FY 2020 OMB Supplemental Data Call

Health and Human Services (HHS)

Contents

Agency-Wide Responses

Question 2: Detecting and Recovering Improper Payments (PIIA Section: 3352(e), 3352(e) (1))

Please describe the steps the agency has taken to detect and recover improper payments.

ANSWER:

Indicate root cause	Indicate mitigation strategy/corrective action(s) taken	Provide any additional detail (optional free text)	Select the actual completion date for action(s) taken
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)		Other
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)		Other
13. Insufficient Documentation to Determine	3-Training (how to complete contracts)		Other
8. Failure to Verify: Other Eligibility Data (explain)	Other (free text)		Other

Question 2 Free Text: Detecting and Recovering Improper Payments (PIIA Section: 3352(e), 3352(e) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The Children's Bureau (CB) periodically and systematically reviews state-level compliance in meeting federal eligibility requirements for federal financial participation in the Title IV-E Foster Care Program and validates the accuracy of a state's claim for reimbursements of foster care maintenance payments. The Title IV-E Foster Care Eligibility Review protocol recovers Title IV-E funds claimed by states for ineligible cases and, in conjunction with required Program Improvement Plans (PIPs), helps change the behavior of states not meeting review compliance so that subsequent reviews will result in lower improper payment rates.

OCC provides periodic training to states through a Program Integrity Webinar series. Topics include fraud identification, detection, and prevention.

HHS corrective actions include providing additional guidance and oversight to states' enrollment and eligibility processes for providers and beneficiaries. HHS corrective actions also include additional guidance and technical assistance, as well as greater state oversight. For more information, see #10.

HHS has taken several actions to detect and recover improper payments:1. During FY 2020, Medicare Administrative Contractors (MACs) continued performing medical review following the Targeted Probe and Educated (TPE) process by conducting up to three rounds of claims review of 20 to 40 claims per

round, with one-on-one education provided at the end of each round.2. In FY 2020, the Supplemental Medicare Review Contractor (SMRC) performed medical reviews on a post-payment basis for various types of claims. The SMRC shares the results of its medical review with the MACs for claim adjustments upon the review's completion.3. During FY 2020, Medicare FFS Recovery Audit Contractors (RACs) continued to identify and collect improper payments related to outpatient claims for several factors, including insufficient documentation.4. The review Choice Demonstration for Home Health Services gives Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas an initial choice of three options (i.e., pre-claim review, post-payment review, or minimal post-payment review with a 25 percent payment reduction for all home health services).

RADV Audits are HHS's primary corrective action to recoup overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment.

HHS continued formal outreach to plan sponsors for invalid or incomplete documentation. HHS distributed Final Findings Reports to all Part D sponsors participating in the prescription drug event (PDE) review process. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.

Question 3: Recovery Audits (PIIA Section: 3352)

Please describe the steps the agency has taken to recover improper payments identified in recovery audits. Please note there is a 3000 character limit.

ANSWER: Neither the Foster or Child Care programs conduct Recovery Audits as described in PIIA, Section 3352. Overpayments are recaptured outside of payment recovery audits through payment disallowances via the ACF error rate measurements and eligibility reviews.

States assure that programs meet statutory requirements to establish and implement State Medicaid RAC programs. However, federal law authorizes states to request exemption from the requirements (several states operate under granted exemption).

Medicare FFS RAC program is required in all 50 states and a variety of claim types are reviewed. In FY20, approximately $266 million overpayments were identified and $220 million were recovered. The majority of collections were from outpatient claim reviews. HHS released quarterly Provider Compliance Newsletters with information on FFS RAC findings, which HHS used to implement local and/or national system edits to prevent improper payments.

RADV audits payments to corroboate diagnoses submitted with medical records. RADV program currently operates with the support of contractors. RACs have found Part C to be untenable due to payment structure, narrow scope of payment error, and unlimited appeal timeframe. The FY21 budget proposed to remove the requirement to expand the RAC program to Part C and require plan sponsors to report Part C fraud and abuse incidents and corrective actions. The proposal creates programmatic and administrative efficiencies while strengthening fraud and abuse reporting as these functions are performed through other program integrity mechanisms.

The FY21 budget included the same proposal to remove the requirement to expand the RAC program to Part D. The Part D RAC contract has ended. There were no new improper payments identified by the Part D RAC in FY20. HHS recouped $1.17 million in overpayments identified in previous years. PPI MEDIC is a robust program to identify improper payments, similar to Part D RAC. After PPI MEDIC identifies

improper payments, plan sponsors are asked to delete PDE records related to potential overpayments. HHS validates that plan sponsors delete PDEs and do not resubmit for payment. In FY20, the NBI-MEDIC continued audits that identified potential improper payments and conducted education and outreach for Part D plan sponsors.

Question 4: Excluded Programs (PIIA Section: 3352(e) (7))

Please list any programs the agency excluded from review under its payment recapture audit program because a payment recovery audit program was determined to not be cost-effective and provide a summary of the justification used to make that determination. Please note there is a 3000 character limit.

ANSWER: Cost benefit analysis to determine which ones should formerly be excluded has not been performed for programs.

