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 Did Not Fully Comply With the Payment Integrity Information Act of 2019 and Applicable Improper Payment Guidance for Fiscal Year 2024

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

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

We conducted a performance audit of the U.S. Department of Health and Human Services' (HHS or the Department) compliance with the required calculation and disclosure of improper payment rates as of and for the fiscal year (FY) ended September 30, 2024, to determine if HHS is in compliance with the Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA). We determined HHS' compliance with PIIA based on the guidance prescribed by the Office of Management and Budget's (OMB) Circular A-123, Appendix C (M-21-19, March 2021); OMB Circular A-136 (May 2024); 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 FY 2024 Payment Integrity Annual Data Call Instructions; and the OMB Payment Integrity Question and Answer Platform.

We conducted this performance audit in accordance with *Generally Accepted Government Auditing Standards* and the PIIA audit guidance established by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The nature, timing, and extent of the procedures selected depend on our judgment. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The specific scope and methodology are summarized in Section II of this report. This report also addresses the extent to which HHS has identified and implemented internal controls to comply with PIIA. However, this performance audit did not constitute an audit of financial statements or internal control over financial reporting in accordance with auditing standards generally accepted in the United States. Additionally, because of their nature and inherent limitations, the internal control may not prevent, or detect and correct, all deficiencies that may be considered relevant to the audit objectives. Furthermore, conclusions about the suitability of the design of the internal controls to achieve the related audit objectives is subject to the risk that internal controls may

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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 2024. Our detailed findings and recommendations are documented in Section III of this report.

Ernst & Young LLP

May 16, 2025

EXECUTIVE SUMMARY

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

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

We conducted a performance audit to determine whether HHS complied with the PIIA improper payment reporting requirements. We conducted our performance audit to determine whether HHS complied with PIIA based on the improper payment reporting requirements established by Office of Management and Budget (OMB) Circular A-123, Appendix C (M-21-19, March 2021); OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources* (March 2021); OMB Circular A-136 (May 2024); the OMB FY 2024 Payment Integrity Annual Data Call Instructions; and OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with *Generally Accepted Government Auditing Standards* and the Council of the Inspectors General on Integrity and Efficiency (CIGIE) *Guidance for Payment Integrity Information Act OIG Compliance Reviews* (October 2024) 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), Provider Relief Fund (PRF), COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP), 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 Head Start were OMB-designated high-priority programs in 2024. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for Head Start and Medicaid programs.

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

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 2024 Agency Financial Report (AFR), including the required IP disclosures, on November 14, 2024.

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 2024.

During FY 2024, HHS conducted program-specific risk assessments of 89 programs based on FY 2023 outlays and did not identify any additional programs that are susceptible to significant improper payments. HHS is responsible for ensuring that all programs with annual outlays greater

than $10 million have been assessed for IP risk at least once every three years. While HHS conducted program-specific risk assessments of 89 programs, they did not risk assess each program with annual outlays greater than $10 million at least once every three years.

Additionally, as discussed in Finding # 5, HHS had not completed recovery audit activities for the identified improper payments for the Medicare Advantage (Part C) program in FY 2024, 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 in the accompanying materials to the annual financial statement	Published corrective action plans for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement	Published IP and UP reduction target for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement	Has demonstrated improvements to payment integrity or reached a tolerable IP and UP rate	Has developed a plan to meet the IP and UP reduction target	Reported an IP and UP estimate of less than 10 percent for each program for which an estimate was published in the accompanying materials to the annual financial statement
Medicare FFS	C	C	N/A (a)	N/A (a)	C	C	C	NC (b)	NC (b)	C
Medicare Advantage (Part C)	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C
Medicare Prescription Drug Benefit (Part D)	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C
Medicaid	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C (k)
CHIP	C	C	N/A (a)	N/A (a)	C	C	C	C	C	C (k)
APTC	C	C	N/A (a)	N/A (a)	NC (e)	C	(e)	(e)	(e)	C (e)
PRF	C	C	N/A (a)	N/A(a)	C	C	(c)	(c)	(c)	C
UIP	C	C	N/A (a)	N/A (a)	NC(h)	C	(c)	(c)	(c)	C
Foster Care	C	C	N/A (a)	N/A (a)	NC (i)	C	(f)	(f)	(f)	C
TANF	C	C	N/A (a)	N/A (a)	NC (g)	(g)	(g)	(g)	(g)	(g)
CCDF	C	C	N/A (a)	N/A (a)	C	C	C	(j)	(j)	C
Head Start	C	C	N/A (a)	N/A (a)	C	C	C	NC (d)	C	NC(d)

[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 2024, HHS conducted program-specific risk assessments of 89 programs and adequately concluded whether the program is likely to make IPs and UPs above or below the statutory threshold. However, as described above and in Finding #1, HHS did not risk assess each program with annual outlays greater than $10 million at least once in every three years.

