STATUS OF THE MEDICARE TRANSACTION SYSTEM: THE HEALTH CARE FINANCING ADMINISTRATION'S PLANNED DATA SYSTEM TO CONTROL FRAUD/ABUSE

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, AND TECHNOLOGY

AND THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

NOVEMBER 16, 1995

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CONTENTS

Page

Hearing held on November 16, 1995 1

Statement of:

Huntzinger, George, CSC, Healthcare Systems, Inc.; Gary Rudin, EDS, corporate vice president, Health Care Group; Thomas Owens, GMIS, Inc., accompanied by John Kelly, M.D., Ph.D., chief medical officer and senior vice president, Clinical Information Services 86

Reilly, Frank, Director, Information Resources Management/Health, Education and Human Services, General Accounting Office, and Christopher Hoenig, Director, Information Resources Management/Policies and Issues, General Accounting Office, accompanied by Helen Lew and L.J. Latham, Accounting Information Management Division, GAO . 45

Vladeck, Bruce, Administrator, Health Care Financing Administration 9

Walton, Carol, Director, Bureau of Program Operations, Health Care Financing Administration, accompanied by Jared Adair, MTSI Program Manager, HCFA 139

Letters, statements, etc., submitted for the record by:

Clinger, Hon. William F., a Representative in Congress from the State of Pennsylvania, prepared statement of 5

Green, Hon. Gene, a Representative in Congress from the State of Texas, prepared statement of 28

Horn, Hon. Stephen, a Representative in Congress from the State of California:

Organizational chart for MTS, list of HCFA staff associated with MTS, and 1994–95 time line for MTS 38

Prepared statement of 3

Huntzinger, George, CSC, Healthcare Systems, Inc., prepared statement of 89

Owens, Thomas, GMIS, Inc., prepared statement of 117

Reilly, Frank, Director, Information Resources Management/Health, Education and Human Services, General Accounting Office, and Christopher Hoenig, Director, Information Resources Management/Policies and Issues, General Accounting Office, prepared statement of 50

Rudin, Gary, EDS, corporate vice president, Health Care Group, prepared statement of 104

Shays, Hon. Christopher, a Representative in Congress from the State of Connecticut:

Prepared statement of 8

Prepared statement of the American Medical Association 68

Towns, Hon. Edolphus, a Representative in Congress from the State of New York, prepared statement of 34

Vladeck, Bruce, Administrator, Health Care Financing Administration, prepared statement of 13

Walton, Carol, Director, Bureau of Program Operations, Health Care Financing Administration:

Information concerning automated systems 149

Information concerning Medicare 142

Information concerning new technology 152

STATUS OF THE MEDICARE TRANSACTION SYSTEM: THE HEALTH CARE FINANCING ADMINISTRATION'S PLANNED DATA SYSTEM TO CONTROL FRAUD/ABUSE

THURSDAY, NOVEMBER 16, 1995

HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, AND TECHNOLOGY; JOINT WITH THE SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS, COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittees met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the Subcommittee on Government Management, Information, and Technology) presiding.

Present: Representatives Horn, Shays, Fox, Clinger, Maloney, Souder, Morella, Towns, and Green.

Staff present: Subcommittee on Human Resources and Intergovernmental Relations: Lawrence J. Halloran, staff director/counsel; Kate Hickey and Bob Newman, professional staff members; Thomas Costa, clerk; Government Management, Information, and Technology Subcommittee: J. Russell George, staff director/counsel; Mark Uncapher, professional staff member and counsel; Andrew G. Richardson, clerk; David McMillen and Cherri Branson, minority professional staff; and Elisabeth Campbell, minority staff assistant.

Mr. HORN. A quorum being present, this joint session of the Subcommittees on Government Management, Information, and Technology and on Human Resources and Intergovernmental Relations will come to order.

This hearing will be a review of the information and data systems that support America's Medicare Program. Today, approximately 70 different claims-processing contractors are using any of nine separate independently designed private automation systems, in order to compute and pay the hospital or doctor bills of people covered by Medicare.

The Health Care Financing Administration, part of the Department of Health and Human Services, has been working since 1992 on a single new Government system called the Medicare Transaction System, or MTS. We are told the new system would replace the nine different private systems in use today.

If all goes as planned, we can expect the MTS to lead to a more efficient Medicare service, simpler paperwork, and faster coordination among the many benefit insurers. The General Accounting Of-

fice is not so sure it will turn out that way, unless several far-reaching recommendations are adopted and implemented.

Together our two subcommittees will try to find out where the real truth lies. We need now to improve existing processes and software routines in order to help Medicare do a better job of detecting and preventing fraud. Introduction of innovative software into the Medicare claims processing system is essential.

Our witnesses today come from the Health Care Financing Administration and its task force for the New Medicare Transaction System; from the General Accounting Office and from three private sector companies involved with health care automated systems.

Ladies and gentlemen, we thank you all for joining us. We look forward to your testimony.

It is now my pleasure to yield to the chairman of the full committee, Mr. Clinger of Pennsylvania, for an opening statement.

[The prepared statement of Hon. Stephen Horn follows:]

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Opening Statement by
The Honorable Stephen Horn, Chairman
Subcommittee on Government Management,
Information and Technology
November 16th, 1995

A quorum being present, this joint session of the Subcommittees on Government Management, Information and Technology and on Human Resources and Intergovernmental Relations will come to order. This hearing will be a review of the information and data systems that support America's Medicare program. Today approximately seventy different claims-processing contractors are using any of nine separate independently-designed private automation systems, in order to compute and pay the hospital or doctor bills of people covered by Medicare.

The Health Care Financing Administration, part of the Department of Health and Human Services, has been working since 1992 on a single new Government system, called the Medicare Transaction System, or M-T-S. We are told the new system would replace the nine different private systems in use today. If all goes as planned we can expect the M-T-S to lead to more efficient Medicare service, simpler paperwork, and faster coordination among the many benefit insurers. The General Accounting Office is not so sure it will turn out that way, unless several far-reaching recommendations are adopted and implemented. Together our two subcommittees will try to find out where the real truth lies.

We need now to improve existing processes and software routines in order to help Medicare do a better job of detecting and preventing fraud. The introduction of innovative software into the Medicare claims processing system is essential.

Our witnesses come from the Health Care Financing Administration and its task force for the new Medicare Transaction System; from the General Accounting Office; and from three private-sector companies involved with health care automated systems.

Ladies and gentlemen, we thank you all for joining us, and we look forward to your testimony.

It is my pleasure now to yield to my co-chair, the distinguished representative from Connecticut, the Honorable Christopher Shays.

Mr. CLINGER. Thank you very much, Mr. Chairman.

I want to thank you and Chairman Shays for holding this joint hearing this morning. Medicare needs assistance to avoid bankruptcy, and I want to commend you both for focusing on the financial system that manages this very vast system that we have.

The General Accounting Office has estimated that 10 percent of health care spending in this country is consumed by fraud and abuse. Congress is currently undertaking a historic effort to restore fiscal soundness to the Medicare Program.

An essential component of any reform package must be a strong antifraud program. We are here today to find out if the MTS system fits that bill.

The Medicare Program cannot sustain unlimited losses to fraud and abuse. Rather it demands an aggressive approach to curb such activities. The Medicare Program cannot continue losing money hand over fist.

As we balance the budget, all of us need to work together to establish a zero tolerance for fraud. The current claims processing operation involving dozens of fiscal intermediaries and carriers, allows what is estimated to be up to $26 billion to be siphoned away from medical care into the pockets of unscrupulous providers.

Having an organized method of tracking the more than 800 million Medicare claims which are filed each year is an attractive idea. The HCFA has initiated the Medicare Transaction System with the goal of preserving the security of these claims.

At a hearing held earlier before Congressman Shays' subcommittee on June 15 of this year, testimony was given on the importance of the MTS to detect and curb abuses within the overall Medicare system. I would judge that everyone in this room would agree that current fraud and abuse controls have been proven to be inadequate. The system really is too easy to crack, too easy to take advantage of, too easy to bilk.

However, before the MTS system has even had a chance to be implemented, concerns have been brought before this committee about the direction that HCFA is taking this program at the present time. You have already seen a midstream revision of HCFA development requirements for the MTS and a rollback in the date these requirements are to be completed.

I am also concerned with the potential for cost overruns in the system. The MTS already carries a proposed price tag of $127 million, I understand, and the GAO has reported that the costs of the MTS will probably be significantly higher than that. But today's testimony will be, I am sure, instructive in judging whether the proposed MTS system is going to effectively serve its intended purpose or whether this procurement is as problem-riddled as some suggest.

Clearly, if we can really get a handle on what appears to be massive waste, fraud, and abuse in this system, that would mean much less pressure to reduce services that are desperately needed. So I commend you, Chairman Horn and Chairman Shays for the oversight you are providing in this very, very critical area.

[The prepared statement of Hon. William F. Clinger follows:]

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Opening Statement
Chairman William F. Clinger, Jr.,
Joint Hearing on Oversight and Review
of Medicare Information and Data Systems
November 16, 1995

Good Morning. I would like to thank Chairman Shays and Chairman Horn for holding this joint hearing. Medicare needs assistance to avoid bankruptcy, and I commend them for focusing on the financial system that manages it.

The General Accounting Office estimates that ten percent of health care spending in this country is consumed by fraud and abuse. Congress is currently undertaking an historic effort to restore fiscal soundness to the Medicare program. An essential component of any reform package must be a strong anti-fraud program. We're here today to find out if the MTS system fits that bill.

The Medicare program cannot sustain unlimited losses to fraud and abuse, rather it demands an aggressive approach to curb such activities. The Medicare program cannot continue losing money hand over fist. As we balance the budget, all of us must work together and establish a zero tolerance for fraud.

The current claims processing operation, involving dozens of fiscal intermediaries and carriers, allows $26 billion to be siphoned away from medical care into the pockets of unscrupulous providers. Having an organized method of tracking the more than 800 million Medicare claims filed each year is an attractive idea. The Health Care Financing Administration has initiated the Medicare Transaction System with the goal of preserving the security of these claims.

Continued

At a hearing before Chairman Shays' subcommittee on June fifteenth of this year, testimony was given on the importance of the MTS to detect and curb abuses of Medicare. I think that everyone in this room will agree that current fraud and abuse controls are inadequate. The system is too easy to crack.

However, before the MTS has even had a chance to be implemented, concerns have been brought before this committee about the direction that HCFA is taking this program. We have already seen a midstream revision of HCFA development requirements for the MTS, and a rollback in the date these requirements are to be completed.

I am also concerned with the potential for cost overruns. The MTS already carries a proposed price tag of $127 million, and the GAO has reported that the costs of the MTS will probably be significantly higher.

Today's testimony will be instructive in judging whether the proposed MTS system is going to effectively serve its intended purpose or whether this procurement is as problem riddled as some suggest. I commend Chairman Horn and Chairman Shays for the oversight they are providing.

Mr. HORN. Thank you very much, Mr. Chairman.

I am putting in the record at this point the statement of Representative Christopher Shays, the chairman of the Subcommittee on Human Resources and Intergovernmental Relations. It will be without objection put in the record.

[The prepared statement of Hon. Christopher Shays follows:]

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Statement of Rep. Christopher Shays
November 16, 1995

The development of the Medicare Transaction System (MTS) by the Health Care Finance Administration (HCFA) raises important questions about the acquisition and use of computer technology in government health programs. Our subcommittees meet today to assess the MTS development process, and to measure the promise of the MTS against its anticipated performance.

Our hearings on waste, fraud and abuse in the Medicare and Medicaid programs pointed to the increasing sophistication and staggering costs of the rip-offs that take ten cents, or more, of every federal health care dollar. We need equally sophisticated tools to safeguard the integrity of federal health care spending.

The MTS is intended to be such a tool. Through the centralized processing and automated review of claims data, HCFA hopes to capture efficiencies and discern violations that elude the current multi-contractor system. HCFA's own work to standardize billing identification numbers for vendors of durable medical equipment demonstrates the potential of this more unified technological approach.

But will the MTS deliver the benefits of advanced data processing to Medicare, or will it succumb to the delays and design flaws that often doom government computer acquisitions to early obsolescence? Are the goals, deadlines and cost estimates for the MTS realistic? Are important opportunities to enhance Medicare being missed while HCFA pins all its hopes on MTS?

These are the questions we asked our witnesses to address today. I look forward to their testimony.

Mr. HORN. We have a tradition in this committee, Mr. Vladeck, of swearing in all witnesses, and if you would rise and raise your right hand.

[Witness sworn.]

Mr. HORN. Thank you very much.

The clerk will note that the witness affirmed.

You have one of the most difficult jobs in Government, Mr. Vladeck. Thirty-five—thirty years ago, I guess it was, I was on the drafting team for Medicare when I was a Senate staff member.

Mr. VLADECK. I know who to hold responsible now.

Mr. HORN. Well, I want to see what our craftsmanship did. I merely give you one thing to cogitate on and that is our projections of hospital bills per day were $40 a day, skilled nursing home bills per day were $20 a day and we only know of one city with home care and that was Detroit, and that was $10 a day. So you see we have come a long way. But we welcome you here and we look forward to your testimony.

Mr. Vladeck is the administrator of the Health Care Financing Administration that pays the bills on Medicare.

STATEMENT OF BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman.

I very much appreciate the opportunity to appear before this hearing today and to talk about what I believe you have already correctly identified as one of the most important initiatives in the history of the management of the Medicare Program.

The Medicare Transaction System, or MTS, will provide state-of-the-art information management for Medicare and its beneficiaries in the 21st century. It will give beneficiaries, providers, as well as us, the information we need to deal with the changing program and with increasingly complex health care systems.

I should note at the outset that HCFA is already a leader in some aspects of the electronic automated management of health insurance. We are the world leader in electronic data interchange. We process a higher proportion of our claims electronically than any other major insurance operation in the world and we administer the claims payments side of the Medicare Program for less than 1 percent of benefit costs.

In the early part of this decade, however, in the face of increasing workloads and limited administrative budgets, as well as our projections as to what the future would hold, we concluded that not only did we need to further lower our administrative costs, but that we had to substantially improve the quality of our services to our beneficiaries.

In addition, we recognized that the health care system is changing rapidly and that a growing proportion of our beneficiaries would not be served in traditional fee-for-service kinds of arrangements; so that we needed an information system that could accommodate the full range of choices beneficiaries would have.

To address all of these issues, we undertook the work to develop the Medicare Transaction System, which is the heart of an information management strategy to improve services to beneficiaries and providers, to better manage Medicare Program expenditures,

to significantly upgrade our tools for combating fraud and abuse and to integrate the basic data systems for fee-for-service, capitated and partially capitated services under the Medicare Program.

In developing the MTS, we have three major goals in mind: First, to provide our beneficiaries with superior customer service; second, to give the program an information system commensurate with our responsibilities to our beneficiaries, our partners in the provider community and our colleagues in the executive and legislative branches.

And third, we want to make sure that payments are made appropriately the first time.

Fulfilling our mission of assuring beneficiaries access to high-quality, affordable health care depends on topnotch customer service and on communication with beneficiaries, their families, providers, and the host of partners with whom they work. When MTS is fully implemented, beneficiaries and providers will be able to call a customer service representative who has on-line access to all claims processing and enrollment information and who can resolve minor difficulties on the spot.

Using the system, beneficiaries will be able to check on claims, start appeals, clarify issues of enrollment status, and see where they stand relative to annual deductibles. It will also help beneficiaries better navigate a world of multiple choices of types of plans.

By the year 2000, beneficiaries will have many more choices in their health care delivery arrangements, not only including health maintenance organizations and preferred-provider organizations, but point-of-service plans, and we expect, of course, provider service networks as well.

To help beneficiaries make informed choices, MTS will maintain information on various options available and be able to provide telephone assistance to people making choices. We will also provide beneficiaries in the fee-for-service sector, single-integrated notice of benefits.

Since information on all part A and part B payments will finally be available in one system, we will be able to send each beneficiary a single monthly summary notice of all transactions, much like a credit card bill. This notice will help beneficiaries better understand their claims while giving us significant administrative efficiencies and savings.

No longer will a beneficiary, who has just experienced an illness that required multiple services, receive stacks of notices, each of which is labeled, "This is not a bill," which generates more confusion and complaints, I think, than any other aspect of the system. The MTS will provide us with current detailed information about expenditures and service utilization in part A, part B and capitated plans.

We can then use that information for updating our policies, simulating the effects of policy changes and responding to requests from the Congress and others. And it will critically improve program safeguards.

We will have a single, uniform claims processing system across the Nation. We will have a single, integrated, comprehensive data base. We will be able to apply the most modern, sophisticated and

analytic tools to detect patterns of fraud and abuse and increasingly to prevent mispayment of claims before they are paid.

For example, MTS will greatly improve our ability to profile data by type of service provider. We use profiles to identify aberrant patterns for more detailed review. We recently entered into an agreement, for example, with Los Alamos National Laboratories for them to develop state-of-the-art artificial intelligence software tools that can be plugged in, in a modular fashion to MTS to help prevent the payment of fraudulent and abusive claims.

MTS will also integrate a data system that will help us build on the best practices and information systems to incorporate new technologies. Our contractor staff will be better able to work with each other and with law enforcement agencies.

The important role that our beneficiaries already play in the detection in fraud and abuse will be augmented by the summary notice process. Beneficiaries will get a comprehensive picture of the claims that have been paid on their behalf, and fraud reminders and alerts will advise them of what to look for and who to contact if fraud is suspected.

Our current system needs replacing. You made reference to it. In the interest of time, I won't go into the details, I would be happy to do that.

Mr. HORN. Wind it up in 2 minutes or so. We do need to get the framework.

Mr. VLADECK. I want to say something about project management, which is a major subject of this hearing. We recognize that MTS is a very complex undertaking. It is clearly the most aggressive systems modernization project we have ever undertaken.

Now, we are also aware that there are considerable risks associated with it, and we are conducting the project throughout with a keen appreciation of the need to manage those risks. For example, in formulating the planning and procurement strategy and in organizing the project, we have reached out to learn from other large data users, both in the Government and the private sector, that have undertaken similar projects. To maintain the adaptability required by rapid change in the health care industry and in Medicare, our MTS design contract is taking a flexible approach to systems requirements, so that we can build a dynamic system that will meet our needs not only now, but well into the next century.

The many changes in the program in the past few years, not to mention the more extensive changes, are now under consideration, demonstrate how essential such flexibility is. As you know, at the time we awarded a contract for the design of MTS, we also awarded a separate contract for what's called in the trade, Independent Verification and Validation. Our IV&V contractor assists us in identifying and resolving problems during development and implementation and helps us to continuously improve the development process.

We use that as a mechanism for continual evaluation of how we are doing and to make midcourse corrections as necessary.

Finally, we believe MTS is a capital investment that will yield significant returns when fully implemented. It will lower contractor overhead and administrative costs, increase efficiency through data

standardization, and avoid the cost of updating multiple software systems.

Once the system is fully implemented, we expect it to yield approximately $200 million a year in current dollars, in administrative savings as well as impossible to quantify, but much more substantial savings in reduced benefit payments because of better deterrence of fraudulent or abusive practices.

We are on schedule for transition to the MTS beginning in September 1997, with full transition completed by September 1999. We hope in March 1997 to award contracts to operate the MTS at several sites. We at GTE, our design contractor, are working closely together to see that we meet those time lines.

The last point I can make, if I could, that we can implement MTS without statutory change but to take full advantage of this new system will require some changes in the law. We have talked to various committees of jurisdiction in the contract about our draft bill, the Medicare Contractor Reform Act, which would provide us increased flexibility in contracting.

It would enable HCFA to operate more like the private sector in writing contracts. Under current law, we are not allowed to contract like other Government agencies. We are not under general Federal procurement regulations for the administration of the Medicare Program.

We may only contract with health insurers, even though other firms may be better or cheaper at performing part of our work. We lack the flexibility to divide up functions to permit specialization and to avoid conflicts of interest. Obviously we would very much appreciate your support for this bill.

In conclusion, as we approach implementation of the MTS, we certainly don't expect 100 percent perfection. Medicare is a continuously changing and evolving program, and its data requirements will continually change and evolve.

We need not only a new data processing system, but one that is flexible and that can be adjusted and adopted both to changes in technology and changes in the health care system. None of this is going to work perfectly, but we are consulting as widely as we can and managing as carefully as we can to keep on track the implementation of a new system that will modernize the capabilities of the Medicare Program and permit us to face management of the program in the 21st century with the kind of confidence our beneficiaries deserve.

Again, I appreciate the opportunity to appear before you today and of course I am happy to take any questions you might have.

Mr. HORN. Thank you very much.

[The prepared statement of Mr. Vladeck follows:]

BRUCE C. VLADECK

ADMINISTRATOR

HEALTH CARE FINANCING ADMINSTRATION

I. INTRODUCTION

I am pleased to be here today to discuss the Medicare Transaction System (MTS) and how it will provide an information management system for Medicare and its beneficiaries in the 21st century. The MTS will give Medicare beneficiaries and providers the information they need to deal with a changing Medicare program and with increasingly complex health care delivery systems.

HCFA is already a leader in electronic claims processing. For example, in 1994 HCFA processed 74 percent of Medicare claims electronically, compared to just 8 percent for private insurance companies. We have lowered our unit costs significantly over the years by encouraging electronic claims submission and standardizing claims formats. Administrative costs for claims processing are now less than one percent of Medicare benefits.

In the early 1990s, facing increasing workloads but limited administrative budgets, we concluded that we needed to further lower our administrative costs while upgrading service to our beneficiaries. In addition, the Medicare program is moving more and more into managed care and will need to support a variety of insurance options from which beneficiaries can choose.

Our answer is the Medicare Transaction System, which will put Medicare on the cutting edge of information technology.

The MTS is the foundation of an information management strategy that will improve service to beneficiaries and providers; better manage Medicare program expenditures; upgrade our tools for combating fraud and abuse; and deal with new health care delivery options for Medicare beneficiaries.

II. THE MTS WILL IMPROVE CUSTOMER SERVICE.

In developing the MTS, HCFA is striving toward three goals:

- To provide Medicare beneficiaries with superior customer service;
- To give the Medicare program an information system commensurate with our responsibilities to our beneficiaries, our partners in the provider community, and our colleagues in the executive and legislative branches; and
- To safeguard the Medicare Trust Funds by ensuring payments are made appropriately.

Fulfilling HCFA's mission of assuring beneficiaries access to quality, affordable health care depends on top notch customer service. The key to successful customer service is communication -- with beneficiaries, their families, the general public, providers, other government agencies, and the host of partners with whom we work.

At present, beneficiaries and providers sometimes have difficulty getting up-to-date information

regarding claims or having billing problems resolved quickly. This is partly because claims are processed by a variety of different contractors, depending on the type of claim.

With the MTS, beneficiaries and providers will be able to call a customer service representative who has on-line access to all claims processing information and who can resolve minor difficulties on the spot. Using this system, beneficiaries will be able to start appeals or check on their enrollment status.

Medicare in the year 2000 will be a different program than it is today. Beneficiaries will have many more choices in health care delivery arrangements, such as health maintenance organizations, preferred provider organizations, and point of service plans. To decide which Medicare options are best for them, beneficiaries will need even more information than they do today. The MTS will make information on various options available in one system, with one call or visit.

