

EXAMINING BILLION DOLLAR WASTE THROUGH IMPROPER PAYMENTS

HEARING

BEFORE THE
SUBCOMMITTEE ON
GOVERNMENT OPERATIONS
OF THE
COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES
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EXAMINING BILLION DOLLAR WASTE THROUGH IMPROPER PAYMENTS

Thursday, September 22, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT OPERATIONS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 3:05 p.m., in Room 2247, Rayburn House Office Building, Hon. Mark Meadows [chairman of the subcommittee] presiding.

Present: Representatives Meadows, Connolly, Maloney, and Clay.

Also Present: Representative Palmer.

Mr. MEADOWS. The chair would ask unanimous consent that we can suspend the rules, the House rules, and go ahead and start this subcommittee hearing.

And hearing no objection from my learned colleague and friend, since there is no objection, the committee is considered in order and starting. So we'll go ahead.

The subcommittee will come to order. Without objection, the chair is authorized to declare a recess at any time. And as we have noted, I want to thank each of you for being here today.

Certainly, as we come to this time of the year where we look at improper payments and where we are and what has taken place, what should have taken place, what may have taken place, I look for each one of you to, hopefully, help us eliminate what changes that we can make in terms of, not only our accounting process, but our expenditures. And part of it is just reporting.

And when we look at that, the American people expect us to truly be the stewards of their hard-earned taxpayer money. And the interesting thing that I found is, in light of so many improper payments and where we are, it is troubling many times because of the number and how high it is. And eventually, as I said, it adds up to real money.

And so when we look at the numbers, it can be troubling. I would also say, however, though, what I have found is going from agency to agency to agency is a real dedication on behalf of the Federal worker to be accountable, and that has been one of the interesting aspects.

So sometimes it is a number of our Federal employees who have to deal with a bureaucracy that they did not create. And by saying that, it is imperative that this committee look at the bureaucracy that has been created and, hopefully, start to address that and how we can, not only have better reporting, but also have an issue

where we start to really focus in on making sure that we are accountable to the American taxpayer.

So in that, I just—I've got a longer written opening statement that we'll submit for the records, but because my good friend, Mr. Connolly, has now arrived, I will—if he is ready, I will recognize him for his opening statement.

Mr. CONNOLLY. Thank you, Mr. Chairman.

My opening statement is going to be eerily similar to that of Mr. Clay. So we'll enter something for the record and forgo a verbal statement. He and I are like twins. We think alike, we act alike, we speak alike, and I can't add to the wisdom of my friend from St. Louis.

Mr. MEADOWS. Well, I will go ahead and acknowledge the presence of the twins here to my right and also go ahead and introduce our witnesses.

I will hold the record open for 5—

Mr. CONNOLLY. I have been informed my friend did not read our brilliant statement. Lord Almighty here. Here's what he would have said, Mr. Chairman.

No, I will enter it into the record and not take up the time of the committee. Thank you.

Mr. MEADOWS. I'll hold the record open for 5 legislative days for any members who would like to submit a written statement.

We will now recognize our panel of witnesses. I'm pleased to welcome the Honorable David Mader, controller at the Office of Federal Financial Management and Office of Management and Budget, OMB. Welcome.

Ms. Sheila Conley—is that correct, Conley?

Ms. CONLEY. Yes, sir.

Mr. CONNOLLY. Spelled wrong, Mr. Chairman.

Mr. MEADOWS. I wanted to verify.

— deputy chief financial officer at the U.S. Department of Health and Human Services. Welcome.

Ms. Laurie Park, deputy assistant secretary of finance at the U.S. Department of Veterans Affairs. Welcome.

Ms. Marianna LaCanfora—that's close, right?

Ms. LACANFORA. Right.

Mr. MEADOWS. All right.

— assistant deputy commissioner of policy and chair of the Improper Payments Board at the U.S. Social Security Administration. Welcome.

And Mr. Jeff Schramek, assistant commissioner of the Bureau of Debt Management Services at the U.S. Department of Treasury. Welcome to you as well.

And pursuant to committee rules, all witnesses will be sworn in before they testify. And so if you would please rise and raise your right hand.

All right. Do you solemnly swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

Thank you.

Let the record reflect that the witnesses answered in the affirmative.

And in order to allow time for discussion, please limit your oral testimony, if you would, to 5 minutes, but your entire written statement will be made part of the record.

So I'll go ahead, Mr. Mader, we'll recognize you for 5 minutes.

WITNESS STATEMENTS

TESTIMONY OF DAVID MADER

Mr. MADER. Thank you, Chairman Meadows, Ranking Member Connolly, and distinguished members of the subcommittee for inviting me here today to discuss the administration's efforts to reduce improper payments.

Addressing improper payments has been a central component of this administration's overall effort to eliminate fraud, waste, and abuse. When the President took office in 2009, the improper payment error rate was 5.2 percent, an all-time high. Since then, the administration, working together with this Congress and the IGs, has made progress strengthening accountability and transparency through annual reviews by agency IGs and has expanded the review requirements for high-priority programs.

As a result of this concerted effort in fiscal year 2015, the past year, the rate was 4.39 percent. It's important to note that agencies recovered almost \$20 billion in overpayments through payment recapture audits and other methods in fiscal year 2015. However, this recovery amount is not factored into the calculation of the 2015 improper payment rate or amount.

Two notable success stories of major government programs that experienced significant decreases in improper payments is the Unemployment Insurance Program and HHS' Medicare fee-for-service. Under the improper—under the unemployment program, decreased improper payment rates amounted to \$2 billion, or 1 percent, between fiscal year 2014 and 2015. This program was able to achieve this reduction by using an enhanced national directory of new hires crossmatch and providing enhanced monitoring and assistance to the States.

The HHS Medicare fee-for-service improper payment rate also decreased by \$2 billion between 2014 and 2015 by reducing improper payments for inpatient hospital, durable medical equipment, prosthetics, orthotics, supplies and claims through the use of prior authorizations, new regulations, and changes in agency's provider education. And I mention these two programs in particular because, as you know, these are programs—and there are many programs—that while funded by the Federal Government, are actually administered by States, and that adds to complexity in ensuring that proper payments are made.

Prior to fiscal year 2015, agencies were required to categorize their improper payment estimates into three categories. However, several years ago, these categories were recognized as providing limited value in determining the root cause of improper payments.

As a result, OMB developed improper payment categories that expanded the existing categories and created 13 predefined categories for agencies to use. Page 3 of my written statement actually has a nice graphic that shows the before and after. And these allow

agencies now to do a better job of analyzing the root cause in particular programs.

Corrective actions to address root causes are an area we want agencies to do more of. Beginning in fiscal year 2015, with the issuance of OMB Circular A-136, OMB began to address a disconnect between agencies' corrective action plans and the root cause analysis. OMB has held townhall meetings with both agency representatives and IGs over the past 2 years.

Also in 2015, MITRE, a federally funded research and development center, conducted an independent research project that focused on governmentwide payment integrity and improper payments. And as a result of that study, my office is looking at exploring and determining whether there's a viable need to create another program integrity group at the executive level. Although, I do note in some of the—my fellow witnesses here, actually, from the agencies have started their own group over the last several months, which allows them to share best practices and other ideas on how to improve improper payments.

In May of 2016, we also facilitated a meeting between senior officials from GAO, HHS, and CMS to discuss corrective action plans and specific challenges in their particular high error programs. GAO—and Gene Dodaro was there for this entire meeting—was able to offer some insights around additional areas where HHS may want to explore corrective actions.

The administration appreciates the opportunity to work with the Congress to achieve the passage and enactment of S.614, the Federal Improper Payment Coordination Act. And I'm pleased to report that OMB is working now with agencies to implement those requirements. And my colleague from Treasury has responsibility for implementing a lot of that as part of the do-not-pay initiative, and I'm sure he'll touch on that in his testimony.

We also worked with Congress on S.2133, the Fraud Reduction and Data Analytics Act of 2015, which was recently signed into law. And, again, when we reissued our Circular A-123 in the summer, we actually started including now some of the requirements for that. So in both of these cases, we've moved aggressively to implement these new requirements in the legislation.

In December 4 of 2015, we submitted to Congress the first report required by OMB for the do-not-pay initiative. The report outlined the multiple components of our phased strategy for screening payments. And Mr. Schramek is going to talk extensively about the successes that they've had since the initiation of this program.

I think it's important to note that, in addition to Treasury, there are agency payment integrity centers at CMS, at DOD, at SSA, and the Department of Labor. So it's not just unique to the do-not-pay initiative at Treasury. We have multiple efforts going on across the executive branch.

There's a compelling evidence that investments in administrative resources can significantly decrease the rate of improper payments and recoup many times their initial investment. That's why this administration for multiple years has proposed making significant investments in program integrity initiatives, both in the 2016 as well as the 2017 budget. And many of these initiatives do not involve additional expenditure of funds. They actually require legisla-

tive changes. And I believe that this is an area where this committee can help with other committees in Congress in educating them on the wisdom of making some of these legislative changes.

Combating improper payments continues to be a top priority for this administration, and we continue to explore new and innovative ways to address these problems. Although progress has been made, much more remains to be done, and we need your help.

We look forward to working with the Congress to pass many of the provisions contained in the President's 2017 budget. Thank you for inviting me today, and I look forward to your questions.

[Prepared statement of Mr. Mader follows:]

**EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET**
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**Testimony of the Honorable David Mader
Controller, Office of Management and Budget, Executive Office of the President**

**House Oversight and Government Reform Committee
Subcommittee on Government Operations**

September 22, 2016

Introduction

Thank you Chairman Meadows and Ranking Member Connolly, and distinguished members of the Committee, for inviting me here today to discuss the Administration's efforts to reduce improper payments. I appreciate the opportunity to provide an update on this important topic. Our ongoing interactions with the Congress and consultation with the Government Accountability Office (GAO) and the Inspector General (IG) community over the years has been critical to addressing improper payments.

It is important to keep in mind that not all improper payments are fraudulent or represent a loss to the Government. When an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment even though eventually it may be determined to be proper. In the interest of ensuring that the Federal Government improper payment estimate was conservative, the Office of Management and Budget (OMB) actually included "documentation errors" as part of the improper payments definition back in 2006, even though current statutes do not require this particular categorization. While not all improper payments represent a monetary loss to the Government, all improper payments do undermine taxpayers' confidence in program delivery.

Addressing improper payments has been a central component of the Administration's overall efforts to eliminate waste, fraud, and abuse. When the President took office in 2009, the improper payment error rate was 5.42 percent, an all-time high. Since then, the Administration, working together with the Congress and the IGs, has made progress by strengthening accountability and transparency through annual reviews by agency IGs, and has expanded review requirements for high-priority programs. In FY 2015 the Government-wide improper payment rate was 4.39 percent, which corresponds to an improper payment dollar amount of \$136.9 billion. Notably, agencies recovered almost \$20 billion in overpayments through the payment recapture audits and other methods in FY 2015, but this recovery amount is not factored into the calculation of the FY 2015 improper payment rate or amount.

Improper Payments Results Overview

Between FY 2014 and FY 2015 almost half of the programs reporting improper payment rates in both FY 2014 and FY 2015 experienced improper payment rate increases. The Department of Veterans Affairs (VA) Purchased Long Term Services and Support program improper payment

rate increased from roughly 9 percent in FY 2014 to 59 percent in FY 2015 and the VA Community Care program increased from just over 9 percent in FY 2014 to 55 percent in FY 2015. Both of these programs experienced improper payment rate increases due to an OIG recommendation to change the way that these programs defined improper payments. In addition, there were other programs that experienced large improper payment dollar amount increases between FY 2014 and FY 2015. For instance, the Department of Health and Human Services (HHS) Medicaid program improper payment dollar amount increased by over \$10 billion. This increase is largely due to states needing further time to bring systems into compliance with new program requirements, as is often the case when new requirements take effect.

As background to a better understanding of the improper payment rate, the HHS Medicare Fee-for-Service (FFS) program continues to account for the largest portion of the Government-wide total in FY 2015, whereas the Internal Revenue Service (IRS) Earned Income Tax Credit (EITC) and Medicaid, combined, account for over a third of the Government-wide total. In other words, these three programs alone account for nearly two thirds of the government-wide total in FY 2015. During the period reflected in FY 2015 Agency Financial Reports (AFRs), the improper payment rate decreased in several major programs including EITC, Medicare FFS, and Unemployment Insurance (UI).

Success Stories

Two notable success stories of major Government programs that experienced significant decreases were the UI program and the Medicare FFS program. The Department of Labor's (DOL) UI program decreased its improper payment error amount by over \$2 billion between the FY 2014 and FY 2015 reporting period, decreasing their rate by almost a percentage point. The UI program was able to achieve this reduction in part because of their decreased workloads resulting from the improving economy (the total program outlays decreased by roughly \$15.5 billion) and also by using a number of successful techniques such as implementing an enhanced National Directory of New Hires (NDNH) cross-match and providing enhanced monitoring and assistance to States with persistently high UI improper payment rates. The HHS Medicare FFS improper payment estimate also decreased by over \$2 billion between FY 2014 and FY 2015 by reducing improper payments for inpatient hospital and durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) claims through a combination of activities such as the expansion of prior authorization, new regulatory provisions, and changes in the agency's provider education strategy.

Challenges

During the period reflected in FY 2015 AFRs, the improper payment rate increased in several major programs, including Medicaid. The Medicaid improper payment rate increased from 6.7 percent in FY 2014 to 9.78 percent in FY 2015, which equated to the improper payment dollar estimate increasing by over \$10 billion. This increase was largely due to States needing additional time to bring their systems into compliance with new requirements for: (1) all referring/ordering providers to be enrolled in Medicaid; (2) screening providers under a risk-based screening process prior to enrollment; and (3) the inclusion of the National Provider Identifier (NPI) of the attending provider on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because

it takes time for states to implement systems changes required for compliance. The Medicaid program measures improper payments using a 17-State rotational approach for the 50 States and the District of Columbia over a three-year period. As a result, each State is measured once every three years. The Medicaid improper payment rate reported each year includes findings from the most recent three measurements cycles.

Key Administration Efforts in FY 2015 and FY 2016

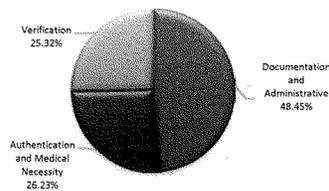
New Root Cause Category Matrix

Prior to FY 2015 reporting, agencies were required to categorize their improper payment estimates into three categories: (1) documentation and administrative errors; (2) authentication and medical necessity errors; and (3) verification errors. However, those categories proved to be of limited value in determining the root causes of improper payments in most programs. Therefore, OMB—in consultation with agencies—developed new improper payment categories that expanded on the existing categories and created a more meaningful and useful way to break out root causes for each agency. These new categories: (1) prove more pertinent to the vast array of programs across the Federal landscape; (2) help agencies better present the different categories of improper payments in their programs and the percentage of the total improper payment estimate that each category represents; and (3) provide more granularity for improper payment estimates—leading to more effective corrective actions at the program level and more focused strategies for reducing improper payments at both the individual agency as well as the Government-wide level. OMB provided 13 pre-defined categories for agencies, with the additional option of allowing an agency to create their own category if the 13 pre-defined categories did not suit their needs. These new categories were released on October 20, 2014 and agencies were encouraged to implement these new categories immediately in their FY 2014 reporting. FY 2015 marked the first year that the new OMB root causes reporting was required.

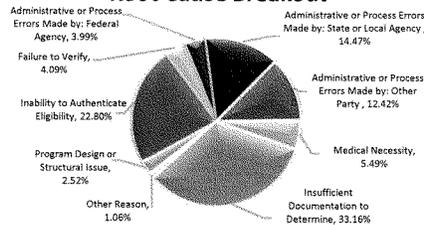
Root Cause Category Matrix Results

In looking at the total agency response, the two categories that contribute the largest incidents were: (1) “insufficient documentation to determine” (\$45.4B, 33.2 percent) and (2) “inability to authenticate eligibility” (\$31.2B, 22.8 percent).

FY 2014 Improper Payment Root Cause Breakout



FY 2015 Improper Payment Root Cause Breakout



Roughly \$45 billion of the Government-wide improper payments in FY 2015 were caused by insufficient documentation. A lack of supporting documentation could be a situation where missing information is necessary to verify the accuracy of a payment, such as the lack of documentation to support a beneficiary's eligibility for a benefit.

Roughly \$31 billion of the Government-wide improper payments in FY 2015 were caused by the inability to authenticate eligibility. The inability to authenticate eligibility is a situation in which an improper payment is made because the agency is unable to authenticate eligibility criteria. This could be because no database or other resource exist to help the agency make a determination of eligibility. For example, in the EITC program, IRS does not have a way to verify how long a child has been residing with one parent versus another parent when both parents do not reside in the same residence, a key measure of whether the taxpayer can claim that child under EITC. The inability to authenticate eligibility can also happen when statutory constraints exist preventing a program from being able to access the information that would help prevent the improper payment. For instance, not being able to confirm a recipient's benefit eligibility status due to statutory limitations that prevent data sharing across agencies.

