that exceed the \$10 million threshold in FY 2021, HHS should consider what additional resources are needed to perform these risk assessments for an organization as large and complex as HHS or what enhancements can be made to the current process to reduce the time and effort to risk assess each program.

Finding #2 – TANF improper payment and unknown payment estimate not published in FY 2021

HHS did not calculate or report an improper payment and unknown payment estimate for TANF. HHS stated in its FY 2021 AFR that it did not report an improper payment estimate for TANF because statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. PIIA requires federal agencies to review all of their programs to identify those that may be susceptible to significant improper payments. OMB implementing guidance states that OMB can also designate programs as susceptible to significant improper payments regardless of risk assessment results. OMB has designated TANF as a federal program susceptible to significant improper payments. Accordingly, HHS should have estimated and

reported improper payments in the AFR for TANF. Since HHS did not report an improper payment estimate for the TANF program, HHS did not publish a corrective action plan for TANF addressing the root causes for TANF's improper payments.

We acknowledge that HHS continues to work on a multi-faceted approach to support states in improving TANF program integrity and preventing improper payments. In FY 2019, HHS also conducted a comprehensive needs assessment of all TANF states, territories, and the District of Columbia, including information about payment integrity efforts to understand existing state approaches and alternative methods for measuring TANF improper payments. This assessment is helping HHS understand existing state approaches and alternative methods for measuring TANF improper payments, including the feasibility and cost-benefit analysis of different approaches. In the FY 2021 AFR, HHS continued to report on a series of actions, including awarding a contract to promote and support innovation in TANF data, and working with states to mitigate potential payment risk identified as part of the detailed risk assessment of the program performed in FY 2019.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF improper payments in FY 2022. This process will aid in identifying root causes of TANF improper payments and allow HHS to report CAPs in the AFR.

Finding #3 – APTC improper payment and unknown payment estimate not published in FY 2021

HHS did not calculate or report an improper payment and unknown payment estimate for APTC. While an HHS risk assessment concluded that the APTC program is susceptible to significant improper payments, the program is not yet reporting improper payment estimates for FY 2021. HHS stated that in FY 2021, the Department commenced the improper payment measurement program for the Federally facilitated Exchange and anticipates reporting an improper payment estimate for the Federally facilitated Exchange in the FY 2022 AFR. HHS continues to develop the improper payment measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status. As with similar HHS programs, developing an effective and efficient improper payment measurement program requires multiple time-intensive steps, including contractor procurement; developing measurement policies, procedures, and tools; and extensive pilot testing to ensure an accurate improper payment estimate. Accordingly, HHS should have estimated and reported improper payments in the AFR for APTC. Since HHS did not report an improper payment estimate for the APTC program, HHS did not publish a corrective action plan for APTC addressing the root causes of APTC's improper payments.

Recommendation:

We recommend that HHS continue to work with OMB and other relevant stakeholders, to complete the improper payment measurement program for the Federally facilitated Exchange in FY 2022.

We also recommend that HHS continue to make progress in the development of an improper payment measurement methodology for the State-based Exchange to report an accurate improper payment estimate.

Finding #4 – Foster Care improper payment and unknown payment estimate not published in FY 2021

HHS did not publish an improper payment and unknown payment for the Foster Care program due to the impact of COVID-19. HHS stated that Foster Care is not reporting an error rate for FY 2021 or an improper payment plus an unknown payment target for FY 2022. Given the impact of COVID-19, HHS is uncertain when it will be safe to resume conducting onsite Title IV-E Reviews and how many states will be newly reviewed in time for the FY 2022 improper payment reporting cycle. Considering this uncertainty, as well as the unknown impact of the recent programmatic changes on the improper payment rate, HHS is unable to set an improper payment plus unknown payment reduction target for FY 2022.

Recommendation:

We recommend that HHS continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Foster Care in FY 2022.

Finding #5 – Medicaid and CHIP improper payment and unknown payment rate percentages exceed 10 percent for FY 2021

In accordance with PIIA, if the program reported an IP and UP estimate of 10 percent or more for the FY, the program will be noncompliant. The reported improper payment rate percentage in the HHS AFR for the Medicaid and CHIP programs in FY 2021 was 21.69 percent and 31.84 percent, respectively, which are above the compliance threshold of 10.00 percent.