The MTS will allow HCFA to implement a single integrated notice of benefits, the Medicare Summary Notice. For the first time, information on all Medicare Part A and Part B payments will be available in one system. We will be able to send each beneficiary a summary notice of all transactions on their account during a month. This notice, similar to a monthly credit card statement, will include information on bills that have been paid, on other insurance the beneficiary may have, on claims that have been sent to other insurors for payment, and on enrollment status. This notice will yield administrative efficiencies and savings in postage. No longer will beneficiaries receive stacks of notices labeled, "This is not a bill."

The MTS will also provide current, detailed information about expenditures and service utilization. We will be able to combine information about both Part A and Part B for fee-for-service enrollees and follow enrollees in managed care options as well. This information can then be used for updating our policies, simulating the effect of policy changes, and responding to requests from Congress and others.

III. THE MTS WILL IMPROVE PROGRAM SAFEGUARDS

HCFA is responsible for assuring that Medicare payments are appropriate. In the current system, this is a challenge. In a 1992 report, GAO raised concerns about uneven implementation of payment controls resulting from Medicare's complicated claims administration system. The nationally uniform MTS, with integrated data and improved analytic tools, responds to this concern.

HCFA's strategy for payment integrity emphasizes preventing inappropriate claims from being paid in the first place, thus avoiding the need to "pay and chase" when fraudulent or abusive claims are paid. The MTS has several elements that will help fulfill this strategy.
At present, beneficiaries' claims for different services are frequently paid by different contractors. Consolidated information from several contractors would be helpful in determining whether a claim is appropriate. However, at present, a HCFA contractor is able to cross-reference a claim

with other contractors only after payment is made. The MTS will allow us, for the first time, to compare across contractors before claims are paid.

The MTS will also greatly improve our ability to "profile" data on a national or regional basis by type of provider or type of service. We will use these profiles to identify aberrant patterns for review. HCFA has retained the Los Alamos National Laboratories to reassess how we look for abusive billing patterns in the Medicare program and to develop state-of-the-art artificial intelligence software tools that we can insert into the MTS to prevent the payment of fraudulent and abusive claims.

The integration of data from Part A, Part B and managed care in the MTS will provide the opportunity to build on "best practices" in information systems and to incorporate new technology to facilitate innovative investigative techniques. GAO recommended these improvements in a recent report. With more comprehensive, up-to-date information at their fingertips, Medicare contractor staff can work in concert with each other and with law enforcement agencies at both the local and national levels to detect and deter fraud and abuse.

The important role that beneficiaries already play in the detection of fraud and abuse in the Medicare program will be augmented by the summary notices. The notices will give beneficiaries a comprehensive picture of the claims that have been paid on their behalf. Fraud reminders and alerts will appear on the notice to advise beneficiaries what to look for and who to contact if fraud is suspected. In this way, beneficiaries can be more active partners in detecting fraud and abuse.

IV. THE CURRENT SYSTEM NEEDS REPLACING.

Medicare's current system is essentially devoted to claims processing, with other functions added as needed. The MTS, on the other hand, is fundamentally an information system, with a large claims processing component, that can adapt to changing needs.

In Medicare's early years, we had more than 100 hardware sites and software systems to process Medicare claims. By the 1980s, we started reducing the numbers of standard software systems and hardware sites.

Today there are nine standard systems, a Common Working File that contains beneficiary data at nine separate sites, more than 70 intermediaries and carriers, and more than 56 hardware sites. It is expensive and difficult to make a single change in Medicare policy or procedures because all these systems need to be modified.

The MTS will replace the varied claims processing systems in existence today, greatly reduce the number of hardware sites, and substantially lower the cost of system changes.

V. THE MTS IS ON TRACK.

The Medicare Transaction System is an enormously complex undertaking. It is the single most

aggressive systems modernization project in HCFA's history. For the first time, HCFA will integrate data from Medicare Part A, Medicare Part B, and managed care into one system. In fact, few government agencies or private organizations have undertaken a systems project of this scope -- one that would affect payments for 38 million people, affecting access to health care for the elderly and disabled throughout the country.

In short, we are well aware that this is a high risk venture. We are conducting the project with a keen appreciation of the need to manage the risks involved. For example, we are reaching out to learn from other large data users that have undertaken similar projects. We have looked closely at their experiences in formulating our planning and procurement strategy and in organizing the project.

Early in the planning for the MTS, we realized that rapid change in the health care industry meant that we had to go beyond merely updating our claims processing system. We knew the MTS had to make available standard data on all Medicare providers, plans, beneficiaries, and services, and it must be able to accommodate virtually any option for receiving health care benefits that might be made available to Medicare beneficiaries.

To maintain the adaptability required by this environment, the MTS design contract took a flexible approach to systems requirements and sought to build a dynamic system that would meet our needs now and well into the 21st century. The many changes in the Medicare program in the past few years and the more extensive changes now under consideration prove that we were right to plan for a flexible system.

The MTS is the platform that will permit Medicare to adapt effectively to these changes. Without the MTS we would be forced to develop discrete systems, which would not readily communicate with each other, to support each type of change. We can no longer afford to do business this way. Only with a single, national system can we efficiently and effectively operate in the rapidly changing health care environment.

Because this project is so important to Medicare, we hold our design contractor to a very high standard of performance. We have continued to improve the processes which the contractor must follow.

At the time we awarded the design contract, HCFA also awarded a separate contract for "Independent Verification and Validation." This contractor assists us in identifying and resolving problems during MTS development and implementation and helps us to continuously improve the MTS development process. We use this contract to help us continuously evaluate our progress and adjust our course as necessary to insure the MTS will work properly and begin operation on time.

From the outset, the MTS has been an agency-wide initiative, with the strong support of the Secretary and the Administration. Responsibility is shared among a number of people, but lines of accountability are clear.

The MTS Management Board, which includes executives from several components across the agency, provides leadership for the project team. The Bureau of Program Operations, which runs our contractor network, manages day-to-day operations. The Bureau of Data Management and Strategy, the agency's information resource management group, is the other major component involved with managing the project. We believe that our team approach has met the challenge of addressing agency-wide needs for the project while effectively tapping expertise from HCFA's various components.

In the development of the MTS, we have found that different skills and different organizational arrangements are needed for different stages of the process. HCFA is currently transitioning to a new stage of the MTS development, moving from a largely free-standing planning effort to the integration of the project throughout the organization. As we move into this phase, each component of the agency must incorporate planning for the MTS in its ongoing responsibilities. This effort requires changes in our management strategy because it involves aligning project activities with the organizational components that will ultimately be responsible for the new system. At this stage, detailed decisions will be made by the people who will implement those decisions. The business of MTS is becoming a major element of the business of HCFA.

A necessary complement to the MTS is our Medicare Transaction System Initiative (MTSI). While the MTS comprises the software, hardware and data components of the project, the MTSI is an internal project designed to bring about the cultural changes in HCFA that will be necessary for our effective use of the MTS. For example, the MTSI will allow HCFA to convert from a more fee-for-service environment to one that addresses multiple payment schemes. The MTS will also require changes in how HCFA writes operational instructions for implementing policy changes, and we need to learn how to do that before the new system is upon us.

The MTS is a capital investment that will yield significant returns when fully implemented. The MTS will lower contractor overhead and administrative costs, increase efficiency through data standardization, and avoid the costs of updating multiple software systems. Once the MTS is fully implemented, we expect it to yield approximately $200 million dollars a year in administrative savings as well as additional savings in benefits.

HCFA and its contractors are on schedule for transition to the MTS beginning in September 1997 and ending by September 1999. In March 1997, we plan to award contracts to operate the MTS at several sites. HCFA and GTE, the MTS design contractor, will work closely together throughout the life of the project to ensure timely and successful implementation of the MTS.

VI. MEDICARE NEEDS INCREASED FLEXIBILITY IN CONTRACTING.

While the MTS can be implemented without statutory change, optimum use of this new tool would require changes in our contracting practices, which in turn depend on passage of contracting reform legislation. Our draft bill, the "Medicare Contractor Reform Act of 1995," would provide Medicare increased flexibility in contracting with organizations that process claims and perform related tasks under Part A and Part B.

This legislation would enable HCFA to operate more like the private sector in writing contracts. Under current law, HCFA is not allowed to contract even like other government agencies. First, only health insurers may become Medicare carriers. Second, for Part A, HCFA can only contract with organizations nominated by health care providers. Third, HCFA must pay termination costs for all contracts which end -- even if the contract is terminated for cause or the contractor withdraws from the program, HCFA must pay full termination costs to the contractor. We think these provisions unduly hamper our ability to do business, prohibiting us from making the most advantageous contracting arrangements for the Medicare program.

We would appreciate your support for this bill.

VII. CONCLUSION

HCFA's challenge is to develop and manage information systems for the health care system of the future. As we approach implementation of the MTS, we do not expect 100 percent perfection. We do expect change, and we have designed the MTS to be flexible. We also anticipate that we will experience minor performance difficulties. GAO has assured us that problems of this sort are to be expected in projects of this magnitude, and we will work closely with GAO in addressing these issues. We have the organization and processes in place to be able to respond effectively to these challenges and to keep the project on track.

It is the right time for the MTS. The MTS puts HCFA in a unique position to take full advantage of quickly evolving information technology, enabling us to more efficiently and effectively finance beneficiaries' health care. We are carefully managing the design, development and implementation of the MTS. The MTS will then help us achieve our goals of modernizing our information system, helping to safeguard the Trust Funds, and providing Medicare beneficiaries with superior customer service.

MEDICARE CONTRACTING LEGISLATIVE REFORM

- **Improve Customer Service**
  - Currently, a beneficiary may have to deal with up to 8 different Medicare contractors for different services. This proposal allows us to designate one contractor to act as a single point of contact and information for each beneficiary.
  - Hospitals and nursing homes will also have a contractor as their single point of contact in resolving issues.
- **Eliminate Contractor Conflict of Interest:**
  - The distinction between health insurer and provider is becoming blurred as insurers purchase provider groups. This creates a direct conflict of interest as Medicare contractors process claims for providers they own.
  - Medicare could retain current, good performing contractors, which purchase health care providers, by using their services in selected functional areas which are not subject to conflict of interest.
- **Improve Fraud and Abuse Operations:**
  - In certain instances, specialty contractors would focus on the prevention, detection and investigation of Medicare fraud and abuse alone or in connection with related functions, such as medical or utilization review. Currently, all Medicare contractors are required to perform all payment integrity activities.
- **Increase Competition:**
  - Any qualified company (not just health insurers) will be able to compete for Medicare contracts. This flexibility will increase competition and enhance contractor performance by allowing Medicare to contract with entities who excel in a specific function.
  - Because Medicare contracts will no longer be automatically renewed from year to year, contractors will be accountable to continuously improve their service to beneficiaries and providers and to safeguard program dollars in order to retain their contracts.
  - Every five years hospitals and nursing homes will have the opportunity to select a new fiscal intermediary. This will provide contractors with additional motivation to provide the best quality of service.

Medicare Contractor Reform Act of 1995

This bill provides for increased flexibility in contracting for Medicare claims processing.

- Permits the Secretary to enter into contracts with agencies and organizations that are not health insurers.
- Allows providers to nominate a fiscal intermediary every 5 years from a list of three approved by the Secretary.
- Permits the Secretary to selectively contract out certain functions traditionally performed by all contractors, such as medical review.
- Eliminates special requirements for termination of contractors.
- Subjects new contracts to the same competitive requirements that apply generally throughout the Federal government.
- Allows more flexibility in the payment of contractors.

Mr. HORN. I am going to yield 5 minutes to the chairman of the full committee, Mr. Clinger.

Mr. CLINGER. Thank you, Mr. Chairman and Dr. Vladeck, thank you very much for your testimony.

As you have heard, the figure $28 billion waste, fraud, and abuse that GAO has estimated, there have been other estimates of that; is that in the ballpark?

Mr. VLADECK. Sir, I don't want to disagree with GAO on this or most other subjects, but I must say that if you stop and think about it, if we knew exactly how much fraud and abuse there was in the program, we would be much more successful about eliminating it. Either that—or we would be totally negligent. It's clearly a multi-billion dollar problem. It's clearly a problem that particularly got out of control over recent times and is something we are beginning to move on aggressively.

But I do not believe we are fully on top of the problem yet. And until I have a sense that we are, I would be very reluctant to try to make a quantitative estimate. But I am certain GAO's is as good an estimate as anyone's.

Mr. CLINGER. Having on my other hat that I wear across the hall here in the Transportation Committee, and one of the things we have dealt with now for a number of years is upgrading, bringing on the line a whole new air traffic control system which has been fraught with incredible problems, hangups, delays. We are way behind schedule.

So you will understand that I am a little skeptical when we have a time line presented here. What assurance can you give us, do you think at this point, that, in fact, you will be able to meet that time line?

Mr. VLADECK. Well, the only assurance I can give you, sir, is that we are on it. We believe we are very much on it at the moment and have been pretty much on it for about the last year.

Now, our colleagues in the GAO, I know, think that we are—we are over optimistic, in some regards, and that we are pushing this—the development in a way that may cause us some difficulties down the road because we are trying to meet that end of 1999 date for full implementation.

My feelings about that, to be direct about it, are that so long as we don't make any irrevocable mistakes in pushing ahead, we ought to continue to try and push ahead, having contingency plans at all times. If we don't meet the deadline, the world will not end. The systems will continue to operate.

We actually will have a particular problem if we get to January 1, 2000, there's an awful lot of reprogramming of the existing systems that have to be done that would be very, very expensive, if we are still running them, just to change the digits for the century. So we would really like to be up and running by December 31, 1999. But we may not make it.

I think as managers, our job is to turn the heat up as high as we need to, to keep everybody focused on that, while making appropriate contingency plans if we don't meet it. Because otherwise this—my fear is it could take forever and indeed never happen once you take the deadlines off.

Mr. CLINGER. Clearly, one of the ways that we could have a better control on fraudulent claims in the system is if the beneficiaries, the recipients of the care, are advised of what has purportedly been provided on their behalf. And I understand—you indicated that all recipients of care will now be informed of what they supposedly received from a provider?

Mr. VLADECK. Sir, we do that now for about 85 percent of the claims we pay. Beneficiaries receive what's called the "Explanation of Medicare Benefits."

In the past, for those services for which there were no copayments or deductibles, my colleagues, I think, in a misguided—my predecessors in what I think was sort of misguided pennywise, pound foolish, suppressed those notices. So, for home care visits where there's no coinsurance for the last number of years, we had not been routinely sending out such notices. But for physician services, and for most outpatient services, and for hospitalizations, we do send out perhaps a total of 500 million notices per year. The principal source of tips we get about potential fraud and abuse cases are from beneficiaries who report to us, literally thousands of times a year, on problems where they know there's something wrong, whether or not it is a fraudulent situation.

The problem at the moment is that anyone who has tried to help a relative negotiate between their Medicare and supplemental insurance talks about the shopping bags full of paper. We generate one of these forms for every claim, and it's not uncommon for someone, again, who's been hospitalized for a serious illness to have 30 or 40 claims associated with that illness, each one of which generates a notice. And when they—depending on who their supplemental insurer is, may generate additional paperwork with the supplemental insurer as well. So, it's very hard for people to navigate through all of that paper.

Under MTS, people will get a single monthly mailing that will itemize all the services they received. We think that will be much easier for folks to understand. And the better they understand what we have paid on their behalf, the more likely we believe it is that they will actually look at it and identify questionable charges in the process. So we do expect it will substantially increase the number of such inquiries or reports we get. But we already get literally thousands and thousands of them.

Mr. CLINGER. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Thank you.

Mr. HORN. Let me follow up on something that goes back several years. As I remember, in the closing days of the Bush administration, Secretary Sullivan had the insurers in to get some coordinated agreement on whether the last name went first or last, I wondered why Secretaries had not done so since 1965.

Where are we on that and how does that interface with your particular system?

Mr. VLADECK. The group that Secretary Sullivan pulled together for that, the acronym for which is WEDI. W–E–D–I, and I know the last three letters are electronic data interchange, I can't remember what the first one stands for, is continuing to meet largely under private sector leadership, although we are continuing to ac-

tively participate. We are working together with private insurers and payers and the hardware and software industries on a set of uniform standards for health information data and health information data transmission in an electronic environment.

As the world has changed, this has become a part of the broader initiatives in the administration under the Vice President's leadership to look at a national policy on the information superhighway, and has been integrated into that broader look at the future information infrastructure.

There's actually considerable interest on the part of many private insurers and payers, and the provider groups. AMA has taken the leadership on outpatient forms in developing this standardization.

As you know, some of your colleagues in both Houses have been working with us on some of the issues of privacy and confidentiality that have to be addressed in this system. We need to get on top of those issues before we can really get to those standardized systems.

Mr. HORN. On the latter point, we will get to that in the next few months. As you might know, hearings were held when Mr. Condit was chairman of the equivalent subcommittee in the last Congress. I think some very useful documents and legislation were developed by that subcommittee.

The Inspector General of HHS mentioned to me a few months ago that $8 billion had been collected last year in Medicare/Medicaid fraud and abuse. Is most of that collected by your people or the Inspector General? How does that work?

Mr. VLADECK. Well, we are always arguing with all of the accountants in Government about how to do that. That $8 billion included both collection and identifiable expenses averted because we were able to change procedures or practices that were encouraging particular kinds of abusive behavior. Most of the actual cash collections come in through settlements of legal cases brought either by the Inspector General or by the Department of Justice.

The averted expenses, which are payments not made because we have prevented something, tend to be on our side of the ledger.

Mr. HORN. Let me ask you now specifically about this project. There seems to be a strategic decision on the part of HCFA to take control of the claims processing away from the claims processing contractors. Instead of requiring these contractors to upgrade the capacity of their automated systems to meet higher standards using an open systems environment that could accommodate a number of different systems, as I understand it, HCFA has decided to develop its own automated system forcing the existing systems to be scrapped.

Is HCFA's intention to take more control from the claims processing contractors as one of your primary purposes for pushing MTS? And I would like you to elaborate on the reasons for HCFA's strategic decision to change the prior successful policy, as I understand it, of relying on a diversity of automated systems.

Mr. VLADECK. Well, I don't want to argue with the presumption about how successful the existing policy has been, but I would say we feel very strongly that there should be a national, a single national claims processing and information system for the Medicare Program, which is, after all, a national program. We do not believe

it should be administered from a single central site. We do not believe it should be administered directly by the Government or operated directly by the Government, because our experience is that the private sector has substantially more flexibility. We can have more flexibility if we don't operate these systems directly ourselves. But we do feel very strongly that there should be a single national set of rules, set of systems, set of codes and so forth, which can then be administered in a variety of ways.

Mr. HORN. Well, that is heartening because we have just analyzed some of the debt collection of the Federal Government and the job just hasn't been done. There is a need to really contract some of that out and get the job done. We are talking about $60 billion out there in IRS uncollected debt, $50 billion in other agencies uncollected debt, and here we are struggling to find the next penny in the budget.

Mr. VLADECK. Mr. Chairman, if I could turn that around a little bit. We have been criticized by our Inspector General, appropriately, because as we have sought to come into compliance with the Federal Financial Manager's Act and develop financial statements for the Medicare Program that are in conformance with accepted accounting principles, there are three or four major elements of those statements that we have not been able to bring into conformance. The reason is that each of our contractors maintains data on certain categories of receivables, certain kinds of credit balances and so forth, under their own systems. Each of those systems has different—somewhat different set of definitions, entirely different software and so forth, and we have not been able to give a single Medicare-wide estimate of some of those basic financial numbers that meets—that meets the IG's standards for accuracy. That's exactly why we feel we need a single accounting system as it were in the Medicare Program.

Mr. HORN. Your testimony projects about $200 million annually in administrative savings as a result of MTS. However, GAO estimates that the Medicare fraud, waste, and abuse is 10 percent of the program, which was discussed with Chairman Clinger. By the time MTS is scheduled to be in place, this could be about $25 billion a year.

Are we placing too much emphasis in holding administrative costs down when we could save money by investing in waste, fraud, and abuse detection systems?

Mr. VLADECK. Mr. Chairman, you are playing a tune that is somewhat familiar to us. We have felt for a long time that the arbitrary separation of administrative costs and appropriated accounts from trust fund expenditures in the entitlement accounts probably caused us to underinvest in certain program integrity activities. And, in fact, the administration has proposed legislation and has worked with the congressional majority in both Houses on legislation that would permit us to develop new financing vehicles so that the savings in—some of the savings in trust fund outlays could be reinvested in administrative activities, both on our part and that of the law enforcement agencies.

Mr. HORN. I now yield to the chairman of the full committee, Mr. Clinger.

Mr. Clinger will go and try to be back to carry this on and then I will vote. So this is the—this is democracy at work, folks.

Mr. VLADECK. Yes, it is.

Mr. HORN. We do vote, even on motions to table, one of the sillier motions.

Let me ask you about the Blue Cross/Blue Shield Association proposal of a couple of years ago, on a joint procurement implementation effort involving both HCFA and its Medicare contractors. That report was an alternative strategy for the Medicare Transaction System.

Why did HCFA reject this approach, try to develop the system itself, and what are the benefits of your single system strategy?

Mr. VLADECK. Again, I think we talked about some of the advantages of a single system strategy, just a few minutes ago. And I could—I won't elaborate on them further unless you would like, but I think to us the Blue Cross proposal, apart from the dynamics of contractors potentially losing a lucrative monopoly, also struck as though an effort to build a 21st century system by taking some parts from a 1937 Chevy and some from a 1952 Dodge and cobbling them together.

We think that the state-of-the-art in data processing, particularly on the software side of data processing, has developed to the point that we can have a single uniform software platform that permits a variety of custom applications that permits and encourages various kinds of innovation, that allows us to modularly build on to meet needs as they change and so forth, but that you ought to start from a single system before you begin to decentralize or differentiate it, rather than trying to take four existing systems, none of them perfect, and cobble them into one camel.

Mr. HORN. I assume there have been quite a bit of overlap with the existing systems and between them. Is that not correct? I mean, you have to ask certain questions regularly.

Mr. VLADECK. They all perform the same business functions but they do them often in significantly different ways.

Mr. HORN. And do you feel you have taken the most effective and efficient ways showed and to integrate those systems into your MTS system?

Mr. VLADECK. Part of the—a major part of the MTS planning effort has been both an extensive review of the existing systems and operations and a series of discussions with the contractors and the people who operate the existing systems about what they would do differently if they were starting all over again or what their wish lists would be for characteristics of the new system.

Mr. HORN. Getting back to fraud, waste, and abuse, what incentives does HCFA really provide to the claims processing contractors area?

Mr. VLADECK. Well, we define payment safeguards, which includes fraud and abuse activities, as well as certain other activities, as one of the four basic functions of our contractors. And they are evaluated on that annually with increasingly stringency, and in the last several years we have demonstrated to our contractor community that within the constraints of the existing law we are not going to continue to engage contractors who don't meet our performance standards. So there's no particular sort of score card in-

centive that if you bat 300 you will get a $10,000 bonus. It is an expectation that they all meet our expectations in order to continue as Medicare contractors.

Mr. HORN. When a claims processing contractor uses fraud detection programs, will HCFA compensate those contractors with some portion of the savings for the additional costs associated with more effective screening of claims? How does that work?