Corrective Action Plans

Beginning in FY 2015 with the issuance of OMB Circular A-136, *Financial Reporting Requirements*, OMB began to address a disconnect between agencies corrective action plans and root causes. OMB plans to issue guidance later this month that will further refine FY 2016 corrective action plan reporting, providing an even larger focus on corrective actions that focus on the root causes for those programs reporting above the IPERA statutory thresholds. OMB regularly engages one on one with all agencies throughout the year to discuss improvements that can be made in areas such as corrective action plans, sampling and estimation plans, reporting, and internal controls around payment accuracy. As well as agency and IG town hall meetings for the past two years. Continued agency engagement and guidance is critical to reducing the government wide improper payment error rate.

Corrective Action Plan Analysis

OMB is currently conducting a corrective action plan (CAP) analysis and review based on the CAPs that agencies submitted in FY 2015. Our analysis is covering all programs that reported improper payment above the statutory thresholds in FY 2015. Once the analysis is complete we will be contacting agencies that have been identified as those needing to improve their CAP. This effort is intended to ensure that agencies are developing CAPs that will directly impact the root causes identified and also to ensure that agencies are prioritizing their efforts to focus on CAPs that will have the greatest impact on improper payments.

MITRE Study

In FY 2015, MITRE, a Federally Funded Research and Development Center (FFRDC), conducted an independent research project that focused on Government-wide payment integrity and improper payments. MITRE's work focused on assessing improper payment trends and more importantly analyzing improper payment root causes and best practices available to improve program integrity.

Technical Advice on Legislation

OMB appreciated the opportunity to work with the Congress to achieve passage and enactment of S. 614, the “Federal Improper Payments Coordination Act of 2015.” The Administration looks forward to continued partnership with the Congress on efforts to reduce improper payments, and OMB is working with agencies to issue guidance on implementation of the recently enacted authorizations of the Do Not Pay Initiative (the Initiative) for the legislative and judicial branches of the Federal government, and for states, to improve federally funded program integrity, to ensure protection of individual privacy, and to achieve greater payment accuracy across the Government using improved data sources and data analytics.

We also appreciate the opportunity to work with Congress on S. 2133 the “Fraud Reduction and Data Analytics Act of 2015.” This legislation will bring important focus to the importance of Data Analytics and anti-fraud technique sharing for reducing improper payments in the Federal Government. OMB issued Circular A-123, *Management’s Responsibility for Enterprise Risk Management and Internal Control* in July of 2016, which provided guidance and addressed fraud and data analytics and highlighted the implementation of this very important piece of legislation.

As requested in the FY 2015 and FY 2016 Budgets, the FY 2017 Budget re-proposes to amend the Social Security Act to provide Treasury’s Do Not Pay system and the agencies that use it access to the full death data from states to prevent improper payments to the deceased. S. 1073, the “Stopping Improper Payments to Deceased People’s Act,” and the corresponding bill in the House, H.R. 2003, include the necessary proposals to amend the Social Security Act to provide agencies access to the full death data at the Social Security Administration (SSA), and we appreciate the continued collaboration with you to provide the more complete data to reduce improper payments to the deceased. Additionally, the FY 2017 Budget proposes to allow additional programs and agencies to access the HHS National Directory of New Hires (NDNH) data through the Do Not Pay system at Treasury to improve the efficiency and effectiveness of data matching and overall program integrity.

OMB Actions to address IPERA Compliance

OMB discussed the FY 2015 IPERA compliance results with specific agencies during our annual FedStat meetings. I also met with numerous IGs over the past two years to discuss the IPERA compliance reports and also discuss other observations that the IGs had for their particular agency. In addition, OMB held two separate town hall events for IGs at the end of FY 2015 to outline the IPERA compliance requirements, how they linked with OMB guidance, and share observed best practices from various IG reports to help them get ready for their FY 2015 IPERA compliance reports. The meetings with agency IGs and the town hall events helped solidify the importance of the OIG role in reducing the Government-wide improper payment rate. OMB held an additional IPERA compliance town hall for the IG community on September 20, 2016 to discuss additional areas where improvement could be made as well as highlight some best practices observed among the FY 2015 OIG IPERA compliance reports. The agency IPERA compliance reports are a critical tool that can help the agencies identify areas for improvement around reducing their improper payments.

The Do Not Pay Initiative and Improving Payment Integrity Research and Analytic Capabilities Across the Government

The President signed the Improper Payments and Elimination and Recovery Improvement Act of 2012 (IPERIA) into law on January 10th, 2013, to reinforce the Administration's efforts to prevent improper payments and to codify actions initiated on November 20, 2009, under Executive Order 13520, *Reducing Improper Payments and Eliminating Waste in Federal Programs*, and the June 18th, 2010, Presidential Memorandum, *Enhancing Payment Accuracy Through a "Do Not Pay List."*

Since the enactment of IPERIA, OMB has:

- developed, in consultation with agencies, a phased plan for database integration into the Do Not Pay system;
- issued Memorandum M-13-20, *Protecting Privacy while Reducing Improper Payments with the Do Not Pay Initiative*;
- worked with agencies to integrate, into existing business practices, reviews of all payments and awards before and after payment processing, as appropriate;
- implemented agencies reporting progress on payments reviewed, by establishing requirements in OMB Circular A-136, *Financial Reporting Requirements*;
- developed with agencies payment integrity centers with analytical payment reviews;
- provided the Congress a report on the initial results of over \$2 billion stopped; and
- offered additional legislative proposals to improve payment accuracy in each of the President's Budgets for FY 2013 through FY 2017.

Specifically, on December 4th, 2015, OMB submitted to Congress the first report on the Initiative as required by section 5 of IPERIA. The report outlined the multiple components of our phased strategy for screening payments. The Initiative includes designated data sources and analytics to support agencies as they verify entity eligibility for an award or payment. The Initiative is enhanced by tools such as the centralized data portal at Treasury, and agency-specific initiatives that effect particular program operational improvements. The Initiative has been a catalyst for agencies to review the full life cycles of their payment operations and provided a path to reduce improper payments through available data.

The Treasury Do Not Pay Business Center offers agencies a single-point of entry to access data and matching services to help detect, prevent, and recover improper payments during the award or payment lifecycle. Increased access to data sources including commercial data sets will increase the accuracy of matching results and allow agencies to make better informed decisions regarding awards and payments. Upon request Treasury now offers agencies data quality assessments, data pattern analysis, and anomaly detection and analysis. These analyses allow agencies and programs the opportunity to identify areas for further exploration and help to strengthen the pre-award and pre-payment process. Furthermore, the Do Not Pay Business Center has begun analyzing data across agencies to identify potential duplicative benefit payments in programs with related goals and beneficiaries.

In addition to Treasury, agency payment integrity tools include the Center for Medicare & Medicaid Services (CMS) Center for Program Integrity (which has implemented CMS' Fraud

Prevention System [FPS]); the Department of Defense Business Activity Monitoring tool; and the Department of Labor's Unemployment Insurance (UI) Integrity Center of Excellence, a federal-state partnership that helps prevent, detect, and reduce improper payments in state run programs. The SSA has a process to intercept payments to beneficiaries who have died or been incarcerated, and has established an Analytics Center of Excellence which works on capturing real-time data and building more meaningful metrics, thereby allowing SSA to focus efforts on those projects or initiatives that yield the most promise.

As a result of the Initiative, agencies cumulatively identified and stopped over \$5.7 billion of improper payments as of the end of FY 2015. The Initiative continues to be a significant opportunity for the Federal Government to reduce improper payments, as agencies learn to implement additional analytic tools and techniques that prevent and identify improper payments or awards. While these results are important, there is more work that can be done to improve payment accuracy across the Government. To realize the full potential of the Initiative, agencies need access to the most relevant data and to refine their business processes, which will require additional legislative actions.

Opportunities to improve payment matching and reviews continue to develop as more agencies implement the advanced tools of the Treasury Do Not Pay Business Center. Noteworthy success includes synchronized payment access to the System for Award Management (SAM) Exclusions restricted database via Treasury's Payment Integration capabilities, which led to a 99.7 percent reduction in "false positive" matches when compared to the public version of information.

The Budget

There is compelling evidence that investments in administrative resources can significantly decrease the rate of improper payments and recoup many times their initial investment. That is why this Administration has always proposed in each Budget to make significant investments in activities to ensure that taxpayer dollars are spent correctly. While a few proposals in the FY 2016 budget have been enacted, there are still several program integrity proposals await Congressional action. Below, I have highlighted a small number of the program integrity proposals that were proposed in the FY 2016 and the FY 2017 Budgets to help reduce improper payments. It is important to note that many of these proposals do not require additional funding but are legislative changes that are necessary to help our Government run more efficiently.

Program Integrity Proposals Proposed in FY 2016 and Re-Proposed in FY 2017

- *Improve Collection of Pension Information and Transition to an Alternative Approach based on Years of Non-Covered Earnings after 10 Years.* The FY 2017 Budget re-proposes legislation that would improve reporting for non-covered pensions by including up to \$70 million for administrative expenses—\$50 million of which would be available to the States—to develop a mechanism so that the SSA could enforce the Windfall Elimination Provision (WEP) and Government Pension Offset (GPO). The proposal would require State and local governments to provide information on their non-covered pension payments to SSA so that the agency can apply the WEP and GPO adjustments. Under current law, the WEP and GPO adjustments are dependent on self-reported pension data and cannot be independently verified. This proposal will help SSA tackle one of their largest root causes for improper

payments which is the inability to authenticate eligibility (estimated savings: \$8 billion over 10 years).

- *Hold Fraud Facilitators Liable for Overpayments.* The FY 2017 Budget re-proposes to hold fraud facilitators liable for overpayments by allowing SSA to recover the overpayment from a third party if the third party was responsible for making fraudulent statements or providing false evidence that allowed the beneficiary to receive payments that should not have been paid (estimated savings: \$8 million over 10 years).
- *Government Wide Use of Custom and Border Patrol (CBP) Entry/Exit Data to Prevent Improper Payments.* The FY 2017 Budget re-proposes to provide for the use of CBP Entry/Exit data to prevent improper OASDI and SSI payments. An SSI beneficiary who is outside the United States for 30 consecutive days is not eligible for benefits for that month. For the OASDI program, U.S. citizens can generally receive benefits regardless of residence, but non-citizens may be subject to additional residency requirements depending on the country of residence and benefit type. This data also has the potential to be useful across government to prevent improper payments, helping programs reduce the improper payments caused by the inability to authenticate eligibility (estimated savings: \$177 million over 10 years).
- *Allow the Secretary of HHS to Require Prior Authorization of all Medicare Fee-For-Service Items and Services.* The FY 2017 Budget re-proposes to allow the Secretary to require prior authorization for specified Medicare FFS items and services. This would provide authority to allow the Secretary to require prior authorization for items and services that are at the highest risk for improper payment. By allowing prior authorization on additional items and services, CMS can make sure in advance that the correct payment goes to the right provider for the appropriate service, and prevent future audits on those payments (estimated savings \$75 million in savings to Medicare over 10 years).
- *Suspend Coverage and Payment for Questionable Part D Prescriptions and Incomplete Clinical Information.* The FY 2017 Budget re-proposes to give the Secretary authority to suspend coverage and payment for drugs when those prescriptions present an imminent risk to patients or when they are prescribed by providers who have been engaged in misprescribing or overprescribing drugs with abuse potential. It also provides the Secretary authority to require additional clinical information on certain Part D prescriptions (estimated savings \$650 million over 10 years).
- *Allow Civil Monetary Penalties for Providers and Suppliers Who Fail to Update Enrollment Records.* The FY 2017 Budget re-proposes to allow civil monetary penalties for providers and suppliers who fail to update enrollment records. Currently, providers and suppliers are required to update enrollment records to remain in compliance with the Medicare program. Unreported changes in provider enrollment information leave room for fraud to take place. This proposal would increase CMS' authority to enforce appropriate reporting of changes in provider enrollment information through civil monetary penalties or other intermediate sanctions to mitigate associated risk (estimated \$32 million collected over 10 years).
- *Retain a Portion of Medicare Recovery Audit Contractor (RAC) Recoveries to Implement Actions that Prevent Fraud and Abuse.* While the Medicare Access and CHIP Reauthorization Act of 2015 did allow for HHS to retain up to 15 percent of RAC recoveries for certain purposes related to addressing improper payments, the FY 2017 Budget re-proposes to allow CMS to use up to 25 percent of RAC recoveries to implement additional

corrective actions to prevent improper payments and fraud. (estimated savings \$800 million over 10 years).

- *Extend Funding for the Medicaid Integrity Program.* The FY 2017 Budget re-proposes an increase in funding for the Medicaid Integrity Program (MIP) by \$580 million over 10 years above the current funding level. The additional investment starts with an additional \$25 million in FY 2017 and increase gradually to an additional \$100 million in FY 2026. Thereafter, the total would be annually adjusted by the Consumer Price Index. The funding would be used to expand the Medicaid Financial management program reviews and address other program integrity vulnerabilities (estimated savings \$1.3 billion over 10 years).
- *Allow Medicaid Fraud Control Units (MFCUs) to receive Federal matching funds for investigation and prosecution in additional care settings.* The FY 2017 Budget re-proposes to allow MFCUs to receive Federal matching funds for investigation and prosecution in additional care settings. MFCUs currently receive Federal funding to investigate and prosecute allegations of abuse or neglect against Medicaid beneficiaries occurring in institutional settings. This proposal would expand MFCU authority to include non-institutional settings such as the beneficiary's home, day care facilities, and transportation to a health facility (estimated savings \$72 million over 10 years).
- *Track High Prescribers and Utilizers of Prescription Drugs in Medicaid.* The FY 2017 Budget re-proposes to require states to monitor high risk billing activity to identify and remediate prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs in the Medicaid program (estimated savings \$770 million over 10 years).
- *Permit Exclusion from Federal Health Care Programs if Affiliated with Sanctioned Entities:* The FY 2017 Budget re-proposes to expand the current authority to exclude individuals and entities from federal health programs if they are affiliated with a sanctioned entity by: eliminating the loophole in current law that allows an officer, managing employee, or owner of a sanctioned entity to evade exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity (estimated savings \$70 million over 10 years).

New FY 2017 Program Integrity Proposals

- *Allow SSA to Use Commercial Databases to Verify Real Property Data in the SSI Program.* The FY 2017 Budget proposes to reduce improper payments and lessen recipients' reporting burden by authorizing SSA to use private commercial databases to check for ownership of real property (i.e. land and buildings). The data will reduce improper payments by allowing SSA access to better data on potentially countable assets. The inability to verify eligibility is the largest root causes for improper payments in the SSI program and this proposal would help. Consent to allow SSA to access these databases would be a condition of benefit receipt for new beneficiaries. All other current due process and appeal rights would be preserved (estimated savings: \$559 million over 10 years).
- *Increase Overpayment Collection Threshold for SSA's Old Age Survivors and Disability Insurance.* The FY 2017 Budget proposes to increase the Minimum Monthly OASDI Overpayment Collection from \$10 a Month to 10 percent of monthly benefit payable. The Budget would change the minimum monthly withholding amount for recovery of Social Security benefit overpayments to reflect the increase in the average monthly benefit since SSA established the current minimum of \$10 in 1960. By changing this amount from \$10 to

10 percent of the monthly benefit payable, SSA would recover overpayments more quickly and better fulfill their stewardship obligations to the combined Social Security Trust Funds. The SSI program already utilizes the 10 percent rule (estimated savings: \$848 million over 10 years).

- *Authorize SSA to Use All Collection Tools to Recover Funds in Certain Scenarios.* The FY 2017 Budget proposes to allow SSA a broader range of collection tools when someone improperly cashes a beneficiary's check. Payment in excess of the amount due or paid after death are considered overpayments. In the case of a joint account and a deceased worker, if the joint account holder is entitled on the deceased worker's record, any payment in excess of amount due or paid after death is deemed an overpayment. The Budget proposes to deem both as overpayments and subject them to the broader range of collection procedures (estimated savings: \$35 million over 10 years).
- *Allow the Secretary to Reject Claims for New Providers and Suppliers Located Outside Moratorium Areas.* The FY 2017 Budget proposes to permit the Secretary of HHS to reject claims for services or items provided by newly enrolled providers or suppliers in geographic areas not subject to temporary moratoria when the services or items are provided to beneficiaries living in areas where a temporary enrollment moratorium has been established. Some providers and suppliers are circumventing enrollment moratoria by setting up businesses right outside the moratorium areas and providing services to beneficiaries living in the moratorium area (estimated savings of \$50 million to Medicare over 10 years).

As I mentioned above, investments in administrative resources can significantly decrease the rate of improper payments and recoup many times their initial investment. That is why this Administration continues to propose significant investments in activities to ensure that taxpayer dollars are spent correctly.

