STATEMENT OF

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ON

"HHS EFFORTS TO REDUCE IMPROPER PAYMENTS"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT OPERATIONS

SEPTEMBER 22, 2016

U.S. House Committee on Oversight & Government Reform

Subcommittee on Government Operations

Hearing on

HHS Efforts to Reduce Improper Payments

September 22, 2016

Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee, thank you for the invitation to discuss the U.S. Department of Health and Human Services' (HHS or the Department) efforts to reduce improper payments and for your leadership on this important aspect of financial management. As the Deputy Assistant Secretary for Finance at HHS, as well as its Deputy Chief Financial Officer, one of my responsibilities is to lead the Department's efforts to reduce and recover improper payments in some of the Federal government's largest programs. As you may know, strengthening program integrity and reducing improper payments continues to be a key priority of the Administration, extending to each of our Divisions and programs.

Improper payment estimates help us identify the drivers and root causes of improper payments that enable us to take targeted corrective actions to address the root causes of error. While we have many tools and resources, we look forward to continuing to work with Congress to further expand our tools, such as by enacting program integrity proposals included in the President's Budget. These proposals include the authority to conduct prior authorization on services that account for a large portion of the overall Medicare Fee-for-Service (FFS) improper payments, particularly those that are the highest risk for improper payments. This new authority would support us as we continue our progress in moving beyond the 'pay and chase' model and build on our prevention-oriented approach by stopping improper payments before they occur.

As you may know, financially, HHS is the largest department in the Federal Government. In Fiscal Year (FY) 2015, our outlays were approximately $1 trillion, accounting for almost a quarter of all Federal outlays. In addition, we are the largest grant-making agency in the Federal Government. We administer hundreds of programs ranging in types and sizes – from large Federal entitlement programs to grants provided to states and other grantees to funding for disease research and prevention, as well as responding to new and emerging diseases. Given our size, that we serve a large portion of the population, and the diversity of our portfolio, it is critical that we are committed to the highest standards of program integrity and accountability.

Today, I will describe our commitment and progress in addressing improper payments, as well as some of our major initiatives to prevent, reduce, and recover improper payments moving forward.

Background on Improper Payments

The Improper Payments Information Act of 2002 (IPIA), amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and

Recovery Improvement Act of 2012 (IPERIA), requires HHS to periodically review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the annual amount of improper payments, submit those estimates to Congress, and report on actions HHS is taking to reduce improper payments. In addition, the Disaster Relief Appropriations Act of 2013 (DRAA) states that all funds received under the law are deemed "susceptible to significant improper payments" for the purposes of IPIA, as amended, which requires HHS to develop and report improper payment estimates of Superstorm Sandy funding. By annually determining estimates of improper payment rates through an open and transparent process, HHS is able to identify and address areas at risk for – and factors contributing to – improper payments.

An improper payment can be a payment made to an ineligible recipient, a payment made in the wrong amount, a payment made without proper documentation, duplicate payments, or payments for services not rendered. It is important to note that not all improper payments constitute fraud, and high improper payment rates do not necessarily indicate a high rate of fraud. While fraud may be one cause, improper payments are not always the result of fraud or payments that should not have been made. For example, most Medicare FFS improper payments resulted from insufficient documentation to determine whether the service or item was medically necessary, such as the provider failing to document something in the medical record as required by Medicare policy, even if the services or items were rendered or delivered to an eligible beneficiary. For this reason, many improper payments may actually be corrected if the documentation was properly maintained and provided upon request. HHS remains committed to reducing all forms of waste and addressing all types of improper payments within our programs.

Improper Payment Results

In HHS's FY 2015 Agency Financial Report (AFR)[1], released on November 16, 2015, HHS reported improper payment estimates for seven risk-susceptible programs (Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Children's Health Insurance Program (CHIP), Child Care Development Fund (Child Care), and Foster Care. Fiscal Year 2015 was the second year where we reported improper payment estimates for the seven programs that received disaster relief funding under DRAA (the Administration for Children and Families' (ACF) Social Services Block Grant, Head Start, and Family Violence Prevention and Services programs; National Institutes of Health (NIH); Assistant Secretary for Preparedness and Response (ASPR); Centers for Disease Control and Prevention (CDC) Research; and Substance Abuse and Mental Health Services Administration (SAMHSA)). Lastly, beginning with the FY 2013 AFR, the Office of Management and Budget (OMB) approved HHS's request for relief for annual improper payment reporting for Head Start (which was formerly a risk-susceptible program) based on strong internal controls, monitoring systems, and previously reported low error rates.