(b) As described in Finding #7 below, HHS has not demonstrated improvements to the payment integrity rate for the Medicare FFS program. In FY 2021, HHS published an improper payment error rate of 6.26 percent. Since then, the reported improper payment error rate has ranged from 7.46 percent (FY 2022) to 7.66 percent (FY 2024) in published AFRs.

(c) HHS did not report an IP plus UP payment reduction target for PRF and UIP for FY 2024 due to the passage of the Fiscal Responsibility Act of 2023 (Public Law 118-5) (FRA) in June of 2023 and the related recession of program funds. As a result, no further PRF and UIP payments will be issued.

(d) As described in Finding #4 below, HHS did not report an IP and UP estimate of less than 10 percent in FY 2024 for the Head Start (11.98 percent) program. As published in the FY 2023 AFR, the Head Start IP rate was 5.10 percent. There was an increase of 6.88 percent IP and UP estimates compared with FY 2023.

(e) As described in Finding #6 below, the APTC improper payment rate reported only represents improper payments for the Federally facilitated Exchange. HHS is still in the process of developing the improper payment measurement methodology for the State-based Exchanges and has not published an improper payment rate for the State-based Exchanges component for APTC. As the reported rate does not include the State-based Exchanges component, HHS is not in full compliance for the APTC program. As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an improper payment reduction target for APTC in the FY 2024 AFR and was subsequently unable to develop a plan to meet the reduction target for future IP and UP levels.

The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and report a full baseline.

(f) As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), HHS did not report an IP plus UP reduction target for FY 2024 since FY 2024 is the first year HHS resumed Title IV-E reviews, and the program needs to establish a baseline. Appendix C allows programs

up to 24 months to establish a baseline. As a result, HHS was not able to develop a plan to meet the reduction target for future IP and UP levels.

(g) As described in Finding #2 below, an IP and UP estimate was not published for TANF due to statutory limitations. Consequently, HHS was not able to develop and publish a plan to establish and meet a reduction target for future IP and UP levels, publish corrective action plans (CAPs), and achieve an improper payment rate of less than 10 percent.

(h) In its FY 2024 AFR, HHS published an IP and UP estimate of 0.91 percent, representing $175.81 million. However, as described in Finding #8, HHS Sampling and Estimation Methodology Plan (S&EMP) did not completely measure all key characteristics of the UIP program. Due to limitations in available data, management was unable to adequately perform insurance verification checks to determine if patients had existing health insurance coverage.

(i) In FY 2024, HHS reported error estimates for the Foster Care program based on the review of six states. HHS uses a three-year process to test all states in estimating an improper payment rate for the Foster Care program. Because the process is in its first year of resuming Title IV-E reviews, HHS indicated that it had not completed a full rotation of all states. As discussed in Finding #3, while we noted an improvement from FY 2023, the FY 2024 error rate calculation is generated based only on the six States visited as the other nine States in the first-year rotation had been scheduled for Title IV-E reviews after the review period of February 1, 2024 to May 31, 2024 ended for FY 2024 annual estimates of improper payments. Management has indicated that as the balance of states are reviewed, they will be included in future annual estimates of improper payments. Management also believes that all states will be reviewed by FY 2027.

(j) As permitted by OMB Circular A-123, Appendix C (Part VI.A.5a), OMB does not expect a program to publish a reduction target until a baseline has been established and reported. If a program does not publish a reduction target, it is not required to demonstrate improvements or develop a plan to meet the reduction target. Since CCDF began reporting a reduction target in the FY 2024 AFR, it is not required to demonstrate improvements or develop a plan to meet the reduction target.