Conclusion

Combating improper payments within the Federal Government is a top priority for the Administration and we will continue to explore new and innovative ways to address the problem. Prior success reducing improper payments was achieved by working with Agencies, the IG community, and the Congress. This approach continues to have merit, and the Administration will remain focused on actions like: (1) annual reviews by agency IGs; (2) improving corrective action plans so that they focus on the main root causes of improper payments; (3) working with the Congress to move forward critical program integrity initiatives, that have been proposed year after year and yet languish in the Congress and (4) using cutting-edge technology to identify and prevent improper payments.

Although progress has been made, through clarified guidance, enacted budget proposals, and focused corrective action plans to name a few, much remains to be done. We look forward to working with the Congress to pass the provisions within the President's FY 2017 Budget I have mentioned today. We are confident our strategy will yield results for the taxpayer. I appreciate the attention this Committee and the Congress dedicates to preventing improper payments, along with the efforts of the GAO, the IG community, and agencies. I remain committed to achieving our mutual objective of achieving payment accuracy and integrity in Federal programs.

Thank you again for inviting me to testify today. I look forward to answering your questions.

Mr. MEADOWS. Thank you so much.
Ms. Conley, you're recognized for 5 minutes.

TESTIMONY OF SHEILA CONLEY

Ms. CONLEY. Good afternoon, Chairman Meadows, Ranking Member Connolly, and distinguished members of the subcommittee. Thank you for your leadership in improving Federal financial management, and thank you for inviting me to testify about the Department of Health and Human Services' efforts to reduce improper payments.

I appreciate the opportunity to describe HHS' commitment and progress in addressing improper payments as well as some of our major initiatives. With outlays of approximately \$1 trillion and responsibility for some of the government's largest programs, strengthening program integrity and reducing improper payments is a top priority of the Department. This focus extends to every member of HHS' senior leadership team and throughout all of our operating divisions and programs. While we've made significant progress, more work remains.

Improper payments result from many circumstances, including a lack of or insufficient documentation to support a sampled claim. Improper payments are not measures of fraud, although the concepts are often mistakenly used interchangeably.

HHS is focused on improper payments since 1996 when we worked with the HHS Office of the Inspector General to establish a Medicare fee-for-service error rate. Since then, we've established error rate processes for several additional programs and continue to implement targeted corrective actions.

For fiscal year 2015, HHS reported error rates for seven programs that are susceptible to significant improper payments. Two programs, Medicare fee-for-service and foster care, reported lower rates since last year. However, five programs reported higher rates compared to the previous year. Through these seven programs, about 95 percent of the Department's outlays are subjected to the rigors of an annual error rate measurement process and the scrutiny of public disclosure.

In fiscal year 2015, we also reported rates for seven Superstorm Sandy programs as directed by law. We've learned that our efforts to reduce improper payments must be strategic, multifaceted, and continuous. To that end, we're pursuing three approaches that deliver results: Leveraging technology, strengthening key partnerships, and exploring innovative solutions.

As for leveraging technology, one of our major initiatives is the fraud prevention system, which uses predictive analytics technology to automatically screen Medicare fee-for-service claims prior to payment. That's an average of 4-1/2 million claims per day that are screened. It also flags suspicious patterns and identifies investigative leads. For 2015, we reported a return on investment of \$11.50 for every dollar the government spends on this system.

As for strengthening key partnerships, it's important to recognize that many of our programs are State administered, which make the States critical to our success. We're working closely with State and Medicaid and CHIP officials to implement important requirements

that will both strengthen program integrity and directly impact the error rates.

A very promising innovative solution relates to HHS' use of prior authorization initiatives in Medicare fee-for-service, an approach used in the private sector and other healthcare programs. HHS began using prior authorization for power mobility devices and is expanding this practice to other areas.

While our priority is to make payments properly in the first place, we also focus on recovering improper payments when they do occur. For example, the Medicare fee-for-service recovery audit program has collected over \$10 billion since 2009.

While the Department has made progress, more work remains. We have a proven track record of working hard to address improper payments, and this area is and will continue to be a top priority for the Department. We look forward to working with this subcommittee and our partners and other Federal agencies as well as the States to reduce improper payments and strengthen our programs.

Thank you again for this opportunity to testify. I'm happy to answer any questions that you may have.

[Prepared statement of Ms. Conley follows:]

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STATEMENT OF
SHEILA O. CONLEY

DEPUTY ASSISTANT SECRETARY FOR FINANCE AND DEPUTY CHIEF
FINANCIAL OFFICER

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 IPERIA, 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.

Mr. MEADOWS. Thank you, Ms. Conley.
Ms. Park, you're recognized for 5 minutes.

TESTIMONY OF LAURIE PARK

Ms. PARK. Good afternoon, Chairman Meadows, Ranking Member Connolly, and members of the subcommittee. Thank you for inviting me here today to discuss VA's accomplishments and plans for reducing improper payments and achieving sustained compliance to IPERA.

As the VA deputy assistant secretary for finance, I am responsible to the interim chief financial officer for the departmentwide financial management activities. I am keenly aware that VA's financial management needs to improve, and I assure you that the Department is taking aggressive action to address our financial management challenges, including compliance with IPERA, as part of our stewardship of taxpayers' dollars.

The Department is currently responsible for ensuring accurate testing, projections, and annual reporting of improper payments in 14 programs. These 14 programs provide a wide range of goods and services, including care in the community for our Nation's veterans, medical supplies to VA hospital and clinics, benefits including compensation for disabilities, education, and vocational rehabilitation for our veterans, rebuilding after Hurricane Sandy, and payments to Federal employees.

I am responsible for issuing departmentwide guidance for implementing IPERA and for providing oversight on related departmental activities. In an effort to ensure commitment and accountability, a senior accountable official is responsible for identifying and reducing improper payments in their programs.

In May 2016, the VA Office of Inspector General reported that VA did not comply with two of six IPERA requirements because it did not meet reduction targets and maintain a gross improper payment rate of less than 10 percent for all programs. Eight of these programs did not meet reduction targets established in fiscal year 2014, and two of these programs also exceeded the 10 percent threshold. OIG also reported that VA's increase was due primarily to improvements in estimating improper payments.

In 2015, the Department improved its testing in response to an OIG finding that acquisition regulation requirements were not appropriately considered. VA collaborated closely with the Office of Management and Budget and the IG to ensure the accurate understanding of the effect of this concern. As a result, VA classified payments that did not comply with applicable Federal procurement laws, including the Federal Acquisition Regulation, as improper.

Prior to 2016, VA's longstanding practice had been to rely on authorization with individual providers to procure care in the community when other arrangements were not practical or would delay care that our veterans urgently need. Some smaller providers and those who only treat a few veterans a year may consider following all five requirements a disincentive to treating veterans.

In an effort to find a way to comply with statute and regulation, the VA has sought legislative authority to enter into provider agreements. This legislation would greatly reduce improper pay-

ments that were considered technically improper, but do not represent any form of fraud, waste, or abuse.

In 2015, the VA increased senior leadership collaboration and awareness of improper payment challenges. We also repurposed existing resources to establish a new office focused on driving identification and reduction of improper payments. This office's singular focus on achieving IPERA compliance has elevated the priority and awareness of this important objective across the Department.

Furthermore, the VA is working with the Department of Treasury through Do Not Pay and the Social Security Administration using death-to-match capabilities to identify improper payments in both the pre- and the postpayment phases.

We still have additional opportunities to leverage these resources, and VA supports Treasury's legislative proposal to enhance the effectiveness of Do Not Pay. We are continuing our collaboration with Treasury on debt collection and utilizing other Treasury offerings that improve our financial management performance.

In addition, we have initiated a planning for a new financial management system, which will strengthen our internal controls, provide an opportunity to reengineer our financial business processes, and increase the visibility of our financial position.

VA acknowledges its current improper payment rate and is taking actions to increase IPERA compliance, while at the same time providing veterans the benefits and the services that they have earned and deserve. Those actions include continuing to ensure that the improper payment definition is applied correctly and may result in an increase of reported improper payments in some programs in 2016 as well. However, most of these new improper payments are instances where VA paid the right person the right amount for goods and services received and do not represent a loss to the government.

Thank you for the opportunity to appear before you today and for your continued support of veterans. I look forward to your questions.

[Prepared statement of Ms. Park follows:]

**MS. LAURIE PARK
DEPUTY ASSISTANT SECRETARY FOR FINANCE AND
ACTING DEPUTY CHIEF FINANCIAL OFFICER
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SUBCOMMITTEE ON GOVERNMENT OPERATIONS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES**

September 21, 2016

Introduction

Good afternoon, Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee. Thank you for the opportunity to discuss the actions the Department of Veterans Affairs (VA) is taking to reduce improper payments and to achieve sustained compliance with improper payment laws and implementation guidance under the Improper Payments Elimination and Recovery Act (IPERA).

As the VA Deputy Assistant Secretary for Finance, I am responsible to the Interim Chief Financial Officer (CFO) for Department-wide financial management activities. I am keenly aware that VA's financial management needs to improve and I assure you that at the direction of Secretary McDonald, Deputy Secretary Gibson, and my boss, Ed Murray, the Interim Chief Financial Officer, we are taking aggressive action to address our financial management challenges, including compliance with IPERA. Reducing improper payments is a very visible and high-priority element of our overall effort to strengthen VA financial management, and we are committed to achieving compliance with IPERA and remediating improper payments as part of our stewardship of taxpayer dollars.

Background

The Department is currently responsible for ensuring accurate testing, projections and annual reporting of improper payments in 14 programs. These 14 programs provide a wide-range of goods and services, including care in the community for our Nation's Veterans; medical supplies to VA hospitals and clinics; benefits

including compensation for disabilities, education, and vocational rehabilitation for Veterans; rebuilding after Hurricane Sandy; and payments to Federal employees. I am responsible for issuing Department-wide guidance for implementing IPERA and for providing oversight on related Departmental activities. In an effort to ensure commitment and accountability, a Senior Accountable Official for each of the 14 programs is responsible for assessing risk in their program, identifying improper payments, and executing corrective actions for remediation.

In its May 2016 report, the VA Office of Inspector General (OIG) reported that VA did not comply with two of six IPERA requirements because it did not meet reduction targets and maintain a gross improper payment rate of less than 10 percent for all programs. Eight programs did not meet reduction targets established in fiscal year (FY) 2014, and two of these programs also exceeded the 10-percent threshold. OIG also reported that VA's increase in improper payments was due primarily to improvements in estimating improper payments.

In FY 2015, the Department improved its testing in response to an OIG finding that acquisition regulation requirements were not appropriately considered. VA collaborated closely with the Office of Management and Budget (OMB) and OIG to ensure an accurate understanding of the effect of this concern. As a result, VA classified payments for contracted goods and services that did not comply with applicable Federal procurement laws, including the Federal Acquisition Regulation (FAR), as improper. Prior to FY 2016, VA's long-standing practice had been to rely on arrangements called individual authorizations to procure care in the community, when other arrangements were not practical or would delay care that Veterans urgently need. Individual Authorizations are contractual in nature, and are therefore subject to Federal procurement laws. VA has sought legislative authority to enter into provider agreements that would allow VA to contract with providers on an individual basis in the community, without forcing providers to meet excessive compliance burdens while still ensuring that Veterans are able to quickly access quality care in the community.

In 2015, VBA also introduced a more vigorous methodology to test compensation claims, identifying additional improper payments. Training on the improved methodology has proven to be effective in identifying improper payments and areas of process improvement. VA is correcting the issues causing improper payments through continuous process improvement and the use of standardized tools to improve claims processing outcomes. In addition, VA is taking action to adjust claims more timely through reduction of the claims backlog; the use of an automated rules-based processing system; and increased automation. Subjectivity in decisions has also been reduced due to mandatory use of tools, such as the Rating Evaluation Builder and the Special Monthly Compensation Calculator. VA has and will continue to prioritize training on improper payment error trends, implement corrective action plans, and review procedural guidelines to ensure process clarity.

Commitment to Accurate Reporting, Remediating, and Ensuring Accountability for Improper Payments

In FY 2015, VA increased senior leadership collaboration and awareness of improper payment challenges. We also established a new oversight office, the Improper Payments Remediation and Oversight Office, focused on driving identification and remediation of improper payments. We recruited staff with expertise in IPERA compliance, internal control assessment, systemic issue identification, and corrective action development. This office's singular focus on achieving IPERA compliance has elevated the priority and awareness of this important objective across the Department. Actions initiated in 2016 include:

- Ensuring consistent application of the definition of improper payments across the Department in the area of acquisitions. VA recently issued acquisition guidance mandating testing procedures and providing instructions on what constitutes a proper payment;
- Revising IPERA policy to clearly define roles and responsibilities, in addition to processes and procedures; and

- Reviewing improper payment risk assessments, testing plans, and corrective action plans for each program to ensure a consistent enterprise-wide approach and compliance with policy.

Furthermore, VA is working with the Department of Treasury (Treasury) and the Social Security Administration (SSA) to identify improper payments in both the pre- and post-payment phases. We still have additional opportunities to leverage these resources to prevent future improper payments. VA is working with Treasury to improve the number of payments identified via their Do Not Pay tools. We also actively participate in Government-wide efforts to improve financial management, such as the OMB CFO Council. Likewise, we are continuing our collaboration with Treasury on debt collection and utilizing other Treasury offerings that improve our financial management performance. In addition, we have initiated planning for VA's new financial management system, which will strengthen our internal controls, provide an opportunity to re-engineer financial business processes, and increase the visibility of our financial position. Our comprehensive efforts to improve financial management will assist in reducing improper payments.

Path Forward

Even with these efforts, VA recognizes it has many challenges to overcome, while at the same time providing Veterans the benefits and services they have earned and deserve. VA acknowledges its current improper payment rate and is taking actions to increase compliance and remediate improper payments, but VA needs legislative authority to enter into provider agreements to purchase care in the community for our Veterans. This legislation would greatly reduce improper payments that were technically improper but do not represent a loss to the Government. The Department remains committed to both obtaining compliance with IPERA and remediating improper payments.

Thank you for the opportunity to appear before you today and for your continued support of Veterans. I look forward to your questions.

Mr. MEADOWS. Thank you, Ms. Park.
Ms. LaCanfora, you're recognized for 5 minutes.

TESTIMONY OF MARIANNA LACANFORA

Ms. LACANFORA. Chairman Meadows, Ranking Member Connolly, and members of the subcommittee, thank you for inviting me to discuss our efforts to reduce improper payment. I'm Marianna LaCanfora, assistant deputy commissioner for Retirement and Disability Policy and chair of Social Security's Improper Payments Oversight Board.

Few government agencies touch as many people as we do. This fiscal year, we expect to pay more than \$906 billion in Social Security benefits to more than 60 million people and about \$59 billion in supplemental security income to more than 8 million people. For fiscal year 2014, we did not meet our accuracy targets for the SSI program or for the Old-Age, Survivors, and Disability Insurance Program. Pursuant to IPERA, we sent a remediation plan for each program to Congress. Although we didn't meet our targets for the OASDI program, we have maintained a very high payment accuracy rate in that program. In fiscal year 2015, for example, 99.6 percent of the benefit dollars we paid were free of overpayment.

Our greatest challenge is the SSI program. SSI is a means-tested program for aged, blind, or disabled individuals with limited income or resources. The SSI program has inherent complexities. We're required to consider many factors each month, including income, resources, and living arrangements, in deciding whether and how much a recipient should receive. Since these factors can change often, the program's design makes it vulnerable to payment errors. The SSI overpayment accuracy rate for 2015 was 93.9 percent, our highest rate since 2003. We've made progress, but we must continue to target the root causes of improper payment and further improve accuracy.

Our remediation plan focuses on strategies to address these root causes. For example, we're combating errors concerning financial accounts by using an automated process to verify bank account balances with financial institutions to identify access resources.

In addition, last year's Bipartisan Budget Act gave us several important new authorities. Perhaps most critical will be the ability to obtain timely and accurate earnings information from third-party payroll providers. We're working now to implement that and other provisions.

We're also identifying new sources of reliable and timely data that will allow us to lessen our reliance on beneficiary reporting. Also worth noting is our creation of a data analytic center of excellence to inform our efforts and help measure progress, as well as two Federal communities of practice; one for data exchange and another for improper payment prevention. Through these efforts, we bring together more than 30 agencies to collaborate and share best practices.

Before concluding, I'd like to emphasize our need for funding. We're among the most efficient and effective agencies in the Federal Government. Our administrative costs represent only about 1.3 percent of the benefits we pay. Our medical continuing disability reviews save \$8 on average over 10 years for every \$1 in-

vested, and our SSI nonmedical reviews save \$3 for every \$1 invested.

While we appreciate the recent increases in program integrity funding, we also need adequate and sustained funding to provide basic Social Security services. Since 2010, this part of our budget has decreased by nearly 10 percent after adjusting for inflation, while the number of our beneficiaries has increased by 12 percent. Consequently, we are seeing service degradation in many areas, including increased wait times in our field offices and on our telephones. Moreover, we're dealing with an unprecedented backlog in our program service centers where we handle much of the work to prevent improper payment.