The area driving the FY 2021 Medicaid and CHIP improper payment estimates is the continued reintegration of the Payment Error Rate Measurement (PERM) eligibility component, which was revamped to incorporate the Patient Protection and Affordable Care Act requirements in the PERM eligibility reviews. HHS began using the updated eligibility component in the FY 2019 measurement cycle. The PERM program is designed to measure the error rate for each state and territory once over a three-year cycle. This was the first time Cycle 3 states were measured using the methodology. Under the updated eligibility component, a federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid eligibility determinations and increased oversight of identified vulnerabilities. With the measurement of Cycle 3 states, HHS has completed the measurement of all states under the revamped eligibility component and established a national baseline in FY 2021. Eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated, but the state provided no documentation to validate the verification process was completed.

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

Recommendation:

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

Finding #6 – Medicare Part C improper payment and unknown payment rate percentages exceed 10 percent for FY 2021

In accordance with PIIA, if the program reported an IP and UP estimate of 10 percent or more for the FY, the program will be noncompliant. The reported improper payment rate percentage in the HHS AFR for the Medicare Part C program in FY 2021 was 10.28 percent, which is above the compliance threshold of 10.00 percent.

Refinements to the denominator methodology implemented in FY 2021 to only include the calculation of the population of Medicare Advantage payments reviewed and at risk for diagnostic error led to the increase in the FY 2021 error estimate. Prior to FY 2021, the Part C denominator methodology reflected total Medicare Advantage payments and included some payments that were non-risk adjusted or were based on a different model resulting in a reported error biased downward. Therefore, the FY 2021 reporting year is a baseline and should not be compared with prior reporting years.

The primary error category of FY 2021 Medicare Part C improper payments consisted of medical record discrepancies, with a smaller portion of improper payments resulting from insufficient documentation (such as missing medical records). Improper payments due to medical record discrepancies occur when medical record documentation does not substantiate the clinical diagnosis codes that the Medicare Advantage organization submitted to CMS and for which it received payment.

Recommendation:

We recommend that HHS focus on the root causes of the improper payment percentage and evaluate critical and feasible action steps to assist Medicare Advantage organizations with the

compliance efforts. This would include working with the Medicare Advantage organizations, specifically those organizations with repeated noncompliance, to ensure that medical record documentation is sufficient and substantiates clinical diagnoses. These efforts could reduce medical record discrepancies, which would assist HHS in its efforts to decrease the improper payment rate percentage below 10 percent.

Finding #7 – Minimal recovery audits and activities were performed during FY 2021 to recover improper payments for Medicare Advantage and Medicare Part D programs

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

Contract-level Risk Adjustment Data Validation (RADV) audits are HHS's primary action to recoup Part C overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MA organizations for risk-adjusted payment. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. However, these audits are significantly delayed, and no recoveries have been made or reported in the AFR for several years. As reported in the FY 2021 AFR, HHS completed the payment year (PY) 2014 RADV audit medical record review phase and the PY 2015 RADV audit medical record submission phase.

HHS believes that the PPI-MEDIC performs the Part D recovery audit function. The PPI-MEDIC has a robust program to identify improper payments. In FY 2021, the PPI-MEDIC continued previously contracted audits that identified potentially improper payments and conducted education and outreach for Part D plan sponsors. In addition, HHS conducted 13 plan sponsor audits in FY 2021. However, no continuing recovery audit efforts are under contract for FY 2021. Therefore, HHS is not in compliance with this specific section of the law/regulations.

Recommendation:

We recommend that HHS improve its recovery audit efforts as required under PIIA Section 2(i), to identify and recoup overpayments for Medicare Part C and Medicare Part D unless not deemed cost effective. HHS should also continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C and Medicare Part D programs in FY 2022 in the event that the RADV and PPI-MEDIC programs cannot effectively serve as HHS's sole recovery audit strategies.