(k) In its FY 2024 AFR, HHS reported an IP below 10 percent for Medicaid and CHIP, 5.09 percent and 6.11 percent, respectively. Flexibilities given to states related to COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, continue to have an impact on these IP rates. As these flexibilities expire, the IP rates for Medicaid and CHIP are expected to increase and may exceed 10 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 2024 is considered year four of noncompliance for the Foster Care, APTC, and TANF programs, year two of noncompliance for UIP, and year one of noncompliance for Head Start and Medicare FFS.

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

WHAT WE RECOMMEND

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

- perform a risk assessment over all programs with annual outlays in excess of $10 million at least once every three years;

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

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

- for the Medicare Part C program, HHS should perform recovery audits to identify and recoup overpayments in FY 2024.

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

- for Medicare FFS, enhance corrective action plans that focus on the root causes of the improper payment percentage, such as insufficient documentation and medically unnecessary errors, which make up nearly 75 percent of the Medicare FFS improper payment percentage. Evaluate and document critical and feasible action steps to improve reduction target and demonstrate improvements to payment integrity.

- 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.

- 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.

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

HHS MANAGEMENT COMMENTS

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

- Recommendation #1: As HHS has over 250 programs subject to an improper payment risk assessment, HHS continues to implement enhancements to gain efficiencies and allow for a greater number of risk assessments to be completed each year. These enhancements include extending the risk assessment period to allow for a greater number of risk assessments to be completed each year, establishing a complete inventory of programs and three-year risk assessment cycle, streamlining the questionnaire to improve the effectiveness and usefulness of the data, and developing a modified risk assessment approach for programs with outlays between $10 million and $100 million. Leveraging these enhancements to the risk assessment process, HHS has increased annual risk assessments by 107 percent.

- Recommendation #2: HHS has previously proposed new statutory authority that would allow TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions. HHS will examine options to allow TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions.

- Recommendation #3: In FY 2024, HHS resumed conducting title IV-E reviews, using data from the first six states reviewed between February and May 2024. Due to the length of time that has passed, Foster Care will establish a new baseline measurement for improper payments once all cycles of states have been measured. The full cycle of reviews will be completed in early FY 2027.

- Recommendation #4: Most Head Start improper payments resulted from missing or insufficient documentation errors, which accounted for 79 percent of all overpayments. To address the identified issues, HHS will implement a series of corrective actions focused on strengthening oversight and improving recipient compliance. These efforts, such as enhanced monitoring, training, technical assistance, and real-time monitoring, are designed to reduce the improper payment rate, enhance accountability, and ensure compliance with statutory requirements.

- Recommendation #5: In FY 2023, HHS finalized a rule to begin the recovery of overpayments under the RADV program. Also, in April 2024, HHS finalized a rule to clarify the RADV appeals regulation and process. As of November 2024, HHS began new RADV audits, beginning with Payment Year (PY) 2018. In January 2025, HHS began releasing RADV audit results, starting with PY 2011. In March 2025, HHS began processing appeals and plans to initiate recoveries for the PY 2011 RADV audits, while also preparing to initiate the PY 2019 RADV audit. HHS is exploring ways to accelerate the pace and effectiveness of future RADV audits.

- Recommendation #6: HHS continues to develop the improper payment methodology for the state-based Exchanges in order to report an estimate for all components of the APTC program. HHS has launched the Improper Payment Pre-Testing and Assessment (IPPTA) program to help states prepare for upcoming measurements.

- Recommendation #7: HHS is committed to strengthening corrective action plans to address the root causes of IP in the Medicare FFS program, particularly those related to insufficient documentation and medically unnecessary services. 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, while also expanding provider outreach and education efforts following policy changes.

- Recommendation #8: As the UIP program has been discontinued with related rescissions of program funding, HHS will no longer report an IP rate in future periods. Therefore, there is no recommendation specific to this finding.

Contents

INTRODUCTION

PIIA was enacted on March 2, 2020, and requires the Office of the Inspector General (OIG) of each agency to review and report on the agency's annual improper payment information compliance with PIIA.

The HHS OIG engaged us to assist in its evaluation of the accuracy and completeness of HHS' improper payment reporting to determine if HHS is in compliance with PIIA and the applicable improper payment guidance.

We conducted a performance audit to determine whether HHS complied with the PIIA improper payment reporting requirements. We determined HHS' compliance with PIIA based on the guidance prescribed by OMB Circular A-123, Appendix C (M-21-19, March 2021); OMB Memorandum M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources* (March 2021); OMB Circular A-136 (May 2024); the OMB FY 2024 Annual Data Call Instructions; and OMB Payment Integrity Question and Answer Platform.