The fiscal year 2017 President's budget request would allow us to increase our program integrity efforts, while providing quality service to the millions of people who depend on us. Conversely, under the House Appropriations bill, we would be forced to furlough all employees and close field offices around the country for up to 2 weeks next year. It's imperative that we receive adequate funding in fiscal year 2017.

We appreciate your interest in our efforts to maintain high payment accuracy and quality service. Thank you for inviting me to testify, and I'd be happy to answer questions.

[Prepared statement of Ms. LaCanfora follows:]



**COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT OPERATIONS**

UNITED STATES HOUSE OF REPRESENTATIVES

SEPTEMBER 22, 2016

STATEMENT FOR THE RECORD

**MARIANNA LACANFORA
ASSISTANT DEPUTY COMMISSIONER
OFFICE OF RETIREMENT AND DISABILITY POLICY
SOCIAL SECURITY ADMINISTRATION**

Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee:

Thank you for inviting me to discuss our efforts to reduce improper payments each year and our compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA), as well as our role in supporting the Treasury's Do Not Pay Business Center. I am Marianna LaCanfora, Assistant Deputy Commissioner for Retirement and Disability Policy. I am also the Chair of SSA's Improper Payments Oversight Board.

We take our responsibility to reduce improper payments very seriously. As good stewards of our resources and taxpayer funds, we remain focused on the integrity of our programs and minimizing improper payments, which include both paying too much and paying too little. We balance these program integrity responsibilities with our commitment to serve the public and issue timely benefits. In addition, we strongly support the Federal Government's efforts to reduce improper payments through the Department of Treasury's Do Not Pay initiative.

Program Overview

We administer the Old-Age, Survivors, and Disability Insurance (OASDI) program, commonly referred to as "Social Security." Social Security is a social insurance program, under which workers earn coverage for retirement, survivors, and disability benefits by working and paying Social Security taxes on their earnings.

We also administer the Supplemental Security Income (SSI) program, which provides monthly payments to people with limited income and resources who are aged, blind, or disabled. Adults and children under the age of 18 can receive payments based on disability or blindness. General tax revenues fund the SSI program.

Few government agencies touch as many people as we do. Social Security pays monthly benefits to more than 60 million individuals, consisting of 40 million retired workers and 3 million of their spouses and children; 9 million workers with disabilities and 2 million dependents; and 6 million surviving widows and widowers, children, and other dependents of deceased workers. During fiscal year (FY) 2016, we expect to pay more than \$906 billion to Social Security beneficiaries. In addition, in FY 2016, we expect to pay about \$59 billion in Federal benefits to over 8 million SSI recipients. In carrying out these programs, we are among the most efficient and effective agencies in the Federal Government—our discretionary administrative costs represent about 1.3 percent of benefit payments that we pay under the OASDI and SSI programs.

Program Integrity

Improving program integrity is one of our top priorities. We have demonstrated throughout the years that we are effective stewards of our program dollars, and have made great strides in minimizing improper payments. We have long used a robust review process to measure the quality of our payments and identify the major causes of payment errors in our programs. This allows us to focus our efforts on the key initiatives that address the root causes of these errors.

For FY 2015—the last year for which we have complete data—our quality reviews show that approximately 99.6 percent of all the OASDI dollars we paid were free of overpayment, and nearly 99.9 percent were free of underpayment.¹

That same year, we also achieved high levels of payment accuracy in the SSI program despite the inherent complexities (described below) in calculating monthly payments due to beneficiaries' changes in income, resources, and living arrangements. For FY 2015, 93.9 percent of all SSI benefit dollars we paid were free of overpayment, and over 98.6 percent were free of underpayment. While year-to-year changes are not statistically significant, this overpayment accuracy rate is our highest measured rate since FY 2003, while our underpayment accuracy rate is our highest since FY 2005.

I will discuss below what we have done and what we are planning to do to improve SSI program integrity. First, I want to highlight two of our most successful program integrity measures for which we receive special dedicated funding—our continuing disability reviews² (CDRs) and SSI non-medical redeterminations that save billions of dollars.

Medical CDRs are periodic reevaluations to determine if beneficiaries continue to meet the eligibility requirements to qualify for benefits, and SSI redeterminations are periodic reviews of non-medical factors of eligibility, such as income and resources. Please note that changes in benefits that result from CDRs do not necessarily mean that SSA was making improper payments. Rather, these activities ensure that beneficiaries continue to meet the eligibility requirement to receive payments. Dedicated program integrity funding, including the cap adjustment amounts authorized in the *Bipartisan Budget Act of 2015*, allows us to work down our backlog of CDRs and helps prevent its recurrence over the next 10 years.

With the program integrity funding provided to us in FY 2015, we completed approximately 799,000 full medical CDRs and approximately 2.267 million redeterminations. In FY 2016, we are in progress to successfully meet our target to conduct 850,000 full medical CDRs and 2.5 million redeterminations. We will continue the commitments of our important program integrity work on CDRs and redeterminations with full funding of the FY 2017 President's Budget request. Current estimates indicate that medical CDRs conducted in FY 2017 will yield a return on investment (ROI) of about \$8 on average in net Federal program savings over 10 years per \$1 budgeted for dedicated program integrity funding, including Old-Age, Survivors, and Disability Insurance; SSI; Medicare; and Medicaid program effects. Similarly, we estimate that non-medical SSI redeterminations conducted in FY 2017 will yield a ROI of about \$3 on average of net Federal program savings over ten years per \$1 budgeted for dedicated program integrity funding, including SSI and Medicaid program effects.³

For our Social Security disability insurance (DI) program, we also conduct work CDRs, which

¹ For a discussion of the primary reasons for improper payments in the OASDI program, and our efforts to reduce such payments, see The Social Security Administration's Agency Financial Report (AFR) for Fiscal Year (FY) 2015 (pp. 174-177, 184-191), available at <https://www.ssa.gov/finance>.

² We conduct medical CDRs on both SSI and DI cases.

³ Using PB 2017 Budget Assumptions.

evaluate a beneficiary's work activity to determine continued eligibility for benefits. In FY 2014, we completed about 250,000 work CDRs for DI beneficiaries.

In addition, as required under the Social Security Act, we conduct pre-effectuation reviews of at least half of all initial and reconsideration allowances for DI and SSI adult disability benefits. For every dollar spent in FY 2014 on these reviews, we estimate a lifetime savings of \$11 in DI and SSI benefits.

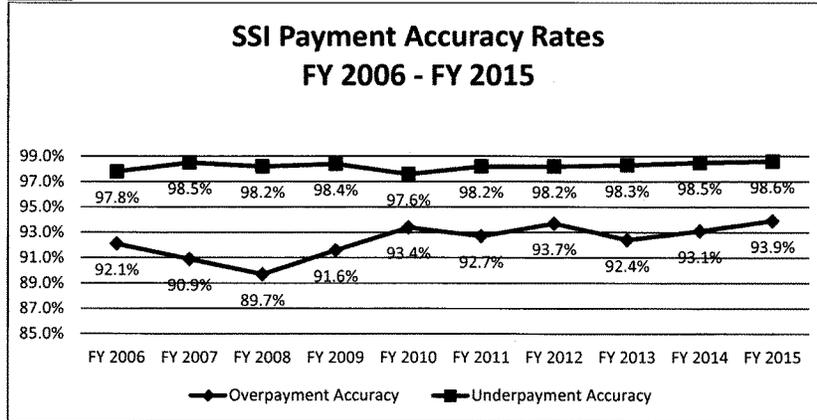
Payment Accuracy in the SSI Program

Our greatest payment accuracy challenge is the SSI program. SSI is a means-tested program for individuals who are blind, disabled, or aged and have limited income and resources. The SSI program is complex, requiring us to consider many factors every month—including income, resources, and living arrangements—in deciding whether a beneficiary is eligible and how much his or her monthly benefit should be. These factors can and often do change, and improper payments occur when recipients or deemors⁴ (or representative payees reporting on their behalf) fail to report changes on time in any of these factors, which is one of the biggest causes of payment errors. Furthermore, even if an SSI payment is correct when paid at the beginning of the month, a change that occurs later in the month, even if reported on time, can result in a beneficiary being overpaid or underpaid for that month. For example, a beneficiary who works may receive a bonus or overtime pay during a month, which may result in ineligibility for that month. In other words, the program's responsiveness to changing circumstances makes it prone to payment errors.

Due in large part to these complexities, which are inherent in the design of any means-tested program, the improper payment rate in the SSI program has been consistently higher than that of the OASDI program (where payment accuracy has exceeded 99 percent for many years). Chart 1 shows the payment accuracy rates for the SSI program for FY 2006 through 2015.

⁴ A "deemor" is someone (such as a parent or spouse) whose income and resources we consider in determining an SSI applicant's or recipient's eligibility and payment amount.

Chart 1



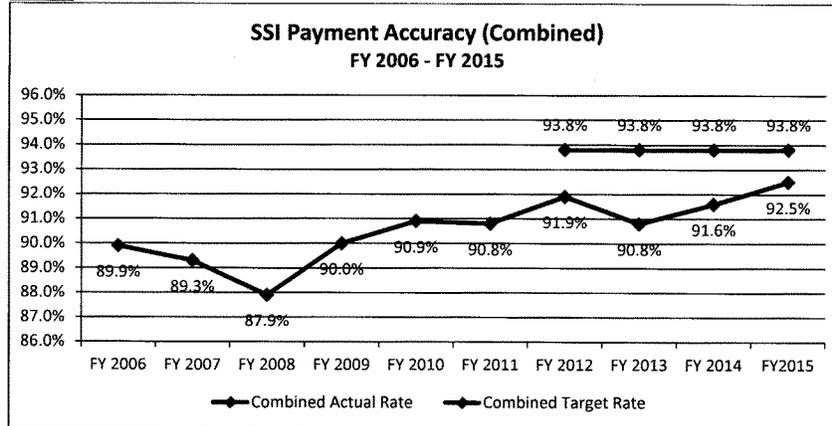
Notes: While year-to-year changes are not statistically significant, the increase in overpayment accuracy from FY 2008 to FY 2015 is statistically significant.

Regardless of these challenges, we remain committed to simplifying the SSI program, and we are exploring ways to do this in a fair and equitable manner. Further, as discussed below, we have developed some legislative proposals that would enhance our ability to prevent improper payments in the SSI program.

Following OMB's guidance,⁵ we established reduction targets for improper payment levels. For FY 2012 through the present, our reduction targets for each year have been ambitious: underpayment error of less than 1.20 percent and overpayment error of less than 5.00 percent — i.e., a combined accuracy rate of 93.8 percent. As Chart 2 shows, this target accuracy rate is considerably higher than the actual accuracy rates for the SSI program over the past ten years. Nevertheless, we selected this rate to demonstrate our commitment to further our strategic goal of reducing improper payments, and we developed a number of strategies (described in the next section) that should, in time and with adequate funding, continue to measurably reduce the improper payment rate for the SSI program.

⁵ Office of Management and Budget M-15-02, Appendix C to Circular No. A-123, *Requirements for Effective Estimation and Remediation of Improper Payments*, Oct. 20, 2014.

Chart 2



Notes: The combined accuracy rate for a given year may not equal the sum of the accuracy rates in Chart 1 due to rounding. Furthermore, while year-to-year changes are not statistically significant, the increase in the accuracy from FY 2008 to FY 2015 is statistically significant.

While the accuracy rate in the SSI program generally has increased from FY 2009 to FY 2014, we have not yet met the target of a 93.8 percent accuracy rate. FY 2014 is the third consecutive year for which we reported that the SSI program did not meet the target rate. Accordingly, our OIG determined that the SSI program was noncompliant with IPERA for failing to meet our reduction targets for improper underpayments and overpayments. On June 3, 2016, as required under IPERA, we submitted our remediation plan to Congress (attached),⁶ some elements of which are described below.

Corrective Actions for SSI Improper Payments

Our quality review findings over the last five years show that the major causes of overpayments in the SSI program have been errors or omissions in the following:

- Financial accounts (e.g. bank savings or checking accounts, or credit union accounts balances);
- Wages;
- Other real property (i.e., ownership of non-home real property); and
- In-Kind Support and Maintenance.

Described below are some of our recent efforts to implement initiatives that would address these primary causes of improper payments. For a broader discussion of our current initiatives,

⁶ We also submitted this remediation plan to Chairman Chaffetz of the House Oversight and Government Reform Committee.

see The Social Security Administration's Agency Financial Report (AFR) for Fiscal Year (FY) 2015,⁷ and our June 3 remediation plan.

Financial Accounts

In the SSI program, when an applicant, recipient, or deemor has financial accounts with values exceeding the allowable resource limits, these accounts may result in periods of SSI ineligibility. Historically, resources in financial accounts that exceed the allowable resource limits are the leading cause of SSI overpayment errors. In FY 2015, over 99 percent of the financial account overpayments were caused by the failure of the beneficiary or his or her representative to report either ownership of an account or an increase in the value of a financial account we already know about.

However, we have made strides to combat this cause of improper payments through implementing the Access to Financial Institutions (AFI) program.⁸ AFI is an automated process through which we verify alleged bank account balances with financial institutions to identify potential excess resources in financial accounts held by SSI applicants, recipients, and deemors. We reduce SSI improper payments resulting from excess resources held in financial institutions by using the AFI electronic process on initial claims and redeterminations (i.e., a review of a recipient's non-medical eligibility factors such as income and resources to determine continued eligibility and payment amount). In FY 2014, we expanded our use of AFI to cover more SSI initial claims and redeterminations.

Wages

For the past decade, wage discrepancies have been a leading cause of SSI overpayment and underpayment errors. Wage discrepancies occur when recipients or deemors have actual wages that differ from the wage amount used to calculate the SSI payment. We rely on individuals to self-report wages to us on time, but we know that many fail to report soon enough to prevent an improper payment; our quality reviews have shown that over 98 percent of the wage-related overpayment errors are because a recipient failed to report a change in his or her wages.

Over the years, we have implemented initiatives that allow individuals to more timely report wages. For instance, in FY 2008, we implemented SSI telephone wage reporting, which allows recipients, representative payees, and deemors to report prior monthly gross wages via an automated telephone system. In FY 2013, we implemented a similar initiative involving mobile wage reporting through smartphones. In FY 2015, we processed 453,842 successful wage reports through our smartphone wage reporting application and 441,763 through our automated telephone system. These reports are important because we generally receive them in time to prevent improper payments.

⁷ Available at <https://www.ssa.gov/finance> (pp. 192-199).

⁸ The AFI program was made possible by the *Foster Care Independence Act of 1999*, which contained a provision requiring SSI applicants and recipients to provide their authorization to obtain all financial records from all financial institutions as a condition of SSI eligibility.

However, as we recognized that telephone and mobile reporting continued to rely on recipients and others to self-report wage information, we also sought other means to increase our access to timely wage information. Consequently, through the President's FY 2016 Budget (which was submitted in February 2015), we submitted a legislative proposal to Congress that would allow us to use commercial databases and payroll provider information to verify wages in the SSI program. The proposal would reduce improper payments by authorizing SSA to conduct data matches with private commercial databases and payroll providers, and use that information to automatically increase or decrease benefits accordingly. Congress enacted a provision similar to our proposal in the *Bipartisan Budget Act of 2015* (section 824).⁹ We are excited about this provision as we anticipate that it will allow us to make meaningful reductions in SSI and DI overpayments, and we are working to begin accessing private wage data; we plan to implement in late calendar year 2017. We will issue a Request for Proposal later this year, and we expect to begin using the authority provided under section 824 beginning in the latter half of 2017.

Other Real Property

SSI ineligibility may result if a recipient owns real property other than his or her principal place of residence (referred to as "non-home real property"), and the equity value exceeds the resource limit. For the five-year period from FY 2011 through FY 2015, our stewardship reviews identified average projected overpayments of \$262 million per year resulting from undisclosed real property. We currently rely on the applicant or recipient to report ownership of non-home real property.

In 2013 and 2014, we tested the viability of using commercial data providers (e.g., LexisNexis/Accurint) to identify undisclosed real property. In FY 2017, we plan to integrate third-party non-home real property data with SSI systems for use during initial claims and redetermination interviews.

Other Corrective Actions

We have made enhancing quality and improving payment accuracy one of our critical goals. As I mentioned, I chair SSA's Improper Payments Oversight Board, which serves as an in-house clearinghouse and oversight body over our many program integrity-related initiatives.

We must move away from a model that relies on beneficiaries to report changes that affect benefits to one where we use reliable data to learn about these changes directly. In addition to the initiatives I previously mentioned, SSA also conducts data sharing, which is an effective and efficient method of providing accurate and timely payments. One of our strategic goals is to increase payment accuracy by expanding the use of data exchanges to produce a more efficient and accurate process for obtaining information that may affect benefits. We are constantly looking for and evaluating new sources of reliable data to reduce improper payments while also reducing the burden on beneficiaries to report information to us. In addition, we created and are leading a Federal Data Exchange Community of Practice, with more than 30 Federal departments

⁹ In enacting section 824, Congress also provided us the authority to use payroll provider information in the DI program. In addition, section 826 of the *Bipartisan Budget Act of 2015* required us to develop electronic means through which DI beneficiaries may report wages to us.

and agencies, that develops a collective knowledge base; finds common solutions to data exchange challenges; identifies cross-organizational solutions; resolves problems; shares best practices; and builds a network of Federal data exchange partners.