Of the seven risk-susceptible programs that reported improper payment rates in FY 2015, two programs reported improved performance and lower improper payment rates (Medicare FFS and

[1] HHS's FY 2015 AFR is available at http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf.

Foster Care), while five programs reported higher improper payment rates (Medicare Part C, Medicare Part D, Medicaid, CHIP, and the Child Care programs) compared to the previous year. In addition, all seven DRAA programs reported error rates below three percent, including two programs that decreased from over ten percent to less than two percent between FY 2014 and FY 2015.

Only one risk-susceptible program remains without an improper payment estimate – the Temporary Assistance for Needy Families (TANF) program. Statutory limitations prohibit HHS from requiring states to participate in, calculate, or report a TANF program error rate. However, HHS continues to work on variety of efforts to prevent improper payments and strengthen program integrity in the TANF program.

In addition, HHS continues to collaborate with other agencies to conduct risk assessments required by the IPIA, as amended, for programs created under the Affordable Care Act (ACA). As disclosed in the FY 2015 AFR, the Department is conducting improper payment risk assessments of programs created under the ACA. We will report an update on the status and preliminary results of the risk assessments in the FY 2016 AFR, which will be released in November 2016. For those ACA programs determined to be susceptible to significant improper payments, we will work with our partners to develop and implement improper payment estimation methodologies.

While HHS is making progress in reducing improper payments in programs like Medicare FFS (which decreased from 12.70 percent in FY 2014 to 12.09 percent in FY 2015), more work needs to be done to improve upon this progress. The remainder of my testimony will reflect these efforts.

Efforts to Prevent and Reduce Improper Payments

The following generally describes our overall process for reducing our error rates. It is a continuous quality improvement program that starts with measuring and reporting payment error rates for our largest programs based on samples of payment information from those programs.

Establishing error rates—and the subsequent measurement process—for a program allows HHS to examine the errors, classify them into error types, and establish corrective action plans that address the root causes of the errors. Both the factors contributing to improper payments as well as each program's methodology for estimating the error rate are complex. This is especially important to note since programs are constantly changing as new statutory requirements are implemented, and, therefore, we continuously work to refine and strengthen each program's error rate methodology to reflect these changes. Similarly, as HHS has new and updated error rates and more detailed error type information, we review and modify corrective action plans to address the errors. The modifications can include speeding up the timeline for implementing a corrective action to devising new corrective actions to better address root causes of the errors. Generally, each program develops a multi-faceted approach to corrective actions with multiple efforts underway concurrently. As a result, it is not possible to identify the specific impact of any one corrective action. However, we believe the corrective actions that focus on the major drivers of errors have the most impact in reducing improper payments.

HHS employs a variety of approaches across our programs to prevent improper payments before they occur. For example, within our Federal health care programs, HHS continues to leverage successful corrective actions, such as increasing prepayment medical reviews, expanding prior authorization initiatives, using advanced analytics (e.g., predictive modeling), implementing provider enrollment safeguards, conducting robust accuracy reviews of contractor decisions, and conducting additional education and outreach to the provider and supplier communities. Similarly, for many of our human services programs – like Foster Care and Child Care – HHS is expanding training and technical assistance, and issuing guidance on how programs can better determine and verify program eligibility.

Due to the complexity of the corrective actions and program integrity initiatives, the results of these actions are generally not immediately reflected in the error rate measurement and can take years before the effect is realized. Furthermore, some corrective actions (like strengthening program requirements) can lead to short term improper payment increases while programs and stakeholders implement new business processes and change management to meet new requirements. For example, in recent years, HHS has identified high rates of error for hospital services that are rendered in medically-unnecessary settings (i.e., inpatient rather than outpatient). To address these errors, HHS has launched efforts to improve and clarify regulations (Inpatient Admission Policy Changes and A/B Rebilling "Two-Midnight" Rule, effective October 2013; and Hospital Outpatient Prospective Payment System Rule, effective in calendar year 2016) and strengthen education efforts through "Probe and Educate" reviews, where a small number of inpatient hospital claims were reviewed for every hospital, and if needed, education and/or training were provided to improve hospital billing. As a result of these corrective actions, the inpatient hospital claims improper payment rate decreased from 9.2 percent in FY 2014 to 6.2 percent in FY 2015.