Question 5: Financial and Administrative Controls (PIIA Section: 3357(d))

Please describe your agency's progress:

- *Implementing the financial and administrative controls established by OMB in OMB Circular A-123 to identify and assess fraud risks and design and implement control activities in order to prevent, detect, and respond to fraud, including improper payments; the fraud risk principle in the Standards for Internal Control in the Federal Government published by the Government Accountability Office (commonly known as the "Green Book"); and Office of Management and Budget Circular A-123, with respect to the leading practices for managing fraud risk;*
- *Identifying risk and vulnerabilities to fraud, and*
- *Establishing strategies, procedures, and other steps to curb fraud.*

ANSWER:

Implementation of OMB Circular A-123	Implementation of GAO Green Book	Identifying Risk and Vulnerabilities	Establishing Strategies, Procedures and Other steps
0 – Have not Started	0 – Have not Started	0 – Have not Started	0 – Have not Started
1 – In Beginning Stages	1 – In Beginning Stages	1 – In Beginning Stages	1 – In Beginning Stages
2 – Established	2 – Established	2 – Established	2 – Established

Question 5 Free Text: Financial and Administrative Controls (PIIA Section: 3357(d))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: ACF has not yet started the formal process of developing and implementing a fraud risk assessment framework to assess fraud risk for the Foster Care program. However, the Foster Care program does have effective control activities to assist in the detection or prevention of fraud within the program.

ACF is in the process of developing and implementing a fraud risk assessment framework which will be used to assess fraud risk for the CCDF program and direct efforts towards implementation of control activities to assist in the detection or prevention of fraud within the program.

HHS follows guidance contained in OMB Circular A-123, Appendix C, when determining how to group programs or activities for risk assessments, if applicable. In FY 2020, HHS revamped its risk assessment methodology and platform. HHS revised the improper payment risk assessment questionnaire and scoring

process to generate a more effective, efficient, and systematic way of determining susceptibility to improper payments. Drawing from Appendix C guidance and risk assessments developed by other federal agencies, HHS developed a robust set of questions to assess programs for a broader range of risk factors, while also developing a new methodology for quantifying these risk factors. HHS also created an automated platform for collecting risk assessments, allowing for more efficient data collection and risk factor calculation. HHS continues to review Government Accountability Office (GAO) reports and resources, capture best practices from other agencies, and solicit feedback from HHS's Operating Divisions (OpDivs) to further improve its processes. HHS will continue to develop policies, procedures, and supporting tools throughout 2021.

HHS also continues to take steps, at both the Department and OpDiv/StaffDiv levels, to implement fraud requirements under PIIA, and to adopt leading practices in fraud risk management, as presented in GAO's Fraud Risk Management Framework and Selected Leading Practices published in July 2015. Select fraud risk management activities at the Department include: • Drafting a Fraud Risk Management Implementation Plan that outlines actions taken or planned in order to enhance financial and administrative controls relating to fraud; • Conducting internal control assessments to include the consideration of fraud and financial management risks, in accordance with the law and OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, as well as designing control activities to mitigate these risks; and • Beginning in FY 2018, HHS's improper payment risk assessments included consideration of fraud risk in individual programs or payment activities, and HHS is analyzing the FY 2018, FY 2019 data, and FY 2020 data.

Foster Care

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
promptly detect and recover improper payments that are made
prevent improper payments from being made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Performance plans for agency managers and appropriate program office staff address efforts to reduced improper payments and meet obligations under the PIIA.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
N/A	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Every corrective action plan does not have an ROI amount to determine the “cost prohibitive” calculation. Analysis has not been performed on new data element.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
NO

Question 8 Free Text: Tolerable Rate

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: While the Foster Care program's error rate for FY 2020 declined, the program is committed to continuous quality improvement efforts that will continue to prevent improper payments.

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
YES	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The program has the needed staffing, resources, internal controls and systems needed to continue to reduce improper payments.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	FY2020 Q2	

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The Children's Bureau in HHS periodically and systematically reviews state-level compliance in meeting federal eligibility requirements for federal financial participation in the Title IV-E Foster Care Program and validates the accuracy of a state's claim for reimbursements of foster care maintenance payments. The Title IV-E Foster Care Eligibility Review protocol recovers Title IV-E funds claimed by states for ineligible cases and, in conjunction with required Program Improvement Plans (PIPs), helps change the behavior of states not meeting review compliance so that subsequent reviews will result in lower improper payment rates. In FY 2020, HHS trained 6 six states reviewed on the federal eligibility and payment requirements and provided technical assistance prior to, during, and after the Foster Care Eligibility IV-E Reviews.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	FY2021	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The Children's Bureau in HHS will continue to conduct title IV-E Foster Care Eligibility Reviews to assess state-level compliance in meeting federal eligibility requirements for federal financial participation in the Title IV-E Foster Care Program, recover improperly claimed title IV-E funds and require program improvements by state agencies. In FY 2021, the Children's Bureau will provide additional guidance and instructional tools to further deepen federal and state staff knowledge on the federal requirements for state implementation and maintenance of required policies and practices, including requirements changed by the Family First Prevention Services Act.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets
Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Foster Care. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Foster Care was deemed compliant as part of the most recent IG compliance review. Thus, zero consecutive years. The most recent IG compliance review concluded that Foster Care eliminated its noncompliance by publishing a reduction target and meeting the prior year's target for the first time in 3 years. For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b)(5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Foster Care does not use DNP.