The audit was conducted in accordance with *Generally Accepted Government Auditing Standards*, and the Council of the Inspectors General on Integrity and Efficiency (CIGIE) *Guidance for Payment Integrity Information Act OIG Compliance Reviews* (October 2024) 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), Provider Relief Fund (PRF), COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP), 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 Head Start were OMB-designated high-priority programs in 2024. As part of our procedures, we evaluated the improper payment sampling and estimation methodology for Head Start and Medicaid Programs.

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

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 meeting the IP and UP reduction target; and

6. reported IP and UP estimate of less than 10 percent for each program or activity for which an estimate was obtained and published in the accompanying materials to the annual financial statements.

SECTION I – BACKGROUND

To improve the accountability of Federal agencies' administration of funds, PIIA requires the 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 2024, there are 12 HHS programs that are deemed or identified to be susceptible to significant IPs. HHS reported approximately $89.48 billion in gross IPs and UPs in its FY 2024 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 2024 AFR and published on PaymentAccuracy.gov. HHS included information on the following 12 programs that are determined to be susceptible to significant IPs: Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, APTC, PRF, UIP, TANF, Foster Care, CCDF and Head Start.

Methodology

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

- reviewed applicable Federal laws and OMB circulars;
- reviewed IP information reported in the HHS FY 2024 AFR;
- assessed internal control around significant processes impacting the IP process in conjunction with the audit of the consolidated financial statements;
- obtained and analyzed other information from HHS on the 12 programs determined to be susceptible to significant IPs;
- interviewed Department staff to obtain an understanding of the processes and events related to determining IP rates;
- verified that the IP rates for the relevant programs were less than 10 percent in FY 2024 and that the results were published in the HHS FY 2024 AFR;
- assessed HHS' disclosure of IP requirements in the AFR by verifying that the HHS FY 2024 AFR included required disclosures per OMB Circular A-136;
- verified that the HHS FY 2024 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 2024 AFR and information collected through the data call and published on PaymentAccuracy.gov for each program;
- performed walk-throughs to gain an understanding of management's process and assessed internal controls for the programs selected as part of our testing of HHS' processes over financial reporting; and

- evaluated the control environment to determine if HHS maintained adequate internal controls over the IP process and payment accuracy input process.

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' approach within the context of OMB's guidance;

- made inquiries of Department officials about the quality of the IP estimates and the methodology for each program, including any changes in methodologies from the prior year;

- reviewed key processes, steps, and documentation used to estimate IPs of programs reporting an error rate;

- asked program officials about the methodology for determining the estimated IP rate target for the subsequent year for each program;

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

- evaluated the revised IP sampling and estimation methodology plan for the Head Start program.

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

- verified that HHS demonstrated improvements to payment integrity in FY 2024 and that the results were published in the HHS FY 2024 AFR and on PaymentAccuracy.gov;

- reviewed HHS' program-specific efforts to recapture IPs in FY 2024;

- reviewed HHS' application of the Do Not Pay Initiative at a program level in FY 2024;

- verified that the CAPs for the relevant programs were published in the HHS FY 2024 AFR and appropriately prioritized within HHS; and

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

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

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

SECTION III – FINDINGS AND RECOMMENDATIONS

This report consolidates the instances of noncompliance with PIIA from an overall perspective and for each of the IP measurement programs. Although HHS met many PIIA and other OMB reporting requirements, it did not fully comply with PIIA. This report also addresses the extent to which HHS has identified and implemented internal controls to comply with PIIA. Except for those identified below, we did not identify internal control findings during the performance of the audit.

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

HHS conducted a program-specific risk assessment of 89 programs based on FY 2023 outlays and did not identify any additional programs that are susceptible to significant IPs. PIIA and OMB guidance states that the Department must conduct an IP risk assessment at least once every three years for each program with annual outlays greater than $10 million to determine whether the program is likely to make IPs plus UPs that would be in total above the statutory threshold. The agency is responsible for ensuring that all programs with annual outlays greater than $10 million have been assessed at least once every three years. While management continued to develop policies, procedures, and tools to facilitate coverage of all programs over $10 million in accordance with PIIA, HHS did not meet the requirement to assess each program with annual outlays greater than $10 million at least once in every three years. Management indicated that HHS will continue making additional enhancements during 2025 to capture all programs greater than $10 million in its three-year assessment.