HHS realizes that the correlation between corrective actions and a reduction in improper payments is not a one-to-one relationship, and as a result, we utilize a variety of corrective actions to prevent and reduce improper payments. However, we believe that the corrective actions that could have the biggest impact on preventing and reducing erroneous payments fall under three distinct areas: leveraging technology, strengthening partnerships, and exploring innovative solutions.

Leveraging Technology

With technology continuing to advance, its expanded use helps us greatly improve our stewardship of Federal resources. While more work remains to be done to identify and implement additional technological solutions to address improper payments in a financially prudent manner, HHS – with the support of this Subcommittee and others in Congress – has been a government-wide leader in efforts to leverage technology to prevent, detect, and reduce improper payments.

One of our more recent technology initiatives is the Fraud Prevention System (FPS), or the predictive analytics technology (required under the Small Business Jobs Act of 2010), that identifies investigative leads to further protect the Medicare program from inappropriate billing

practices and provide oversight on provider-enrollment actions. Since its June 2011 inception, the FPS has identified significant savings by running sophisticated analytics on the 4.5 million Medicare claims that are run through FPS on a daily basis, prior to payment. In 2015, HHS reported a return-on-investment of $11.50 for every dollar the Federal Government spends on this program integrity system.

Another tool that we are utilizing is the Do Not Pay (DNP) Business Center, which is an effort led by the Department of the Treasury and OMB to provide agencies access to databases and tools that could help them prevent or reduce improper payments. Since its inception, HHS has worked very closely with Treasury and OMB on this initiative, as evidenced by the multiple offices and programs across the Department that are utilizing DNP for a variety of purposes. We are committed to continuing this successful partnership with Treasury and OMB to enhance the use of DNP, which, in FY 2015, reviewed approximately $362 billion of HHS payments for possible improper payments.

Strengthening Partnerships

Like many other agencies, we recognize that HHS alone cannot prevent and reduce every improper payment. Accordingly, we are placing an increasing emphasis on breaking down barriers between and within our own agencies and strengthening partnerships with our Federal, state, and local government colleagues to prevent, reduce, and recapture improper payments.

One partnership that I would like to highlight is the ongoing relationship that exists between Federal and state or local agencies, which is a key component of HHS efforts to reduce improper payments. As you know, not every program is directly administered by the Federal government. In fact, many HHS programs – including Medicaid, Foster Care, TANF, and Child Care – are jointly funded by the Federal Government and states, and administered by states or local governments. Accordingly, to address improper payments in these programs, the Federal Government must work with state agencies to identify root causes and implement corrective actions. This type of inter-governmental coordination is occurring across our programs and each year HHS further strengthens its relationships with the states in an effort to reduce improper payments in state-administered programs. Two examples of this coordination are described below:

- In the Medicaid and CHIP programs, HHS has engaged with states to address error rate measurement results and issues identified in their corrective action plans; conducted additional program integrity reviews; facilitated national best practice calls to share ideas across states; offered ongoing and targeted technical assistance; and provided additional guidance, as needed. For example, HHS now conducts focused program integrity reviews to assess state compliance in accomplishing corrective actions and has developed toolkits (e.g., Medicaid enrollment and screening federal requirements) to help address some of the most frequent findings from these reviews. These methods to strengthen the states' capacity to protect the Medicaid program (and thereby both Federal and state funds) also help us inform and educate providers about approved and accepted practices in the Medicaid program.
- In the Child Care program, HHS has taken several steps to support states, territories, and tribes as they engage in the process of updating and promulgating new policies and rules

related to implementing the Child Care Development Block Grant Reauthorization Act of 2014 (the Act). To meet the requirements of the Act, HHS has mobilized its technical assistance network to support states in their efforts to balance policies that support high quality services for children and families while ACF continues to work with states through the National Center for Child Care Subsidy Innovation and Accountability (NCCCSIA). The NCCCSIA was funded to specifically provide technical assistance to states and territories on program integrity and accountability and has been targeting technical assistance to states as it relates to reauthorization.