Mr. VLADECK. We don't now have the—have the authority to create such incentive contracts. Under law, we are on a, basically a pure cost reimbursement contract arrangement with our contractors. One of the aspects of the legislation we have proposed would permit us to do incentive contracting. We have experimented with it in the past. It makes good sense. Our MTS contract is on an incentive contract and we definitely believe we ought to be able to do that in the future.

Mr. HORN. One of the most effective ways to get at fraud, waste, and abuse is what you said earlier, and a lot of us have said for years, and that is giving the consumer the information to know and hopefully they will know whether they had that service or didn't.

How do you feel about the type of input you are getting from the customers, now? Is there some other way we might want to design these forms to be a little more consumer friendly for the senior citizen in terms of visibility of numbers? Have we thought of that in the development of this system?

Mr. VLADECK. Again, sir, I think the single monthly notice will be much more customer friendly than the paper beneficiaries receive from us now, but I don't think that's the critical element that we need to improve.

The problem is, at the moment, because of the antiquatedness of some of our systems and because of the fact that we are really just beginning to reorganize ourselves to do this better, once a beneficiary calls in and says, you know, I understand you paid claims for X, Y, and Z on such a date, I don't think I received such a service. The question is what happens to it then and particularly what sort of feedback is there to the beneficiary?

In the past, we were not linked in an automated way with the Inspector General or with the law enforcement agencies so that once our contractor staff investigated such a report, if they thought there was something to it and made a referral, there was not automated tracking of that. If the beneficiary called back a month later to say, you know, I called you guys in November to tell you about this and my doctor is still in business, why isn't he in jail, we would not be able to track the complaint through processing.

We are in the process of implementing, at the moment, some of those automated systems on a pilot basis. And the real customer service piece is not so much, I don't believe, the first contact as the feedback loop. That's where we need to do much more work, and that's very much on the agenda in MTS development.

Mr. HORN. In the development of the MTS, are you using some focus groups of senior citizens on Medicare to look at some of these samples that might come out from this system? They are going to be the recipients and if they can't comprehend it or understand it, and we aren't communicating, then we have all failed.

Mr. VLADECK. Absolutely, sir. I have attended one such session myself and we have conducted several dozen of these sessions. We are doing it intermittently. We first had focus groups around the general problem. We then did a dummy draft design. We checked it out with a number of beneficiary groups, both through focus groups and other opinion research techniques. We revised the document on the basis of what we learned, and we are going to test the revised document again. So there will be three or four generations of such consumer testing before such a document is implemented.

Mr. HORN. I am going to ask this question. Please put the answer on the record and then when you finish that answer, the committee will go into recess until Mr. Clinger or I return.

Mr. GREEN. Mr. Chairman, could I ask some questions?

Mr. HORN. Certainly. I am sorry. I didn't see you here.

Mr. GREEN. We have some folks on this side.

Mr. HORN. Yes. You sneaked in on me. I yield 5 minutes. You have voted, have you?

Mr. GREEN. No, I haven't voted and I was going to run over at the same time.

Mr. HORN. Please. We will recess.

Mr. GREEN. I am glad you are here again, Doctor, and I appreciate being on the subcommittee in the joint hearing today because this is probably the biggest complaint I receive in my office in Houston, is, you know, the example you gave. You know, I don't think I received this service and yet I see it has been paid and it is frustrating to not only the Medicare recipients but to their children, who I talk to on a regular basis who assist in that paperwork that our chairman was talking about. And I don't know if we need to make it more user friendly. I think sometimes it would be better to have a voice on the end of that phone that is more user friendly.

But I, first of all, Mr. Chairman, I would like to ask unanimous consent to place in the record an opening statement.

[The prepared statement of Hon. Gene Green follows:]

Statement of Representative Gene Green
Subcommittee on Human Resources and Intergovernmental Relations
November 16, 1995

Thank you, Mr. Chairman for calling this hearing, which is one in a series of oversight hearings we have had on various aspects of the Medicare system. The elimination of waste, fraud and abuse in our Medicare system is imperative if we are to control costs as well as maintaining public support for the program. In both areas, our current performance is not good.

The subject of today's hearing is the attempt of the Health Care Financing Administration (HCFA) to update its computer system to improve fraud and waste tracking. Several questions have been raised regarding the cost of the system and the technical capacity of HCFA to run the system in-house.

I look forward to today's hearing and hope we can

shed some light on the where we stand on the subject of fraud and abuse prevention.

Mr. GREEN. But Mr. Vladeck, in response to, again, a constituent concern, and from Texas, I know Blue Cross/Blue Shield is our local contractor and I know I have asked you this at other hearings, and concerning the enforcement of someone reporting to the local State contractor, and this is not just a problem in Texas, I have heard it all over the country.

In the followup, in the system, the MTS system, in your testimony today, your answers, show that once we receive—or are able to achieve the MTS system they will then be able to report and they will be able to followup much easier than today.

Mr. VLADECK. Part of that, sir, the answer is, yes, but not all of that will be attributable to the MTS, as much as we would like to claim the system can do everything. There are other things that need to be done. And the real issue here has been the relationship and the interface between our contractors, the Inspector General, the local operating arms of the Department of Justice, whether the FBI or the U.S. Attorney's Office, in terms of getting those sorts of feedback mechanisms.

We are now developing, in conjunction with the Inspector General and Department of Justice, automated referral tracking systems. So that if the contractor, Texas Blue Cross/Blue Shield, does a preliminary investigation, they think there's something funny about these claims, they will then refer them to the Inspector General. The Inspector General will make their own evaluation and if they think there's a potential criminal prosecution, bring in the FBI, for example, or the U.S. attorney.

By the time MTS is up and running, we should have all of these folks sharing a single data system that will track all of the referrals and complaints that come in to them. Then the beneficiary who made the initial complaint will be able to find out what became of it. That's not part of MTS, per se, but it will be implemented in conjunction with the MTS development.

Mr. GREEN. Well, I know we will have some other Members, if you want to have the committee stand in recess until the majority come back, and I appreciate the time to ask you questions.

Mr. VLADECK. Yes, sir.

Mr. HORN. I apologize for the delay. We had a little parliamentary snarl on the floor and one never knows what's next, but here we are.

Let me ask you, Mr. Administrator, is there anything you would like to say in conclusion besides what the Members have asked? And if you were us, what kind of question would you ask you that we haven't answered—asked, OK? One of those days.

Mr. VLADECK. Well, if I may, Mr. Chairman, I was—I was thinking further about Mr. Clinger's question about the FAA experience and, obviously, I am not an expert.

Mr. HORN. I have had the same. I sit on that committee, too.

Mr. VLADECK. Although I am obviously a customer, as we all are, I think it's important to emphasize as we develop MTS, that while the system is new and while the integration of many functions is a very ambitious task, as opposed to what's being done in the air traffic control system or some of the other procurements at which we have looked as we have tried to develop our own strategy for MTS, we are not relying on any new, not-yet-developed tech-

nologies. We are not pushing the envelope, as it were, on data processing technology or data interchange technology.

This is a systems development and systems integration project of significant size and complexity. I don't mean to minimize that, but we don't need to invent anything that doesn't yet exist in order for this to work. And in my own layman's look at some of these kinds of cases and some of these kinds of instances, that really is a significant difference. I believe that should render this less scary in some important ways than some other kinds of systems developments where you really had to invent the technology that didn't exist.

The other thing I would say without trying to gild the lily at all, Mr. Chairman, is that we were talking during the break about the extent to which even when you think you are monitoring something closely, preparations for a hearing of this sort are a very useful spur to the organization and a way to make sure one's doing his homework. And so we have to this point worked closely with the committee staffs on the MTS development.

We very much welcome your continuing involvement and interest. And I would hope, I would expect and hope that we will periodically be checking in with you and updating you on progress and changes we have made as this goes forward.

Mr. HORN. I appreciate that answer. I think you made a very good point how administrators can use these hearings to shape up their own bureaucracy. That's a point I made 35 years ago in a book and I am glad to see somebody finally confirmed it.

Let me just ask you on one closing question, this is on the software. What pilot projects did HCFA engage in to test the potential software modules for incorporation into either MTS or the existing systems? And as you suggest, the private sector has been moving toward on-line, real-time processing systems, and do we have any pilot projects for that?

Mr. VLADECK. In terms of the core claims processing system, we have not pilot-tested existing software. In terms of some of what might be described, as in the computer terminology, although probably not in a totally semantically accurate way, is as peripheral systems, some of those for checking for the unbundling and rebundling of codes, some of the pattern recognition software that you used for fraud and abuse kinds of things, some of the software used for particular applications.

We have evaluated and tested, in some cases, our contractors have procured, in some instances, we have procured special-purpose commercial or preexisting software, and we expect again that the core of the design of the MTS will be a core software information platform into which we can plug through standardized interfaces, applications developed or used by others and that we can test in a variety of ways before we fully integrate them into our system.

Mr. HORN. Well, I am glad you are proceeding the way you indicated with not reinventing the wheel, because that was exactly what happened on the FAA. They went billions of dollars beyond estimate. They had everybody with a peachy keen idea at FAA add their particular little wrinkle to the system and the result was they immobilized themselves. It didn't work, and the corporation doing it had to really get out of the business and let someone else do it.

They didn't know how to say no. I think you're right to test existing systems because a lot of these problems have been solved in many large corporations or large enterprises.

Mr. VLADECK. When again, sir, our basic philosophy has been here, that on the technological side, in fact, we had taken so long before beginning the modernization of the Medicare information systems that multiple generations of development had occurred and so we didn't have to get to the next step beyond the state-of-the-art to give us the systems performance we needed. We could work within the envelope of established technologies and not run the risks associated with untested technologies in a system of this kind.

Mr. HORN. I am now very glad to yield to a very distinguished colleague on the Shays subcommittee and the former chairman of that committee, Mr. Towns of New York. We happened to go to his home State in the last Congress when I served on his committee—and found quite a substantial bit of Medicaid fraud in this case. I don't know how much Medicare fraud you found. But he's well-gifted on this by experience.

Would you like to ask some questions?

Mr. TOWNS. Thank you very much, Mr. Chairman. Appreciate the opportunity to participate in this hearing.

What cost savings—let me begin by that, can you—What cost savings will be achieved simply by consolidating these systems?

Can this consolidation be accomplished without MTS?

Mr. VLADECK. The answer to that is just on the administrative overside, Mr. Towns, we have projected savings of about $200 million a year that come about from the implementation of a single integrated system and, therefore, by definition are not available as long as we have multiple systems operated independently within the program.

Mr. TOWNS. There was a hearing held by our subcommittee I think in June. We learned of significant gaps in HCFA's efforts to exclude fraud or abusive problems of providers, I should say, from participation in Medicaid and Medicare programs. How will MTS correct these problems?

Mr. VLADECK. Actually, the issue of provider exclusions and provider patterns of behavior is a very good illustration of what MTS will permit us to do that we haven't been able to do to this point. In concert with the implementation of the MTS, we will have a single unitary national provider file, and we will be processing claims in a way that can cross-reference national claims on a real-time basis. There are two kinds of problems we now have that MTS should permit to us address: One, is the provider we catch committing fraud against the system, we exclude them, they move to another State, reapply for licensure, do business under another name, apply for a provider number with another contractor and are back in business in no time at all. Again, with the single national provider file with some entry checks in it, that won't be able to happen.

The second problem we have had is—is of providers who may do business in a number of States, who we put out of business in one State, but continue to bill us in others because, again, each of the contractors is maintaining separate records, separate exclusion

lists, and so forth. Under MTS with a single integrated system, we should be able to put a stop to that kind of problem.

Mr. TOWNS. Fraud and abuse, you know, it is a very, very serious problem, as the chairman mentioned, you know. We have looked at it in Florida and of course New York and some other places. My concern now, which I guess is not really your area but I will raise it based on the fact that I know you have had a lot of experience with this, is that as we look at cutbacks, what are we doing to enforcement?

If we find out that there is something wrong and we are eliminating people that are supposed to go out there and to pursue it and there's nobody to do that, then it's just having information and not doing anything with it.

Mr. VLADECK. Well, Mr. Towns, that's why we have proposed and talked to the relevant committees about making sure that as part of any Medicare or Medicaid legislation that's enacted this year, that provision is made for adequate resources to continue to do the sorts of program integrity things that may become even more necessary in the future.

We still have a ways to go, I think, in terms of the specifics. But I must say that we have found a receptive ear in Members and staff from both parties to recognize that any reform of Medicare and Medicaid must include, not only continued vigilance on fraud and abuse, but mechanisms for ensuring that there's adequate resources to do both the prevention and investigational tasks that will become increasingly important.

Mr. TOWNS. I thank you, and I agree with that. I think that's important that we do it.

You know, sometimes we get caught up in phrases and terms around here that sound good but, when you start asking questions you know they are not too good. So when we talk about reform, we are hoping that the reform is going to be in the positive kind of way and that of course all these things must go together.

Reform is like prayer, it can be either positive or negative. So if somebody is said they are going to pray for you, ask them what they are going to say. You know, they might pray that you break your neck. Anyway, so I am not impressed with the word reform unless I know exactly what it means.

So let me close, Mr. Chairman, by asking unanimous consent to place my statement in the record and also to recognize the Allen Senior Citizens Center who are here today, that they are very concerned about fraud and abuse and have been very outspoken down through the years, so we are delighted to see them here as well.

Mr. HORN. Put up your hands if you come from that center. Good.

Mr. TOWNS. Yes, Allen——

Mr. HORN. We are delighted to have some of Mr. Towns' constituents here. And since you are from New York, you certainly know a lot about reform, I know that.

Thank you.

Mr. TOWNS. I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

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Statement of
Representative Edolphus "Ed" Towns
Ranking Democratic Member
Subcommittee on Human Resources and Intergovernmental Relations

Before a Joint Hearing of the Subcommittee on Human Resources and Intergovernmental Relations and the Subcommittee on Government Management, Information and Technology on Health Care Finance Administration's Medicare Transaction System

November 16, 1995

I want to thank the Chairmen for holding today's hearing on the Medicare Transaction System. While this is an important issue, I am concerned that today, the Federal Government is shut down because my colleagues on the other side of the aisle have repeatedly chosen to attach Medicare and Medicaid reductions to the Continuing Resolution that would have kept this government running. Therefore, I find our presence here today, in our oversight role of the Health Care Financing Administration's implementation of the Medicare Transaction System (MTS) a little ironic.

Medicare currently covers health care services to 36 million people. The great majority of the beneficiaries are over 65 years old. In 1993 alone, Medicare processed almost 700 million claims. In a national system which involves 79 contractors and millions of beneficiaries, small unintentional errors can translate into large problems. Intentional acts of improper billing can result in multi-million dollar cases of fraud. Old and multiple billing systems make fraud more difficult to detect. Therefore, it only seems logical that we should look at ways to streamline and simplify the Medicare claims processing system.

MTS, a 1990 HCFA initiative is an attempt to provide a single system which will process claims, provide patient treatment information and facilitate fraud detection. This system is scheduled to be fully operational in 1999. In considering this starting date, I am reminded of a car which promises 60 miles per gallon. It is a revolutionary achievement unless the gas tank is empty. Given the recent cuts and promised future cuts in Medicare, I am concerned that there may not be a program by the time MTS is in place. I guess this question can only be answered by the American public. I look forward to hearing the testimony of the witnesses here today.

Mr. HORN. I now yield 5 minutes to the distinguished gentlewoman from Maryland, Mrs. Morella.

Mrs. MORELLA. Thank you very much, Mr. Chairman. Thanks for calling the meeting.

I ask unanimous consent that my opening statement be included in the record.

Mr. HORN. Without objection, so ordered.

Mrs. MORELLA. In order to save time, I really have just one question to ask Dr. Vladeck.

Good to see you. We support you. We certainly feel that what you are doing is the right direction and more needs to be done.

As I pose the question, let me just tell you that in my office I have received from two different constituents, checks. They didn't know the other was sending it. These checks are each in the amount of one penny, .01 cent.

Now, what they are saying to me, you know, as you are looking at the integrity and solvency of Medicare and waste, fraud and abuse, do you realize how much it costs to process that refund check for one penny? I have no answer for them, so I said I'll save it and when I have an opportunity, I will certainly make sure that we do something about it.

What are we doing about that?

Mr. VLADECK. Can you tell me the dates on that check?

Mrs. MORELLA. One is recent, but I will bring them.

Mr. VLADECK. If you can supply us with copies, if the beneficiaries wouldn't mind. When I arrived here about 2½ years ago, I got that question and I was told that it costs us about a dollar and a quarter to process a part B claim, including postage, and I was told it would cost about $2 per claim to not pay the .01-cent checks.

After I had been around for a few months and had somewhat more sophistication about dealing with the various bureaucracies with which we work, I had a fit and I insisted on a policy that, henceforth, we would no longer write checks for less than a dollar. And I have been advised that the procedures for doing that are put in place. If that hasn't fully happened, I would like to know about it, and I would appreciate it if your office could get us that information. We will see what has fallen through the cracks.

Mrs. MORELLA. I promise I shall, because I believe it was quite recent.

Mr. VLADECK. That shouldn't have happened. And I think by and large, we have stopped writing checks for less than a dollar. I'd like to know where that one went wrong.

Mrs. MORELLA. Thank you. I appreciate it.

Also in your testimony you project that about $200 million annually will occur because of administrative savings as a result of MTS; however, the General Accounting Office estimates that the fraud, waste, and abuse in Medicare is about 10 percent of the program. By the time MTS is scheduled to be in place, this could be about $25 billion per year. So are we placing too much emphasis on holding administrative costs down while we could be really saving more money by investing in waste, fraud, and abuse detection systems?

Mr. VLADECK. Actually, we have a long-standing dialog, as you may know, with our colleagues in the Office of Management and Budget and General Accounting Office and the Congressional Budget Office about how to score potential savings from the prevention or deterrence of fraud and abuse or other problems of that kind. Traditionally everyone—I think with some GAO theoretical reasons, have been reluctant to make dollar estimates of how much you can save. But to us it's exactly the heart of the MTS that—because, frankly, it will be replacing 1970's technology with 1990's technology, we will be able to save perhaps $200 million a year in administrative costs and have significantly increased power to detect problems of fraud and abuse.

This will be a much more effective system for identifying fraudulent billing patterns, for using new technologies and software developed by others for tracking problem claims, and so forth. It will be such a leapfrog in the technology of our information systems that we will be able to run the system less expensively and yet much more productively on the detection of problems and in other regards as well.

Mrs. MORELLA. It just also seems to me, looking more at waste, fraud, and abuse is going to bring in more money, but indeed you need to be moving administratively with the MTS system.

Thank you very much, Mr. Chairman.

Thank you.

Mr. HORN. You are quite welcome.

Let me ask, are there any further questions on the minority side?

Mr. TOWNS. No further questions, Mr. Chairman.

Mr. HORN. Does the chairman have any further questions?

Mr. CLINGER. Thank you, Mr. Chairman.

I just have one additional question, Dr. Vladeck. I understand that GTE, which is undertaking the design, is supposed to test as they begin utilizing the system that they have been hired to design; in other words, they have a self-testing role as well. In addition, a company called Intermetrics has been hired by HCFA, as I understand it, to test the efficacy as you go along or as the system is being implemented. And now my understanding is that you have hired Los Alamos National Labs to test what appears to be the same matters.

Is there a redundancy here? Is there an overlap? Or are they doing different things? It does sound like the same.

Mr. VLADECK. Let me explain, if I can, the relationships among those three contracts. GTE has the principal design responsibility working very closely with us to figure out what MTS is supposed to do, and to design it. That extends all the way to writing the actual software and testing the actual software for the system.

The involvement of an independent verification and validation contractor, Intermetrics, is a technique that we learned, frankly, from our colleagues in the Department of Defense. We have contracted with Intermetrics at the same time as GTE to be an in-house critic and monitor, both of GTE's performance and ours. So that is another firm that is expert in the development of this sort of system, which is monitoring GTE's performance and our performance on our behalf, and which reports to us periodically on their evaluations of the system as it's going along.

The Los Alamos contract is a very different kind of activity altogether. The folks at Los Alamos, as you know are, from their work on national defense-related matters, have enormous experience with high-speed computing with very, very large databases. They have done some very important and interesting work on the—I don't know all the right technical terminology, but on the analysis of large databases to detect patterns of odd or disturbing kinds of phenomena. They have begun working to apply that expertise and technology to areas like credit-card billings and health insurance billings to see if they can use some of this same software and technologies to detect patterns of fraud or abusive behavior in large patterns of bills.

And so our contract with them is to take existing Medicare data to see if their pattern detection and recognition software will turn up problems in Medicare billing. Then, if that turns out to be the case, as we expect it will, to design again one of these sort of plug-in modules to incorporate into the MTS sort of on the front end so that we have that extra screening capability on claims before we pay them. If it all works, that will be a piece that gets plugged into MTS as sort of an additional fraud and abuse detection technology.

Mr. CLINGER. Los Alamos will not be involved in sort of double-checking the work that GTE is doing?

Mr. VLADECK. No, sir. This is a very discreet, separate piece, particularly around this pattern recognition technology.

Mr. CLINGER. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Thank you very much.

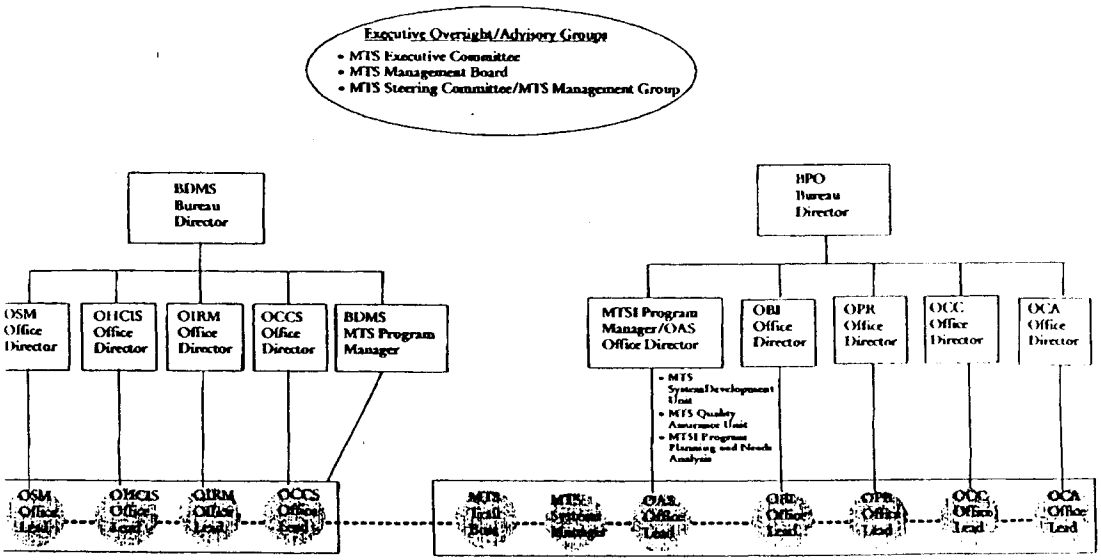
Let me just say in conclusion, we want to thank you very much.

I am inserting in the record several attachments: The organizational chart for MTS, the list of HCFA staff associated with MTS and the fiscal year 1994–95 time line for MTS.

[The information referred to follows:]

As of October 1995

Medicare Transaction System Initiative (MTSI) Matrix Organization



Vertical Flow = Functional Authority and Responsibility
Horizontal Flow = Project Authority and Responsibility

November 1995

Following is a listing of the names associated with the titles identified in the organizational chart dated October 1995. Please note that attached is an updated organizational chart which more accurately depicts the "big picture" of the Office Lead structure.