Child Care

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
meeting applicable improper payments reduction targets
prevent improper payments from being made
promptly detect and recover improper payments that are made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 1 - CCDF did not report a 2020 improper payment target. The Child Care and Development Block Grant Act of 2014 (CCDBG) and CCDF regulations (2016) require states to create and put in place new policies and procedures. For this reason, a full baseline has yet to be established. Rolling implementation of the new requirements will continue to affect the improper payment rate in the FY 2021 measurement, making it challenging to determine a target rate. HHS anticipates that the improper payment rate may continue to rise as states work to meet the new requirements. CCDF state grantees are implementing large-scale changes to their child care programs. Further, as a result of uncertainties due to the COVID-19 PHE, states' abilities to complete planned actions is impacted.

2 - CCDF is a state administered block grant and states have flexibility regarding implementation of CCDF, including how they implement internal controls to ensure integrity and accountability and prevent improper payments. OCC continues to provide training and technical assistance to states to support their efforts to prevent improper payments from being made. In addition, in FY 2020, states reported the following corrective actions to prevent improper payments: providing training and technical assistance to eligibility staff and local agencies; ongoing case reviews or audits; monitoring of local eligibility agencies; updating policies and procedures; and updating or implementing information systems.

3 - CCDF is a state administered block grant and states have flexibility regarding implementation of CCDF, including whether they recover overpayments not due to fraud and the amount of overpayment recovery. (CFR 98.68)

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
N/A	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Every corrective action plan does not have an ROI amount to determine the “cost prohibitive” calculation. Analysis has not been performed on new data element.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 8 Free Text: Tolerable Rate

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Analysis has not been performed on new data element.

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
N/A	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: CCDF is a state administered block grant and states have flexibility regarding implementation of CCDF including internal controls, human capital, information systems, and management of resources. While OCC provides training and technical assistance to states to strengthen internal controls and program integrity, OCC does not require each state to report specifically on each of the data topics listed above. In FY 2020, some states reported challenges with information systems and human capital through narrative report responses.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
13. Insufficient Documentation to Determine	3-Training (how to complete contracts)	FY2020 Q3	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	FY2020 Q3	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	FY2020 Q3	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: OCC conducted joint reviews of methodology implementation with all states reporting in FY2020. Through the reviews, OCC helped states identify areas where policies and procedures can be modified and provided training, technical assistance, additional support and oversight to identify areas for correction.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
13. Insufficient Documentation to Determine	3-Training (how to complete contracts)	FY2021	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	FY2021	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	FY2021	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: OCC will conduct joint reviews of methodology implementation with all states reporting in FY2021. Through the reviews, OCC will help states identify areas where policies and procedures can be modified and will provide training, technical assistance, additional support and oversight to identify areas for correction.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets
Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Child Care. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Child Care was deemed compliant as part of the most recent IG compliance review. Thus, zero consecutive years. For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Child Care does not use DNP.

CHIP

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
prevent improper payments from being made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS addresses improper payments in CHIP through various corrective actions. While HHS takes broad steps to reduce CHIP improper payments at the federal level, CHIP is a federal-state partnership, and states are equally responsible for developing and implementing state-specific corrective action plans at the state level. HHS works closely with all states through enhanced technical assistance (including liaisons that are assigned to each state to assist states with identifying and overcoming barriers to corrective action implementation) and guidance to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the corrective action plan's effectiveness, with assistance and oversight from HHS. When developing corrective action plans, states focus on the major causes of improper payments. HHS works with states to develop corrective action plans to address these causes.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
NO	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS does not believe reducing the CHIP improper payment rate is cost prohibitive.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
YES	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: One area driving the FY 2020 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with 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 indication that the eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. The CHIP improper payment rate was also driven by claims where the beneficiary was ineligible for CHIP, but was eligible for Medicaid, mostly related to beneficiary income, third party insurance, or household composition/tax filer status. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Additionally, since FY 2014, improper payments cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately enrolled and screened by the state or a provider

did not have the required NPI on the claim have also driven the CHIP rate (see Section 11.4 for further description of HHS's review of these errors). HHS has completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, HHS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
10. Administrative or Process Errors Made by: State or Local Agency	4-Change Process (instructions, checklist, policy)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	6-Audit (improve IC)	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	5-Cross Enterprise Sharing	Other	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 1. Enhanced State PERM Corrective Action Plan Process: In FY 2020, HHS implemented a more robust process that provides enhanced technical assistance and guidance to states. HHS worked with the states to coordinate state development of corrective action plans to address each error and deficiency