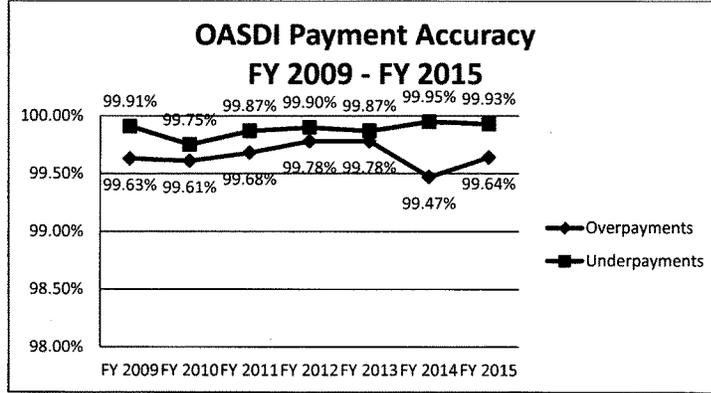
We are also looking at efforts across the Federal sector to address improper payments. Late last year, we established an Improper Payment Community of Practice, modeled after the Federal Data Exchange Community of Practice. Our goal was to bring together colleagues, identify common challenges, find opportunities to synchronize our efforts, and establish a forum for learning across government. We held our first meeting in January – and the community has now expanded to include nine Federal benefit-paying agencies.

In addition, we have established a new component within SSA – the Analytics Center of Excellence within the Office of the Chief Strategic Officer – to help answer key business questions to determine the effectiveness of our improper payment prevention and reduction efforts. Capturing real-time data and building more meaningful metrics will help us infuse data-driven decision-making throughout our processes, allowing us to focus our efforts on those projects or initiatives that yield the most promise.

Payment Accuracy in the OASDI Program

Our OASDI program has very high payment accuracy. As Chart 3 shows, the overpayment and underpayment accuracy rate for this program, both separately and combined, has been over 99 percent for a number of years.

Chart 3



Nevertheless, as with the SSI program, we selected ambitious accuracy rate goals to demonstrate our commitment to further our strategic goal of reducing improper payments. In reviewing our FY 2015 AFR, our IG found us not compliant with improper payment requirements because we did not achieve our target overpayment accuracy rate for FY 2014 of 99.80 percent. Our actual overpayment accuracy rate for that year was 99.47 percent.¹⁰ Pursuant to IPERA, in response to the IG's finding, we sent the attached report to the Congress on August 3, 2016.

Our quality reviews show that the main causes of OASDI improper payments on average over the last five fiscal years were: (1) DI benefits not correctly adjusted when beneficiaries have earnings above the "substantial gainful activity" (SGA) level, (2) benefits not correctly adjusted when beneficiaries also receive a pension based on earnings that were not covered by Social Security (also known as the "Windfall Elimination Provision" or WEP), and (3) benefits not correctly adjusted when spousal beneficiaries¹¹ also receive a pension based on government service that was not covered by Social Security (also known as the "Government Pension Offset" or GPO).

As explained in our report, we continually improve our process to ensure that we timely update beneficiaries' earnings. For example, we recently improved our reviews of beneficiaries' work activity by incorporating information from the National Directory of New Hires. We are also implementing two provisions of the *Bipartisan Budget Act of 2015* (Public Law 114-74) that we expect will improve our ability to more timely update our records with information concerning DI beneficiaries' earnings.

¹⁰ The attached OASDI remediation plan provides that the overpayment error rate in FY 2014 was .36 percent (i.e., an accuracy rate of 99.64 percent) and the underpayment error rate was .07 percent (i.e., an accuracy rate of 99.93 percent). However, these were the rates for FY 2015. The overpayment accuracy rate for FY 2014 was as provided in the paragraph above, and the underpayment accuracy rate was 99.95 percent (i.e., an error rate of .05 percent).

¹¹ This includes people who receive spouses' benefits based on the earnings of a living worker, as well as widows and widowers who receive benefits based on the earnings of a deceased worker.

We are also in the process of implementing a corrective action plan that we developed to mitigate improper payments caused by WEP and GPO. Our plan includes critical training to ensure that staff process WEP and GPO cases consistent with our policies, as well as solutions that address the underlying causes of these errors. These solutions include obtaining new sources of non-covered pension data, improving our automation, and clarifying our policies and instructions. Furthermore, the President's Budget for FY 2017 includes a legislative proposal that would improve administration of the WEP and GPO by providing access to non-covered pension information from the States in the near-term and, in the long-term, modifying the WEP and GPO so the reduction in benefits would be based on the non-covered earnings information we already have in our records.

Debt Collection

In addition to our efforts to prevent and detect improper payments, we have a comprehensive debt collection program to recover improper payments (and other debts). We collected \$3.363 billion in OASDI and SSI benefit overpayments in FY 2015 at an administrative cost of \$0.07 for every dollar recovered. We collected \$16.6 billion over a five-year period (FY 2011 through FY 2015). We recognize that as our benefit rolls increase and beneficiaries receive cost of living adjustments, our debt balance has grown. Therefore, we see a balanced approach to pursue corrective actions to prevent improper payments and continue to enhance our debt collection program. To recover overpayments, we use internal debt collection techniques (i.e., payment withholding, billing, and follow-up), as well as external collection techniques authorized by the *Debt Collection Improvement Act of 1996* for OASDI debts and the *Foster Care Independence Act of 1999* for SSI debts.

Treasury's Do-Not-Pay Business Center

The Department of the Treasury's Do Not Pay Business Center is an important part of the Administration's efforts to prevent, reduce, and stop improper payments while protecting citizens' privacy. By using the portal, Federal agencies can carry out a review of available databases with relevant information on eligibility before they release any Federal funds.

We collect information from Federal, State, and local entities to provide us with information we need to stop benefits or to change the amount of benefits we pay. For example, we have about 2,300 data exchanges with prisons that allow us to collect the information we need to suspend benefits to prisoners quickly and efficiently.¹² We are also working closely with Treasury's Bureau of Fiscal Service to provide prisoner information to the Internal Revenue Service.

In addition, we collect information about deaths to administer our programs. We post about 2.7 million new reports of death each year, and our records are highly accurate. These reports come to us primarily from family members, funeral homes, financial institutions, and States. This information, along with other information that we collect, allows us to stop paying benefits to a deceased beneficiary and establish benefits for survivors. For instance, in FY 2015, we used this

¹² We also have a proposal before Congress to adjust the incentive payments that we are allowed to provide to prisons, ensuring that we receive this information in a timely fashion, and thus preventing improper payments.

death information, along with prisoner information and other data, to stop payments of \$640.8 million in the OASDI program.

Of note, under current law, we are not authorized to provide the death information we receive from the States to the Do Not Pay Business Center. The FY 2017 President's Budget includes a legislative proposal that would further protect Federal payments by granting us legal authority to share all our death information, including data from the States, with the Do Not Pay Business Center.

Need for Adequate and Sustained Funding

Before concluding, let me emphasize that we need adequate, sustained funding to carry out our important program integrity and stewardship, while also ensuring adequate levels of service to beneficiaries and claimants. We are working hard to manage the agency with far less money than we need – our FY 2016 enacted budget was around \$350 million less than the President's request. Consequently, we have been forced to constrain every aspect of the budget including hiring, overtime, and information technology, and we are seeing service degradation in many areas. Service delays are causing hardships for our most vulnerable citizens, who are at an increased risk of both homelessness and disability. Of great concern is the hearings backlog, but we are also dealing with an unprecedented backlog in our program service centers, where we handle a lot of the work that leads to fewer improper payments.

That being said, we are greatly concerned about FY 2017, when we will serve a record number of beneficiaries. People are already facing longer wait times for service on our National 800 Number, in our frontline offices, and for decisions on disability hearings. With services already in a fragile state, additional funding constraints in FY 2017 would put our services at greater risk of long-term damage. It is pivotal that we get a funding level that allows us to rebound from this year's constraints and to improve service to the public. The President's Budget request of \$13.067 billion will do so. The President's Budget will allow us to increase our program integrity efforts while improving service for the millions of people who depend on us.

Conclusion

We appreciate the Subcommittee's interest in our efforts to maintain high payment accuracy rates and to further our efforts to lower improper payments, especially in the SSI program. The SSI accuracy rate has been improving over the past couple of years, and FY 2015 saw the highest SSI overpayment accuracy in over a decade. This progress is only possible through adequate and sustained funding. We are working to implement the payroll provider provision in the *Bipartisan Budget Act of 2015*, and to carry out other initiatives designed to reduce improper payments in the SSI and OASDI programs. Further, we will continue to work with the Congress and the Treasury to support the Do Not Pay Business Center. Thank you for inviting me to testify. I would be happy to answer any questions.

Mr. MEADOWS. Thank you.

Mr. Schramek—I tell you, for a guy from North Carolina, that's a tough one to be able to pronounce.

You're recognized for 5 minutes.

TESTIMONY OF JEFF SCHRAMEK

Mr. SCHRAMEK. Thank you. Good afternoon, Chairman Meadows, Ranking Member Connolly, and members of the subcommittee. Thank you for the opportunity to discuss the Department of Treasury's efforts to help federally funded programs to prevent improper payments through the Do Not Pay Business Center.

The Improper Payments Elimination and Recovery Improvement Act of 2012, IPERIA, directed OMB to administer the do-not-pay initiative. To implement section 5(d) of IPERIA, OMB designated the Department of Treasury to host the do-not-pay initiative working system. Treasury's Bureau of the Fiscal Service carries out this assignment, which is consistent with our mission to promote financial integrity within the Federal Government.

The Do Not Pay Business Center, which I will refer to simply as Do Not Pay, is a broader government effort—governmentwide effort that is designed to prevent improper payments. Four agencies, represented by some of my colleagues here, have robust payment integrity programs. This direct support puts them in the best position to address improper payments in their own programs. Though we do partner with these agencies, Do Not Pay can have a bigger impact on agencies that do not have their own dedicated analytic center. In short, we fill an important gap.

Do Not Pay's goal is to provide timely, accurate, and actionable information in a secure environment. Do Not Pay provides a secure Web-based portal that automatically matches pay data to sources that can indicate a payment may be improper. In addition to the portal, Do Not Pay provides advanced analytic services to detect systemic improper payments. Fifty-seven agencies currently use the portal, and since 2015, we completed 21 analytics projects for nine agencies.

Our work has resulted in a number of successes. For instance, this year, agencies identified nearly \$18.4 million of improper payments through the use of the Do Not Pay portal. This is more than doubled the amount reported in fiscal year 2015 and is significantly more than in previous years. This increase is the result of two factors: More agencies are using the portal, and through technology we introduced in 2015, agencies can report the amount of improper payments more easily. Do Not Pay developed a customized function that helped one agency this year stop nearly \$34 million in improper payments before the payments were disbursed.

In addition, through its partnership with OMB, Do Not Pay has helped agencies meet IPERIA's requirements. We did this providing agencies centralized access to the data sources identified in the law, including information about deceased individuals, government vendors, Medicare and Medicaid providers, and individuals and entities that owe a delinquent debt to the United States.

Do Not Pay has accomplished much by working closely with OMB and the agencies, and we are committed to continuous improvement and innovation. Our partnership with agencies are crit-

ical. Without them, we could not test advances in our analytics, such as new risk models and better data matching techniques on real world challenges facing those agencies. Through our services and existing data sources, Do Not Pay helps agencies identify improper payments that their internal processes may have missed.

In addition, the President's fiscal year 2017 budget contains two proposals that would expand Do Not Pay's data sources. Specifically, one proposal would amend the Social Security Act to provide do-not-pay access to the full debt file. A second proposal would allow programs to access the national directory of new hires through Do Not Pay, if those programs are already authorized to use the data.

In sum, Do Not Pay's data matching and advanced analytics have evolved significantly, and agencies' use of Do Not Pay has grown substantially. Do Not Pay is viewed more and more as an important tool for improving payment integrity and ensuring that the right recipient receives the right payment for the right reason at the right time.

I welcome any questions you may have.

[Prepared statement of Jeff Schramek follows:]

****EMBARGOED FOR DELIVERY****

**Statement of Jeffrey J. Schramek
Assistant Commissioner, Debt Management Services
Bureau of the Fiscal Service**

**U.S. Department of the Treasury
“Treasury’s Do Not Pay Business Center’s Role in Preventing Government-wide Improper Payments”**

**House Oversight and Government Reform Subcommittee on Government Operations
September 22, 2016**

Good afternoon Chairman Meadows, Ranking Member Connolly, and members of the Subcommittee. Thank you for the opportunity to discuss the Department of the Treasury’s (Treasury) efforts to help federally funded programs prevent improper payments through the Do Not Pay Business Center. In response to legislation and an Executive Order, the Office of Management and Budget (OMB) designated Treasury to host a working system to assist agencies in identifying and preventing improper payments.¹ Treasury’s Bureau of the Fiscal Service (Fiscal Service) operates the Do Not Pay Business Center (DNP) by providing a secure web-based portal available to federal agencies. This portal helps agencies identify potential improper payments by automating the process of matching payee data against multiple data sources. Once identified through the portal, agencies can make informed decisions regarding whether to make an award or payment. In addition to the portal, DNP provides a variety of other advanced analytics services to support agency programs in their efforts to prevent and detect systemic improper payments. The partnerships between DNP and agencies are critical: while DNP can identify potential improper payments, agencies must determine for themselves whether the payment is actually improper.

DNP is part of a broader government-wide effort—the Do Not Pay Initiative—designed to prevent improper payments. Some agencies have robust internal payment integrity programs and are in the best position to address improper payments in their respective programs.² Although Fiscal Service supports these agencies in several ways, DNP is best suited to assist other agencies with high-risk programs that require analytics services to identify improper payments. DNP’s goal is to provide timely, accurate, and actionable information in a secure environment to support agencies in improving federal payment integrity.

¹ The Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), codified Administration efforts first launched by the President in 2009, through Executive Order 13520, Reducing Improper Payments and Eliminating Waste in Federal Programs. Specifically IPERIA, Section 5, the Do Not Pay Initiative, identified the Office of Management and Budget (OMB) to determine eligibility and prevent improper payments. OMB designated the Treasury to host the Do Not Pay Initiative working system through OMB Memorandum M-13-20, Protecting Privacy while Reducing Improper Payments with the Do Not Pay Initiative. Treasury’s Fiscal Service operates the Do Not Pay Business Center to fulfill IPERIA Section 5(d).

² The four agencies with internal payment integrity programs are the Department of Health and Human Services, Internal Revenue Service, Social Security Administration, and the Department of Labor.

Treasury, in partnership with OMB, continues to assist agencies in meeting the requirements set forth by the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). Today, DNP provides 57 separate agencies access to IPERIA specified data sources, as permitted by law and the stipulations outlined in data source owners' Memoranda of Understanding.³ DNP users may centrally access data about some deceased individuals, government vendors, Medicare and Medicaid providers, and individuals and entities that owe delinquent debt to the United States, among others.⁴ Under an agreement between the Social Security Administration (SSA), Fiscal Service, and the Internal Revenue Service (IRS), DNP also shares information regarding incarcerated individuals that it receives from the Social Security Administration with the IRS for tax administration purposes.

In addition to implementing IPERIA requirements, DNP has played an important role in assisting agencies in addressing improper payments:

- DNP's portal assists agencies in identifying improper payments. In the first three quarters of Fiscal Year (FY) 2016, agencies reported identifying nearly \$18.4 million dollars of improper payments through the use of DNP's portal. This is more than double the amount reported during all of FY 2015 and is significantly more than previous years. The increase in reporting of identified improper payments is the result of two factors: (1) increased agency use of the portal, and (2) increased documentation of improper payments through the portal after DNP introduced technological innovations to ease the administrative burden of reporting.
- In addition to the \$18.4 million agency identified improper payments, DNP developed a customized function that helped one agency, during the first three quarters of FY 2016, stop nearly \$34 million of improper payments before the payments were disbursed.
- DNP also established a Computer Matching Agreement with the Department of Health and Human Service's Center for Medicare and Medicaid Services to enable continuous monitoring of health care providers.
- DNP's advanced analytics services are helping agencies review potential improper payments and target improvements in their business processes. In 2015, in conjunction with Treasury's payment disbursement centers, DNP began analytics projects for a number of agencies. For example, DNP provided summary level analysis to two agencies indicating potential duplicate benefit payments to 4,579 payees. DNP is currently working with program subject matter

³ The following IPERIA required data sources are available to DNP users as permitted by law and the stipulations outlined in data source owners' Memoranda of Understanding: Social Security Administration's Death Master File (public version), General Services Administration's Excluded Parties List System (now known as System for Award Management), Fiscal Service's Debt Check Database, Department of Housing and Urban Development's Credit Alert System, and Department of Health and Human Services' List of Excluded Individuals/Entities.