A second partnership that I would like to highlight is with our Office of Inspector General (OIG), OMB, and the Government Accountability Office (GAO). We are working with these entities to identify opportunities and leverage their experiences to help strengthen program integrity across HHS through informational briefings and discussions and to implement outstanding recommendations.

Lastly, I would like to highlight our cross-agency collaborations in our Federal health care programs, especially as it relates to a subset of improper payments or those believed to be fraudulent. Since improper payment measurements are not a measurement of fraud, HHS and its partners pursue other activities to prevent, identify, and recover fraudulent payments. For example, HHS and the Department of Justice (DOJ) have nurtured a ground-breaking partnership that unites public and private organizations in the fight against health care fraud, known as the Healthcare Fraud Prevention Partnership (HFPP). The voluntary, collaborative partnership includes the Federal Government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups. As of September 1, 2016, the HFPP included 67 partner organizations from the public and private sectors, law enforcement, and other organizations combating fraud, waste, and abuse.

Exploring Innovative Solutions

While our efforts to leverage technology and to strengthen partnerships are helping to address improper payments, it is also important that we continue to explore innovative new ways to further improve our efforts.

One important solution HHS utilizes is prior authorization initiatives in the Medicare FFS program. Prior authorization is a practice that is used by private sector companies and other health care programs, and we are working to expand this practice in Medicare. Specifically, HHS began using prior authorization for power mobility devices (PMDs), non-emergent ambulance transport, and non-emergent hyperbaric oxygen therapy, and is expanding this practice to other areas, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and chiropractic services. One example is prior authorization of PMDs which began as a demonstration in seven states in 2012 and was expanded to 12 additional states in 2014. Initial results of the PMD prior authorization, among other factors, led to a decrease in PMD expenditures in both the demonstration and non-demonstration states. Specifically, monthly expenditures for the PMD codes included in the PMD demonstration decreased by $9 million in the seven original demonstration states, by $7 million in the additional 12 expansion states, and by $7 million in the non-demonstration states. These savings were achieved while maintaining

beneficiary access to needed care. While feedback from the industry and beneficiaries continues to be largely positive related to the timeliness of prior authorization reviews, access to necessary services, and the quality of care, HHS will continue to monitor and evaluate the effectiveness of the demonstration.

A second example of our efforts to identify innovative solutions—and a key component of our strategy for minimizing improper payments—is to take steps to ensure that only eligible providers are allowed to enroll in the Medicare and Medicaid programs. The Department's work involves implementation of the new provider enrollment safeguards authorized by the ACA to better screen providers. We believe that provider enrollment safeguards are important tools in helping prevent improper payments by keeping fraudulent and abusive providers out of the program.

Efforts to Recover Improper Payments

Recovery Audit Programs

The recovery audit contractor (RAC) program is an important part of HHS's comprehensive strategy to reduce improper payments. HHS developed a risk-based strategy to implement the recovery auditing provisions of IPERA and Section 6411 of the ACA, which expanded the RAC program to Medicare Part C, Medicare Part D, and Medicaid. Specifically, HHS focuses on implementing recovery audit programs in Medicare and Medicaid which accounted for the majority of HHS's outlays in FY 2015.

Today, recovery auditors are reviewing Medicare FFS, Medicare Part D, and Medicaid payments to identify and correct improper payments. In addition to recovery auditors, other activities at HHS also help to identify and recover improper payments:

- The national Medicare FFS RAC program became operational in FY 2009 and has resulted in over $10 billion in program corrections, including correcting $434.5 million in improper payments through the first three quarters of FY 2016. As you are aware, HHS has announced a number of enhancements to the Medicare FFS RAC program in response to industry feedback. These enhancements focus on three main areas: improving program transparency and provider communications; reducing provider burden; and improving contractor accuracy and program oversight. In addition, the Medicare Secondary Payer RAC began full recovery operations at the end of FY 2013 and collected approximately $150 million in mistaken payments in FY 2015.
- The Part D RAC program became fully operational in FY 2012 and provides information to HHS to help prevent future improper payments through its review of prescription drug event data. Since its launch, the Part D RAC has recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers or filled at excluded pharmacies and recouped approximately $5.2 million in FY 2015. Other, non-recovery auditor activities such as the voluntary reporting and repayment of overpayments, resulted in approximately $650 million and $12 million being returned by Medicare Advantage Organizations and Medicare Part D Prescription Drug plans, respectively, in FY 2015.