identified during the PERM cycle. HHS monitored and followed up with all states on their progress in the implementation of the corrective actions and continued using lessons learned from this process to inform areas to evaluate for future guidance and education.2. Medicaid Eligibility Quality Control (MEQC) Program: Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits and reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. In FY 2020, HHS worked with the Cycle 1 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission; the Cycle 2 states to restart their MEQC reviews; and the Cycle 3 states to submit the required MEQC pilot planning documents. Refer to HHS FY 2020 AFR for more information on the MEQC Program.3. Conduct Audits of State Beneficiary Eligibility Determinations: As part of HHS's CMIP for FYs 2019-2023, in FY 2020, HHS conducted audits of beneficiary eligibility determinations in states with eligibility errors in previous OIG and State Auditor reports. These audits included assessments of state eligibility policies, processes, and systems. Future audits may focus on states that may be at higher risk of errors, such as those with higher eligibility improper payment rates under the PERM program, eligibility errors based on GAO or OIG reports, issues identified by states through the MEQC program, and issues identified through HHS's various corrective action plan oversight processes.4. Education: In FY 2020, HHS launched a newly designed Medicaid Integrity Program web page for state officials, providers, and beneficiaries that include a collection of resources, including toolkits for providers, fact sheets for state Medicaid agencies, infographics, and more. These resources help educate providers, beneficiaries, and other stakeholders in promoting promising practices and raising awareness of Medicaid fraud, waste, and abuse. Lastly, HHS oversees multiple state technical assistance group (TAG) calls that focus on preventing fraud, waste, abuse, and other improper payments. TAG calls offer a forum for sharing issues, solutions, resources, and experiences among the states to develop promising practices, provide technical assistance, and advise on policies, procedures, and program development.See additional information as part of the Corrective Actions to be Taken response for the remaining corrective actions.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
10. Administrative or Process Errors Made by: State or Local Agency	4-Change Process (instructions, checklist, policy)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	6-Audit (improve IC)	Other (select date)	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other	3-Training (how to complete contracts)	Other (select date)	

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
organization administering Federal dollars)			
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other (select date)	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	5-Cross Enterprise Sharing	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other (select date)	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 5. Enhanced Assistance on State Medicaid Provider Screening and Enrollment: HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment. In addition, HHS updated the Medicaid Provider Enrollment Compendium in July 2018 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements, and is planning further updates in FY 2021. HHS also continued state site visits during FY 2020 to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities. HHS internally provided screening and enrollment assistance through visits to CO, OK, and WY in FY 2020.6. State Medicaid Provider Screening and Enrollment Data and Tools: HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements. Specifically, HHS shares the Medicare provider enrollment record via the PECOS administrative interface and via data extracts from the PECOS system and OIG exclusion data. Since May 2016, HHS has offered a data compare service that allows a state to rely on Medicare's screening in lieu of conducting a state screening, particularly during revalidation. This allows states to remove dual-enrolled providers from the revalidation workload. Using the data compare service, a state provides a Medicaid provider enrollment data extract to HHS, and then HHS returns information indicating which of these providers have undergone a Medicare screening on which the state can rely (thus reducing the state's work load). In FY 2020, HHS screened these two states' Medicaid-only providers and produced a report of the providers found with licensure issues, criminal activity, and Do Not Pay activity. IA and MO are currently evaluating the screening results. HHS evaluated pilot impact and results and expanded the service to additional states. Looking forward, OK and NV have agreed to participate in the pilot and HHS continues to contact other states to gauge their interest.7. Medicaid Integrity Institute (MII): HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the MII. In FY 2020, HHS continued a robust training program, which included both residential and virtual training opportunities. For example, FY 2020

offerings included coding courses, investigative skills courses, and a session to discuss the future of the MII in an ever-changing program integrity landscape.See additional information as part of the Corrective Actions Taken response for the first set of corrective actions. These corrective actions are ongoing and HHS will develop new or modify existing corrective actions, as needed.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Non-Compliant	6. Report a gross Improper Payment Rate of Less than 10%
Compliant	5. Publish and Meet Annual Reduction Targets
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	3. Publish Improper Payment Estimates

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for CHIP. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate how many consecutive years this program was deemed non-compliant as of the most recent IG compliance review (regardless of which of the six (6) criteria were determined non-compliant).

ANSWER:

Indicate consecutive years
5

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Please indicate whether the program uses the DNP (yes/no) and whether the Do Not Pay Initiative has reduced/prevented improper payments (yes/no). Additionally, please provide the frequency of corrections (week/month range) or identification of incorrect information (range of false hits?).

ANSWER:

Does the program use the Do Not Pay Initiative (DNP) (yes/no)	Has the DNP reduced/prevented improper payments (yes/no)	How frequently are corrections made?	How frequently is incorrect information identified?
YES	YES	Daily	Daily

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: CHIP uses DNP but the frequency of making corrections and frequency of identifying incorrect information is N/A.

Medicaid

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities

(where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
prevent improper payments from being made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d)(5)(A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS addresses improper payments in Medicaid through various corrective actions. While HHS takes broad steps to reduce Medicaid improper payments at the federal level, the Medicaid program is a federal-state partnership, and states are equally responsible for addressing improper payments at the state level by developing and implementing state-specific corrective action plans. HHS works closely with all states through enhanced technical assistance (including liaisons that are assigned to each state to assist with identifying and overcoming barriers to corrective action implementation) and guidance to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the corrective action plan's effectiveness, with assistance and oversight from HHS. When developing corrective action plans, states focus on the major causes of improper payments.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d)(2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
NO	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d)(2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS does not believe reducing the Medicaid improper payment rate is cost prohibitive.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
NO	1. Internal Controls
NO	4. Resources

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: One area driving the FY 2020 Medicaid improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the Patient Protection and Affordable Care Act (PPACA) requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, 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 the eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Additionally, since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Most improper payments cited on claims were for a newly enrolled provider that had not been appropriately screened by the state; a provider without the required NPI on the claim; or a provider that was not enrolled.