Recommendation:

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

Finding #2 – TANF IP and UP estimate not calculated nor published in FY 2024

HHS did not calculate and report an IP and UP estimate for TANF. HHS stated in its FY 2024 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.

HHS continues to support state-level efforts to enhance the TANF program's integrity and prevent improper payment. HHS conducts regular improper payment and fraud risk assessments of the program, with the most recent fraud risk assessment finalized in FY 2024. Management indicated that an improper payment risk assessment is scheduled for FY 2025. HHS utilizes the information from the assessments to help identify areas for risk mitigation and inform improvements in supporting States.

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 #3 – Foster Care IP and UP estimate calculation did not use complete data for FY 2024.

HHS uses a three-year process to test all states in estimating an improper payment rate for Foster Care program. Because the process is in its first year of resuming Title IV-E reviews, HHS indicated that it had not completed a full rotation of all states and generated an error rate based on six states. While an improvement from FY 2023, where no error rate was published, the FY 2024 error rate calculation is calculated using only the data of the first six states visited as the other nine states in the first-year rotation had performed Title IV-E reviews outside the reporting period of February 2024 to May 2024. As the other nine states were not included in the FY 2024 IP and UP reporting estimates based on the timing of the reviews and final reports, the selection of the states does not represent a statistically valid process. Management has indicated that as the balance of states are reviewed, they will be included in future annual estimates of improper payments. Management also 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 that a full rotation of states will be included in the estimate in FY 2025 and that all states will be included in the estimate by FY 2027.

Finding #4 – Head Start IP and UP rate percentage exceeded 10 percent for FY 2024

In accordance with PIIA, 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 2024 was 11.98 percent, which is above the compliance threshold of 10 percent. The FY 2024 Head Start improper payment rate reported (11.98 percent) increased by 6.88 percent when compared to FY 2023 (5.10 percent). This increase represents approximately $769 million in improper

payments year over year. ACF reported that the majority of the improper payments 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 #5 – Recovery audits and activities performed during FY 2024 to recoup improper payments for the Medicare Advantage program are delayed

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

Contract-level Risk Adjustment Data Validation (RADV) audits are HHS' primary action to recoup Part C overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by Medicare Advantage (MA) organizations for risk-adjusted payment. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. As reported in the FY 2023 AFR, HHS finalized CMS-4185-F2, a regulation that codifies HHS' ability to recover extrapolated RADV audit findings starting from payment year (PY) 2018 and later as part of the RADV audit methodology, 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 2024 in the event that the RADV program cannot effectively serve as HHS' sole recovery audit strategy. If using a recovery audit contractor approach is determined not to be cost-effective, HHS should document how existing programs are cost-effective when compared to the use of a recovery audit contractor.

Finding #6 – HHS has not calculated and reported an improper payment estimate for the State-based Exchanges of the APTC program

Although HHS has calculated and reported an improper payment estimate for the Federally facilitated Exchange of the Advance Premium Tax Credit (APTC) program, it has not calculated and reported an IP estimate for the State-based Exchanges. HHS stated in their AFR that they have begun the Improper Payment Pretesting and Assessment program in 2024 to prepare states for the

upcoming measurement as they continue to develop the IP measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status. Additionally, the APTC program is not reporting an IP target. The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and report a full baseline.

Recommendation:

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

Finding #7 – HHS did not effectively demonstrate improvements to the payment integrity rate for the Medicare FFS program in FY 2024.

HHS has not demonstrated improvements to the payment integrity rate for the Medicare FFS program. In FY 2021, HHS published an improper payment error rate of 6.26 percent. Since then, the reported improper payment error rate has ranged from 7.46 percent (FY 2022) to 7.66 percent (FY 2024) in published AFRs. While improvements to certain drivers of the improper payment error rate have been made each year, such as hospital outpatient claims, new root causes often driven by policy changes such as documentation required to support the medical necessity of laboratory diagnostic tests, have resulted in increased improper payments.