MTS EXECUTIVE COMMITTEE:

Chair, Director Bureau of Program Operations (BPO) – Ms. Carol Walton

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Stewart Streimer, BPO
Mary Hogan, OMC
Jared Adair, (BPO) representing MTSI
Dennis Carroll, Philadelphia RO
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Chuck Booth, BPD
Elaine Olin, BPO, GTE Project Officer
Jim Heath, GTE Project Manager
Larry Pratt, BPO, Intermetrics Project Officer
Tony Gonski, Intermetrics Project Manager

** NOTE: The **MTSI Program Management Team** no longer exists. The functions of this group have been incorporated into the office lead structure and the functions of the MTS management group.

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Office Director, Bob Moore
MTS Office Lead, Mary Kavanagh

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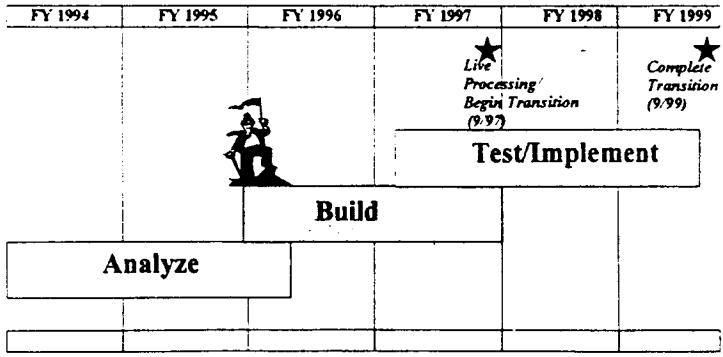
Jerry Hankin, OFHR
William Saunders, ORD
Dennis Carroll, Philadelphia RO
Sharon Arnold, OLIGA
Lori Harris, OLIGA
Mary Hogan, OMC

STATUS OF MTS DEVELOPMENT



Mr. VLADECK. I appreciate that.

Mr. HORN. And as I note here, you are right now in the end of the analyze phase, the beginning of the building phase in fiscal year 1996, and we have really 4 years to go before complete implementation of the MTS system under the plan, as I understand it now.

Mr. VLADECK. Correct.

Mr. HORN. Are we on track and on time?

Mr. VLADECK. Again, we are on track. As of now, we have been pretty consistently on track for about the last year. I expect we will be periodically checking in with you as we go down the road, and we will keep you posted as it moves down.

Mr. HORN. Thank you very much, Dr. Vladeck. We appreciate your appearance here today and you have been very patient with democracy in action as we go to answer votes, so thank you very much.

Mr. VLADECK. It's my pleasure, Mr. Chairman. I'll be back, I imagine.

Thank you.

Mr. HORN. Our next witnesses are part of the legislative branch that are essential, namely, Mr. Christopher Hoenig, the Director of Information Management Policy and Issues; Mr. Frank Reilly, the Director of Information Management Technology Division of the General Accounting Office.

Gentlemen, you know the routine, and if those accompanying you please also take the oath.

[Witnesses sworn.]

Mr. HORN. All four witnesses, including staff, have affirmed.

Please begin, Mr. Hoenig.

Mr. SHAYS. Mr. Chairman, could I just——

Mr. HORN. I apologize.

Mr. SHAYS [continuing]. Apologize first to you, and then to the first panel for not being here. This is a joint hearing with primary sponsorship from the Management Subcommittee. I just want to say that for the record that gift ban and lobby disclosure are coming before the Chamber, two activities that I have been very closely involved in, and slightly before that debate I will be leaving here about 12:15. I just want to explain why I haven't been here.

Mr. HORN. I will be leaving here at 11:55, Mr. Chairman. So hopefully between our two subcommittees we will have an acting chairman.

Mr. SHAYS. Mr. Towns, do you mind being chairman while we are gone?

Mr. HORN. This is true bipartisanship.

Mr. TOWNS. Thank you for the consideration.

Mr. HORN. OK.

Thank you.

And well, gentlemen, Mr. Hoenig, I believe will go first, is that—or would you like Mr. Reilly?

Mr. REILLY. Mr. Reilly will actually go first.

Mr. HORN. Go ahead Mr. Reilly.

STATEMENTS OF FRANK REILLY, DIRECTOR, INFORMATION RESOURCES MANAGEMENT/HEALTH, EDUCATION AND HUMAN SERVICES, GENERAL ACCOUNTING OFFICE, AND CHRISTOPHER HOENIG, DIRECTOR, INFORMATION RESOURCES MANAGEMENT/POLICIES AND ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY HELEN LEW AND L.J. LATHAM, ACCOUNTING INFORMATION MANAGEMENT DIVISION, GAO

Mr. REILLY. Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss our ongoing review of the Health Care Financing Administration's effort to design, develop and implement a critical new claims processing system, the Medicare Transaction System, or MTS.

With your permission, Mr. Chairman, I would like to submit my full statement into the record and submit a brief summary at this time.

Mr. HORN. That is automatic with all witnesses. We put your statement in right after we introduce you.

Mr. REILLY. Before I begin, I would like to introduce my colleagues, Chris Hoenig on my right, who will also offer a brief oral statement this morning. He is in charge of our group looking at information resources, management policy and issues government-wide, and it was this group that developed what has come to be known as "Best Practices." And Mr. Hoenig will discuss these practices for large systems development projects and how they relate to HCFA and MTS.

And also accompanying me on my left are Ms. Helen Lew and Mr. L.J. Latham of our Accounting Information Management Division, and we have all jointly worked together on this project.

The goal of MTS, which Mr. Vladeck talked at great length, is the current nine separate systems that process Medicare is going to be into a single system, and this means that when the administrator or legislative changes call for an adjustment in payment policies, each system must be individually updated; that is a problem. MTS is meant to be the single unified system to replace the separate systems, increasing service efficiency and oversight and the prevention of fraud. This is a vision we certainly support.

We are finding, Mr. Chairman, while HCFA's approach to developing MTS contains several strengths, it also contains important weaknesses that are adding unnecessary risk. On the plus side, HCFA is attempting to build as much flexibility as possible into the system so it can be easily modified, that this is especially important given the variety of Medicare proposals before the Congress today. HCFA also plans to build, test and implement MTS in stages so that problems that arise can be addressed more manageably.

In addition, the system will allow direct access to claims by beneficiaries and provide—pardon me, providers. The problems we see, however, seem to come from the lack of a disciplined management process. HCFA is not managing MTS as an investment.

As a result, difficulties are emerging in three key areas: First, the system requirements, which are crucial because they spell out exactly how the system must operate and what it will be enabled to do. These are not being defined as fully or as early as necessary.

Second, shrinking the development schedule has led to significant overlap of development phases meant to be largely sequential.

Third, there is a lack of reliable information about costs and benefits.

The good news is, however, that if management exercises investment control and other "Best Practices" these risks can be greatly reduced. Since MTS development is still in its early stages—and I want to stress that, within a limited outlay of funds, this is an excellent time to assess what changes in approach could enhance the likelihood of success. HCFA has expressed interest in learning more about "Best Practices" and we are very happy to work with them in this area.

HCFA expects MTS to be ready for initial operation in September 1997, and full capability in September 1999. A contract for the design, development and implementation had been awarded to GTE, and as Dr. Vladeck said, the independent verification and validation or IV and V's to Intermetrics, which is a separate technical check of GTE's work and works closely with HCFA as well.

I want to make one observation, Mr. Chairman. The MTS project represents a role shift for HCFA, one that may be difficult to master. The nine existing processing systems were built entirely by experts in systems development. HCFA's role is to manage the development of MTS using its contractors GTE and Intermetrics.

In other words, Medicare program managers are tasked with developing guidelines for GTE to follow. This technical management responsibility introduces additional risks to the extent that HCFA program personnel are inexperienced in such direction and this is to be expected with this kind of a transition.

Early symptoms of risk: In our experience, problems related to requirements definition, schedule and cost often contribute to extensive delays, large cost increases and a systems inability to achieve the potential benefits it was designed to produce. Such risk is not merely theoretical. Symptoms are appearing.

For example, in the area of requirements, the needed level of specificity has not been achieved, a fact also highlighted to HCFA by the IV and V contractor. Since requirements provide the foundation for developing the system, they must be precise. They also need to be in place before design and other decisions that follow from the requirements are set.

One indicator of an undisciplined approach is that HCFA has gone back and forth with GTE initially saying the requirements are too broad, then too detailed. At this point, while HCFA officials believe requirements have been sufficiently defined, both we and the IV and V contractor disagree. I'd like to have you take a look at our board here.

Mr. HORN. And all of those will be included in the record at each point.

Mr. REILLY. Thank you.

Schedule compression is another potential flag and the graphic shows the sequence of a normal systems development, and the topline is taken from an early HCFA plan, and is not meant to indicate delay but merely that the latest revised scheduled underneath where it says 11–95 shows a good deal of phase overlap which can cause problems.

HCFA officials explain such schedule compression by saying it is important that the 1997–99 dates not be delayed because doing so would mean incurring additional expense because of the so-called millennium change in the year 2000 where the digits change. But if you look at that schedule and—Karen, show where the 1996 line is and where the 1997 line is—at the end of 1996, that's 10–96, the analysis, design is supposedly completed and they begin programming and testing and evaluation, but you will see there's only an 11-month period between the end of design and the beginning of implementation. And this is a time compression.

So we think what is needed is an evaluation of these costs versus the risk of compression, and HCFA has not developed a tool for such risk assessment.

Finally, cost estimates have not been updated for over 3 years and internal costs, such as for personnel training and travel, have been and are not being tracked. In conclusion, signs of risk are present but can be reduced—pardon me, be reduced.

Mr. Chairman, the pattern is all too familiar when systems are not developed according to sound discipline practice. Major and expensive problems crop up later on, and Mr. Clinger's mention of FAA we will discuss later on.

The larger project, the bigger and the bigger the risk, and MTS is an extremely large project. These risks can be reduced. My colleague Mr. Hoenig will detail what is necessary to do just that, after which we will be happy to entertain questions.

Mr. HORN. Very well.

Mr. Hoenig.

Mr. HOENIG. Good morning, Mr. Chairman and members of the subcommittee. The purpose of my remarks today is to bring a larger perspective to the discussion of this MTS effort.

I'd like to cover the following three areas with you. The wheel doesn't have to be completely reinvented with MTS. We can learn from the success and failure of others; there are three management areas especially critical to its success and each of those three areas leads to an important oversight issue for you to consider.

Let me start with the idea that there is much experience in reducing risk with large systems that most professionals agree on. These practices make a difference and we in Government ignore them at our peril, as you have talked about already.

It is easy to talk about, but the difference is really in execution. Although some successes have been frequently touted in the IT area, high failure rates for large projects are a problem and have been for years in both the private and the public sector. However, certain selective leading organizations have figured out how to reduce the risk and repeat successes.

Last year, we completed a 2-year research effort to study how they did it, private and public sector, senior management teams repeatable successes—you should have this in front of you—professional consensus is developing on these critical issues in Congress, in the administration and the agencies, in law, in regulation, and in day-to-day practice.

Second, the essence of what we learn comes down to this; experience and discipline must be proportional to the scale and complexity of the effort. MTS is a large effort. And the three management

areas that are especially important for its success come down to this: First, they must define the right problem and set measurable goals. Just one example from our studies, an organization, which needed to improve productivity just like HCFA needs to improve fraud. They set a target for 6 percent real improvement every year and showed how it was going to go down with system implementation. That helped them keep a tight focus.

Second, you have to create the organizational capability to deliver. One of the organizations we looked at created the key technical officer positions, the CIO, and project management. They trained everybody religiously and they made sure even the chief executive was trained and educated so that he was not a layman and was actually keeping weekly updates on his 27 top systems projects.

Third, carefully control implementation. An example here; all the leading organizations we studied had investment control processes where senior management selected control and evaluated the results of all major systems. Xerox, when they put this in place, went from getting 13 cents on the dollar for their major systems investments to $1.33 on average. It makes a big difference.

Although risk always exists in large systems projects, if HCFA can learn from and apply these practices, their chances of success will increase significantly.

Finally, Congress, including oversight, authorizing and appropriating committees, needs to ask and get specific regular answers to three questions that focus oversight on how well HCFA is doing in the current practice areas I have mentioned. In the MTS effort, it is currently too early to tell whether we will end up with a real chance of benefits or unnecessary risks of failure, but one thing is certain: Which we end up with depends heavily on the quality of the answers to these questions over the next 3 years—next few years.

First question: What is the net benefit to the public in specific terms? How much faster, better, cheaper, by when and why it's necessary?

The answers you should get include specific measurable targets for things like fraud reduction, cost savings and service improvements over the system's timeframe, and sound, clearly articulated cost-benefit risk assessments. With good answers the chances of real fraud reduction in administrative cost savings, provider and beneficiary service improvements increase. Without such answers we could end up in a situation where we don't get what we expect, only a fraction of what's possible or even take a step backward. This could mean few fraud reduction benefits or worse, new problems.

From our experience elsewhere in Government, we know what this means; Veterans benefits, $256 million modernization, 6-month wait time, only a 10 percent targeted reduction in the overall goal.

Second question: Does the agency have the capability to deliver? The answers you should get include evidence of active institutionalized processes to identify key positions, existing and required skills and the hiring, education and training efforts to fill the gaps.

With good answers, the chances increase of getting the right people in the right jobs, with the right skills. The agency can go through a healthy learning process with a big project like this and in 1999, everything can be finished with minimal risk or failures.

Without these answers there is additional risk that capabilities will be highly variable. The agency could quickly fall behind the curve and never catch up. We could spend many years and still have it very unclear whether we will ever have the capability to get anything at all.

Again, Mr. Chairman, we have been down this road before with the IRS. Eight years, $2.5 billion spent on an $8 billion project, and right now we still don't know. The system is in serious risk and we don't know what we are going to get for it.

Third question: Is the agency showing evidence of making consistent, real progress in managing risk? The answers you should get include quarterly senior management decisions and actions that address selection of project modules, their risks, progress against plan, and independent evidence of net benefits achieved after implementation versus projections.

With good answers, the chances increase of going through a minimal number of cost and schedule revisions, basically meeting deadlines with reasonable variations and producing solid evidence that investments will increase returns for the public. Without these, the risk rises of constant cost and schedule revisions, reduced benefit and functionality at every step of the way for more money, and finally, after many years, actual cancellation of the system that may not even work—FAA, which you are both very familiar with.

Mr. Chairman, the risks in large-scale systems development are real. There are ways to minimize these risks and increase the chance of capturing benefits. All of us in the Federal Government need to learn to apply them or face the consequences. It takes time to get these things right. We need to start now.

That concludes my statement. Mr. Reilly and I will be happy to answer any questions.

[The prepared statement of Mr. Reilly and Mr. Hoenig follows:]

Statement of Frank W. Reilly
Director, Information Resources Management/
Health, Education, and Human Services
and
Christopher W. Hoenig
Director, Information Resources Management/
Policies and Issues
Accounting and Information Management Division

Mr. Chairmen and Members of the Subcommittees:

We are pleased to participate in this joint subcommittee hearing today to discuss our ongoing review of the Health Care Financing Administration's (HCFA) efforts to design, develop, and implement a critical new claims-processing system, the Medicare Transaction System (MTS). At the request of Chairman Shays, we have been evaluating HCFA's progress; specifically, we were asked to focus on the process for defining MTS requirements, and the reliability of the development schedule and project cost estimates. In connection with our ongoing work to identify recognized best practices for large systems-development efforts, we are also providing observations on HCFA's overall approach to managing MTS.

We are finding, Mr. Chairmen, that HCFA's approach has several strengths, and several weaknesses that have contributed to early symptoms of unnecessary risk. On the positive side, HCFA plans to design and develop MTS to allow for future modifications. With the vast and varied Medicare reform issues before the Congress, this is essential. HCFA also plans to build, test, and implement MTS in increments, or segments, thereby mitigating the impact of large-scale problems; similarly, the system is planned for deployment initially at a limited number of sites, which means that HCFA should be able to identify problems and correct them before further implementation. Finally, HCFA's plans include worthwhile goals

such as improving customer service through direct access to Medicare claims information through MTS, both for beneficiaries and providers. These are all good ideas.

We see problems, however, that seem to stem from the lack of a disciplined management process that has as its hallmark managing information systems and technology as *investments.* Not managing MTS in this way has led to system design and development proceeding despite (1) difficulties in defining requirements, (2) a compressed schedule containing significant overlap of system-development phases, and (3) a lack of reliable information about costs and benefits. These deficiencies increase risk.

The results of our work looking at systems-development initiatives shows, however, that management attention to implementing effective investment-control practices can reduce such risk. HCFA officials have expressed interest in learning more about effective management practices that have helped other organizations succeed with similar projects, and we have agreed to continue to work with them by suggesting successful approaches to reduce MTS development risks. Now is the time for careful scrutiny and improvement to enhance the chances that MTS will

perform as required: fortunately, the project is still in its early developmental stages, and the outlay of funds has been limited.

MTS: AN IMPORTANT VISION

HCFA's vision, which we support, is for a single, unified system to replace the nine current systems now used by Medicare, the nation's largest health insurer, serving about 37 million Americans. The goals of MTS are to better protect program funds from waste, fraud, and abuse; allow better oversight of Medicare contractors' operations; improve service to beneficiaries and providers; and reduce administrative expenses. At present, HCFA expects MTS to be fully operational in September 1999, and to process over 1 billion claims and pay $288 billion[1] in benefits per year by 2000. These are ambitious goals, and we realize that developing such a system is complex and challenging.

Currently, when legislative or administrative initiatives result in revised payment or coverage policies, each of the nine automated systems maintained by Medicare

[1]The Economic and Budget Outlook: an Update, Congressional Budget Office, August 1995, p. 26.

contractors to process claims must be modified. An integrated system would eliminate the need for such cumbersome and costly multiple processes. In January 1994, HCFA awarded a contract to GTE Government Systems Corporation to design, develop, and implement the new automated system for processing claims. Two related contracts were awarded: to Intermetrics, Inc., in April 1994 for what is known as independent verification and validation, or IV&V--a separate technical check on GTE's work; and to SETA Corporation in September 1995 for systems testing.

BEST PRACTICES: DISCIPLINED MANAGEMENT PROCESS ESSENTIAL FOR SUCCESS

Over the last 12 years, the federal government has spent more than $200 billion on information technology, and we have evaluated hundreds of these projects. On the basis of this work, we have determined that two basic, recurring problems constrain the ability of organizations to successfully develop large systems: (1) failure to adequately select, plan, prioritize, and control information system projects; and (2)

failure to take advantage of business process improvements that can significantly reduce costs, improve productivity, and provide better services to customers.[2]

These problems have often led to meager results in federal agency efforts to design, develop, and acquire complex information systems. For example, after investing over 12 years of effort, the Federal Aviation Administration (FAA) chose to cut its losses in its problem-plagued Advanced Automation System by cancelling or extensively restructuring elements of this modernization of the nation's air traffic control system. The reasons for FAA's problems included the failure to (1) accurately estimate the project's technical complexity and resource requirements, (2) finalize system requirements, and (3) adequately oversee contractor activities.[3]

Similarly, our work on IRS' Tax Systems Modernization, designed to automate selected tax-processing functions, identified several weaknesses. For example, IRS lacked (1) a disciplined process for managing definition of requirements, and (2) a

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[2]Managing For Results: Steps for Strengthening Federal Management (GAO/T-GGD/AIMD-95-158, May 9, 1995); Government Reform: Using Reengineering and Technology to Improve Government Performance (GAO/T-OCG-95-2, Feb. 2, 1995).

[3]Advanced Automation System: Implications of Problems and Recent Changes (GAO/T-RCED-94-188, Apr. 13, 1994).

management process for controlling software development. These problems caused significant rework and delays.[4]

Last year, to help federal agencies improve their chances of success, we completed a study of how successful private and public organizations reached their goals of acquiring information systems that significantly improved their ability to carry out their missions. Our report[5] describes an integrated set of fundamental management practices that were instrumental in producing success. The active involvement of senior managers, focusing on minimizing project risks and maximizing return on investment, was essential. To accomplish these objectives, senior managers in successful organizations consistently followed these practices--which have become known as *best practices*--to ensure that they received information needed to make timely and appropriate decisions.

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[4]Tax Systems Modernization: Management and Technical Weaknesses Must Be Corrected If Modernization Is To Succeed (GAO/AIMD-95-156, July 26, 1995).

[5]Executive Guide: Improving Mission Performance Through Strategic Information Management and Technology (GAO/AIMD-94-115, May 1994).

Among others, one key practice is for executives to manage information systems as investments rather than expenses.[6] This requires using disciplined investment control processes that provide quantitative and qualitative information that senior managers can use to continuously monitor costs, benefits, schedules, and risks; and to ensure that structured systems-development methodologies are used throughout the system's life cycle.

A consensus has emerged within the administration and the Congress that better investment decisions on information technology projects are needed to help the government improve service. Important changes recently made to several laws and executive policy guidance are instituting best-practice approaches of leading organizations into the federal government.[7] This month, the Office of Management and Budget will issue guidance that describes an analytical framework for making

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[6]Other practices include (1) recognizing and communicating the need to change information management practices, (2) involving and creating ownership on the part of line managers, (3) improving organizational capabilities to manage information resources, and (4) measuring performance.

[7]The Paperwork Reduction Act of 1995, Federal Acquisition Streamlining Act of 1994 (Title V), OMB circulars A-130 and A-11, supp. 1 (9/14/95), and OMB Bulletin 95-03.

information technology investment decisions.[8] Developed in cooperation with GAO, this guidance calls for agencies to implement management practices to select, control, and evaluate information technology investments throughout their life cycles.

MTS DISPLAYS EARLY SYMPTOMS OF UNNECESSARY RISK

HCFA has not yet instituted a set of well-defined investment control processes to measure the quality of development efforts and monitor progress and problems. This situation has contributed to a series of problems related to requirements-definition, schedule, and costs; these problems raise concerns that MTS may suffer the same fate as many other complex systems--extensive delays, large cost increases, and the inability to achieve potential benefits.

First, HCFA has not sufficiently followed sound practices in defining MTS project requirements. As a result, HCFA has twice redirected the approach and, 2 years

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[8]Evaluating Information Technology Investments: A Practical Guide, version 1.0, Office of Management and Budget (Office of Information and Regulatory Affairs, Information Policy and Technology Branch), Document 6-00046, November 1995.

into the contract, requirements definition at the appropriate level of specificity has not been completed. Requirements, which are defined during the analysis phase of a project, document the detailed functions and processes the system is expected to perform and the performance level to be achieved. They are intended to correct deficiencies in the current system and take advantage of opportunities to improve program economy, efficiency, and service. Because requirements provide the foundation for designing, developing, testing, and implementing the system, it is critical that they be precisely defined to avoid ambiguity and overlap, and that they completely and logically describe all features of the planned system. Using an appropriate methodology to define requirements significantly reduces risk that requirements defects will cause technical problems.