While the screening errors described above are for newly enrolled providers, states also must revalidate the enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2020, HHS measured the third cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. HHS completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, HHS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
10. Administrative or Process Errors Made by: State or Local Agency	4-Change Process (instructions, checklist, policy)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	6-Audit (improve IC)	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	5-Cross Enterprise Sharing	Other	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 1. Enhanced State PERM Corrective Action Plan Process: In FY 2020, HHS implemented a more robust process that provides enhanced technical assistance and guidance to states. HHS worked with the states to coordinate state development of corrective action plans to address each error and deficiency identified during the PERM cycle. HHS monitored and followed up with all states on their progress in the implementation of the corrective actions and continued using lessons learned from this process to inform areas to evaluate for future guidance and education.2. Medicaid Eligibility Quality Control (MEQC) Program: Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits and reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. In FY

2020, HHS worked with the Cycle 1 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission; the Cycle 2 states to restart their MEQC reviews; and the Cycle 3 states to submit the required MEQC pilot planning documents. Refer to HHS FY 2020 AFR for more information on the MEQC Program.3. Conduct Audits of State Beneficiary Eligibility Determinations: As part of HHS's CMIP for FYs 2019-2023, in FY 2020, HHS conducted audits of beneficiary eligibility determinations in states with eligibility errors in previous OIG and State Auditor reports. These audits included assessments of state eligibility policies, processes, and systems. Future audits may focus on states that may be at higher risk of errors, such as those with higher eligibility improper payment rates under the PERM program, eligibility errors based on GAO or OIG reports, issues identified by states through the MEQC program, and issues identified through HHS's various corrective action plan oversight processes.4. Education: In FY 2020, HHS launched a newly designed Medicaid Integrity Program web page for state officials, providers, and beneficiaries that include a collection of resources, including toolkits for providers, fact sheets for state Medicaid agencies, infographics, and more. These resources help educate providers, beneficiaries, and other stakeholders in promoting promising practices and raising awareness of Medicaid fraud, waste, and abuse. Lastly, HHS oversees multiple state technical assistance group (TAG) calls that focus on preventing fraud, waste, abuse, and other improper payments. TAG calls offer a forum for sharing issues, solutions, resources, and experiences among the states to develop promising practices, provide technical assistance, and advise on policies, procedures, and program development.See additional information as part of the Corrective Actions to be Taken response for the remaining corrective actions.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
10. Administrative or Process Errors Made by: State or Local Agency	4-Change Process (instructions, checklist, policy)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	Other (free text)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	6-Audit (improve IC)	Other (select date)	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other (select date)	

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	5-Cross Enterprise Sharing	Other (select date)	
10. Administrative or Process Errors Made by: State or Local Agency	3-Training (how to complete contracts)	Other (select date)	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 5. Enhanced Assistance on State Medicaid Provider Screening and Enrollment: HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment. In addition, HHS updated the Medicaid Provider Enrollment Compendium in July 2018 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements, and is planning further updates in FY 2021. HHS also continued state site visits during FY 2020 to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities. HHS internally provided screening and enrollment assistance through visits to CO, OK, and WY in FY 2020.6. State Medicaid Provider Screening and Enrollment Data and Tools: HHS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements. Specifically, HHS shares the Medicare provider enrollment record via the PECOS administrative interface and via data extracts from the PECOS system and OIG exclusion data. Since May 2016, HHS has offered a data compare service that allows a state to rely on Medicare's screening in lieu of conducting a state screening, particularly during revalidation. This allows states to remove dual-enrolled providers from the revalidation workload. Using the data compare service, a state provides a Medicaid provider enrollment data extract to HHS, and then HHS returns information indicating which of these providers have undergone a Medicare screening on which the state can rely (thus reducing the state's work load). In FY 2020, HHS screened these two states' Medicaid-only providers and produced a report of the providers found with licensure issues, criminal activity, and Do Not Pay activity. IA and MO are currently evaluating the screening results. HHS evaluated pilot impact and results and expanded the service to additional states. Looking forward, OK and NV have agreed to participate in the pilot and HHS continues to contact other states to gauge their interest.7. Medicaid Integrity Institute (MII): HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the MII. In FY 2020, HHS continued a robust training program, which included both residential and virtual training opportunities. For example, FY 2020 offerings included coding courses, investigative skills courses, and a session to discuss the future of the MII in an ever-changing program integrity landscape.See additional information as part of the Corrective Actions Taken response for the first set of corrective actions. These corrective actions are ongoing and HHS will develop new or modify existing corrective actions, as needed.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets
Non-Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Medicaid. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate how many consecutive years this program was deemed non-compliant as of the most recent IG compliance review (regardless of which of the six (6) criteria were determined non-compliant).

ANSWER:

Indicate consecutive years
4

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b)(5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Please indicate whether the program uses the DNP (yes/no) and whether the Do Not Pay Initiative has reduced/prevented improper payments (yes/no). Additionally, please provide the frequency of corrections (week/month range) or identification of incorrect information (range of false hits?).