Recommendation:

We recommend that HHS enhance its corrective action plans that focus on the root causes of the IP percentage, such as insufficient documentation and medically unnecessary errors that make up nearly 75 percent of Medicare FFS IP. Furthermore, HHS should work with Medicare FFS providers when policy changes occur, 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 #8 – UIP Sampling and Estimation Methodology Plan did not adequately measure all key characteristics of the UIP program

In its FY 2024 AFR, HHS published an IP and UP estimate of 0.91 percent, representing $175.81 million in IP and UP. However, HHS' Sampling and Estimation Methodology Plan (S&EMP) did not adequately measure all key characteristics of the UIP program. Due to limitations in available data, management was unable to adequately perform insurance verification checks to determine if patients had existing health insurance coverage. By not appropriately measuring the patient eligibility component, the IP rate reported may be understated.

Recommendation:

As the UIP program has been discontinued with related rescissions of program funding, HHS will no longer report an IP rate in future periods. Therefore, there is no recommendation specific to this finding.

APPENDIX A: HHS MANAGEMENT COMMENTS

U.S. Department of Health and Human Services

Office of the Secretary

Washington, DC 20201

Office of the Assistant Secretary
for Financial Resources

May 16, 2025

Carla Lewis
Acting Deputy Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
Washington, DC 20201

Dear Ms. Lewis:

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 2024 (*OAS-25-17-042). 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) 2026 President's Budget will include 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.

Responses to the HHS OIG Recommendations on PIIA Compliance (OAS-25-042)

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. HHS has over 250 programs that expend more than $10 million annually and thus are subject to an improper payment risk assessment. Improper payment risk assessments are a resource-intensive process and must be balanced against resource constraints and other ongoing programmatic activities.

HHS developed the online Risk Assessment Portal to collect and analyze program improper payment risk assessments more efficiently than under previous processes. In addition, HHS implemented enhancements and continued efforts to include all programs in its three-year assessment cycles. These enhancements include: 1) extending the risk assessment period to allow for a greater number of risk assessments to be completed each year; 2) establishing a complete inventory of programs and three-year risk assessment cycle; 3) streamlining the questionnaire to improve the effectiveness and usefulness of the data; and 4) developing a modified risk assessment approach for programs with outlays between $10 million and $100 million. Leveraging these enhancements to the risk assessment process, HHS has increased annual risk assessments by 107 percent.

Recommendation #2: HHS should "continue advocating for legislative changes and work with OMB and other stakeholders to develop and implement an approach to calculate and report on [Temporary Assistance for Needy Families] TANF [improper payments] IPs going forward. 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 preclude HHS from collecting information needed to develop a TANF improper payment measurement or corrective action plans. Section 411 of the Social Security Act lists the exact data elements that HHS can collect from TANF agencies, and therefore limits the agency's ability to measure and oversee payment integrity. Under section 417 of the Social Security Act, HHS cannot collect data elements other than those listed. HHS has previously proposed new statutory authority that would allow TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions. HHS will examine options to enable TANF to collect information from states needed to calculate and report an improper payment estimate, identify root causes of improper payments, and develop and monitor corrective actions.

Recommendation #3: HHS should "continue to follow its plan to conduct Title IV-E reviews so that a full rotation of states will be included in the estimate in FY 2025 and that all States will be included in the estimate by FY 2027."

HHS Response: During the COVID-19 pandemic, HHS postponed onsite Title IV-E reviews to protect the health and safety of state and federal reviewers, ensuring that state child welfare officials remained focused on mission-critical activities. These Title IV-E reviews generate data used to calculate Foster Care's improper payment estimate. While preparing to resume the Title IV-E review process, HHS updated the Title IV-E Foster Care Eligibility Review instrument to reflect changes in Title IV-E eligibility requirements enacted through the Family First Prevention Service Act, enacted as Title VII of Bipartisan Budget Act of 2018. Prior to resuming these reviews, HHS trained regional staff, IV-E agencies, and other stakeholders on the updated Title IV-E review instrument and released training and informational materials. In FY 2024, HHS resumed conducting title IV-E reviews using the updated review guide and reported improper payment estimates, using data from the first six states reviewed between February and May 2024. Due to the length of time passed, Foster Care will establish a new baseline measurement for improper payments once all cycles of states have been measured. Title IV-E Foster Care Eligibility Review Schedules for FY 2025 and FY 2026 are published online at https://acf.gov/cb/policy-guidance/title-iv-e-foster-care-eligibility-reviews-schedule. The full cycle of reviews will be completed in FY 2027.

Recommendation #4: For Head Start, 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 recipients to follow up on repeat root causes of errors and enhance the CAPs for implementation."