APPENDIX A: HHS MANAGEMENT COMMENTS



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Washington, DC 20201

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

Dear Ms. Frontz:

Thank you for the opportunity to review the Office of Inspector General's (OIG) draft report "*U.S. Department of Health and Human Services Met Many Requirements, but It Did Not Fully Comply With the Payment Integrity Information Act of 2019 and Applicable Improper Payment Guidance for Fiscal Year 2021*" (A-17-22-52000). The Department of Health and Human Services (HHS) takes seriously its responsibility to comply with the Payment Integrity Information Act (PIIA, P.L. No. 116-117), which repealed and replaced previous improper payment legislation. HHS's leadership is re-examining the existing corrective actions and exploring new and innovative approaches to reduce improper payments. As a result of these efforts, the recently released FY 2023 President's Budget request included several proposals to enhance HHS's compliance with PIIA. 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-17-22-52000)

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

HHS Response: The Department is dedicated to assessing and minimizing the risk of improper payments made by its programs. HHS has hundreds of programs that expend more than \$10 million annually that are subject to an improper payment risk assessment. Improper payment risk assessments can be a resource intensive process and must be balanced against resource constraints and other ongoing programmatic activities. While HHS has increased the number of programs that are risk assessed in recent years, HHS is considering enhancements to capture more programs in its annual and cyclical risk assessment process.

Recommendation #2: The Department should "...continue to work with OMB and other stakeholders to develop and implement an approach to reporting on TANF improper

payments in FY 2022. This process will aid in identifying root causes of TANF improper payments and allow HHS to report CAPs in the AFR.”

HHS Response: As disclosed in the FY 2021 Agency Financial Report (AFR) (<http://www.hhs.gov/af/>), statutory limitations prohibit HHS from collecting required information needed to develop a TANF improper payment measurement or collecting the required information to develop corrective action plans. Given these limitations, efforts to develop an approach to reporting on TANF improper payments have not been successful. HHS continues to explore options with relevant stakeholders for developing an approach to measure improper payments in TANF. On a parallel track, the Department uses a multi-faceted approach to support states in improving program integrity to prevent improper payments in TANF, including awarding a five-year contract in FY 2017 for Promoting and Supporting Innovation in TANF Data.

Recommendation #3: For the Advance Premium Tax Credit (APTC) program, the Department should “...continue to work with OMB and other relevant stakeholders, to complete the improper payment measurement program for the Federally-facilitated Exchange in FY 2022.” The Department should also “...continue to make progress in the development of an improper payment measurement methodology for the State-based Exchange to report an accurate improper payment estimate.”

HHS Response: The Department is committed to fully implementing an improper payment measurement for the APTC program, as required by PIIA. As disclosed in the FY 2021 AFR, the Department is currently conducting its first improper payment measurement of the Federally-facilitated Exchange and plans to report an improper payment estimate in the FY 2022 AFR. HHS continues to develop the improper payment methodology for the State-based Exchanges and will continue to update its annual AFRs with the measurement development and implementation status.

Recommendation #4: The Department should “continue to work with OMB and other stakeholders to develop and implement an approach to reporting on Foster Care in FY 2022.”

HHS Response: In response to the COVID-19 pandemic, the Department postponed on-site Title IV-E reviews to protect the health and safety of state and federal reviewers, ensuring that state child welfare officials remain focused on mission-critical activities. These Title IV-E reviews generate data used to calculate Foster Care’s improper payment estimates. Due to the postponement of reviews, HHS had no new data for FY 2021 and did not report an improper payment estimate. The Department is monitoring COVID-19 and anticipates resuming Title IV-E reviews, allowing it to report Foster Care improper payment estimates in the future.

Recommendation #5: For Medicaid and CHIP, the Department should “focus on the root causes of the improper payment percentage and evaluate critical and feasible action steps to assist states with their compliance efforts for these new requirements...HHS should work with the states to follow up on repeat root causes for errors and enhance the CAPs

for implementation. In addition...HHS should continue to follow up with states during the interim period to verify that corrective actions identified after the improper payment error rate measurement review are being implemented. HHS should also consider sharing corrective action best practices across states to help address these issues”.

HHS Response: HHS continues to implement robust Medicaid and CHIP corrective action plans that provide technical assistance and guidance to states. HHS works with states to address each error and deficiency identified during the Payment Error Rate Measurement (PERM) cycle and monitors the state’s progress in implementing corrective actions. The Department continues to emphasize to states the need to come into compliance with HHS requirements and to work with providers and plans, as needed, to reduce improper payments in Medicaid and CHIP.

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.

HHS also offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. In FY 2021, HHS continued a robust training program, which included virtual training opportunities on trends in Medicaid COVID-19 Vulnerabilities, a PERM Corrective Action Symposium, and an Education and Outreach for the Territories workgroup.