⁴ DNP CAIVRS makes centrally available the Credit Alert System (CAIVRS) data from four of the six different CAIVRS agencies, namely the Department of Justice, the Department of Housing and Urban Development (HUD), the Small Business Administration and the Department of Veterans Affairs. Because HUD is not the owner of all of the CAIVRS data, DNP must execute separate Memoranda of Understanding with each CAIVRS agency and each agency must ensure that their Privacy Act System of Records Notice allows for data sharing with DNP and DNP's users. DNP continues to work with the remaining CAIVRS data from the U.S. Department of Agriculture and the Department of Education.

experts from these two agencies to determine whether the payments in question represent improper payments.

In sum, since 2013, in collaboration with OMB and agencies, Fiscal Service has established the IPERIA-mandated working system, including centralized access to data sources, facilitated agency compliance with IPERIA's preaward and prepayment screening requirements, and developed analytics services. My testimony today will address two topics: (1) how DNP supports and complements government-wide efforts to prevent improper payments and the impact of these efforts; and (2) our plans for further developing our analytics capabilities to better support agencies.

DNP's Role in Identifying and Preventing Improper Payments Government-wide

By leveraging Treasury's position as the primary disbursing agency of federal payments, DNP is well positioned to help agencies identify improper payments. DNP has two service offerings to support agencies in their efforts to detect and prevent improper payments: (1) its online portal; and (2) its advanced analytics services.

DNP's Online Portal Use and Impact

DNP first focused its efforts on building a working system, as required by IPERIA, to be the means by which agencies could conduct data matching against a centralized collection of data sources. This was a multi-step process that involved establishing the appropriate agreements with the data source agencies and a System of Records Notice for the working system in order to fully comply with the Privacy Act of 1974.⁵ Analysts and data scientists developed the appropriate matching algorithms which support DNP's ability to provide timely, accurate, and actionable information while minimizing "false matches" [ultimately determined not to be improper]. Various means of conducting data matching were also built to support the business processes of agencies. Finally, these steps were incorporated into a system—the DNP portal—accessible via the Internet and built to protect personally identifiable information and other protected information.

DNP's portal provides data-matching services that have broad applicability to a wide range of agencies. In addition, the portal facilitates data matching during several phases of the payment lifecycle, which gives agencies options—depending on which is best suited to their business processes—to identify and review potential improper payments. Specifically, matching can occur as part of an agency's preaward and prepayment eligibility verification as well as later at the time of payment disbursement.

Preaward and Prepayment Screening

As part of preaward and prepayment screening, DNP provides three functionalities to help agencies identify at risk payments. Specifically, agencies can conduct:

- a "single online search" for an individual or entity by entering a name and Taxpayer Identification Number (TIN) for a one-time return of results;

⁵ Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988.

- batch matching in which agencies submit a file containing a number of records that the portal compares automatically to its data sources and returns matched results; and
- continuous monitoring in which agency records are compared to data sources automatically at specific intervals with matched results returned to the agency.

A match of payee data to information in DNP's data sources during the preaward or prepayment process is a first indicator that an award should not be made or that a payment might be improper and therefore warrants additional evaluation by the agency.

Agencies have made active use of DNP's preaward tools and are reporting positive impacts. For example, during the first three quarters of FY 2016, agencies have conducted 54,110 single online searches to verify eligibility before making an award or a payment. In addition, the Department of State, in its FY 2015 Annual Financial Report, reported that its use of the Do Not Pay Business Center's continuous monitoring functionality to review its annuitant payments resulted in preventing \$677,000 in improper payments.⁶

Payment Integration

The portal also matches payments at the time they are disbursed by Treasury—a function referred to as “payment integration.” DNP's payment integration process screens Treasury nontax payments for most federal agencies. Agencies are required to review and adjudicate any matches that occur during this process to determine whether the matched payment was improper.

Payment integration and agency adjudication of matches is especially critical to preventing improper payments that would be recurring—such as a monthly recurring benefit to a deceased individual. Since the beginning of FY 2016 through the end of the third quarter, DNP has screened \$1.1 trillion within the payment integration function. In the first three quarters of FY 2016, a total of 11,557 payments equaling nearly \$18.4 million were matched to DNP data source information through payment integration and then adjudicated as improper by the paying agency.⁷ Almost 96 percent of the 11,557 identified improper payments, corresponding to about \$17.4 million, were identified by the paying agency as monthly benefits and therefore may not have been stopped in future months without being identified through DNP's payment integration. Agency adjudication of match results helps agencies make better informed decisions regarding future awards and payments and can also help improve business processes and rules. In addition, it provides agencies with the necessary information to pursue recovery as appropriate. For example, one agency identified a \$50,000 payment through the payment integration process that was improper and was able to seek repayment from the payee's estate.

Although payment integration is a critical function, DNP's goal is to work with agencies to build the preaward and prepayment data matching functionalities provided through the portal into agency business processes. Doing so will maximize the opportunity for agencies to review at risk payments before the payments are made. Agencies also have the ability to stop a payment utilizing a DNP portal capability that supports use of agency-defined stop payment rules. Building out these business processes, however, takes time because many agencies first need to establish Computer Matching Act

⁶ U.S. Department of State. 16 November 2015. [FY]2015 DOS Agency Financial Report, pg. 133-135.

⁷ Agencies voluntarily report the results of adjudication. As a consequence it is likely that DNP is under-reporting the extent to which payment integration is helping to identify and stop improper payments.

agreements with DNP or amend a System of Records Notice in order to ensure compliance with the Privacy Act⁸ and document the agency and program business rules applicable to stopping payments. DNP continues to look for opportunities to provide technical and other support to agencies interested in leveraging preaward and prepayment data matching as a means to strengthen internal controls.

DNP Advanced Analytics Services

DNP has expanded the range of analytics techniques it makes available to agencies and is continually improving the quality of the results it provides so that agencies can make timely decisions to resolve improper payments. By leveraging data analytics and Fiscal Service's historical payment files, DNP can offer insights that can help agencies determine how best to change business processes to prevent future improper payments fitting a particular pattern.

During 2015, DNP began to focus on applying advanced analytics, within existing legal authorities, to high-risk improper payments for specific agencies. To accomplish this, DNP proactively initiated conversations with agencies to better understand their payment data. This outreach resulted in partnerships with nine different agencies for which DNP provided individualized analytics projects. After completing each project, DNP held feedback sessions to learn how the agency was able to use information from DNP and, when possible, whether that information uncovered any improper payments.

From January 2015 through August 2016, in conjunction with the Treasury payment disbursement centers, DNP completed 21 analytics projects for nine different agencies. These projects, among other efforts to review agency payment data, have provided statistical observations on program specific and agency-wide payments, including payments across multiple programs within an agency and, in one important project, payments in complementary programs managed by two different agencies. In addition, some projects have been designed to help agencies explore new techniques for identifying improper payments stemming from causes such as data quality issues or duplicative payments. Analytics projects completed thus far have addressed:

- *Evaluating Data Quality:* DNP has conducted several projects to help agencies better understand the quality of their payment data and how that quality can affect the identification of improper payments. For instance, improving the quality of TINs in agency data can lead to better data matching results. DNP worked with an agency to review FY 2015 payments that could not be matched to data sources during payment integration.⁹ DNP's analysis revealed that 725 payments equaling \$2.4 million were unmatchable due to missing TINs. The agency has used this information to improve its data entry processes.
- *Statistical Overviews of Agency Payment Data to Identify Patterns and Deviations:* Fiscal Service can further help agencies to monitor payments and payees for normal standard payment activity (e.g., payment amounts, frequency of payment, payment types), or possible anomalies such as spikes in payment amounts on a date that historically had low payment amounts. These

⁸ Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988.

⁹ DNP's payment integration provides results on exact matches based on a combination of payee name and tax identification number.

insights allow agencies and programs the opportunity to view a broad range of information, identify potential red flags, and identify further in-depth analytics projects to look at detected anomalies in greater depth.

- *Identifying Duplicate Payments within an Agency's Payment Data:* Improperly-issued duplicate payments can put pressure on agency budgets by making fewer dollars available for intended recipients. While individual payments are not always large, cumulatively, they can result in large dollar losses. Detecting potential improper duplicative payments within a single program or agency can be difficult because recipients may, for a variety of reasons, be eligible for multiple payments and, as a consequence, separating proper from improper duplicate payments requires tailored analysis. DNP has conducted several analytics projects to help agencies understand payment patterns and identify improper duplicative payments.
- *Duplicative Payment Identification in Complementary Programs:* Identifying improper duplicative payments across complementary programs administered by more than one agency or across more than one program in a single agency has always been a challenge. Because Treasury processes the payments issued by most federal agencies, DNP is in a unique position to help agencies identify inter-agency and intra-agency duplicative payments.

Through agency-specific reports, DNP has learned, along with its partner agencies, that DNP can provide insights that support process improvements and strengthen internal controls, thus helping agencies prevent improper payments. In addition, when agencies improve the quality of payment data, they are able to match more of their data against the data sources available in DNP. This is fundamental to addressing improper payments. Agencies value DNP analytics reports, and several have requested more in-depth analytics projects either in response to an initial statistical observations of agency data or to enlist DNP assistance in solving particular business problems.

Developing DNP's Analytics Capabilities and Enhancements through Expanded Authorities

Evolving Analytics Techniques

DNP took a phased approach in introducing its advanced analytics services by steadily expanding the range of analytics techniques it makes available to agencies and developing more sophisticated analyses. To advance its analytics capabilities, DNP first conducts exploratory research to evaluate the feasibility of introducing new techniques. DNP then seeks to pilot techniques deemed feasible and relevant with a partner agency to accomplish two goals:

- Determine the value of the technique for addressing specific business problems and whether it might be suitable for a broad range of agency challenges and therefore appropriate to consider operationalizing in the portal.

- Identify issues that must shape the application of new analytics techniques to ensure that DNP's work remains consistent with applicable laws (e.g., Privacy Act).

Partnering with an agency on pilot projects is critical to advancing DNP's analytics services because it provides lessons learned from actual business challenges.

DNP is currently in the process of identifying agency partners to pilot several new techniques:

- *Advanced Matching Techniques.* Data matching based on exact matches on personally identifying information provides a high level of assurance that the match is accurate. However, this approach cannot detect improper payments that include data entry errors in the underlying record, nor can this approach detect deliberate efforts to alter data to prevent the record from being matched and identified as improper. For example, an exact match would not identify a potential deceased person if one number in a TIN was incorrect. Advanced matching techniques can capture those improper payments in which, either by accident or intention, data fields are similar but not identical between two data sources. There are a broad range of techniques that can help an analyst gauge the level of similarity between two data fields. For instance, statistical tests can calculate how many digits or letters are different between two TINs or names. Another approach involves leveraging the phonetics of a name to identify similarities. DNP completed an initial evaluation of the performance of these and other techniques, and we are in discussions with agencies to identify a partner agency to initiate a pilot study to evaluate these techniques in identifying improper payments.
- *Risk Modeling:* One challenge in using data matching to identify improper payments is that agencies must first review matched payments to confirm that, for example, a match to death data is accurate and that the recipient is in fact deceased. Validating information gleaned through analytics techniques before stopping a payment is essential and a Privacy Act requirement.¹⁰ Helping agencies set priorities in adjudicating match results by scoring the level of risk is a key evolution in DNP's analytics services. For example, when presented with matching results that use similarity tests like those described above, a risk score could help agencies to prioritize the adjudication of matches with the greatest similarity. Likewise, risk scoring can help in the detection and evaluation of potential duplicative payments. Payments that share the exact payee name, date of payment, amount, and other factors might receive a higher risk score than payments that have fewer qualities in common. We are in discussions with agencies to identify a partner to develop a risk model.
- *Predictive Modeling:* A final technique that DNP plans to develop is predictive modeling, which can help identify at risk payments earlier in the payment lifecycle. Our work on risk modeling is an important foundation toward implementing predictive models. Predictive modeling, along with the acquisition of additional data sources, will help DNP further support agencies in identifying at risk payments early in the payment cycle.

¹⁰ Privacy Act of 1974, 5 U.S.C. 552a(2)(p)(1).

Adding New Data Sources to Identify a Broader Range of Improper Payments

The Administration has requested expanded authorities for data access and use by the Do Not Pay Business Center and agencies. Currently, the President's Fiscal Year 2017 Budget contains two proposals to improve payment accuracy further by sharing available death data across Government agencies to prevent improper payments:

1. Amend the Social Security Act to provide DNP and agencies that use the system access to the full death file to prevent, identify, or recover improper payments.¹¹
2. Allow programs that are statutorily authorized to access the Department of Health and Human Services' National Directory of New Hires data the option to do so via the Do Not Pay working system at Treasury. If implemented, the proposal would increase efficiency and effectiveness of data matching, while ensuring that robust privacy protections are maintained.¹²

Conclusion

One of the primary reasons for establishing a central location and service for data matching and analytics was to help agencies more effectively strengthen and streamline their preaward and prepayment processes in order to reduce improper payments. This eliminates the need for each agency to establish multiple data sharing documents, including multiple Computer Matching Agreements, pay for multiple data sources, and build the necessary data matching systems supported by data scientists and analysts. Treasury's Fiscal Service, through DNP, has built a centralized service that provides timely, accurate and actionable information to agencies to better inform their decision making.

As is important for any centralized service, DNP has been strategically focused in its efforts to build collaborative relationships with those agencies that could most benefit from this shared resource. By doing so, DNP and agencies have witnessed improvements in efforts to prevent, stop, and reduce improper payments. Agencies using DNP reported identifying deceased beneficiaries and annuitants that had not been identified through existing internal agency processes. Through the use of the DNP portal and the available advanced analytics services, agencies are able to better understand when an award or payment is made in the wrong amount or to the wrong person. This helps agencies move away from the traditional "pay and chase" model to a system that identifies the root causes of improper payments and strengthens processes and internal controls in order to mitigate the occurrence of improper payments.

¹¹ Currently, the Do Not Pay Business Center has access to the Social Security Administration's (SSA) Death Master File (public version) (DMF), an abbreviated version of SSA's death data that excludes information from certain sources. In 2013, the Government Accountability Office (GAO) reported that there were about 10 percent fewer records available in the DMF compared to the full death file and that this difference was likely to grow over time. See GAO-14-46, *Social Security Death Data: Additional Action Needed to Address Data Errors and Federal Agency Access*. December 27, 2013.

¹² Fiscal Year, Analytical Perspectives – Budget of the U.S. Government, Fiscal Year 2017 page 136.

DNP, in partnership with OMB, has built collaborative relationships with agencies and has demonstrated how it provides a service that effectively and efficiently augments and enhances agency improper payment reduction activities. DNP's data matching and advanced analytics services have significantly evolved since IPERIA, and agency use of DNP has grown substantially. DNP is, more and more, being viewed as an important tool as agencies work to strengthen payment integrity.

We look forward to continuously growing opportunities to support agencies to ensure that the right recipient is receiving the right payment for the right reason at the right time, so that federal programs can continue to serve and provide access to their intended recipients.

Mr. MEADOWS. Thank you so much.

And the chair recognizes himself for a series of questions.

Before I get started on those, however, all of you, thank you for being here. Thank you for your testimony. You have staff that is probably behind you that has done much of the yeoman's work to get that done, and so I want to acknowledge them, as I'd like to acknowledge both the majority and minority staff on the work that we get done. It is often really that hard work that gets overlooked, and so I wanted to make sure that we did that.

The other part of that that I would say is, is because of some of the questions on improper payments become uncomfortable, I want to make sure that no one takes it personally as an indictment on their work as much as, hopefully, a benchmark for starting to make progress going forward.

Does that make sense?

So let me go ahead. Mr. Mader, let me come to you first. And as we look at OMB and the role that we have, there are some statutory requirements in terms of reporting improper payments and the reports that need to come along with that. It appears that we have a little bit of a difference, our staff talking to your staff, in terms of what that report may or may not look like or should look like, because I think you refer more to paymentaccuracy.gov, which I would suggest is less than robust and illuminating in terms of its full detail.

And so can you help me understand when we are going to see a more robust report from OMB as it relates to improper payments and complying with the statute?

Mr. MADER. So a little history to add to the question. My predecessor, back in 2010, in implementing the statutory requirements, I guess, made that decision back at that time to use the—to create the paymentaccuracy.gov Web site as the way to satisfy the requirement that's in the legislation. That required an annual report to Congress, and they implemented that payment accuracy. And that, you know, started in 2010, 2011. So they were updating it.

I arrived in the summer of—as, you know, the summer of 2014. We updated it in 2015. I assumed that what was being reported on paymentaccuracy.gov was meeting the letter and the spirit of the legislation, only to discover this summer when your staff called us and said, did you know that you weren't doing this and you weren't doing that, that we realized that what started in 2010 was not meeting the—both the spirit and the letter of the law.

To put it in context, what we were displaying was probably roughly 93 percent of the improper payments, but we were missing almost 7 percent of that. And there were a couple of other data elements that the statute required that we were not displaying. So we had a great conversation with your staff back the summer that I participated in personally with my staff, all of who are new and so weren't around in 2010. So that's on me to make the correction.