Originally, HCFA's plans called for GTE to document the current systems' requirements, while HCFA staff defined new or future requirements for MTS. However, in September 1994, HCFA concluded that GTE's analysis of the current systems did not contain enough detail to fully describe the current systems' requirements. HCFA then directed GTE to provide additional detail. In September 1995, HCFA concluded that the products GTE was developing were too detailed,

9

and again directed GTE to refocus its efforts--this time, however, on assisting HCFA staff in defining future MTS requirements.

On the basis of our experience in evaluating other systems, such multiple redirections in the analysis phase of a major project indicate that HCFA's process to control requirements lacks discipline. HCFA currently lacks an effective process for managing requirements, and has not provided adequate guidance to staff responsible for defining requirements. These deficiencies have also been cited by the IV&V contractor as an area of significant risk.

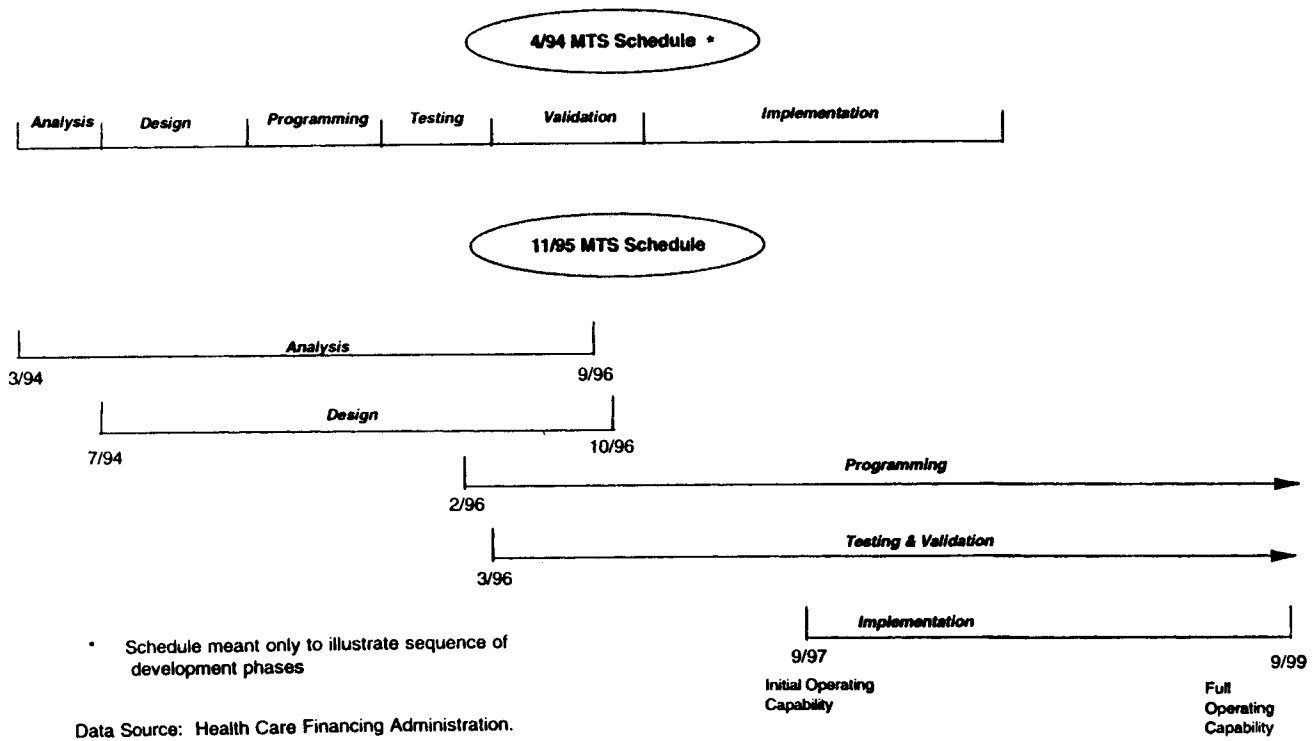
Because of problems in completing the definition of requirements, and HCFA's plans to implement a fully functional MTS in September 1999, HCFA is proceeding into the next phase of system development, the design phase, before requirements have been completed. HCFA plans to select an MTS design alternative by the end of this calendar year, but requirements are not scheduled to be completed until September 1996. Because design alternatives are used to determine how the system will be structured, if the alternatives do not reflect key requirements, the system's future capabilities may be seriously constrained. The IV&V contractor pointed out that HCFA's plan to select the system design in

parallel with defining system requirements also increases risks that the system will not meet important goals.

HCFA officials told us they believe that MTS requirements are sufficiently defined to prepare high-level system-design alternatives, but the IV&V contractor disagrees. To support critical design decisions, requirements need to be sufficiently detailed to include such functions and processes as performance levels and response times. When we reviewed HCFA's preliminary set of requirements, we found that many of them did not contain enough detail.

Second, HCFA's development schedule for MTS contains significant overlap--or concurrency--among the various system-development phases: analysis, design, programming, testing, validation, and implementation. As shown in figure 1, the April 1994 MTS schedule--an early estimate by HCFA--is used only to illustrate the sequential nature of these phases. The November 1995 schedule shows extensive concurrency; for example, the analysis and design phases are occurring simultaneously during the period from July 1994 to September 1996.

Figure 1: MTS Life Cycle Schedule



* Schedule meant only to illustrate sequence of development phases

Data Source: Health Care Financing Administration.

In our January 1994 report on MTS,[9] we stated that if a contractor advances too far into a succeeding system-development phase before sufficient progress has been made in the previous phase, the risk that technical problems will occur is significantly increased. Senior HCFA officials recently told us that the MTS schedule contains concurrency because it is important to deploy the system before the end of the century; otherwise, significant costs would be incurred to modify existing systems. What is needed is quantifiable information on this cost, compared with an assessment of the risks of concurrency. HCFA has not, however, implemented a formal process to assess and manage system-development risks. The IV&V contractor has also cited this lack of a formal risk-assessment process as a problem.

In addition, while HCFA's MTS schedule has been revised several times because of the redirection of requirements definition in the analysis phase, the initial and final system-implementation dates have remained largely unchanged. As a result, the time scheduled to complete the rest of the system-development phases to meet those dates is now significantly compressed. For example, because HCFA did not adjust the initial operating capability date, it is now scheduled, at one point in a 1-

[9]Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

year period, to work concurrently on the remaining development phases--design, programming, testing, and validation. On the basis of our previous work on large systems-development efforts, we believe that failure to allow for sufficient time to complete system-development phases increases risk and will likely result in reduced systems capability.

Moreover, HCFA has not developed an integrated schedule that reflects both HCFA and contractor activities, work products, and time frames needed to perform these activities. Such a schedule provides an important tool for closely monitoring progress and problems in completing various activities. Without detailed insight about the actual status of all development activities, management will not have the information it needs to make timely decisions. HCFA's IV&V contractor also cited concerns about the lack of an integrated schedule baseline for MTS. HCFA officials agreed that such a schedule is important.

Finally, HCFA has not sufficiently developed disciplined processes to adequately monitor progress in achieving cost and benefit objectives, which are important to managing projects as investments. The estimated MTS project costs, pegged by HCFA at $151 million in 1992, have not been updated since then, and HCFA is not

tracking internal costs associated with the project, such as personnel, training, and travel. According to HCFA officials, they plan to update their cost estimate next year, to reflect their current understanding of MTS' capabilities. Similarly, except for estimated administrative savings of $200 million a year during the first 6 years of operation (1997-2002), HCFA has not yet quantified other important expected benefits of MTS, such as targets for reducing fraud, waste, and abuse, and improving services to beneficiaries and providers. Without current information on costs and potential benefits, HCFA executives will not be in the best position to realistically monitor performance or identify and maximize the system's true return on investment.

CONCLUSIONS

We have seen an inescapable pattern in agencies' development of information systems: even on a small scale, those that are not developed according to sound practices encounter major, expensive problems later on. The larger the project, the bigger the risk. It takes serious, sustained effort and disciplined management processes to effectively manage system development. Effective oversight greatly reduces exposure to risk; without it, risk is dramatically and needlessly increased.

The risks we see in the development of MTS can be substantially reduced if HCFA management implements some of the best practices that have been proven effective in other organizations: managing systems as investments, changing information management practices, creating line manager ownership, better managing resources, and measuring performance. HCFA still has time to correct these deficiencies. We are encouraged by HCFA's expression of interest in learning about how to implement the best practices in systems development used by successful organizations, and look forward to working with them.

This concludes our statement, Mr. Chairmen. We will be happy to respond to any questions you or other members of the subcommittees may have at this time.

Mr. HORN. Well, we thank you for that very cogent statement and those excellent suggestions. They will be followed up by the subcommittees and the full committee in a joint effort, as I think you have made some very good suggestions for monitoring progress.

I now yield to my colleague and fellow subcommittee chairman, the gentleman from Connecticut, Mr. Shays for the questioning.

Mr. SHAYS. I thank the gentleman.

I want to start out with a basic concept. Why has it been so difficult for HCFA to know what they send hospitals, why they send it and why is it so difficult for to us resurrect, even after the fact, what they have sent and why?

Mr. REILLY. Well, a question that broad, Mr. Chairman, I would have to start by saying the volume they are dealing with is just incredible. You are dealing with hundreds of millions of claims a year; part are the outpatient claims and part are the inpatient.

The inpatient claims, I have looked at them, are so complicated that unless you worked in a hospital, I don't know how you would understand them. I think the very nature of medicine and the practice of medicine in a hospital setting is very complicated and numerous technologies involved, and I think that the sheer problem of dealing with all these on a piece of paper I think is very hard.

On the outpatient side, I think there are ways that we have dealt with the issue in other GAO reports, that can be handled. But from what I heard from Mr. Vladeck here, essentially they are dealing with a legacy system that goes back 30 years. And as he said, it was essentially based on the old technology and it has not been updated to do the things that we have all become accustomed to doing when we had PC's and see the kind of detailed information that we can get out of those kind of systems. The system today just doesn't do that.

Mr. SHAYS. I realize this example may be almost absurd, but it will at least let you know what I am trying to wrestle with. When I was first elected I had a year to decide whether I wanted to change my computer system and cause tremendous dislocation, not knowing if I would get reelected. I had the choice of making some incremental changes and then worry about it if I was reelected. I made a decision that I would undertake this major change. And so fortunately, after I was reelected, I was able to take the benefit.

Is part of the problem that when we look at anything like with social security or HCFA, that whoever makes a decision now, the benefits are going to basically benefit the next administration rather than their own? And so then do we just try to focus in on the short-run?

Mr. REILLY. I think that is inherent in any organization, public or private, but I don't really think that that is the problem. I do not get that impression from Mr. Vladeck. We have been—we have worked with them now for a couple of years.

Mr. SHAYS. It is not my style just to focus on one administration.

Mr. REILLY. We have had our problems.

Mr. SHAYS. My point I want to make with you, this should have happened years ago. We should have been moving more quickly. So I am not focusing in on this administration. There are enough things we could criticize in any administration—I am just trying to understand this.

I know Home Depot can tell you at 9 a.m. what they sold from 6 to 8:59. They have already started to order new inventory. Is it possible now for me to know what Stamford Hospital received last week if I went to HCFA?

Mr. REILLY. When we—when you have a system, when you have nine systems, not a system, when you have many, many contractors operating from different systems, it is extremely difficult for anybody to get the kind of information I think that you want.

Mr. SHAYS. What that suggests to me, though, is the system is so ripe for waste, fraud and abuse that a 10-percent suggestion of waste, fraud and abuse is almost laughable. I mean, you basically—I have had constituents, one of the things I might say, Mr. Chairman, and something Mr. Towns and I have talked about, is we may decide in our subcommittee to have a hearing on just how Medicare recipients—some of the absurd billings. We have had men that are billed for pregnancy, we have had women who have been billed for things that are not physically possible for a woman, and so on. They just defy logic.

We thought we might just have a public hearing where we would invite rank and file citizens to just come off the street, have it a week long from 8 a.m. to 5 p.m., just to document the incredible absurdity. When I hear you talking, I think how big the billing is—you have answered my question very well. It was a broad question but it speaks to the difficulty of processing a claim.

Now, the doctors—and there is the question I want to get into. The doctors have a problem with a centralized system because they think it is not flexible enough to note their particular analysis of the problem and their solution for that problem. And so your main testimony is that we should have one centralized system, or is your bottom line we should have a variety of systems?

Mr. REILLY. No, in terms of a design, we should have a design. I don't think any person—any person, a systems designer in this country, public or private, would consider anything other than a single design would be appropriate for this.

Mr. SHAYS. With claims forms all the same?

Mr. REILLY. But that could be distributed around the country, I mean the processing of it. But you need a single design, so that the doctors know what the rules of the game are.

Mr. SHAYS. And they are the same anywhere in the country?

Mr. REILLY. Anywhere in the country. Because, I mean, Medicare is a national program.

Mr. SHAYS. I thank you, Mr. Chairman.

Mr. HORN. Thank you.

The gentleman from New York, Mr. Towns.

Mr. TOWNS. I yield to Mr. Green.

Mr. HORN. Very good.

Mr. SHAYS. Could I ask that we put into the record, a statement from the American Medical Association expressing concern about this issue?

Mr. HORN. Without objection, it will go in.

[The information referred to follows:]

Statement

of the

AMERICAN MEDICAL ASSOCIATION

to the

Government Reform and Oversight Committee

Subcommittee's on Government Management, Information and Technology & Human Resources and Intergovernmental Relations

U.S. House of Representatives

Chairman Horn, Chairman Shays and Members of the Subcommittees:

The American Medical Association (AMA) is pleased to provide this statement for the record regarding the important issue of Medicare billing practices. We commend both Chairmen and the Members of the Subcommittee for holding this hearing on an issue critical and timely to the medical profession -- Medicare billing practices and correct coding. The AMA has an active interest in participating in the debate on medical coding issues, especially where the subjects of Medicare billing practices, correct coding and waste, fraud and abuse are discussed.

One such coding system is the AMA's Physicians' Current Procedural Terminology (CPT). CPT is designed and used by physicians to reflect the clinical practice of medicine. Each code corresponds with a medical procedure that is performed then recorded and billed. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services and thereby provide an effective means of communication among physicians, patients, and third parties.

communication among physicians, patients, and third parties.

BACKGROUND

When the AMA began the development of CPT in 1966, it was one of many procedural coding systems that was either in existence or that would be developed within the next 10 years. In fact, in the late-1970s it was estimated that there were over 250 different procedural coding systems in use in the United States. Today, it is estimated that over 95 percent of services provided by physicians are reported using the CPT coding system.

In fact, CPT was adopted as part of the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS) in 1983 based on the government's independent evaluation and because it was determined that CPT was the best available system, and would meet the needs of the Medicare program, namely:

- CPT could be implemented nationally with a minimum of disruption to existing data processing activities;
- CPT could be implemented without fear of increasing costs to the health care system;
- CPT was acceptable to the medical profession; and
- there was a professional commitment to maintain CPT.

In short, the AMA has a long history with respect to the research and development of CPT. In fact, the AMA continuously updates the CPT with the advice and counsel of physicians,

payors, policy-makers and other interested parties. The AMA, therefore, supports the use of a single coding system and is committed to its improvement. The AMA is also concerned about attempts to allow so-called private "edits" into the medical coding system because they would undermine the existence of a single coding system.

GAO ANALYSIS IS INACCURATE AND MISLEADING

The AMA has long maintained a zero tolerance policy with respect to physician waste, fraud and abuse. We are particularly concerned, however, with the potential areas of fraud and abuse identified in the recent General Accounting Office (GAO) report, entitled Medicare Claims - Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135). We believe that the report's findings are inaccurate and misleading based, in part, on the fact that the private sector coding "edits" (algorithms that redefine the procedure codes submitted by the physician to match some predetermined payment policies or objectives) used do not reflect the Medicare law. In short, the GAO report recommends that HCFA be directed to have its carriers purchase and utilize existing commercial, proprietary, automatic data processing equipment (ADPE) to process Medicare claims and detect fraud and abuse. We believe these recommendations are premised on flawed analysis.

COMMERCIAL COST REDUCTIONS OVERSTATED

The GAO developed its report with the objective of (1) determining whether commercially available code manipulation-detection systems can reduce Medicare costs; (2) evaluating whether HCFA's development approach is likely to generate savings comparable to that possible with commercial systems; and, (3) assessing whether commercial systems are cost effective. The report states that "commercial code manipulation-detection systems could have reduced federal outlays for physician services and supplies, on average, by $603 million in 1993 and $640 million in 1994,...this represents about 1.8 percent of Medicare payments..." Our view, however, is that these numbers are inflated because the edits produced by the vendors did not follow relevant Medicare payment and medical review policies. The AMA and other members of organized medicine have long objected to such "black box" review screens because they do not reflect the actual practice of clinical medicine. The "edits" contained in the commercial programs were not, as may have been implied, developed with adequate involvement from independent physician coding experts.

We maintain that if a code is randomly redefined it will no longer reflect the actual medical services provided to patients. For example, a surgeon may include as a part of a total surgical package the office visit that allowed that physician to determine that the patient needed immediate emergency surgery the next day. This type of care is called evaluation and management services and is properly payable under Medicare. If the code for this process is randomly redefined to no longer accurately reflect what has occurred, actual

medical practice patterns may vary and patient care may suffer.

In addition, the codes used in these computer programs will not be required to be publicly disclosed nor will they be developed with the medical expertise of physicians and the input of the physician community. This is would occur based on the claim that the substance of these computer programs is proprietary. Without public disclosure, however, physicians will not know and therefore will not have the opportunity to inform their patients about which services may or may not be covered. Furthermore, if each Medicare carrier is allowed to select different software packages there would no longer be system-wide uniformity with respect to coding thus potentially resulting in the situation where Medicare patients would be treated differently not based on existing Medicare law but on the software purchased by the individual carrier.

HCFA's INITIATIVE TO DEVELOP NEW CODING EDITS

The GAO report seeks to evaluate whether HCFA's development approach is likely to generate savings comparable to that possible with a commercial system. We believe the report mixes apples and oranges when estimating savings based on a comparison of HCFA's coding edits and the commercially developed coding edits. For instance, of the seven examples cited in the report only one can be confirmed as being an accurate reflection of Medicare policy. The GAO report states that the commercial systems found two categories of problems -- unbundling and global service period violations -- which accounted for 93

percent of the savings in the sample. It also cites problems with duplicate procedures and unnecessary assistants at surgery.

Unfortunately, the examples provided in the report do not provide enough information to determine if the claim had already been developed (i.e. kicked out for further review and ultimately paid by Medicare). For instance, examples regarding "global service period violations" do not provide sufficient information to allow others to adequately assess the concerns presented. The report's illustration of a surgeon receiving payment for an office visit the day before a major surgical procedure may or may not be valid. There is insufficient evidence presented about the diagnosis or services provided during the office visit which could be considered part of the global surgical package. It is possible that the office visit should have been reported with an appropriate coding modifier (specifically, -57, Decision for Surgery). Medicare payment policy appropriately allows for the payment of evaluation and management services when a decision for surgery is made in the immediate preoperative period. Other examples cited in the report regarding alleged global service period violations are equally questionable.

We believe that HCFA already has in place an effective process to develop coding edits that would detect any fraud and abuse in the Medicare program with the assistance of AdminiStar.

THE ADMINISTAR PROJECT

Currently, the AMA along with several medical specialty societies, is working closely with HCFA in their ongoing initiative to standardize and eliminate unnecessary payments under the Medicare system. With the assistance of AdminiStar HCFA will now be able to produce and design the next generation of waste, fraud and abuse detection efforts with the necessary input from the medical community. We believe this effort has the potential to lead to actual and substantial savings in the Medicare program. We are encouraged by the progress of the AdminiStar project and are actively participating in this public process. We believe that important projects such as AdminiStar can be successful because they include input from the physician community, include physician education efforts and comply with medicare policy.

The AMA has vowed to continue to work with the relevant government entities to address these important problems. In addition, we have requested that GAO convene a meeting to discuss the relevant underlying Medicare payment policies, clinical judgements and interpretations of existing coding description used in the development of the report issued by the GAO. Specifically, we requested that the appropriate representative from the GAO, the AMA, HCFA, GMIS, Inc., Health-Chex, Inc., Health Payment Review, Inc., and Value Health Sciences, Inc. meet to discuss these important issues and the claims data used in the development of the report and the scientific and medical validity of the conclusions contained therein. Although we sent that request on October 9, 1995, we have yet to receive a response.

We urge caution with respect to legislating the recommendations of the GAO report. As you know, the report directs HCFA to have its carriers purchase and utilize existing commercial, proprietary, automatic data processing equipment (ADPE) to process Medicare claims. Under the rubric of waste, fraud and abuse, these unknown and undisclosed computer programs will be called upon to save Medicare billions. What these programs will actually do is redefine the coding system used by physicians and other medical professionals to report Medicare services and randomly deny beneficiaries their rightful claims. We believe that until a more accurate review of the claims data used in the report can be developed to reflect the actual costs of the proposed recommendations. Until this analysis is completed, we believe it would be misleading to assert that adoption of the GAO report's recommendations would result in the levels of Medicare savings claimed in the report.

AMA IS COMMITTED TO FIGHTING FRAUD AND ABUSE

Presently, the AMA is working in conjunction with the Federal Bureau of Investigation (FBI), the Department of Justice (DOJ) and the Department of Health and Human Services (DHHS) to step up its assault on fraud and abuse within Medicare. While we understand health provider fraud and abuse is responsible for some portion of Medicare's growth, researchers disagree about the actual extent of such practices as "upcoding" and "unbundling." For example, the Physician Payment Review Commission's (PPRC) investigation of physician coding for evaluation and management services between 1991 and 1992 suggested that no "upcoding" had occurred (PPRC 1994). It is also noteworthy that the

DHHS's Office of Inspector General, the government entity responsible for detecting waste, fraud and abuse in the Medicare program, allocates most of its resources for the investigation of non-physician payments and services because of its own experience.

CONCLUSION

All agree, abuse of the Medicare system cannot be tolerated. No one would argue that abusive billing practices should be allowed to continue. But allowing the Medicare coding system to be redefined without the benefit of outside examination will place beneficiaries at risk by not implementing abuse safeguards that are directly consistent with the objectives and structure of the Medicare program. The AMA maintains that computer coding systems should be developed with the medical expertise of physicians and the input of the physician community. Without such expert review physicians will not have the opportunity to become educated regarding these codes and therefore will not have the opportunity to inform their patients about which services may or may not be covered. The AMA is committed to improving the medical coding system and we look forward to working with you and Members of the Subcommittee as this important legislation moves forward.

Mr. HORN. We'll also put in the statement of the Honorable Constance A. Morella, grouping it up with where the statements are at the beginning of the hearing.

Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I thank my colleague from New York for yielding to me.

I have a couple of questions and then I am looking at the GAO report from May 1995, on Medicare claims, commercial technology could save billions lost to abuse and revenue. Particularly in the results in brief on page 2 where HCFA's—you are saying is enhancing its ability to cut code manipulation.

However, MTS shows its efforts will not match commercial capabilities or savings. The GAO's criticism is that HCFA's MTS will not achieve that level of efficiency as a commercial product would. And is that criticism—do you account for the fact that HCFA has the 50 different States, as she has answered to my colleague from Connecticut, or what can we do now, even though it is pretty far down the line to do that to make sure the MTS system can provide what is on the commercial market now?