ANSWER:

Does the program use the Do Not Pay Initiative (DNP) (yes/no)	Has the DNP reduced/prevented improper payments (yes/no)	How frequently are corrections made?	How frequently is incorrect information identified?
YES	YES	Daily	Daily

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicaid uses DNP but the frequency of making corrections and frequency of identifying incorrect information is N/A.

Medicare FFS

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
meeting applicable improper payments reduction targets
prevent improper payments from being made
promptly detect and recover improper payments that are made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d)(5)(A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS developed multiple preventive and detective measures for specific service areas with high improper payment rates, such as hospital outpatient, IRF, SNF, and home health claims. HHS believes implementing targeted corrective actions will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d)(2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
NO	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d)(2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS does not believe reducing the Medicare FFS improper payment would be cost prohibitive.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d)(2)(A) through (C)3352(d)(3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
YES	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS's aggressive corrective actions have led to consistent reductions in the Medicare FFS improper payment rate since 2014. This reduction in improper payments has been achieved as a result of HHS commitment and steadfast efforts to identify the root causes of improper payments, implement action plans to reduce and prevent improper payments, and extend our capacity to address emerging areas of risk through workgroups and interagency collaborations.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
12. Medical Necessity	4-Change Process (instructions, checklist, policy)	Other	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other	
13. Insufficient Documentation to Determine	3-Training (how to complete contracts)	Other	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other	
14. Other	4-Change Process (instructions, checklist, policy)	Other	
14. Other	4-Change Process (instructions, checklist, policy)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 1. Removal of the Post-Admission Physician Evaluation: In the FY 2021 IRF Prospective Payment System (CMS-1729-F) final rule, HHS finalized the removal of the post-admission physician evaluation that was required to be completed within the first 24 hours of the IRF patient's admission to the IRF by the rehabilitation physician.2. Outpatient Prior Authorization: In FY 2020, HHS finalized a regulation through the Calendar Year 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC) establishing a nationwide prior authorization process and requirements for certain hospital outpatient services. This process serves as a method for controlling unnecessary increases in the volume of these services. In FY 2020, HHS provisionally affirmed (approved) 20,178 services through this process.3. Review Choice Demonstration for Home Health Services: The review Choice Demonstration for Home Health Services gives Jurisdiction M (Palmetto) providers operating in IL, OH, NC, FL, and TX an initial choice of three options (i.e., pre-claim review, post-payment review, or minimal post-payment review with a 25 percent payment reduction for all home health services). A provider's compliance with Medicare billing, coding, and coverage requirements would determine the provider's next steps under the demonstration. HHS received OMB Paperwork Reduction Act approval on February 26, 2019. The demonstration began for IL providers on June 1, 2019, for OH providers on September 30, 2019, and for TX providers on March 2, 2020. The demonstration began voluntarily for NC and FL providers on August 31, 2020. In FY 2020, HHS provisionally affirmed (or approved) 786,586 billing periods for home health services.4. DMEPOS Supplier Education: In FY 2020, HHS educated providers and DMEPOS suppliers through Medicare Learning Network (MLN) articles called Provider Compliance Tips. HHS posted 20 articles, each on a different DMEPOS related service area, to the MLN website in FY 2020. These Provider Compliance Tips are added to and updated regularly as a result of improper payment findings, as well as regulatory and other policy changes, including the Calendar Year 2020 ESRD and DMEPOS Final Rule (CMS-1713-F).See additional information as part of the Corrective Actions to be Taken response for the remaining corrective actions.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
12. Medical Necessity	4-Change Process (instructions, checklist, policy)	Other (select date)	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other (select date)	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other (select date)	

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
13. Insufficient Documentation to Determine	3-Training (how to complete contracts)	Other (select date)	
13. Insufficient Documentation to Determine	4-Change Process (instructions, checklist, policy)	Other (select date)	
14. Other	4-Change Process (instructions, checklist, policy)	Other (select date)	
14. Other	4-Change Process (instructions, checklist, policy)	Other (select date)	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: 5. Elimination of Home Health Requests for Anticipated Payment: As part of the Calendar Year 2020 Payment and Policy Changes for Home Health Agencies and Calendar Year 2021 Home Infusion Therapy Benefit (CMS-1711-FC), HHS issued a final rule with comment period that finalized a policy to decrease the upfront, split-percentage payment for 30-day home health periods of care beginning on January 1, 2020 to 20 percent for existing HHAs, and to lower the split-percentage payments to zero for all 30-day periods of care beginning on or after January 1, 2021.6. DMEPOS Prior Authorization: In FY 2020, HHS provisionally affirmed (or approved) over 53,130 DMEPOS items through the prior authorization process. On October 21, 2019, HHS expanded nationwide a requirement for prior authorization expanded nationwide for five Pressure Reducing Support Surface codes. HHS initially required prior authorization for these codes beginning July 22, 2019 in CA, IN, NJ, and NC. On February 11, 2020, HHS published a Federal Register Notice requiring prior authorization for six Lower Limb Prosthetic codes effective May 11, 2020 in CA, MI, PA, and TX, and nationwide effective October 8, 2020. Due to COVID-19, HHS delayed implementation of these additional codes until September 1, 2020 for CA, MI, PA, and TX, and nationwide effective December 1, 2020.7. Ambulance Transport Prior Authorization: In FY 2020, HHS continued a prior authorization model for repetitive scheduled non-emergent ambulance transport in NJ, PA, SC, NC, VA, WV, MD, DC, and DE consistent with Section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The model continues to reduce Medicare spending while maintaining overall levels of quality of and access to care. Based on expenditure data, spending decreased in the initial model states from an average of $18.9 million to an average of $6.0 million per month. Based on data from the additional MACRA states, spending decreased from an average of $5.7 million to an average of $2.7 million per month. On September 23, 2020, HHS announced that it will expand the model nationwide, as the model has met all expansion criteria under section 1834(l)16 of the Act (as added by section 515(b) of MACRA.See additional information as part of the Corrective Actions Taken response for the first set of corrective actions. These corrective actions are ongoing and HHS will develop new or modify existing corrective actions, as needed.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets
Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Medicare FFS. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare FFS was deemed compliant as part of the most recent IG compliance review. Thus, zero consecutive years. For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Please indicate whether the program uses the DNP (yes/no) and whether the Do Not Pay Initiative has reduced/prevented improper payments (yes/no). Additionally, please provide the frequency of corrections (week/month range) or identification of incorrect information (range of false hits?).