HHS Response: Most Head Start improper payments resulted from missing or insufficient documentation errors, which accounted for 79 percent of all overpayments. HHS recognizes the need to address these underlying issues to improve compliance and reduce improper payments. To address the identified issues, HHS will implement a series of corrective actions focused on strengthening oversight and improving recipient compliance. Actions include issuing disallowances for insufficient documentation and enhancing monitoring through random sampling and retroactive testing. HHS will also bolster internal processes by refining the Improper Payment Review and issuing sub-regulatory guidance to clarify requirements.

Additionally, HHS will expand training and technical assistance through their technical assistance contractor and provide targeted fiscal support to recipients. To further improve oversight, the 'Healthy Grant' project will be launched to leverage technology for real-time monitoring of recipient financial performance. These efforts are designed to reduce the improper payment rate, enhance accountability, and ensure compliance with statutory requirements.

Recommendation #5: HHS should "improve its recovery audit efforts as required under PIIA (that part codified at 31 U.S.C. § 3352(i)(1)(A)) to identify and recoup overpayments for Medicare Part C. HHS should also continue to explore alternative vehicles to conduct recovery audits that will fit into the larger Medicare Part C program in FY 2024 in the event that the [Risk Adjustment Data Validation]RADV program cannot effectively serve as HHS' sole recovery audit strategy. If using a recovery audit contractor approach is determined not to be cost-effective, HHS should document how existing programs are cost-effective when compared to the use of a recovery audit contractor."

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

In January 2023, HHS finalized a rule to begin the recovery of overpayments under the RADV program. Also, in April 2024, HHS finalized a rule to clarify the RADV appeals regulation and process. As of November 2024, HHS began new RADV audits, beginning with Payment Year (PY) 2018. In January 2025, HHS began releasing RADV audit results, starting with PY 2011. In March 2025, HHS began processing appeals and plans to initiate recoveries for the PY 2011 RADV audits, while also preparing to initiate the PY 2019 RADV audit. HHS is exploring ways to accelerate the pace and effectiveness of future RADV audits. This includes focusing future audits on areas at highest risk for improper payments, applying extrapolations to PYs 2018 and later, using advanced data analytics to select audit samples, and automating to a greater degree the intake and initial screening of medical records submitted by MA organizations.

Recommendation #6: HHS should "continue to work with OMB and other relevant stakeholders to complete the IP measurement program for the State-based Exchanges to report a full 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 2024, HHS reported its third improper payment measurement for the Federally-facilitated Exchange. HHS is developing the improper payment methodology for State-based Exchanges and has launched the Improper Payment Pre-Testing and Assessment program to help states prepare for upcoming measurements. HHS will continue to update its annual AFR on the progress of measurement development and implementation.

Recommendation #7: HHS should "enhance its corrective action plans that focus on the root causes of the IP percentage, such as insufficient documentation and medically unnecessary errors that make up nearly 75 percent of Medicare [Fee-for-Service] FFS IP. Furthermore, HHS should work with Medicare FFS providers when policy changes occur, 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."

HHS Response: HHS is committed to strengthening corrective action plans to address the root causes of IPs in the Medicare FFS program, particularly those related to insufficient documentation and medically unnecessary services.

In FY 2024, the Medicare FFS improper payment rate was not statistically different from the FY 2023 rate, and estimated monetary loss decreased by $310.86 million year over year. Additionally, the FY 2024 Medicare FFS reduction target was met, as it fell within the 95 percent confidence interval for the reported improper payment rate. This marks the eighth consecutive year that the Medicare FFS improper payment rate has remained below the 10 percent compliance threshold.

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, while also expanding provider outreach and education efforts following policy changes.

Recommendation #8: "As the [Uninsured Program] UIP program has been discontinued with related recissions of program funding, HHS will no longer report an IP rate in future periods. Therefore, there is no recommendation specific to this finding."

HHS Response: With the discontinuation of UIP and the related rescission of program funding, HHS will no longer report an IP rate for UIP in future reporting periods.

Conclusion

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

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 2025 PaymentAccuracy.gov data call. For programs out of compliance for three consecutive years, HHS will submit a separate report to Congress describing proposals to help the programs achieve compliance with PIIA.

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,

Caitrin Shuy
Principal Deputy Assistant Secretary for Financial Resources

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