Mr. REILLY. Well, we will be followed by vendors that provide these commercial off-the-shelf systems, so I think they can tell you much more specifically than I can, exactly what they can do. But as part of our responsibility on auditing the MTS contract, we will certainly be looking very closely to see how this is going to be incorporated into the design. I mean, the abuse of billing that our report dealt with, we have been told is going to be a part of MTS and we would expect that to be the case.

Mr. GREEN. So you have been told that the criticisms in May 1995, will be worked into correct your concerns?

Mr. REILLY. HCFA has a temporary fix, as they call it, by some work that they have had by a contractor, not a commercial off-the-shelf system, but a fix to deal with some of the problems in unbundling, that we mentioned. We do not think the fix is as comprehensive—we know the commercial off-the-shelf products were because we have tested four of them and they almost—while they have a range of capabilities, the numbers come out pretty close in all cases, when you test the advantages of miscoding.

Mr. GREEN. We recognize we obviously have to do something better and I think HCFA knows and all of us that serve are frustrated because of the complaints we receive about problems, and MTS is supposed to solve that.

Is this an example, as we have seen earlier in Government procurement, where there may have been something better off the shelf and yet we are designing a product? The best example we have heard is the hammers that cost hundreds of dollars. You can go buy one at your hardware store for $20. We had to design that hundreds-of-dollar hammer as compared to what we could have bought commercially. Is this an example on a bigger scale than that?

Mr. REILLY. I think we have got two things working here. One, a very old system going back to the sixties literally, and that meant in those days you had an entirely different kind of technology, and we are told by the IV and V contractor that the current systems

range from 1 million lines of code to 10 million lines of code. So that tells you of those nine systems, there's that extreme range, there must be some difference in capability, I would think, in that even though business functions are being handled or they are handled with different levels of specificity.

The other question—so I would say much of what we have today is that because we have legacy systems in there that are legacy in every sense of the word, they are not up to date. The other problem is at the time the Government was designing these kind of systems, first, these commercial off-the-shelf systems did not exist. And second, the Government's attitude toward buying commercial off-the-shelf was very negative. Government was not buying so-called caught systems in those days. Today, any designer worthy of their mettle would certainly go out and look at what's on the market. That is the two differences.

Mr. GREEN. And you have—or GAO did look at other systems—and I know you mentioned our next panel are people who have similar systems that would be compatible with the MTS system.

Mr. REILLY. Yes.

Mr. GREEN. And maybe even better.

Mr. REILLY. By the way, we only talked about the outpatient panel. There are inpatient systems as well. In other words, systems that can look at codes. We are only talking about coding.

I want to stress that we have written another report dealing with fraud, but we are talking about here is basically miscoding problems. It is not fraud because fraud means intents and the miscoding is not classified as fraud, it's classified maybe as abuse or just simple mistakes. They are running about on the outpatient, the miscoding is running about 8 percent of the providers are falling into that category; 90-some percent never have any miscodes at all.

Mr. GREEN. Thank you, Mr. Chairman.

Thank you.

Mr. HORN. On that last point, do we know whether this is a human problem of a failure to train or of comprehension? What are the factors on miscoding? Has that been analyzed?

Mr. REILLY. The miscoding I can tell you from—I have my personal physician I have been going to for many, many years. I got a wrong bill one time and I call him I said, Dick, what the heck is this bill you sent me? And he said, well, you know everybody makes a mistake. And he said, I'll turn you over to my billing clerk, and somebody just made a coding mistake. So I mean, that's legit.

You know, anybody can make a mistake. I mean, erasers are on pencils. Where there's patterns, where the same providers keep making the same mistakes again and again, that is a different kind of story.

Mr. HORN. You were probably here when I went back to Secretary Sullivan's endeavor—and to get commonality among all these forms. When you go into any doctor's office now, whereas they used to have a nurse receptionist all in one person, they now have four clericals to handle the 1,500 insurance companies with whom they deal.

Mr. REILLY. That's correct.

Mr. HORN. How are we coming? Is GAO helping on getting that commonality of forms, which to me is such a simple thing; it should have been done 20 years ago?

Mr. REILLY. Mr. Chairman, you couldn't have asked a better question from the standpoint of this group. We have been working for 5 years to standardize computerized patient records, because the heart of all of this ultimately is clinical data. And without standardized clinical data, you can never really get a billing system that is one, accurate and economical. Because if even looking at some of the data that we have from HCFA's long-term—plans over the next 6 or 7 years, we still see large quantities of forms that are going to be kicked back and have to be manually reworked, I mean, in the hundreds of millions. So it's only when we can get all of these things standardized, which the industry is working at today—I mean, the health care industry recognizes this problem from its standpoint, it can't operate as efficiently as it wants to and it can't transfer data between various groups.

So I think we—we, GAO, have worked very hard on this. We have published numerous reports and have appeared before committees to discuss this subject and would do anything that we can possibly do through this committee to push that we'd be happy to do so.

Mr. HORN. Well, I am delighted because I think that our subcommittee's combined staff and your office ought to work to get a prod to the private insurers here. You call them in and ask, for example, is the first name last or first on this form? And then go right down the line, instead of having 70 versions.

And it just seems to me that is such a simple thing to do. I don't understand what is taking so long.

Let me mention one more question. In California, the State EPA, is working with National EPA, particularly the people that review permits, on electronic filing. To what extent have you looked at the private insurers relating to HCFA in terms of electronic filing? Is there any effort in that area?

They let the private people figure out all the coding and are all in agreement. Everybody is agreed and everybody loves each other. EPA nationally backs it, EPA California backs it, and I have a bill in on that on electronic filing. It just seems to me we ought to promote it.

Mr. HOENIG. I am not familiar with that particular effort. I know in the tax area, especially in Minnesota, there have been a lot of efforts to do just that and particularly in terms of sales tax information, but I am not aware of that particular environmental effort.

Mr. HORN. Well, it solves some of the coding problems. Obviously, you have to recode at various stages along the way.

Mr. REILLY. I would offer a cautionary comment as well as a very supportive comment. We supported very strongly Dr. Sullivan and the work group on electronic data interchange, WEDI that the previous testifier mentioned. The problem is—and this is a serious problem, whether it's IRS, whether it's food stamps, whatever it is. When you go electronic, you increase the speed of filing enormously, which is positive. But if you don't have systems in there to protect you on fraud and abuse, you just lose money faster.

Mr. HORN. Right.

Mr. REILLY. And we have been very concerned about electronic benefit transfer in this regard and GAO just issued a report within the last 2 weeks on this very subject. While we support electronic filing where it's practical, we also have great concern that if it is not controlled it could be a disaster of monumental—with monumental consequences.

Mr. HORN. In the course of your studies—this is my last question then I'll ask Mr. Fox to—in the course of your studies have you found a certain type of delay at HCFA in paying their bills compared to other agencies that have as complicated a situation? Do you have any data on that?

Mr. REILLY. Mr. Chairman, what they have done, they have set a policy that they must pay, if it's electronically delivered within so many days and they pay it.

Mr. HORN. How about it if it isn't electronically delivered?

Mr. REILLY. I think it is twice as long, and you can ask the HCFA people specifically, but I think it is 14 days, 2 weeks, if it's electronically delivered and if it's manually it's a month. The real question comes up, though, what happens if you have a backlog of claims and you can't process them in 2 weeks, do you just let them go through anyway?

Mr. HORN. Yes. A friend of mine who is a doctor, several years ago when they were having a problem paying the claims, simply stamped "second request" on his first request and it seemed to get their attention.

Mr. Fox, the gentleman from Pennsylvania.

Let me say I have to leave for a meeting.

Mr. Fox, if you would be good enough to be the acting chairman?

Mr. FOX. I will fill in later.

Mr. HORN. Next we will yield back to Mr. Green and then yield to the gentleman from Indiana.

Mr. FOX. Mr. Souder.

Mr. HORN. Right.

Mr. FOX. My question would be directed to anyone who would like to answer.

Mr. HORN. And we will recess after you two, until 1:00.

[Recess.]

Mr. FOX [presiding]. There are apparently many exciting developments in health care information technology. GAO reviewed the potential of fraud and abuse software and concluded that this software was quite promising.

Does HCFA have a process for testing on a pilot basis such promising new developments?

Mr. REILLY. Mr. Fox, HCFA currently is testing its own in-house software that they had developed by a contractor. To my knowledge, and again I would—there are contractors that are going to be in the next panel, you can ask them specifically, but to my knowledge, HCFA has not used a commercial off-the-shelf product yet.

Mr. FOX. Are they doing it in-house then?

Mr. REILLY. They are, depending on what they developed in-house.

Mr. FOX. Are you also as part of your in-house operation considering such initiatives as the paperless claims processing, through on-line, real-time processing?

Mr. REILLY. I think that is—they haven't come out and called it paperless yet.

Mr. FOX. Right.

Mr. REILLY. But I think that's—as this thing develops, it almost has to go, sir, to that direction because with this volume, if you have to rework paper claims, you will never catch up on the curve.

Mr. FOX. Right. We see the problem, just in Medicare where we are spending, what, 12 percent of our cost just in paperwork distribution and we want to make sure it goes to services for seniors as opposed to paperwork for—to support if bureaucracy.

So I thank you for your assistance.

Thank you, Mr. Chairman.

Oh, I am the chairman.

Mr. GREEN. Is this a 90-day wonder, Mr. Chairman?

Mr. FOX. This is a 90-day wonder, therefore special.

Congressman Green.

Mr. GREEN. Thank you, Mr. Chairman.

I have a brief question. You mentioned earlier in my questions concerning your report on Medicare fraud, and I have a listing from 1992 to 1993 of various GAO reports on testimony—testimonies on HCFA management and payment safeguards, do you have a particular number on the recent report that you mentioned in earlier questioning on Medicare fraud?

Mr. REILLY. We have one that we did on the claims, was May 1995. The number is GAO 95–135, and the one on Medicare antifraud technology offers significant opportunity to reduce health care fraud is August 1995 and the number is 95–77.

Mr. GREEN. Thank you.

Thank you, Mr. Chairman.

I yield back my time.

Mr. FOX. Thank you, Congressman Green.

Congressman Souder.

Mr. SOUDER. I apologize for missing the testimony and I am trying to catch up. So there are a couple questions I heard you talking about the new systems.

What is done in the interim as the new systems are being brought on line? Are there any incentives for people to upgrade what they are currently doing or——

Mr. REILLY. Well, the intent, Mr. Souder, is to when the new systems come on line that they will—everybody will use them.

Now, how that transition is going to occur on that schedule there, we don't—I can't really tell you now because we really don't understand it. I don't know whether HCFA has laid out its plans in that depth yet. So I—but there will be some day, somewhere down the line where this system, MTS will then be given out to contractors and all the contractors will use it. How that transition is going to occur has not been worked out yet.

Mr. SOUDER. But even before the transition, at this point, are they basically sitting and waiting now for the new system?

Mr. REILLY. Yes.

Mr. SOUDER. There is no interim incentives to try to improve it while we are waiting for the new?

Mr. REILLY. Well, we have written—the point that came up earlier about the May 1995 report that we did on abuse of billing, they

have an interim system on that and we hope that they will be talking to the contractors about it as well. But there are—there are no fixed plans that I know of to set up an interim system between now and MTS.

Mr. SOUDER. If each of you had a single piece of advice to give to HCFA, what would it be?

Mr. REILLY. Well, I guess, if there was one piece of advice, I would have to go back to an assignment we did for the Defense Department on the Composite Health Care System, a $2 billion medical information system. And while there were many things that over a period of time that we recommended, it seems to us the most important was when they changed the project manager to someone that took responsibility for the entire project, was trained to do it and was given the authority and responsibility to pull all the pieces together, at that point we saw a definite improvement. When this person was set in a vertical organization, a project manager organization, responsible for that project, and that project alone, and was given all full-time people to work with and had the authority and those people were then trained and they had the resources, there were many technical things I could tell you, but in terms of management, that was key, and then they were held to strict accountability at the same time.

Mr. HOENIG. My advice on this, Congressman, really comes from not only my own personal experience working with large organizations but also from the leading organizations we studied, and there is one thing that I would advise HCFA on at this stage. If you don't know where you are going exactly, you won't get there. You will be lucky if you get close. It really comes down to that.

To get stakeholders on board and to have a common mode of communication with the Congress, to get the implementers and the technical people in particular, who tend to get lost in the details, to focus on what's really of value to the public, and ensure the senior executives that they are getting the maximum net benefit for the public out of their scarce resources, HCFA needs to define, early on, target ranges of performance measures for each of the key areas of benefits that they plan to deliver: fraud, quality, customer service, and cost-savings. And begin to set ranges and targets for how those will go down, where they are now, what the trends are and how they will go down over time as the system goes in place. Without those, the risk really increases dramatically.

Mr. SOUDER. How do you feel so far—I got kind of a gut feeling just from the little bit of what I have heard, is that you are both uncomfortable that they don't—we may be moving too fast, at the same time, maybe not fast enough.

How do you feel on their progress with that? We have seen it in food stamps. Some of the automated tests are worse than what we had. Not that what we have is very good. How do you feel they are coming in their progress with it and where would you——

Mr. REILLY. I think our biggest concern, quite frankly, is two things: One is compression on the schedule and no change in the final date. Here we are now saying within 11 months after September 1996, we are going to have a system in operation and that's when the design is to be completed and programming, testing, and

validation will all be done in this 11-month period. And we find that a very tight timeframe.

And the second problem that we have is the overlap of activities which to a great extent are sequential, not totally, but to a significant extent, and if you start getting them too much overlap, then you are going to miss major design problems.

Mr. LATHAM. I would like to add one other thing to that. I think the key to—in this compressed timeframe to deliver the system, it is essential that HCFA develop an integrated schedule of all the activities it needs to complete in that timeframe, and along with that, a management plan to manage any risks that may come up during that time.

If they get set back by a month, they need to have some contingency plans as to what do I do from here? Do I reduce the capability I am going to deliver? Do I push out the time when I am going to employ—deploy the system?

I think those kind of decisions have to—the process is to make those decisions in this critical compressed timeframe have to be in place. This is a criticism that the IV&V contractor has placed on HCFA. And we certainly agree someone needs to manage this risk, because it is a very, very critical risk?

Mr. SOUDER. I thank the chairman.

Mr. FOX. Thank you, Congressman Souder.

Congressman Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

I have tried to look for a similar system in the private sector. The best that we can come up with is a fairly good system in the Defense Department.

But the question I have is: What analogy could we make in the private sector to a system so large, involving so many people? Is there nothing like it? Are we totally charting new territory?

Mr. REILLY. I don't know of a health insurance system in the United States.

Mr. SHAYS. Forget health insurance. Just any system.

Mr. REILLY. You are talking about a transaction system?

Mr. SHAYS. Yes.

Mr. REILLY. I am sure telephone company systems are larger than this.

Mr. SHAYS. OK.

And is there anything to be learned by how they do what they do?

Mr. REILLY. Oh, I think it's incumbent upon the Government to always go out and look at the systems in the private sector that are large scale, to find out what you can learn, because you never can tell.

Mr. HOENIG. I think another potential analogy, I am not totally certain of this, but to look for would be in the retail business, which has lots of real-time data that's coming up from customer sales on a day-to-day basis, which is feeding into inventory and logistics and ordering and design quantities for new colors of fabrics, and new types of goods that gets turned around very quickly from multiple operations and locations and it has to operate off of a standard approach.

Mr. SHAYS. When I asked my first question to you and I pointed out it's the volume, but you also said the kinds of claims are so different, and I continually used Home Depot as my example. If Home Depot can do it, why can't HCFA do it? And you answered one question of why it can't.

I mean, it's—you know, a saw is a saw. I mean, there are different kinds of saws, but you are not going to dispute that issue. So I have a little more sensitivity to this.

Before Mr. Horn was leaving, he said since he and I are going to be around in December here, either paid or unpaid, we thought we would like to sit down with you and just pursue this further.

I consider this just a gigantic issue. I mean, I think of it. I mean, we are talking in Medicare, I think, of $178 billion or something close to it, and so—I just make that point to you. In terms of this—I make the point that this is such a gigantic issue with such an incredible payback or cost, which you are making. It's registering.

In terms of my question, though, I need to have a sense of how you rate the risk factor. I mean, you all look at automated systems and where the Federal Government has done well and where it hasn't. If you were to put a grade on this system right now, I mean, this is a high risk, I mean, we should say, look out, this is a big, big problem? I mean, how do you rate it?

Mr. REILLY. There's no question it's high risk. Mr. Vladeck himself in his printed statement said it is.

Mr. SHAYS. I need you to define high risk. Do you grade other systems?

Mr. HOENIG. One thing I can comment on here——

Mr. SHAYS. Let me clear on my question and then I will try to listen here.

Do you take automated systems in general in the Federal Government and decide whether they are low risk, high risk, they are destined to succeed, likely to fail? Do you grade them and then does that bring attention to us?

Mr. HOENIG. There are two responses on that. One is, there are high-risk designations that both GAO, GSA, and OMB do. Right now, 11 of the 18 agencies that compromise 90 percent of Federal IT spending have systems on those high-risk lists.

Mr. SHAYS. Almost every project is on the high-risk list?

Mr. HOENIG. A large proportion.

Second, we are very familiar with how the leading organizations we studied rank risk and the kinds of risk assessment models they use. And just to give you a sense of benchmark, comparable scale-type organizations, Xerox for one, 110,000 staff employees, their highest level of risk is for systems that are over $800,000, just in terms of size. So size is a key scale.

Now, you compare that kind of a system to a Federal Government system, I mean, the private sector grades even very small systems by our comparison as high risk, and then we have also found that they use anywhere between 40 and 60 other variables, from security to technical complexity.

Mr. SHAYS. Maybe I am looking at risk differently than I should be. When we have a troubled housing authority in HUD, which my committee also oversees.

Mr. HOENIG. Right.

Mr. SHAYS. They get graded. Some are on the troubled list. One has even been taken over by HUD because in Chicago it was so poor. Some have been taken over by consultants. Some are on a trouble list where they run by themselves but HUD pays special attention to them. Do you have that kind of grading system?

Mr. REILLY. We don't have a grading system, but to try to relate to that kind of a criteria, the No. 1 criteria, and I think both of us have talked about this, is requirements.

Mr. SHAYS. Is what?

Mr. REILLY. The requirements. Do you have well-defined requirements at a high level, at an intermediate level, and an operating level?

Mr. SHAYS. OK.

Mr. REILLY. And that—if you can lay those out in detail, and by the way, these things—these requirements now can be developed using computer models.

Mr. SHAYS. OK. So now give me an assessment.

Mr. REILLY. They are not at that stage yet.

Mr. SHAYS. OK.

Mr. REILLY. We are saying specifically that the requirements are a problem. Their contractor said it's a problem.

Mr. SHAYS. There are gigantic warning bells going off?

Mr. REILLY. Absolutely.

Mr. SHAYS. You are making both committees aware that 2 years from now if we come back to you all, you have warned us?

Mr. REILLY. I guess you can say it that way. I hadn't thought about it that way.

Mr. SHAYS. Fair enough. We are going to be sitting down and talking to you to find out your solutions in greater depth.

Mr. HOENIG. We look forward to that.

Mr. SHAYS. I know you do. It is just I want you to know——

Mr. REILLY. By the way, we are working actively with HCFA now, and anything that we can do working with the committee concerning HCFA is certainly in our interest.

Mr. SHAYS. I understand, and in the scale of things, this is a nuclear bomb. That's kind of how I view it.

Mr. HOENIG. Yes, it is.

Mr. FOX. Thank you, Chairman Shays.

Thank you, Member Souder.

I want to thank all the witnesses on behalf of the Chair for your excellent testimony today. I know it will be very fruitful for us.

Panel 3 will convene at 1 p.m.

Chairman Horn will preside at that time.

We are in recess.

[Recess.]

Mr. HORN. Ladies and gentlemen, a quorum having been established, we will convene the afternoon session.

We have panel 3 of Mr. Huntzinger and Mr. Rudin, Mr. Owens, and is that an assistant to Mr. Owens?

Dr. KELLY. Yes.

Mr. HORN. OK.

What is your name?

Dr. KELLY. I am Dr. John Kelly.

Mr. HORN. Dr. John Kelly.

Dr. KELLY. Yes, Mr. Chairman.

Mr. HORN. All right.

Gentlemen, as you know, we have a tradition of swearing in witnesses on this committee, so if you will stand and raise your right hand.

[Witnesses sworn.]

Mr. HORN. I take it all four of you affirmed on that?

All four have affirmed.

We will begin, I believe, Mr. Huntzinger, president of Computer Sciences Corp., Healthcare Systems, Inc.

Welcome.

We are delighted to have you here, sir.

STATEMENTS OF GEORGE HUNTZINGER, CSC, HEALTHCARE SYSTEMS, INC.; GARY RUDIN, EDS, CORPORATE VICE PRESIDENT, HEALTH CARE GROUP; THOMAS OWENS, GMIS, INC., ACCOMPANIED BY JOHN KELLY, M.D., PH.D., CHIEF MEDICAL OFFICER AND SENIOR VICE PRESIDENT, CLINICAL INFORMATION SERVICES

Mr. HUNTZINGER. Mr. Chairman, members of the committee, good afternoon. I am George Huntzinger, president of CSC Healthcare Systems.

On behalf of CSC and ITAA, I am pleased to be here and appreciate this opportunity to share our views and expertise on the role information systems play in the health care industry, especially in assisting managers and controlling costs.

CSC Healthcare Systems markets information systems consulting and outsourcing services to support managed care organizations, point-of-service plans, medical groups, and private practices. We are the largest supplier of information systems to HMO's, including 31 percent market share.

The Information Technology Association of America [ITAA] is the premier trade association of our Nation's computer software and services industry. ITAA's more than 6,700 direct and affiliated member companies provide business applications and systems software, customs software programming services, information systems integration, and information processing services.

Today's health care system, put simply, has an abundance of opportunity for efficiency improvements in both the cost of administering and delivering health care. The industry has grossly underinvested in information technology and overinvested in administrative personnel.

Industry such as banking and insurance are spending 10 and 6 percent respectively on information technology, while health care IT spending is in the range of 1 to 2 percent. As the health care industry moves to a true business model where competition is a way of life and the customer or patient is supplied with enough information to make an informed choice, the industry will look toward information technology for gains in competitive positioning.

The challenges confronted by today's administrators and caregivers cannot be solved by information systems alone. Investment is necessary in three key areas: infrastructure, business and process reengineering, and information systems. I will concentrate on information systems and focus on those areas that provide the

greatest potential payback. They are as follows: electronic commerce, the computerized patient record, information warehouse and decision support systems and telemedicine.

Electronic commerce: One area in which the health care industry has made substantial gains is electronic claims. Claims processed electronically significantly reduce administrative costs.

The work group for EDI, WEDI, estimates gross administrative savings for its four core transactions, that's claim payment, enrollment, claims submission, and eligibility, at $8 to $20 billion per year. If 11 EDI transactions are included, the gross administrative savings range from $13 to $26 billion a year as reported in GHAA 1993.

The computerized patient record, when fully implemented, will change the way medicine is delivered. The system would incorporate complete patient histories, inpatient and physician visits and results and clinical and functional outcomes.

In addition, clinical management information, including preferred protocols, practice guidelines and practice pattern information needs to be available at point of care. System-wide process savings would be significant in addition to increases in quality of patient care and reductions in redundant and/or inappropriate testing.