In addition, HHS will collect promising practices states have implemented and share them with all states. Due to the similarities between Medicaid and CHIP improper payments, the Medicaid corrective actions discussed here also largely apply to CHIP.

Additional information on these and other corrective actions can be found in HHS’s FY 2021 AFR and will be updated in the FY 2022 AFR.

Recommendation #6: To reduce the Medicare Part C improper payment rate below 10 percent, the Department should “...focus on the root causes of the improper payment percentage and evaluate critical and feasible action steps to assist Medicare Advantage organizations with the compliance efforts. This would include working with the Medicare Advantage organizations, specifically those organizations with repeated non-compliance, to ensure that medical record documentation is sufficient and substantiates clinical diagnoses.”

HHS Response: The Department continues to ensure that each risk susceptible program has an effective and accurate improper payment estimation methodology. As part of these efforts, in FY 2021 HHS changed the Medicare Part C error rate estimation methodology to improve the accuracy of the estimate and reduce potential sources of bias. The FY 2021

rate, while slightly over one-quarter of a percent above 10 percent, establishes a new baseline for measuring progress in future periods. The new estimation methodology is an improvement in measuring and monitoring risk in this program, thereby strengthening our internal controls.

HHS will also continue to work with Medicare Advantage (MA) organizations to provide complete and accurate medical record submissions. The primary corrective action regarding Part C improper payments has been the contract-level Risk Adjustment Data Validation (RADV) audits. HHS expects payment recovery will have a sentinel effect on risk adjustment data quality submitted by plans for payment because contract-level RADV audits increase the incentive for MA organizations to initially submit valid and accurate diagnosis data. RADV verifies that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation. The payment year (PY) 2014 RADV audit is in the Payment Error Calculation phase and the PY 2015 RADV audit is in the Medical Record Review phase.

HHS also conducts audits of Part C plan sponsors and conducts training sessions for Part C plan sponsors to reduce improper payments. In FY 2021, HHS conducted three audits focused on the program integrity operations of Part C plan sponsors, with the goal of using the findings to educate these plan sponsors on ways to improve their efforts to detect and reduce fraud, waste, and abuse. Training sessions focus on program integrity initiatives, investigations, data analyses, and potential fraud schemes.

Recommendation #7: The Department should "...improve its recovery audit efforts, as required under PIIA (Section 2(i)), to identify and recoup overpayments for Medicare Part C and Medicare Part D unless not deemed cost effective." The Department should also, "...continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C and Medicare part D programs in FY 2022 in the event that the RADV and PPI-MEDIC programs cannot effectively serve as HHS's sole recovery audit strategies."

HHS Response: The primary corrective action regarding Part C improper payments has been the contract-level RADV audits. RADV verifies that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation. In 2015, HHS issued a Request for Information on the proposal to implement RADV audits under the purview of a Part C Recovery Audit Contractor (RAC). HHS received significant feedback from the public against the proposal. RACs have found Medicare Part C to not be viable because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes.

The RADV audit program performs Part C RAC functions. The PY 2014 RADV audit is in the Payment Error Calculation phase and the PY 2015 RADV audit is in the Medical Record Review phase. HHS has implemented a RADV program for many years with the support of contractors. The RADV program is consistent with PIIA's recovery audit requirements and advances corrective actions for the Medicare Part C program.

Similar to the Part C RAC, the Plan Program Integrity Medicare Drug Integrity Contractor (PPI-MEDIC) performs the Part D RAC functions. The PPI-MEDIC's workload is substantially like that of a Part D RAC, and the PPI-MEDIC has a robust program to identify improper payments. As stated in Section 5.1 of the FY 2021 AFR, HHS recovered nearly \$8.7 million from Part D sponsors in the first three quarters of FY 2021 as a result of the PPI-MEDIC projects and Part D plan sponsor self-audits.

Conclusion

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

Office of Management and Budget (OMB) guidance requires agencies to establish a plan for bringing each cited non-compliant program into compliance. Accordingly, HHS will develop a plan to address compliance findings and submit that to OMB as part of the FY 2022 PaymentAccuracy.gov data call.

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,

Norris W.
Cochran IV -S

Digitally signed by Norris
W. Cochran IV -S
Date: 2022.04.27
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Norris Cochran
Acting Assistant Secretary for Financial Resources