ANSWER:

Does the program use the Do Not Pay Initiative (DNP) (yes/no)	Has the DNP reduced/prevented improper payments (yes/no)	How frequently are corrections made?	How frequently is incorrect information identified?
YES	YES	Daily	Daily

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare FFS uses DNP but the frequency of making corrections and frequency of identifying incorrect information is N/A. CMS checks certain payments against PIIA listed databases, outside of the DNP portal. In FY 2020, CMS screened 1.1 billion payments against PIIA-listed databases, representing $394.1 billion in payments. Through these checks, CMS stopped 378,135 payments, representing a savings of $2.0 billion.

Medicare Part C

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
promptly detect and recover improper payments that are made
prevent improper payments from being made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS's corrective actions center upon detecting and recovering improper payments through the use Contract-level Risk Adjustment Data Validation (RADV) Audits to recoup overpayments. HHS also trains plan sponsors on program integrity initiatives, investigations, data analyses, and potential fraud schemes.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
NO	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS does not believe that reducing the Medicare Part C improper payment rate would be cost prohibitive.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
YES	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The Medicare Part C gross improper payment estimate for FY 2020 is 6.78 percent or $16.27 billion. This is a decrease from the prior year's estimate of 7.87 percent.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
13. Insufficient Documentation to Determine	6-Audit (improve IC)	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Both of the corrective action plans below tie to insufficient documentation and administrative or process errors: 1. Contract-Level Audits: Contract-level Risk Adjustment Data Validation (RADV) audits are HHS's primary corrective action to recoup overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. 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 submit valid and accurate diagnosis information. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. In September 2019, HHS launched the payment year 2015 RADV audit. On January 9, 2020 HHS held a contract-level RADV training session for the 2015 payment year audit that included an overview of RADV enrollee data, guidance on preparing and submitting medical records and demonstration of the Central Data Abstraction Tool (CDAT). Due to the COVID-19 PHE, HHS suspended the 2015 audit in March 2020 and resumed it in September 2020. On September 10, 2020, HHS provided a refresher training regarding the payment year 2015 RADV audit that also included updates on enrollee data and how to access systems to submit medical records. The payment year 2014 RADV audit medical record submission phase is complete and the audit is expected to conclude in FY 2021. HHS expects to start contract-level RADV audits for payment years 2016 and 2017 by fall 2021. 2. Training: HHS conducted training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analyses, and potential fraud schemes. In FY 2020, HHS conducted two Medicare Advantage Organization and Prescription Drug Plan fraud, waste, and abuse training webinars in January 2020 and July 2020; a Fraud, Waste, and Abuse Training in April 2020; and two Opioid Education Missions in October 2019 and March 2020. The missions included multi-disciplinary teams of experts and decision makers from HHS and its partners, and allowed them to undertake collaborative efforts to protect the Medicare Part C and D programs.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
13. Insufficient Documentation to Determine	6-Audit (improve IC)	Other (select date)	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other (select date)	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The corrective actions included in the additional information as part of the Corrective Actions Taken response are ongoing and apply to Corrective Actions to be Taken. HHS will continue these activities and will develop new or modify existing corrective actions, as needed.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets
Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Medicare Part C. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate how many consecutive years this program was deemed non-compliant as of the most recent IG compliance review (regardless of which of the six (6) criteria were determined non-compliant).

ANSWER:

Indicate consecutive years
5

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare Part C was found non-compliant for conducting recovery audits as part of the most recent IG compliance review. For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare Part C does not use DNP.