Information warehouse and decision support systems: A decision support system that allows a manager to graphically analyze, interactively retrieve data, identify exceptions, and drill down into the data to view the details, will provide a foundation for better data analysis. This will result in better decisionmaking than traditional reporting methodologies.

In addition to tools that provide ready access to data, software aimed at helping managers better understand health care resource consumption will also result in cost economies. One such application, ambulatory care groups [ACG] was developed by Johns Hopkins. The use of ACG's represents approximately fivefold to twentyfold improvement in explaining health care resource consumption over age and sex alone.

This methodology has many applications in a managed health care environment, including capitation rate development, utilization management, quality assurance, provider profiling, and outcomes research.

Last, telemedicine. With telemedicine, the patient will be able to receive education, have vital signs monitored, participate in interactive video consultations with their physicians and schedule appointments, to name a few, all without leaving the home.

In addition to substantial patient benefits, telemedicine will provide significant cost savings to the caregivers in primary areas of medical training, surgical preceptorship, and point-of-care delivery in clinics and primary care hospitals.

Finally, there is current legislation under review that would increase the number of organizations eligible to support the Medicare Program. The Medicare Contractor Reform Act promotes competition and holds contractors accountable; thereby improving services to Medicare beneficiaries and providers. As a long-standing contractor to State Medicaid programs, CSC believes that improved

administrative efficiencies can be achieved by allowing nonhealth insurers to contract directly with the Medicare Program.

Mr. Chairman, we appreciate the opportunity to share our views, and I would be pleased to respond to your questions.

Thank you.

Mr. HORN. Well, we thank you very much for that very thorough statement.

[The prepared statement of Mr. Huntzinger follows:]

George S. Huntzinger
CSC Healthcare Systems, Inc.

Mr. Chairman, Members of the Committee, Good Afternoon.

I am George Huntzinger, President of Computer Sciences Corporation's (CSC) Healthcare Systems Division. On behalf of CSC and ITAA, I am pleased to be here and appreciate this opportunity to share our views and expertise on the subject of information technology.

CSC Healthcare Systems (CSCHS) markets information systems, consulting and outsourcing services to support managed care organizations, point-of-service plans, medical groups and private practices. CSCHS is the largest supplier of information systems to health maintenance organizations (HMOs), holding 31 percent of the market.

CSC has $3.6 billion in annual revenues for the 12 months ended June 30, 1995. The company is headquartered in El Segundo, California, has 33,000 employees in 575 offices worldwide. CSC provides clients with a wide range of professional services including management consulting, business reengineering, information systems consulting and integration, and outsourcing.

The Information Technology Association of America (ITAA) is the premier trade association of our nation's computer software and services industry. ITAA's more than 6,700 direct and affiliated member companies provide: business application and systems software; custom software programming services; information system integration; and information processing services.

My testimony today centers around the role that information systems plays in the health care industry, especially in assisting managers to control costs.

I would like to begin with a brief statement of the problem. The health care industry has grossly under-invested in information technology and over-invested in administrative personnel. Industries such as banking and insurance are spending 10 percent and 6 percent of annual revenues respectively on information technology (IT), while health care IT spending is in the range of 1 - 2%. According to the New England Journal of Medicine,

> On an average day in 1968, US hospitals employed 435,100 managers and clerks to assist in the care of 1,378,000 patients. By 1990 the average daily number of patients had fallen to 853,000; the number of administrators and clerks has risen to 1,221,600. (August 5, 1993)

In other words, the administrative workforce grew more than 180% while daily admissions decreased 38%. Fortunately, today's health care system has an abundance of opportunity for efficiency improvements in both the cost of administering and delivering health care.

As the health care industry moves into a true business model where competition is a way of life and the customer or patient is supplied with enough information to be able to make informed choices, the industry will look toward information technology for gains in competitive positioning. G2 Research states,

> Non-competitive health care providers, defined as such through a lack of profitability (primarily in the US) or through an inability to satisfy patients (primarily in regions with competition among state and privately owned facilities), will disappear. Insurers that are incapable of meeting the call to limit rising premiums will also fail. The effective use of information will enable firms to stay competitive. (April 1995)

Uncontrolled cost increases have an adverse effect on everyone in the system; the providers, the payors, the employers, and even the customers, better known as patients.

The challenges confronted by today's administrators and care givers cannot be solved by information systems alone. Investment is necessary in three key areas:

1. Infrastructure
2. Business and Process Reengineering
3. Information Systems

I will touch briefly on the first two and focus primarily on the benefits of information systems.

Infrastructure:

To begin, lack of consistent infrastructure inhibits significant cost reductions and quality improvements and has made it difficult to capture and compare information from disparate systems.

Standards - Although some progress has been made, the health care industry continues to suffer from an inherent lack of standards in electronic commerce, nomenclature, fee schedules (CPT, ICD9, HCPIC), payment mechanisms (DRG, ACG, percent charge) and protocols for delivering care (practice patterns) in both the hospital and physician setting.

Unique Identifiers - Legislation mandating some form of unique personal identification will be required to establish accurate links to all appropriate patient, provider and payor information. Unique identifiers are critical to the development and success of community health information networks (CHINs).

Privacy - Uniform Federal confidentiality and privacy laws that supersede many state privacy laws must be developed.

Business and Process Reengineering:

Today's health care is provided on a fragmented basis with each independent function or department (i.e., radiology, pharmacy, labs and physician specialists, etc.) contributing to a paper driven patient record. In addition, the administrative process interjects its requirements for patient control and financial reporting. This results in a health care system with redundant or incomplete information, high data management costs and inefficient data distribution. On top of this, add in inefficiencies resulting from redundant tests and procedures ordered by providers due to lack of readily accessible centralized patient information.

There are significant lessons to be learned from business process reengineering implementations that are directly applicable to heath care. Michael Hammer and James Champy, founders of the reengineering movement, define reengineering as "the fundamental re-thinking and radical redesign of business processes to achieve dramatic improvements in contemporary measures of performance." Reengineering health services is not a technology problem but an information management problem, specifically linked to the goals, objectives and performance measures of the organization.

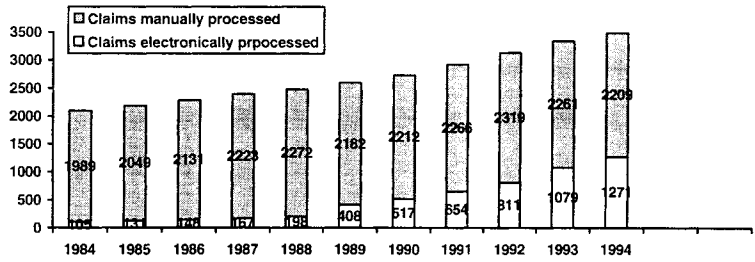
For example, automating patient records requires presenting relevant information to health care providers and customers or patients. Process reengineering can be applied to the computer based patient record (CPR) in several ways.

Information capture and availability during patient encounters will change. The importance of nomenclatures, coding, classification, and data standardization will be greater than ever. The analysis of practice pattern information by practitioners, extracted from machine-readable patient records, will grow. The implementation of practice guidelines and critical pathways will become a widespread reality. Patient outreach that is targeted and specific to the individual needs of each consumer of health services will become a cornerstone of health maintenance. The multiple uses and users of the patient record all constitute potential recipients of benefits from automation, and must be included in any comprehensive economic analysis of the CPR. (1995 HIMSS Proceedings)

Information Systems:

Fortunately, today's technology is no longer an inhibitor to handling the high volume, complex transactions prevalent in the health care sector. Technology capable of handling voice, text, image, and video is now available in a client/server environment. User interfaces have become more intuitive, easier to use and intelligent, and hardware more compact, portable and affordable. Software engineers have the tools necessary to develop information systems for providers of care and other end users that enables them access to complete patient and reference information in a timely manner. Both administrators and care givers can realize tremendous gains from the introduction of new information systems.

Electronic Commerce - One area in which the health care industry has made substantial gains is electronic claims. Claims processed electronically significantly reduces administrative costs. In 1994, 1,271 billion or 36% of all health care claims were processed electronically (up from 32% in 1993). Understandably, payors who are now experiencing substantial savings, are embracing electronic claim initiatives and are trying to accelerate its acceptance. (Automated Medical Directory, 1995)



Source: AMPD Estimate

The Work Group of Electronic Data Interchange (WEDI) estimates gross administrative savings for the four core transactions (claims payment, enrollment, claims submission and eligibility) at $8 - $20 billion per year. If eleven EDI transactions are included, the gross administrative savings range from $13 - $26 billion per year (GHAA, 1993). WEDI also estimates the net savings from 1995 through the year 2000 period at $42 billion. (ibid.)

According to Michael Brohan and Joseph Goedert, editors for Automated Medical Payments News,

> Today it may cost a commercial payor as much as $25 per claim to manually record the injury or accident information on a paper claim form and file it with the State. But if the same date could be automated and sent to the State in standardized electronic batches, some payors project their administrative overhead could drop to around $3 per claim.

Integrated Delivery Systems (IDS) / Integrated Delivery Networks (IDN) - The formation of IDS/IDN organizations (e.g., 4-5 hospitals, 2,500+ providers, multiple payor organizations, and other health care constituents) around the country is now crystallizing the need for information systems that address the electronic connectivity of disparate systems, in addition to the need for enterprise wide applications that enable the IDS to provide seamless service to its customers or patients, and to effectively operate on a competitive front.

IDS/IDN information system development needs center around three key areas:

1. Developing intelligent interfaces to all the disparate systems so data can readily pass among all participating health care constituents.
2. Developing enterprise wide information systems such as a:
    - Master Information Index which captures patient, provider and payor information
    - Resource Scheduling System
    - Centralized Patient Record
    - Centralized data warehouse designed for information analysis
3. Building information systems capabilities to track treatment outcomes, in addition to helping providers quantify, collect and report measures of success in all phases of their operations.

Interstudy Publications' Managed Care Pathway Series states,

> Integrating health care delivery involves a fundamental shift in orientation--from focusing on episodes of illness to assuming responsibility for total health care needs of a defined population. Information systems designed to serve integrated networks must support this continuum of responsibility and be capable of achieving the following goals:

- Replacing the standard paper patient record with a computerized record that details inpatient stay information and incorporates clinical and functional outcomes, physician visit information, patient histories, and other patient-focused information that supports the continuum of care.
- Integrating existing information bases, including financial and administrative as well as clinical information .
- Providing access to clinical management information, including preferred protocols, practice guidelines, practice pattern information, and quality measures.

CSC Healthcare Systems, for example, worked closely with Henry Ford Health Systems in developing an integrated patient care and referral system (PCR) which resulted in approximately $8.5 million in savings per year in processing hospital transfers, request denials and care management transactions. Our continued efforts in developing solutions such as the PCR system for Henry Ford is a testimony to the savings potentially available to other IDS/IDN customers nationwide. Additional examples of information systems and the savings realized by IDS/IDN organizations are attached in an article entitled "Real Solutions for Integrated Delivery Systems" which appeared in the February, 1995 issue of Health Management Technology.

Information Analysis - We have spent decades developing systems capable of handling large volumes of health care transaction data. This information was designed for efficient transaction storage and reporting large amounts of tabular information. Management's challenge was to extract intelligent, usable information from the masses of data collected. This was a nearly impossible task that took multiple iterations of requests to an information systems department, with each request taking days and sometimes weeks between iterations to complete.

In today's world, the architecture of a health care data warehouse should be designed for iterative information analysis with an umbrella tool set capable of providing decision support to health care managers. Such an executive information system (EIS) enables managers to graphically analyze, interactively retrieve data, identify exceptions and "drill down" into the data to view the details of a single encounter. This interactive approach provides the foundation for thorough, flexible, and rapid data analysis, which results in better decision making than traditional fixed reporting methodologies.

Another area of key importance to improved information technology capabilities is helping managers to better understand health care resource consumption. One such application, Ambulatory Care Groups (ACG), was developed by Johns Hopkins. The goal of ACG software is to provide a conceptually simple, statistically valid, and clinically relevant measure useful in predicting the need for ambulatory health services.

ACGs are based on the premise that measuring and tracking a population's "illness burden" can help explain variations in health care resource consumption. ACGs represent a simple method for categorizing a person based on his or her age, sex, and their ICD-9 diagnoses assigned during an extended period of time, usually one year. Unlike other case-mix measures, ACGs describe the mix of person in need of treatment, rather than the mix of services.

The use of ACGs represents approximately a five to twenty-fold improvement in explaining health care resource consumption over age and sex alone.

This methodology has many applications in a managed healthcare environment, including capitation rate development, utilization management, quality assurance, provider profiling, and outcomes research. For example, according to Philip Vogel of the Institute of Health Policy Solutions,

> By drilling down, the analysts found that one [provider] practice in that area was running at 40 percent. Taking out this practice, the rate for the other providers was in the high teens. By going to that one practice and saying, we need to change some practice patterns, we were able to use the data to improve that practice and change the way it does business. (Health Network & Alliance Status Report, 1995)

Telemedicine - Information systems will play a major role in changing the way care is rendered for a selected segment of the population. As we continue to expand our health network capabilities, build information based reference libraries, develop acceptable practice patterns, implement electronic longitudinal patient record and increase the level of technology at home, we will begin to treat and monitor more patients at home. The patient will be able to receive education, have vitals signs monitored, participate in interactive video consultations with their physician(s), and schedule appointments without leaving the house.

In addition to substantial patient benefits, telemedicine will provide significant cost savings to care givers in three primary areas:

1. Medical training;
2. Surgical preceptorship; and
3. Point-of-care delivery in clinics and primary care hospitals.

As for telemedicine's return on investment (ROI), Michael O'Connor, President of United Medical Network, says,

> It is usually 3:1 to 5:1 for the educational application. The buyer must ask himself: If I can free one surgeon up one day per month, what kind of revenue does that amount to? For a great surgeon that may be eight to ten operations; for an average surgeon three to five. In either case, that's a ton of revenue. Or you could add up the revenues saved by keeping three or four residents off the road for a few days each month, saving FTE equivalents and staff costs. (The 1993 Healthcare Communications Directory)

Home care was estimated to be a $40.1 billion industry in 1994 and has been growing 23.8% annually since 1989. Even though it is a small portion of total health care expenditures (approximately 4%), information systems can help care givers be more efficient. Nursing staff equipped with hand held PCs could collect patient data during home visits and immediately transmit data to the medical center via modem. This system eliminates remote care nurse paperwork and increases the number of patient visits a nurse can make each day. People prefer the comfort of their homes and the care of their families. If more care can be rendered at home, significant dollars can be saved. Based on government figures, average hospital charges per day in 1992 were $1,459 and skilled nursing facility charges per day per $264, while average home health charges per visit were $75. Estimates for 1994 were $1,756, $284, and $83 respectively. (HIMSS Proceedings, 1995)

Finally, there is current legislation under review that would increase the number of organizations eligible to support the Medicare program. The Medicare Contractor Reform Act promotes competition and holds contractors accountable, thereby improving services to Medicare beneficiaries and providers. As a long-standing contractor to state Medicaid programs, CSC believes that improved administrative efficiencies can be achieved by allowing non-health insurers to contract directly with the Medicare program.

In closing, there is no question that information technology is an enabler for driving down health care costs and improving quality of care. It will first require a consistent infrastructure, and secondly, highly skilled business reengineering and integration talent, to be combined with superior information system developers, to truly realize the full benefits of the deployment of any major information system solution.

Thank you.

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Mr. HORN. Mr. Gary Rudin is vice president and group executive, Electronic Data Systems Health Services.

Welcome.

Mr. RUDIN. Thank you, Mr. Chairman, and congratulations to you and the members of these subcommittees for your leadership on this critically important strategy to improve effectiveness of the Medicare Program.

EDS operates in 41 countries worldwide with more than 80,000 employees and annual revenue in 1994 of more than $10.5 billion. In the United States, EDS is the largest information services provider to the health care industry.

Our systems and services touch over 88 million lives. We have been a leader in IT for the Medicare Program since its inception and helped process more than 194 million part B claims last year, nearly one-third of the national volume.

Mr. Chairman, Medicare is faced today with market shifts that must be considered in planning future IT strategies. The health care delivery system is now focusing on managed care alternatives. The technology industry is changing at an ever-increasing rate of speed. And finally even though IT has proven to be extremely cost-effective, budget cutbacks have reduced Government outlays for technology.

In my prepared testimony, I suggest that Medicare technology architecture or any technology investment must be based on four principles: risk management, flexibility, speed to market, and return on investment.

This afternoon I want to emphasize the three main points in my prepared testimony regarding the MTS initiative: First, the information technology industry is changing at a rate no one could have predicted when the MTS was conceived.

In the early 1990's, the industry was focused on transaction-based systems. The focus today is not on transactions but on information to provide program improvements. HCFA's vision correctly states that changes are needed within the business processes, hardware and software architecture supporting the Medicare Program, but the MTS approach must be reexamined in light of today's health care environment and technologies becoming available.

Second, successful organizations in the future will be those that muster the foresight to most effectively apply and rapidly deploy the latest innovations in technology. The structure of our health care business is being revolutionized by the convergence of telecommunications, computing, and information services. We should no longer approach IT problems seeking a single final solution. Effective systems in the future will be dynamic, open systems adaptable to new and innovative improvements.

Finally, a new IT paradigm is now clear. It focuses on smaller projects, short-term in development and hard-hitting in scope, that provide marked increased value and add quickly to return on investment.

My concern is that MTS is heading toward development of a new monolithic system that by the time it is implemented may well be obsolete. A strategy of investing in long-term, extremely large and complex systems development will never yield the cost and effi-

ciency improvements that can be achieved through multiple smaller projects, put in operation quickly, with the latest technology.

Mr. Chairman, we recommend that the MTS initiative be revisited considering the dramatic changes in health care and technology over the past 5 years. Rapid changes in IT are altering the way we collect, model, and manage data. Medicare, like other health care organizations, is driven by the need for knowledge that leads to program improvements.

This knowledge is obtainable through the new technology paradigm I have outlined. But it requires a different approach and mind-set than the current long-term costly and monolithic Medicare strategy for MTS.

Thank you again for this opportunity to share our views.

Mr. HORN. Well, we thank you very much, Mr. Rudin.

[The prepared statement of Mr. Rudin follows:]

Testimony of

EDS

Representative Horn, Representative Shays, and members of the joint Government Reform and Oversight subcommittees on Government Management, Information, and Technology, and on Human Resources and Intergovernmental Relations. I am Gary Rudin, Corporate Vice President of EDS and the executive responsible for the Health Care Group. I appreciate the opportunity to discuss the MTS -- Medicare Transaction System -- and how this initiative proposes to leverage improvements in the efficiency and effectiveness of Medicare operations, payment safeguards, and decision support through information technology.

Before I begin, I would like to congratulate the two Chairmen, and the two subcommittees, for the leadership you are demonstrating on this critically important strategy to improve effectiveness of the Medicare program. EDS supports the efforts of these subcommittees and HCFA in looking for solutions that will prevent and reduce fraud and abuse within the Medicare program.

Based just outside of Dallas, Texas, Electronic Data Systems is a major provider of business process improvements through information services, including consulting; systems development, integration and maintenance; and process management. EDS' 1994 revenues were $10.5 billion and our leading markets include Federal, State, and Local Government; Health Care; Insurance; Communications; Manufacturing; Transportation; Financial Services; Energy; and Retail Services. We employ more than 80,000 people in 41 countries.

EDS is the largest information services provider to the health care industry; we have supplied consulting, information technology, and process management services to that industry for more than 30 years. As the provider of outsourcing

services to some 60 health care organizations, EDS systems and services touch more than 88 million lives.

EDS has been a leader in IT for the Medicare program since 1966. In support of eight Medicare contractors, supporting 17 States, we provide business and systems services for more than 194 million Part B (physician originated) claims annually. This represents approximately 31% of the National Medicare Part B claims volume in FY 1995. EDS prides itself on providing the best-in-class portfolio of offerings, such as business process re-engineering, claims processing, image processing, expert systems, and client server tools, to reduce program costs and increase the effectiveness of payment safeguards.

Mr. Chairman, I believe that the Medicare program is faced with a number of industry changes and market shifts that need to be considered in our future IT strategies.

- We have a dynamically changing health care delivery system that must accommodate a combination of fee for services, health maintenance organization, preferred provider organization, and managed care alternatives.

- There is an ever-increasing rate of change in the technology industry. We are seeing a greater deployment of client server architecture and greater acceptance of common communications vehicles such as the Internet.

- We have experienced a reduction in federal budgets allocated to implementation of technologies, putting huge numbers of benefit dollars at risk.

Today's Medicare technology architecture and strategy must be founded on the basic principles of risk management, flexibility, speed to market and return on investment. During my brief time with you today, there are three main points I would like to make :

- Change in the information technology industry is accelerating so rapidly that the industry is being modified at a rate that no one could have predicted when MTS was first conceived. Enormous changes within our communication networks, computer hardware and software, and business process reengineering are reshaping our national information infrastructure.

- Organizations that succeed in the future will be those that muster the foresight to most effectively apply and rapidly deploy the latest innovations in technology. The ability to create and share health care information hinges on the standardization of data, pervasive connectivity, open and flexible systems, and health care organizations' ability to take advantage of change.

- A new information technology paradigm threatens the success of the existing MTS strategy, but it also provides a cost effective and reduced time-to-market alternative. A strategy which focuses on breaking the approach down into smaller, successive projects -- short term and hard hitting in scope -- will deliver added value and a return on investment to the program. This alternate strategy can be achieved rapidly and at a much reduced cost through the continued consolidation of existing systems and processing centers.

When the MTS initiative was conceived (and EDS bid on the concept) in the early 1990s, its strategy was based upon the health care delivery system and supporting

hardware, architecture, and processing environments that could be envisioned at that time. We have since experienced enormous change in both the IT and health care industries. Today's environment is moving away from strictly transaction-based systems toward those based on the collection, modeling, and management of data into information for decision support and program improvements. The magnitude of change occurring over the past five years shows no sign of slowing down through the end of the millennium. In fact, rapid change is providing us with new health care delivery systems and enabling communication networks, business environments, and, most importantly, knowledge that simply could not have been foreseen in 1990. According to Volpe Welty & Company, clinical data integration is expected to grow 22% annually; clinical decision support systems will grow at 53% and health care information management networks are expected to grow at 39% annually until the year 2000.

Information technology is today, and will be in the future, a critical component in controlling program costs and safeguarding benefit payments within the U.S. health care system. This rapid weaving of communication networks, computer hardware and software, and business process re-engineering services together with the laws, regulations and policies which shape how it is deployed, is rapidly reshaping our national information infrastructure.

HCFA's vision points to the fact that changes are needed within the business processes, hardware and software architecture supporting the Medicare program. We applaud HCFA in its efforts to move toward an environment which defines uniform data models and standards in data definition and structures; provides for re-engineering of business and IT processes; strives for shared access of data;

enhances the automation of payment safeguard capabilities; and delivers consistent and high-quality services to the beneficiaries and providers.

Nonetheless, the agency's Medicare approach must be examined in light of today's health care information technologies, which are characterized by rapid change, uncertainty, and increased competition. For example, community and regional health information networks are already in production or being implemented to support access to clinical or patient care data as well as to claims and eligibility information.