And right after the conversation and in our subsequent analysis, we said, okay, we're going to have to totally revise this Web site. So we've been, since the course over the last couple of months, looking at, okay, what are the requirements? What does it look like now? What do we need to do to meet the spirit and the letter of the law? We're ready to launch, in the next couple of weeks, a com-

plete redo of paymentaccuracy.gov in a way that will capture and display the data so that not only the annual report to the Congress, but I think—Mr. Chairman, your earlier point in your opening statement, this is something that the American public needs to see. So, you know, not only will it meet the legislative intent of the annual report, but we believe it will also provide the transparency. We intend to have that done and updated with the new data in the January through March timeframe.

Mr. MEADOWS. Okay. Well, I don't want to prejudge your new innovation, so I won't. But I'm going to withhold, I guess, comment until we see what you come up with. Because I think, clearly, when we look at a report, we're about to put out a report. That's the kind of report that we should be getting from you. The data on the payment accuracy Web site, you know, doesn't really correspond.

And so as we start to integrate that—my good friend, Mr. Connolly from Virginia, knows more about the IT side of things than I ever did,—but when we look at the Data Act, when we look at FITARA, when we look at all of these other issues, we made a bipartisan commitment to have good quality data that actually gives us actionable things. And to that extent, I don't want to create something that's new that doesn't follow along those two lines and implement that data. But the other is I don't want to suggest that just having a Web site is a report.

And so I'm going to be optimistic. You know I'm a trusting individual, and—but we will verify. So I'll wait to see what you have coming up.

In January, is that when you said we can expect—

Mr. MADER. Well, so our plan was to actually, starting next week—and I'm going to get weekly reports from the project team—to actually start now working on what this new display of data will look like. Maybe what we ought to be doing is coming up and meeting with the staff, sort of walking them through what we're about to do. Because what I don't want to do is spend a lot of time and money between now and, you know, March and then go, like, well, that's not meeting your needs.

Mr. MEADOWS. Yeah. If you can do that, I think that will be great.

Mr. MADER. So we can do that. I mean, we have—Mr. Chairman, we also have an executive order that requires, you know, us to do this as well. So, you know, we're going to have to do it for ourselves. You know, if the Congress wants, you know, a different written report, we certainly can do that. But we have to fix the data.

Mr. MEADOWS. Yeah. And I'm not looking for redundancy. In fact, if anything, I'm looking for us to not be redundant. And I guess what I'm saying is, if that meets our needs, we'll all be together and be happy about it. The more we can have it online and the less we have it in terms of a written report, the better off, I think, we all are. I just want to make sure that it's in keeping with finishing.

I want to ask one other question, then I'll recognize the ranking member. And we've got a series of things that I'd like to go over.

But, Ms. Conley, let me come to you. And you had a great opening statement, and we look at the numbers that, you know, your—

the 800-pound gorilla in terms of improper payments, in terms of moneys going out, you and the Social Security Administration. The problem is, is each time we have this, we hear that it is a top priority, and each time the number continues to rise. And we have different hearings where, you know, we get stakeholders that are blamed or States that are blamed and, yet there are times when the States want to come in and help and there seems to be a reluctance from different agency heads on doing that.

My question is real simple. If it's the top priority, is it better suited for someone else to look at improper payments where we start a trend that goes down versus one that continues to go up? Because we continue to—we're not making progress, I guess. And I'm saying that in a kind way but in a frustrating way. This is our third improper payments hearing, and it continues to go up, and we don't seem to be making much progress.

What do we need to do?

Ms. CONLEY. Mr. Chairman, thank you very much for your question. These are critically important programs, and we take them very seriously, as well as program integrity, relating to each of our programs.

These programs are large and they are complex—

Mr. MEADOWS. Listen, I'm a numbers guy. I get all of that.

Ms. CONLEY. You understand. Yes, sir.

Mr. MEADOWS. And I understand that you can talk about percentages when you have a big budget, because the percentage is small but the dollar is big. I get that.

I guess what I'm saying is, is there someone else that needs to look at this to be able to figure it out where we start to get the trend, we're not making progress? Improper payments at HHS continue to go up at a disproportionate rate to the amount of benefits that are being paid out. And that's my concern, is—it'd be different if it were—we were shrink—you know, the numbers were going but the percentage—but that's not happening.

Ms. CONLEY. So if I may follow up on that. One, I think it's important to note, as Mr. Mader indicated in his opening remark, our Medicare fee-for-service program, our rate has come down from last year—

Mr. MEADOWS. Right.

Ms. CONLEY. —to this year, and we were well under our target. It is still a very large program. So while we're making progress there in measuring improper payments and complying, it's—these are still very large numbers.

We've made significant improvements in this program, and you can—we use the improper payment rates. We're very keen on the trajectory, whether we measure them uniformly and then we look to these trends.

And in the case of fee-for-service, we can see that there's some key actions that we're taking in the fee-for-service program that are really paying off and driving that rate down. So as part of our root cause analysis for fee-for-service, we determine—

Mr. MEADOWS. So it went down by what, \$2 billion is what we're looking at? So I'm looking at the numbers. But Medicare part C went up by \$2 billion, Medicare part D went up by \$1 billion. I mean, so—Medicaid went up by \$12 billion. And so when you look

at it, it's easy to highlight the one where we've made a little—and I guess what I'm saying is, when you look at the overall number, we're now up at \$89 billion. And, again, that's real money. I mean, it's not my money, it's not your money, it's the American taxpayer's money.

So here's what I would like, and I'm going to recognize the ranking member. I need from you, specifically, what we're going to do different between now and next year this time when we have this same report that comes out where we start to reverse the trend. I need a specific—not that it's important, not that it's this. I need how are we going to address these particular issues?

And I'll recognize the ranking member, Mr. Connolly.

Mr. CONNOLLY. I thank my friend. And I echo a lot of what he had to say. I will say, however, Congress can't have it two—both ways. We can't ding on you for not getting down that number to the lowest possible number when we're not willing to invest in the tools and resources necessary to recover those dollars or prevent them in the first place.

And we know that in certain respects, certain investments have huge payoff. My friend and I have talked on a bipartisan basis on our committee about, you know, you invest more money in GAO, for example, and it has a big payoff. We invest in—I'll speak only for myself. We invest in IRS. It has a big payoff. So if you're looking for enhancing revenue and getting down—

Mr. MEADOWS. Well, they'll just get your tax return. I mean, we can almost balance the budget on—

Mr. CONNOLLY. I'll take my chances.

So anyway—so we in Congress also need to take responsibility for our part in this. But I know that my friend, Mr. Meadows, and I share a goal, though, that this is something we could do something about it, it seems to me, on a bipartisan basis.

And, actually, in an odd way, if I can use this phrase, it's free money. Every dollar we recover that's not—or we avoid as an improper payment, however you define it, is a dollar we don't have to raise in new taxes. It's a dollar we don't have to cut from a critical investment that we know we need for the future. It's a dollar we don't have to have from sequestration. And why we don't pay more attention to this as a Congress, I don't know, or as a government. And I just thank my friend for continuing this tradition.

My first improper payment hearing was in this room on this—the predecessor subcommittee with our friend, Todd Platts, who was the Congressman from Pennsylvania at the time, who took this very seriously and set the kind of bipartisan cooperative tone I think we need on this.

Mr. Mader, what is the universe, total universe, of improper payments we're talking about right now?

Mr. MADER. So the last—

Mr. CONNOLLY. Dollar figure.

Mr. MADER. So the dollar figure fiscal year 2015 is \$136 billion.

Mr. CONNOLLY. Okay. Now, I want to say, when I first went to my first hearing on this, it was roughly about that. It might have been about \$150 billion then. Sound right, 5 years ago?

Mr. MADER. So 5 years ago, the percentage was higher, the dollar amount was lower.

Mr. CONNOLLY. A little lower. Okay. So it made some progress?

Mr. MADER. We've made progress on the rate, yes.

Mr. CONNOLLY. Okay. Of that \$136 billion, how much is Medicare fraud?

Mr. MADER. I would have to defer to my colleague from HHS on that. I don't keep that data.

Mr. CONNOLLY. All right. Ms. Conley? And you're talking to your cousin here, don't fudge.

Ms. CONLEY. No relation, right?

So you raise a very important question and important topic, because I think when we're talking about the extent of improper payments, it's important to go back and understand what improper payments are and what they are not.

So an improper payment is making sure that—an improper payment can arise from a payment to the wrong person or on behalf of the wrong person, in the wrong amount, for the wrong benefit, or without documentation.

Mr. CONNOLLY. No, we understand. The reason I'm trying to get at fraud is this: There's different strategies. Right?

Ms. CONLEY. Right. That's right.

Mr. CONNOLLY. So the nature—what's behind my question isn't to ding on you for—it's a big program and there's going to be fraud. Human nature is going to be human nature and people are going to cheat.

So working with Mr. Mader or with the Treasury Department, we can come up with systems that start to reduce the number of, oops, you know, we double billed, we double paid. We thought you were 65; you weren't. Whatever it is. We thought you were a veteran, and it was your cousin or your neighbor; a mistake. It happens. And if we can make systems more and more efficient and fool proof, we can cut down on that error rate, save taxpayers' dollars.

Fraud's a different matter. Fraud, I've got to go after it. I've got to have investigative resources. I've got to have prosecutorial resources. I've got to persuade U.S. attorneys that this is really a high priority, and it can become win-win. You know, I've got to make some serious investments. That's a very different kind of improper payment, but I've got to do both.

So I need to know your universe. What is—of the \$136 billion, how much of that is Medicare fraud?

Ms. CONLEY. We do not have a commonly accepted methodology for measuring the extent of fraud. We do, though, have other processes whereby we assess the various risks that fraud could occur.

Mr. CONNOLLY. Ms. Conley.

Ms. CONLEY. Yes, sir.

Mr. CONNOLLY. I can't believe you're a relative.

Is it not somewhere around \$50- or \$60 billion, best estimate, Mr. Mader?

Mr. MADER. Well, I'm not sure of the—the \$136 billion, I don't know, but let me see if I can answer your question maybe a little bit differently.

So of that \$136 billion, \$45 billion, 33 percent of that, is related to documentation errors. And I dare say it's probably not fraud. Okay?

Mr. CONNOLLY. Right.

Mr. MADER. If they filled out the form or they didn't fill out the form. And what's also interesting to note is that this issue—and it's a lot around insufficient documentation, you know, 33 percent of that total, actually isn't required to be reported as improper payments under the underlying statute. It was actually introduced in the previous administration.

And that's not making an excuse, but I think, Congressman Connolly, makes—the point that you're making is that there's ways to deal with those kinds of errors and then there's fraud. And a lot of the things that we're talking about in the way of program integrity initiatives or some of the examples around Do Not Pay, merely speak to that, how do I—how do I get to the documentation errors? How do I do a better job of getting it right the first time? Because if I picked a sample, and a form is missing, improper payment.

Mr. CONNOLLY. Right. But we know that fraud occurs. For example, I know of one U.S. Attorney's Office that recovered—I think, almost identified and helped recover almost \$3 billion in Medicare fraud. That's one. We have 99 U.S. attorneys. So, I mean—and I—this is not a new question, because I remember—unless I'm smoking something, but at this very room, this very subcommittee, we've looked at a figure of estimates of around \$50- to \$60 billion. It could be more. We don't know.

So I'm trying to look at the whole pie. That pie is \$136 billion, 43 percent are documentation error. So what percent do we think are fraud?

Mr. MADER. We're going to have to come back and—I don't know and I don't—you know, I don't want to guess.

Mr. CONNOLLY. All right.

Treasury Department, do you want to help guess with me? Do you know? Any idea? Give me the universe of potential fraud. I mean, out of this pie.

Ms. SCHRAMEK. I don't have the universe.

Mr. CONNOLLY. Don't have the universe.

Ms. SCHRAMEK. Not for fraud.

Mr. CONNOLLY. All right.

Well, Mr. Chairman, I'm frustrated by this because I don't know how we devise strategies that try to get at this if we're not willing to put some percentage or number. And I understand it's an estimate, a guesstimate, fraud's—how much potential fraud is going on out there I know is a tough thing, because—well, to quote Donald Rumsfeld, there are the known knowns and the no unknowns and the unknown unknowns, and okay.

But it's kind of important we get our arms around this so we at least, for planning purposes, declare a universe so that we can devise strategies to reduce it.

Mr. MEADOWS. And I would agree with the gentleman.

Mr. CONNOLLY. Yeah. But let me just say a final thought here. Boy, would I love—I mean, the chairman asked that you come back to us with strategies that we can sort of sink our teeth into in the new year. I would love to see a—sort of a spitball strategy that says—okay. In theory, we know we can't ever get to zero, but what would it take, in theory, to get that \$136 billion to zero? Because every one of those dollars is a dollar for new investment or a dollar where we avoid having to put new burdens on taxpayers or a dollar

to reduce the debt if we want to dedicate it to that. I mean, there are lots of possibilities with this, that's why getting the fraud piece is important.

And I'd love to, at some point, have somebody do some spitballing about this. I mean, I don't want to raise false expectations. It can be zero. But surely, we can do better. Surely, as the chairman indicated, and I echo his sentiments, I mean, it's a little bit like Groundhog Day when we have these hearings, because I thought we might be making not so much incremental progress as maybe spectacular progress with new data systems and new technology investments and the like.

So I think we approach this in the spirit of trying to partner with you, that get our arms around this collectively as a government, because a lot of good can come out of this. And bad things happen when this is left unaddressed.

So I wish you'd get back to us with the fraud estimates so that we have—we can work with you in devising strategies and try to fight for getting the resources you need for those strategies.

Thank you, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman.

So let me—let me see if I can summarize that, because I—if we're going to address this—and we have it titled improper payments for a reason, because we don't put it in a bucket. And that—I mean, we know that it's improper.

Here's what I would like to ask you to do, and it gets, I think, to the gentleman's question, is if we can look at a couple of sub-buckets. Coding errors is one—so I'm going to take HHS, because I know that probably better.

So we know that the RAC audit say, okay, you've got coding errors, you've got issues where you've got the wrong date. And it shows as an improper payment when, indeed, it is—really, it's probably a proper payment that's improperly coded, but yet it shows up and so it drives the numbers up. That's part of it.

The other part of that is, is there are—is the suspected activity that may not be fraud, but we're not sure. And so that's got to go in a bucket, because you're going to have your general counsel who say you can't say it's fraud because we can't prove it's fraud. And we understand the legal requirements here. But if you can put it in a bucket.

Then if we can look from a historical standpoint, and that's what the gentleman is talking about, is a percentage of those that are collected, how much do we go after for fraud? And I'm willing to work with the gentleman to look at these numbers to not say it has to go back to Treasury.

So, you know, if we're looking at SSA, and you're saying, well, we're having a tough time, and you do a better job on that, I'm willing to invest the political capital to say, okay, we have to return it. It's part of what I talked about with Mr. Mader on real estate. You've got one group that disposes of it, but they don't get the money back, so there's no incentive to do it. And so we're willing to work in a bipartisan way. We've got to get the number down. And I'd rather have accurate numbers and accurate reporting versus all of that.

Does that make sense? All right.

I'm going to ask for a unanimous consent to have Mr. Palmer join us, because I've got to run to a WRDA hearing on one critical area that we're trying to address when he comes in. And I may—I didn't want to interrupt the gentleman from Missouri.

Mr. Clay, you're recognized.

Mr. CLAY. Thank you.

In 2009, President Obama signed an executive order to reduce improper payments by, quote, "intensifying efforts to eliminate payment error of waste, fraud, and abuse in the major programs administered by the Federal Government."

Pursuant to this executive order, in 2011, Department of the Treasury established a Do Not Pay Center that offers tools and resources for agencies to use for the reduction of improper payments.

Mr.—pronounce your name.

Mr. SCHRAMEK. Mr. Schramek.

Mr. CLAY. —Schramek, what services does the Do Not Pay Center offer agencies to help curb improper payments?

Mr. SCHRAMEK. Thank you. We offer a couple of services. The first service is that we provide data sources to agencies so they can do a single online search, like a Google search. They can do—if they have more searches they need to do for prepayment or preeligibility, they can send over a file of those information that we can match against data sources. And then before they make a payment, they can send that file again to match—to make sure nothing has changed from when they looked the first time on their validation.

We also, through IPERIA, have entered where payments go across to data sources before they go out the door, to provide information back to the agencies on if those payments are proper and they can adjudicate them. And then our last piece is we offer analytic services to agencies so that—because we have most of the payment data that Treasury disburses, we can look at payments within an agency, within agency—within programs within an agency and even across agencies.

Mr. CLAY. And how many agencies have signed up with the Do Not Pay Center?

Mr. SCHRAMEK. So we have 57 agencies that are currently signed up with the do-not-pay program.

Mr. CLAY. And have these services been effective at stopping improper payments?