Medicare Part D

Question 1: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Please describe the steps the program has taken and plans to take (including timeline) to ensure that agency managers (including the agency head), accountable officers, program official/owner, and States and localities (where appropriate) are held accountable for reducing and recapturing IPs through annual performance appraisal criteria for each of the following:

- *Meeting applicable improper payments reduction targets;*
- *Preventing improper payments from being made; and*
- *Promptly detecting and recovering improper payments that are made.*

ANSWER:

Performance Appraisal Criteria
prevent improper payments from being made

Question 1 Free Text: Annual Performance Appraisal Criteria (PIIA Section: 3352(d) (5) (A) and (B))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS addresses improper payments in Medicare Part D through various corrective actions, such as outreach and training, to prevent improper payments from being made.

Question 7: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Please indicate whether lowering the improper payment rate beyond the current level would be cost prohibitive because applying additional mitigation strategies or corrective actions for improper payment prevention would cost more to implement than the amount that would be saved.

ANSWER:

Cost Prohibitive (Yes/No)	Indicate Root Cause if known	Indicate which corrective action
NO	14. Other	Other (free text)

Question 7 Free Text: Improper Payment Rate Reduction (PIIA Section: 3352(d) (2))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: HHS does not believe that reducing the Medicare Part D improper payment rate would be cost prohibitive.

Question 8: Tolerable Rate

Do you believe the program has reached a tolerable rate of improper payments?

ANSWER:

Indicate Yes or No
N/A

Question 9: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Does the program have the internal controls, human capital, and information systems and other infrastructure it needs to reduce IPs to the levels the agency has targeted? Please indicate additional program needs to reduce IPs to the levels the program has targeted.

ANSWER:

Indicate 'yes' or 'no'	Indicate program needs
YES	5. Other: Explain

Question 9 Free Text: Internal Controls, Human Capital, Information Systems and other Infrastructure and Program Needs (PIIA Section: 3352(d) (2) (A) through (C)3352(d) (3))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The Part D rate increase is likely due to year-over-year variability. As the rate is already low, any variation can cause shifts that are relatively large.

Question 10: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program HAS TAKEN to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate corrective action(s) taken	Select the actual completion date for action(s) taken	If other completion date, please indicate
13. Insufficient Documentation to Determine	5-Cross Enterprise Sharing	Other	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other	

Question 10 Free Text: Corrective Actions Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Both of the corrective action plans below tie to insufficient documentation and administrative or process errors.Outreach: HHS continued formal outreach to plan sponsors for invalid or incomplete documentation. HHS distributed Final Findings Reports to all Part D sponsors participating in the prescription drug event (PDE) review process. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.Training: HHS continued national training sessions on payment and data submission with detailed instructions as part of the improper payment estimation process for Part D sponsors. HHS also conducted in-person training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analysis, and

potential fraud schemes. In FY 2020, HHS conducted two Medicare Advantage Organization and Prescription Drug Plan fraud, waste, and abuse training webinars in January 2020 and July 2020; a Fraud, Waste, and Abuse COVID-19 webinar in April 2020; and two Opioid Education Missions in October 2019 and March 2020. The missions included multi-disciplinary teams of experts and decision makers from HHS and its partners, and supported collaborative efforts to protect the Medicare Part C and D programs.

Question 11: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Please indicate which corrective action(s) the program WILL TAKE to prevent improper payments.

ANSWER:

Indicate identified root cause	Indicate planned corrective action(s)	Select the planned completion date for action(s) program will take	Other planned completion date
13. Insufficient Documentation to Determine	5-Cross Enterprise Sharing	Other (select date)	
11. Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	3-Training (how to complete contracts)	Other (select date)	

Question 11 Free Text: Corrective Actions to be Taken (PIIA Section: 3352(d) (1))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: The corrective actions included in the additional information as part of the Corrective Actions Taken response are ongoing and apply to Corrective Actions to be Taken. HHS will continue these activities and will develop new or modify existing corrective actions, as needed.

Question 12: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Please indicate which of the six (6) criteria (if any) were determined to be non-compliant in the most recent IG compliance review.

ANSWER:

Indicate compliant or non-compliant	Compliance criteria
Compliant	1. Publish an AFR or PAR
Compliant	2. Conduct Program-Specific Risk Assessment
Compliant	3. Publish Improper Payment Estimates
Compliant	4. Publish Programmatic Corrective Action Plans
Compliant	5. Publish and Meet Annual Reduction Targets

Indicate compliant or non-compliant	Compliance criteria
Compliant	6. Report a gross Improper Payment Rate of Less than 10%

Question 12 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: A program-specific risk assessment is not required for Medicare Part D. According to OMB Circular A-123, Appendix C (Part I.C.1), programs already reporting an improper payment estimate do not need to perform an additional improper payment risk assessment as the quantitative method used for reporting the annual estimate fulfills the risk assessment requirement under IPERA (PIIA). For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 13 Free Text: Inspector General Compliance (PIIA Section: 3352(f) (2) (A) and (B); 3353(b) (1) (A); 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare Part D was deemed compliant as part of the most recent IG compliance review. Thus, zero consecutive years. For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 14 Free Text: Bringing the program into compliance (PIIA Section: 3353(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: For additional information, refer to the HHS OIG report, U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2019 (A-17-20-52000).

Question 16 Free Text: Do Not Pay Initiative (PIIA Section: 3354(b) (5))

Based on your selection(s) above, provide additional information below. Please note there is a 3000 character limit.

ANSWER: Medicare Part D does not use DNP.