- For Medicaid, states were required to establish and operate individual recovery audit programs beginning in January 2012. As of the end of FY 2015, 47 states and the District of Columbia had implemented Medicaid RAC programs, but one of those states ended its RAC program when HHS approved an exception due to high managed care penetration. The remaining four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high levels of managed care. From FY 2012 through FY 2015, State Medicaid RAC Federal-share recoveries totaled $244.9 million, including $57.7 million corrected in FY 2015.

Other Payment Recovery Efforts

In addition to the Medicare and Medicaid recovery audit programs, HHS also undertakes other recovery activities, including recoveries from single audits, post-payment reviews, HHS OIG reviews, and improper payment sampling activities. These recoveries cumulatively amounted to more than $12 billion in FY 2015, which was reported in HHS's FY 2015 AFR. While it is imperative to prevent improper payments from occurring in the first place, HHS continues to focus on aggressively recovering improper payments when they do occur through recovery audits and other activities.

Future Efforts

HHS has demonstrated a longstanding commitment to prevent, reduce, and recover improper payments. We have published an error rate for Medicare FFS since FY 1996, which was one of the first error rates developed and published across government. HHS has also reported Foster Care error rates since FY 2004, and has developed improper payment measurements for Child Care, Medicare Part C, Medicare Part D, Medicaid, and CHIP. The commitment to reducing improper payments is taken seriously and shared throughout the Department. For example, HHS management performance plan objectives hold agency managers, beginning with leadership and cascading down through HHS Senior Executives (including component heads) to the lowest accountable program official, responsible for achieving progress on this important area. As part of the semi-annual and annual performance evaluation, HHS Senior Executives and program officials are evaluated on the progress the agency achieves toward this and other goals.

While HHS has made progress in reducing improper payments, more work remains. Reducing waste and errors across our Departmental programs will allow us to target taxpayer funds to provide important health care and human services for our beneficiaries and the individuals that benefit from our programs. The systems controls and ongoing corrective actions that HHS is implementing across our programs will result in continued reductions in improper payments. Lastly, as HHS implements the newly released OMB Circular A-123, "Management's Responsibility for Enterprise Risk Management and Internal Control", this will strengthen our efforts to identify, prioritize, and reduce the risks of improper payments throughout the Department's programs.

We look forward to working with this Subcommittee and our Federal and state partners, including OMB, the OIG, GAO, and DOJ on these important issues.

Thank you for the opportunity to testify, and I would be happy to answer any questions you may have.

Sheila O. Conley

Sheila O. Conley joined the U.S. Department of Health and Human Services in 2006 as the Deputy Assistant Secretary for Finance and Deputy Chief Financial Officer. She is responsible for leading the Department's annual financial statement audit; managing the Department-wide financial management systems portfolio; implementing HHS' internal control and enterprise risk management program under OMB's revised Circular A-123; and reducing improper payments in some of the Federal Government's largest programs.

From 2003 to 2006, Ms. Conley served as the U.S. Department of State's Managing Director for Financial Policy, Reporting and Analysis. From 1992 to 2003, Ms. Conley held various positions at the Office of Management and Budget (OMB) ranging from financial analyst to OMB's Acting Controller.

Before joining OMB, Ms. Conley was a senior manager with KPMG, where she provided audit and financial management services for over 10 years to clients in a wide range of industries including the Federal sector.

Ms. Conley has received numerous awards during her career including the Presidential Rank Award and the HHS Secretary's Award for Distinguished Service.

Ms. Conley is a certified public accountant in the District of Columbia, and a member of the Greater Washington Society of Certified Public Accountants, American Institute of Certified Public Accountants, and the Association of Government Accountants. Ms. Conley obtained a bachelor's of business administration degree (*summa cum laude*) in 1981 from James Madison University.