Mr. SCHRAMEK. They have been, as we've got more and more agencies onboard. So just this year, we had accumulatively identified \$25 million, and this is significantly higher, almost more than double, than we did last year because of the use of this program. Partially because agencies, when we give them the information back to determine if a payment is proper or improper, they—we gave them the ability to tell us how much that back is. So that is helping us to more and more determine how much of those payments are identified in the agency side.

Mr. CLAY. And, Mr. Schramek, I'm pleased to hear that the Do Not Pay Center has saved agencies millions of dollars in improper payments. There are still billions of dollars in improper payments that are spent every year.

How can the Do Not Pay Center use its resources to save additional improper payment dollars?

Mr. SCHRAMEK. So it's very critical for us to continue to work with the agencies and with OMB to do this process. So the data sources we have, we will continue to provide the agencies and talk to them about which ones are best for them and get more agencies to use those data sources. We've also put—and we agree with the President's budget for additional data sources.

So right now we only have the public version of the Death Master File, and when we get the private version, that would help us as well. And then access to the National Directory of New Hires database would give us that information as another tool to provide agencies.

Mr. CLAY. And do some agencies prefer to use their own methods to identify improper payments?

Mr. SCHRAMEK. Agencies do have other programs. Do Not Pay is one of the tools the agencies get to use in identifying improper payments. Treasury cannot make the decision of whether a payment is improper or not. We provide the information to the agencies and then we work with the agencies to determine if it's improper or not.

Mr. CLAY. All right. Thank you for that response.

And, Ms. LaCanfora, I heard you say that currently you allow recipients to volunteer data to make a determination on a monthly basis to determine how much they are paid. Isn't that an easy way to game the system at SSI?

Ms. LACANFORA. You're right. What I said in my testimony was that the Supplemental Security Income program, or the SSI program, is our greatest challenge because we rely very heavily on beneficiaries to tell us information. And the structure of the program is such that we need to track lots of different factors, your income, your resources, who you live with, all of your living arrangements, lots of different data points that we need that we rely on beneficiaries to tell us about. So one of our greatest strategies that holds the most potential is to try to move away from reliance on beneficiaries and move more toward data.

And thank you to the Congress for giving us the Bipartisan Budget Act. One of the most powerful provisions in there is our ability to use third-party payroll data so that we do not need to rely on IRS data, which oftentimes comes very late in the process. We can get timely wage data from payroll providers, and we are working to implement that now. So moving from self-reporting to data is where we think we're going to get a tremendous payoff in improper payment prevention going forward.

Mr. CLAY. And how much, an estimate in savings, do you think you'll be able to identify?

Ms. LACANFORA. I don't have an exact number, but I will say it's in the billions, with a B—

Mr. CLAY. Okay.

Ms. LACANFORA. —because wages or earnings are the greatest— one of the greatest sources of improper payment at our agency.

Mr. CLAY. Thank you.

Mr. Chairman, I yield back. My time is up.

Mr. PALMER. [Presiding.] The gentleman yields back.

The chair now recognizes itself for questions.

To follow up on Mr. Clay's questions about the apparent inability—or to identify people who have died, I mean, there are companies in the private sector that can track everything, I mean, from what laundry detergent we buy to what Web sites we visit, I mean, what political party we affiliate with. How is it—why is it so difficult to gather information when people are deceased so that you stop the payments?

And that's to Ms. LaCanfora. I'm having trouble seeing over this. I'm just average height, so—

Ms. LACANFORA. Thank you for the question. We actually receive 2.5 million death reports each year. So our death data is pretty comprehensive. We receive information from States and from funeral directors and from a host of other places, including families who report death records to us. We share that data with nine Federal benefit-paying agencies directly so they have access to that today.

We are restricted by law from sharing all of our death data with Do Not Pay because the law specifically allows us only to share that data with the Federal benefit paying agencies. So I think Mr. Schramek mentioned a proposal in the President's budget that would authorize us to share all of our death data with Do Not Pay.

Mr. PALMER. Are they calling votes?

Okay. All right. I'm going to continue with this. You said there were 2.5 million deaths reported to Social Security. Is that correct? Do you have any idea how many deaths there were nationwide?

Ms. LACANFORA. Yeah. That number is comparable to the CDC estimates on the number of people who are actually deceased. There's always going to be a few deaths that we don't get because there's strange things happening, but by and large, our death data is comprehensive. I will say, however, that historically, it hasn't always been comprehensive, because our death reporting processes have gotten much better over time and there's something really important in the process that we have called electronic death registration, otherwise known as EDR. It's a very high-quality reporting process that makes our death records virtually error free, but that is a relatively new process for most States and it's not rolled out in every State. So there's also a President's budget proposal to expand electronic death registration to ensure that our death records are complete.

Mr. PALMER. So over the last 2 or 3 years, and the last report I saw was for 2014, and it was what, \$3 billion, something in that range, that went out in death benefits improperly paid? Did that number decrease last year?

Ms. LACANFORA. For the Social Security Administration, death is actually not a leading cause of improper payment. In fact, we use our current set of death records to prevent—

Mr. PALMER. I understand that. I'm just asking you, because you just said that—you lauded where you are on your death reporting. And I come from a think-tank background prior to that engineering degree. I'm very linear in my thinking. So if you got from A to B and B is where you needed to be, there should be some result. Okay.

So have we reduced the amount of improper payments related to death benefits?

Ms. LACANFORA. Yes, but I want to just correct. So the \$3 billion I think that you cited is not related to death. That's our overall improper payment rate for the OASDI program. The death-related overpayment amount for Social Security is much smaller than that. It's actually less than 1 percent of all of our improper payment. I think the broader concern is sharing that data with other agencies that might use it. But improper payments related to death are tiny at the Social Security Administration.

Mr. PALMER. Well, going back on the report that I read last year—actually, I'm on the Budget Committee and that's when I brought this up—65 percent of the improper payments were attributed to Medicare fee-for-service, Medicaid, and earned income tax credit program. It is about \$81 billion. And in 2014, I think we sent out about \$125 billion in improper payments. Last year, I think it was about \$130 something billion, and prior to 2014, it was a lower number. So it seems to be getting worse, not better. And one of the things that I found interesting was that the Treasury hasn't corrected the issue with the earned income tax credit and it appears to be getting progressively worse.

Can you address that? Are you qualified to address that, Mr. Schramek?

Mr. SCHRAMEK. Yes, sir. At the Bureau of the Fiscal Service, I don't have access to the information on the IRS side of the tax information.

Mr. PALMER. Okay. Sounds like that the people I need to talk to are not here, because I'd also like to know why—what statutory limitations there are on Treasury that prevent us from requiring States estimating improper payments in terms of TANF benefits.

Can you answer that?

Mr. SCHRAMEK. Yes, sir. That would be at IRS.

Mr. PALMER. All right. Well, given that they've called votes, let me ask that question to Health and Human Services on the TANF benefits. Ms. Conley.

Ms. CONLEY. Sir, I'm sorry, could you repeat the question about TANF?

Mr. PALMER. Well, in my doing my background on this, I found that there's some statutory prohibition against the States reporting improper payments for TANF benefits. And I apologize, I was working on earned income tax credit with Treasury and now I've switched to TANF, and this question should have been directed to HHS.

What are the statutory limitations that keep the States from reporting improper payments on TANF benefits?

Ms. CONLEY. Yeah. Thank you very much for your question and for clarifying. With regard to TANF, the statutory framework for TANF, this is the Temporary Assistance for Needy Families, is set up such that we don't have the authority to either request or compel States to calculate improper payments, nor do we—are we authorized to compel them to provide us with the information that would be necessary to develop an improper payment rate for TANF.

And we—so even though we don't have an error rate methodology because of the statutory constraints, we do still execute program integrity activities with TANF. For instance, the Single Audit

Act Amendments of 1996, were recognized in the TANF statute of 1996. And those—the single audit basically is an annual audit process at the State level of the TANF funds that are administered by the States, and they’re subjected to an annual audit process by either the State auditors or independent audits. And we go through those audit findings and resolve those findings and ensure that the States are following up to strengthen the integrity of the TANF programs at the State level.

Mr. PALMER. So do we know how much we paid out in improper payments in TANF benefits?

Ms. CONLEY. So there is not a calculation of an error rate for TANF, because of those statutory limitations that we have.

Mr. PALMER. Well, that doesn’t make any sense to me that we don’t at least have an estimate from the States. I mean, is there no concern of making improper payments using Federal money? I mean, what do we need to do to correct that?

Ms. CONLEY. So perhaps we could reconsider, as TANF is reauthorized, to think about an error-rate methodology process and whether or not that makes sense given the statutory framework for TANF.

As I mentioned, while we don’t have an error rate, there are other things that are going on in the TANF program, the oversight of it, as well as the work that is happening at the State levels to ensure we’re complying with the program requirements. TANF has very high level Federal requirements. They’re very broad and overarching, and so the States—the State-administered program and the States develop the various compliance requirements at a more detailed level.

Mr. PALMER. Well, here’s my concern about this and the whole issue of improper payments, is that being on the Budget Committee we do everything in a 10-year window. And if we use the last 3 years, say, for example, as an average, we’re sending out somewhere in the range of \$110- to \$120 billion a year in improper payments. In that 10-year window, that’s \$1.1, to \$1.2 trillion. That’s a lot of money. You know, it has a big impact on our ability to do business, and I think particularly considering that we’re approaching \$20 trillion in debt, it’s incumbent upon us to do everything that we can to make sure that the money we spend is spent properly.

I want to shift back to Treasury, to Mr. Schramek, if I can. Treasury was required to issue a report on the data analytics performed at the Do Not Pay Center under the Federal Improper Payments Coordination Act of 2015. It is my understanding that the report has not been issued. When do you expect to issue that report?

Mr. SCHRAMEK. Now that report has been issued.

Mr. PALMER. It has? When was it issued?

Mr. SCHRAMEK. This past week.

Mr. PALMER. Okay. We need to make sure the committee gets a copy of that report.

Let me ask you this: What are the current data analytics capabilities of Do Not Pay?

Mr. SCHRAMEK. So in the Do Not Pay program, our current analytics come around a couple of different mechanisms. One, we do

data source matching and provide that information to agencies. Two, because we have access to payment data that agencies have provided us, we use that data to provide information related to data-quality errors of the payments that they provide to Treasury to make sure the data is better. We look at if there's duplicate payments or if there have been duplicate eligibility information and provide that to agencies to validate. For example, if somebody paid something twice or paid the same amount twice, is that proper or not? And we're also looking across the Federal Government for agencies to look at if similar payments went out on the same day.

So our analytics programs have grown. We've, as I mentioned, we've got—we've done 21—22 analytics projects for nine agencies just this year.

Mr. PALMER. Ms. Park, Social Security Administration and HHS use third-party payroll data to verify payments and the VA doesn't. Why doesn't the VA use third-party payroll data?

Ms. PARK. So we use various methods to verify pay in the program. Specifically, I can't talk to exactly what those are. I would need our senior accountable official, so I'll have to take that for the record. We are looking at opportunities to partner with industry to get that information and we'll be working on that in the coming year.

Mr. PALMER. Are you—do you know if the VA is considering using additional data sources?

Ms. PARK. Yes, we are, sir. I mean, just this year, we awarded a new contract to support us in our IPERA efforts, and we're hoping that the contractor will bring different methods for us to use, and we're also exploring other areas.

Mr. PALMER. I'll switch over to OMB because I don't want Mr. Mader to feel like he's being left out.

So Mr. Meadows has already asked him these questions, well, then you haven't been left out.

I want to go back to Ms. Conley and HHS. And the Center for Medicare & Medicaid Services failed to meet reduction targets for Medicare Advantage, Medicaid, and the Children's Health Insurance Program. Why weren't you able to meet those targets?

Ms. CONLEY. Thank you very much for your question. I think maybe I'll start with the Medicaid program because this is an important large, broad program. In 2014, we began implementing new requirements of the Affordable Care Act as well as HIPAA, to require States to do three basic things: One, to screen all new enrollees into the program; and two, to reenroll all of their providers; and the third thing is to have all electronic claims include a national provider identification.

So these three efforts, which were very substantive and challenging for agencies, has taken—excuse me, for States—it has taken the States—they're adopting these new requirements at different rates. This is an example—each of these three new requirements is an example of where we're actually strengthening the underlying integrity of the program by knowing who we're doing business with with these—with the new screening and the enrollment process, as well as being able to identify and track payments. So we can reduce the likelihood of fraud by knowing who we're doing business with and having screened them, as well as reduce im-

proper payments by encouraging the States, assisting them, if you will, in complying with these three requirements.

We measure Medicaid over a 3-year period, and so 2014 was the first year that we measured against the first batch of States in compliance with this requirement for 2014, second batch in 2015, and the third and final batch would be captured in our 2016 error rate measurement. So that is why you see that error rate going up from 2014 to 2015 to 2016. We expect States to be in compliance.

We're doing a lot of outreach. We're sharing with them information about the enrollment process that we have encountered at—or executed at CMS for fee-for-service. We're doing a variety of outreach efforts and communication to assist the States, and we expect those rates to go down.

Mr. PALMER. According to the inspector general, Medicare Advantage did not report any recovery amount audits in 2015. How does CMS justify not conducting recovery audits, given the estimated improper payments report?

Ms. CONLEY. So with regard to Medicare part C, we have taken action to begin the procurement process for recovery audit contractors. That program, the Recovery Act, or the RAC, rather—

Mr. PALMER. Wait a minute. I want to make sure that I understand this. You have begun the process to—

Ms. CONLEY. To procure RACs for the part C program.

Mr. PALMER. But why have you just now started the process when we've been losing billions of dollars?

Ms. CONLEY. So we started a while back. So we did a request for information from the private sector to share with us ideas and options for how we could actually carry out the recovery audit contracts in a meaningful way. Information was provided and we are now in the process of—we've done a Request for Proposal and we're going through the procurement process at this point in time.

Mr. PALMER. Well, see, here's the thing that I don't understand. Private companies who have to make sure they don't incur losses in order to stay in business require 100 percent claims to be audited for accuracy in billing, I think. They may be under legal requirements for that as well, and it just—I don't quite understand why CMS doesn't do a better job auditing, why they audit such a small percentage.

Ms. CONLEY. So one thing that I should mention is that with regard to Medicare part C, we conduct what are called RADV audits, risk adjustment data validation audits, of the various plans; about 30 plans destined to go up to about 100 plans of the total 600 eventually. And what happens is we conduct the audit at that contract level so that the results of that testing can be extrapolated out to that particular contractor.

These RADV audits have been executed for a period of time and we're beginning to see the impact of that audit process, not just on the entities subjected to that audit process already, but also on some of the plans that have yet to be audited.

In addition to that, we have implemented a new regulation that requires these plans to submit back to CMS any overpayments that they identify in the process. The combined effect of those two activities has resulted in \$650 million being returned to CMS as a result of this collective work.

Mr. PALMER. Well, obviously, \$650 million is a lot, but it pales in comparison to the \$125 billion that's been lost over the last 3 years. And the thing that concerns me about this, and again, the enormity of the improper payments over the last 3 years, is that the Medicare trustees estimate that Medicare, the program will be bankrupt in 12 years. And I mean, this is serious stuff.

They've called votes. I'm going to transition because I have got to—I know Mr. Meadows asked the question, but just for my own purposes, I'd like to know why OMB hasn't produced an annual report to Congress, including these subjects.

Mr. MADER. Congressman, as I explained to Chairman Meadows, my predecessor in 2010 made a decision that they would use this paymentaccuracy.gov approach to satisfy, not only an executive order, but also the legislative requirement from the annual report to the Congress. I arrived in the summer of 2014. You know, we're in, obviously, the fourth year of generating it, and I assumed that this was meeting the statutory requirements, until we had a call this summer from the staff saying, you know, by the way, you're not. You're missing this and you're missing that.

We had a good conversation with the staff at the time. Immediately then, I took the action to actually start doing an analysis of what was missing and what could we do to relaunch the site going forward so that it was in compliance and totally accurate. We have a project plan underway that would allow us to relaunch the site in the January through March timeframe.

The exchange that I had with Chairman Meadows was, well, maybe we should talk more about, you know, do we want a, you know, a paper document report or do we want a, you know, a Web site that would meet all of the requirements?

So my commitment to the committee is to get together with the staff and sort of work through what, you know, what are the interests, what are the requirements, and you know, come to a decision on what makes sense. I mean, we're going to do the—we're going to relaunch the Web site regardless. If the committee wants a written report, we can do a written report.

Mr. PALMER. Well, I'll discuss that with Chairman Meadows, but I do appreciate the fact that there's been some initiative taken to address this.

I tell you what we're going to do. I'm going to recess the hearing, so you need to hang around, and I'll get with Chairman Meadows on the floor to determine if we need to come back. I don't want to adjourn the hearing without talking to the chairman. And—

He's okay with it?

Apparently, someone has talked to the chairman. This is like at home. I'm the last one to know. So I'm very comfortable in the situation.

But anyway, if there's no further business, our hearing is adjourned.

[Whereupon, at 4:31 p.m., the subcommittee was adjourned.]