Growing demands for open system, client/server computing, microprocessor technology, and high-speed public and private networks have caused some fundamental changes in the use of information technology. Healthcare Information and Management Systems Society (HIMSS) recently surveyed 1000 respondents in the process of formatting integrated systems and found that applications technologies that will experience the most rapid growth in health care are: clinical data repositories (24%), networking (17%), mobile computers/wireless technologies (13%) and electronic data interchange (EDI) (13%). The pace of change is putting stress on business systems and decision makers without the luxury of having time stand still.

Clearly, the structure of health care business is being revolutionized by the convergence of telecommunications, computing, and information services. It's hard to tell where one begins and another ends. At the same time, we're seeing bulky hardware begin to disappear as we strap new technology around our wrists and cradle it in our hands. Let's face it. The world of information technology is

changing so rapidly that we don't even know what to call the information technology paradigm of today. That's how fast we are moving.

As I stated earlier, the ability to create and share health care information hinges on the standardization of data, pervasive connectivity, open and flexible systems and health care organizations' ability to take advantage of change. There must be a continuing investment in health care information systems. Many of us supporting the health care industry share an optimistic vision of the 21st century health care system. It is a system where users have easy and immediate access to the comprehensive information required to make sound health care related decisions. It should also be a system with far less waste, fraud, hassle and paperwork.

Ironically, while health care is one of our most information-intensive industries, it is also one in which IT has been taken advantage of the least.

Each patient encounter with the health care system -- and there are well over a billion each year -- generates massive data: medical, financial, and administrative. To date, that data has not been harnessed effectively. As a result, Medicare's ability to generate useful information from their data -- to support coverage, to support patients seeking care decisions, to support providers of care in making treatment decisions, and to improve the detection of fraudulent or abusive billing practices -- has not been realized. The net result is this: by shortchanging investment in technology, we are wasting benefit dollars.

I am concerned, Mr. Chairman, that a Medicare strategy predicated on aggressive time frames for the development of a new, monolithic system will yield a

technology architecture that, by the time it is fully implemented, may be considered obsolete -- especially considering the Medicare processes it must serve.

Regardless of these process changes, for a program as large and complex as the MTS, an aggressive completion date exponentially increases the risk and decreases its probability of success.

Combining the current 12-month MTS development period with an 18-24 month transition period, current projections suggest that the initial phases of MTS will not be fully implemented until the end of 1999 -- nearly three years after systems development and nine years after the MTS initiative was conceived. That's the equivalent of several generations of change in today's environment. In that time, the potential for great savings is being lost. According to a recent study by Arthur D. Little Inc., annual U.S. spending on health care could be reduced by $36 billion if information technology was utilized nationwide.

In simplest terms, given that the transition of Medicare contractors to existing and proven shared systems currently takes between four and eight months each, a transition plan calling for the conversion of more than 70 contractors to a newly developed system over an 18- to 24-month period is risky.

Alternatively, a strategy which focuses on breaking the vision down into smaller, successive projects, and which is short term and hard hitting in scope, will deliver added value and impact to the program. This strategy can be achieved rapidly and at a much reduced cost. Furthermore, this adjustment would not only reduce the risks inherent in deploying a vision of this magnitude, but would also increase the

probability of success in attaining a Medicare environment that safeguards the Medicare trust fund dollars and the confidence of those it serves.

We recommend that the MTS initiative be revisited, taking into consideration the dramatic changes in the health care and IT markets over the past five years. Through this effort, HCFA and Congress can be assured that the strategy and approach taken are based upon the most current knowledge and solutions available for deployment in the Medicare program, with a rapid return on investment for managing program costs and payment safeguards.

I have suggested that the current MTS strategy threatens the project's success and may result in an antiquated or even obsolete solution. In considering this situation, I hope our decision-makers fully appreciate the technology paradigm I mentioned earlier that threatens the viability of the current approach. Today's technology architecture paradigm has four principles: risk management, flexibility, speed to market, and return on investment.

First, the focus in health care today is on program improvements. Information analyses critical to the achievement of these improvements are driven by data integration and enhancement technologies that create the decision support required to achieve improvements. Data integration and enhancement capabilities already exist and can be leveraged today with the current systems at minimal risk. For example, nearly 42% of HMOs and approximately 40% of Blue Cross Blue Shield plans and commercial organizations plan to add to or enhance their existing reporting capability during 1995, according to a survey conducted by Charles J. Singer & Co. Included in this survey are health care organizations which have recently

integrated and enhanced their existing data and systems to better manage care proactively.

Second, an open systems architecture maintains the flexibility needed to take advantage of "plug and play" or "commercially off the shelf" specialty applications that enable decision support processes with minimal risk. Therefore, transformation of the existing Medicare systems and capabilities, to utilize these "plug and play" applications in conjunction with data warehouses, enables contractors to take advantage of systems which have already proven themselves in the Medicare program as well as specialty applications in which others have already invested.

Third, as these specialty applications become outdated, they can be replaced with newer applications at a lesser cost than redeveloping or re-engineering an entire monolithic system. This approach enables organizations to increase the speed to market for new innovations and to effectively and rapidly deploy best-in-class applications.

Fourth, decisions regarding how technology is to be applied must consider cost, both in terms of the expectation for return on investment and the cost at which technology can be obtained. An organization's strategy for applying and deploying newer technologies greatly influences when and how the return on its investment is realized. Organizations demanding a faster return on their investment often cannot withstand the pressure to perform or transform their businesses with the "big bang" approach. But a strategy of long term, extremely large and complex systems development and transition efforts will never yield the greater impacts

achieved through multiple, smaller projects that are, again, realizable in today's existing technology environment.

And finally, with regard to overall cost, the technology industry must be given incentives to be innovative and to build best-in-class systems that support the "plug and play" strategy. Market competition will continue, as history has shown us, to reduce the overall cost for organizations to rapidly take advantage of new efficiencies.

Rapid changes in information technology are changing the way we collect, model, and manage data. Medicare, like other health care organizations, is driven by the need for knowledge that leads to program improvements. This knowledge is attainable through the new technology paradigm I outlined earlier. That paradigm -- based upon the four principles of risk management, flexibility, speed to market, and return on investment -- requires a different approach and mindset than the current long term, costly, and monolithic Medicare strategy for MTS.

Mr. HORN. The next witness for this panel is Thomas Owens, the chairman of—do you pronounce it GMIS?

Mr. OWENS. G-M-I-S.

Mr. HORN. GMIS, Inc., Malvern, PA, and he is accommodated by John T. Kelly, M.D., the chief medical officer of the firm, who was formerly director of the Office of Quality Utilization Management at the American Medical Association.

Welcome.

Mr. OWENS. Thank you, Mr. Chairman.

As you mentioned, I am accompanied by John Kelly who is here to assist me with any issues that may arise concerning both the clinical nature of the products that I am going to describe, as well as the provider reaction to those products that have been experienced in the marketplace since we have introduced these technologies close to 7 years ago.

Let me begin, though, by recognizing that the focus of this hearing is on the MTS, and while we believe that improvements in that system are necessary, I'd like to talk about some of the proven technologies that are widely available in the private sector that are not being considered or planned for in the MTS implementation as we understand it, that we think will have tremendous value to the public sector, as it has in the private sector.

Let me begin by talking a little bit about GMIS and how we are differentiated from most of the information technology companies that you will have heard from today, as well as others in the marketplace. When you consider GMIS, what you should be thinking about are the nature of the core competencies that our company has amassed.

Our company is comprised of medical professionals, whether they be clinicians, nurses, biostatisticians, health care researchers, a whole variety of skill sets that we have focused on the issue of addressing the clinical nature of information in health care and how we can start to address looking at that information to determine appropriateness of care, appropriateness of payment, and the outcomes of care that are received by patients.

We believe that that unique skill set, when married to technology, can begin to make the information that is available on health care much richer in terms of the value that it provides in assessing the payments, as well as the care that's received by patients.

What we have focused on are building systems that look at appropriateness, look at quality, look at outcomes, and look at efficiency. And we do that by using our own staff of experts, as well as panels of physicians from around the country, that represent every medical specialty.

We have over 200 physicians on retainer that help us to develop the clinical rules in the intelligent content that is provided through our systems. Unlike other companies that focus solely on the technical side of development, we marry clinical expertise with technical development capabilities to bring medical intelligence to the issue of evaluating information and data.

We found that that has been very successful in starting to look at issues of payment, look at issues of appropriateness of care, and it's used by most of the major commercial insurers in this country,

Aetna, Signa, Prudential, as examples of those very large processors. Most of the Blue Cross/Blue Shield plans are our customers, over 75 percent of them nationwide, as well as many of the HMO's, leading HMO's such as Harvard Community Health Plan, U.S. Health Care, Humana, and so forth.

We have had terrific experience in unveiling these technologies through this customer base, which, by the way, and I think this is an important fact, their subscriber represent over 125 million Americans. So half the country is being evaluated through these technologies today.

And our experience to date has been that the reaction of both the provider community has been negligible and the reaction of the industry itself has been to realize very significant savings because of the nature of the problem that we detect. And when we talk about the issues of billing abuse, what we are really talking about here is double billing. It's very creative double billing. It's double billing that perhaps I will ask John to describe, because it's subtle. The average layman can't detect it.

But perhaps you could give some examples, John, that would show the committee how medically sophisticated a system has to be in order to address this issue.

Mr. HORN. Dr. Kelly.

Dr. KELLY. Mr. Chairman, just to amplify on Mr. Owens' comments, I think that, as you recognize, physicians are trained in the practice of medicine. Coding is an area in which most physicians do not have substantial training. Beyond that, the rules of coding are relatively complex and they keep changing. Even the terms or the language which is used to describe particular services, what the rules are for billing, all of these are somewhat complex and they keep changing. And so it's a difficult matter for physicians to remain current and fully knowledgeable on this.

Add to it, there are a huge number of different kinds of services that physicians provide and so the issue of submitting bills accurately is a major challenge. And so as Mr. Owens has described, part of what we do is to use large numbers of physicians to carefully review the coding rules and then to translate this into standardized software which we can make widely available that other organizations can then use as part of their claims payment process.

Where necessary, the software that we develop can be modified to take into account local variations in payment policy, so that there is the value of both standardized coding, standardized decisionmaking, as well as customized decisionmaking, based upon input from the medical community.

And so what we find is that what these kinds of tools allow is fair and consistent and appropriate payment, and as Mr. Owens has indicated, these tools are now very widely used throughout the health care industry. They are used throughout the private system. They are used in many of the Medicaid programs. They are used in the CHAMPUS Program. In fact, the only significant part of the delivery system that does not have the benefit of these kinds of tools is the Medicare Program. And we think that that is a loss to the program, as well as a loss to the country.

Second, as far as the input from the physician community, not only do we have significant input in the development of our tools,

we also have significant input from the medical directors and the physicians who ultimately have their decisions reviewed by these tools. We have met with the Health Care Financing Administration and showed them the tools, showed them our rules. We have met with the American Medical Association, showed them our tools, showed them our rules and invited them to provide input and comment to us.

And so I think that what we have here is a tremendous opportunity to take advantage of technology which is available today to bring to the program, to help provide for more standardized kinds of decisionmaking, fair payment, with proper input from the medical community to assure that the decisions are fair and appropriate.

Obviously, as Mr. Owens indicated, I could go into detail over some of the very specific kinds of coding issues. I think it might be more helpful to do that in writing and to bring that to the committee rather than to take the time from all the participants here to try to go through all the different kinds of rules that we have.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Owens follows:]

Thomas R. Owens

Chairman, President & Chief Executive Officer

Good afternoon. My name is Tom Owens. I am the Chairman, President, and Chief Executive Officer of GMIS Incorporated, a developer of expert systems software used by health insurers and payers. I am accompanied today by Dr. John T. Kelly, M.D., GMIS' Chief Medical Officer. Dr. Kelly was formerly the Director, Office of Quality and Utilization Management, at the American Medical Association.

GMIS develops software used in a variety of contexts by the health payer industry. Traditional indemnity insurers, Blue Cross Blue Shield plans, managed care organizations, government programs including Medicaid, CHAMPUS, CHAMPVA, and the Department of Justice, a variety of third party administrators and, increasingly, health care providers, utilize GMIS' systems to manage and process the myriad of medical data they receive daily.

GMIS' products are used to ensure:

- that the codes used to describe medical procedures and the diagnoses associated with them are accurate and make clinical sense so that claims may be paid correctly;

- that the accumulation of data compiled by health payers may be properly warehoused and analyzed from medical, financial, and statistical viewpoints; and

- that risky or overused procedures are only performed when appropriate.

In sum, GMIS' products enable our clients to promote more appropriate treatment for their constituencies, to pay their claims more accurately, consistently, and efficiently, and to retrospectively analyze their data in order to better manage their networks of providers for the benefit of their customers. Two products, ClaimCheck® and Provider Insight® may be of interest to you today.

ClaimCheck, is used by more than 160 organizations to guarantee accurate and appropriate payment of claims. Approximately 125 million Americans have their health care coverage from GMIS' customers. These companies, some of the largest financial institutions in the world, have historically internally developed all information systems, unless outsourced to companies like those represented by my colleagues at the table. However, they generally outsource development of clinical applications to companies like GMIS. Quite simply GMIS brings to clients specialized technology not commonly found in information systems companies. Specifically, our professional staff of clinicians, coders, programmers and analysts are focused solely on clinical development. Our customers put their trust in an outside developer because of the dynamics of medical care and coding systems: ever changing practices, updated coding systems, and interpretations of both. Use of our products eliminates, for our customers, any appearance that their decisions are made in an arbitrary or capricious manner.

ClaimCheck does not make any judgement with respect to diagnosis or appropriateness of care. ClaimCheck only detects and corrects coding errors on a health insurance claim form.

Providers of care represent the services performed for a patient using the five digit CPT-4 coding system developed and updated each year by the American Medical Association. These codes may represent very discrete services, such as 47600 for removal of the gall bladder and 74320 for an X-ray of the gall bladder, or more comprehensive services such as 47620 for removal of the gall bladder *and* its X-ray, when performed at the same time. If a provider billed the insurers with the two discrete codes I just described, 47600 and 74320, ClaimCheck would instantaneously recommend that they be replaced with the code that includes both services performed simultaneously, 47620. ClaimCheck would also provide extensive documentation that our clients may use as part of their Explanation of Benefits to the provider. In this way ClaimCheck has ensured that the provider is paid correctly for the services performed. Revenue savings are realized because of the sum of the reimbursements for the two discrete codes would improperly exceed the reimbursement for the code that includes both services. This practice is commonly referred to as unbundling and is very expensive to the health insurance industry.

Private and public sector programs utilizing ClaimCheck typically realize a savings in the range of 1% to 8% in their payout on professional claims with anecdotal evidence suggesting average savings of 5%. For the largest insurers like Aetna, CIGNA, and the Prudential, and large Blue Cross Blue Shield plans like Blue Shield of California, Empire Blue Cross Blue Shield, Blue Cross Blue Shield of Connecticut, and Blue Cross Blue Shield of Michigan, the annual savings are calculated in the tens of millions of dollars. Our initial experience with Medicaid programs has shown savings of equal magnitude. Even Alaska Medicaid, one of the smaller of the Medicaid programs, has saved millions of dollars since implementing ClaimCheck.

The private sector overwhelmingly employs ClaimCheck or similar products from other companies as a part of their claim payment processing. Nearly all indemnity insurers, Blue Cross Blue Shield plans, or managed care organizations use commercially developed and marketed software to prevent claim overpayments. Any organization that is at financial risk for beneficiaries' medical services protects its investment by licensing, rather than developing itself, the technology necessary to safeguard claim payments. Increasingly public sector programs are discovering the value in this approach. Medicaid programs in Kentucky, Kansas, Alaska, Wisconsin, Pennsylvania, and Virginia have licensed technology directly from GMIS. The Department of Defense's CHAMPUS and CHAMPVA programs have procured our technology. The Department of Justice has used ClaimCheck to support civil prosecutions and is currently studying possible applications in support of criminal investigations.

The savings experienced by private and public sector organizations are completely consistent with the findings of several studies performed by various United States Government Agencies done to determine the value of claims editing technology. The Department of Health and Human Services Office of Inspector General study, released in July of 1994, showed that eight Medicaid programs, California, Ohio, Michigan, Illinois, Missouri, Nebraska, Colorado, and West Virginia, had a collective projected annual savings of over $60 million if a claims editing system were used. This study confirmed the findings of a 1991 study of the Office of Inspector General. And, this past May, the United States General Accounting Office released a study of Medicare claims projecting annual savings of at least $640 million for the program if it used commercially available software like ClaimCheck. This GAO study merits more discussion.

The GAO contacted GMIS in 1994 to learn what cost containment technologies the private sector used that could be made applicable to public sector programs such as Medicare. The GAO thereafter entered into an agreement with GMIS and three other private sector companies with similar claims editing technology to review previously paid Medicare claims. GMIS received from GAO over 500,000 paid claims that were then reprocessed using ClaimCheck. The GAO carefully reviewed ClaimCheck's output and eliminated any findings that it believed were in conflict with established Medicare payment policies and guidelines. Further, the GAO eliminated any of ClaimCheck's edits that they believed could be perceived as being controversial to the provider community, despite the widespread existing use of those edits throughout the health insurance industry. The GAO took the most conservative approach possible in analyzing the extent of claim overpayment problems in the Medicare program. None of our private sector customers have ever taken such a restrictive approach in either their pre-implementation analysis of ClaimCheck or in their actual use of this technology. As a result, in my opinion, the savings quoted by the GAO in their study are vastly understated.

GMIS has developed a number of systems incorporating medical rules and protocols. One, Provider Insight, is used to retrospectively analyze health care claims to detect those providers whose practices are variant from their peers. GMIS' panels of physicians consultants have created rules that enable the grouping of claim records into logical Episodes of Care. An Episode of Care represents all services utilized by one or more providers to treat the single occurrence of a disease or injury to a single beneficiary. In this way, Provider Insight is able to compare provider medical practices to determine which providers may be over utilizing resources,

a possible sign of fraud. In a managed care environment, where, through capitation, the provider assumes some or all of the financial risk, Provider Insight is used to determine which providers may be underutilizing resources. In managed care, this underutilization of resources may be a sign of fraud. In any case, the comparison of provider practice patterns, carried out in a fair and consistent manner, is essential to any insurer or managed care company to adequately protect its beneficiaries.

What does a private sector insurer have to lose by using commercially available software like ClaimCheck? The answer is, potentially everything. If our products make inaccurate or inappropriate recommendations, then our customer risks losing their customer. Also, in this day and age of managed care, with the development of close linkages between insurers and the provider community, the last thing an insurer can afford is to alienate providers with inaccurate or inappropriate recommendations. Consequently, the implementation of products such as ClaimCheck and Provider Insight is done with great caution by the private sector. The growing and widespread use of this technology attests to the excellent job done by companies like GMIS and its competitors.

With respect to implementation, a private sector insurer typically takes less than six months to install and begin getting value from products such as ClaimCheck. The typical insurer dedicates several full time employees to ensure that ClaimCheck processing rules correspond with their medical payment policies and also dedicates several full time employees to making the necessary software modifications to achieve a full integration of ClaimCheck's functionality with

their processing system. The typical insurer often has several claim payment systems and perhaps dozens of benefit plans to account for as its performs its process of implementation. With appropriate professional consultation and proper planning, this technology is fully implemented into large scale processing environments in not more than 180 days and, in some instances, less than 90 days. Implementation of this technology in the Medicare program, though certainly a large scale project, would not be dissimilar to what we have done for our existing clients. We are confident that any organization that makes the necessary commitments in personnel and resources and has the will to succeed can implement this technology in a timely fashion.

One issue of concern to GMIS is the proprietary nature of our products. As you know GMIS has invested significant resources to develop and maintain our medical databases. GMIS employs over 200 people to develop and maintain its products, including personnel with software and/or medical expertise. Additionally, we retain over 200 physicians to ensure that our products stay current with changes and trends in the health care industry. It is critical that GMIS protects its investment. GMIS believes that utilization of its products in public sector programs poses no threat to the proprietary information it has developed. It is important that rules for products such as ClaimCheck be published along with examples illustrating their application. However, it is neither practical nor desirable to publish the entire edit database because there are over 10 million edits and publishing them would enable unscrupulous providers to invent new ways to manipulate the system. GMIS' private and public sector customers have routinely published dozens of rules that form the foundation for the millions of ClaimCheck edits. A provider's office that understands these rules and observes them is unlikely to submit a combination of procedure codes

that would cause a denial of a claim payment. In fact, GMIS' studies consistently show that over 90% of providers do not have one claim denied by ClaimCheck in a given year.

In summary, the goals of the Medicare program and commercially available software are complementary. Commercially available software insurers that claim payments are made accurately and that provider's medical practices are evaluated fairly and consistently. Software companies that automate medical rules and protocols must be responsive to changes in practices and the needs of their customers in order to remain viable. To ignore the realities of the changing practices of the health care industry is to risk extinction. GMIS has prospered for many years by helping its customers protect its more precious asset: its beneficiaries.

Mr. HORN. Well, we appreciate that offer of assistance, Dr. Kelly, and we will take you up on it.

Let me just ask you, on the coding, since you brought it up, it seems to me one of the problems we have in coding is there's a constant change in expansion of various processes. As I recall, when HCFA started squeezing the hospitals and the doctors to save money nationally, what you had in physician coding was a subdivision of processes for which used to make a certain charge, in order to get their fees up in gross say—by subdividing them and making them separate processes. So when it all added up, they were either equal to what they had been prior to HCFA squeezing them, et cetera.

Now, to what extent was that a true description of the situation and how does one deal with that in a constantly changing system, either based on new technology that changes the nature of medicine, new processes, new ways of serving people.

You have to have obviously a very flexible system, a system that can take expansion and contraction, and yet this is nationwide even though you mentioned some regional practices there, which I am sure are true, that the medical community in some parts just sort of feels this is the way we do things around here, whether it's 20 years old or 10 years ahead. And to talk a little bit about that and how much of a problem that is? Is it any sort of a problem in a modern, technically up-to-date system to be flexible?

Dr. KELLY. Thank you, Mr. Chairman.

I appreciate that.

First of all, as you know, medicine keeps changing. There are new kinds of services that are developed, that then become widely available because, in fact, they benefit patients. And so there are many services that physicians are providing today that weren't even available or even possible several years ago. And so there's clearly a need for new codes to describe those kinds of services so the coding system itself changes in that regard.

Second of all, over time, the range of services that are encompassed within a particular code, that also changes as well. As you know, there are organizations such as the American Medical Association, CPT effort, which meets regularly to try to develop accurate descriptions of the kinds of services that might be provided, what's included in that. That group continually updates the coding system and publishes new codes every year.

Part of what we find is one of the major challenges, first of all, is making sure that the code itself is accurate, and that's a major part of the services that we provide, helping to facilitate the accuracy of coding.

The second part that Mr. Owens was speaking to and that part of our software addresses, that oftentimes physicians provide multiple service—services to a patient at a given time. And, so part of the challenge is how many of those services are included within one code or included in a different code or multiple codes?

There are, in fact, in our system, well over 10 million different possible code combinations that could be provided and that we have rules to address, and so the challenge that physicians face, and those that assist them with their billing, is when the physician provides, for example, a particular surgical procedure, there may be a

radiological procedure which is part of that and there may be an office visit which is part of it as well, is that described by three different codes, each of which is billed independently, or is there one code or some other combination of codes that more accurately reflect and characterize that service?

And so that's really the nature of this, because what we want to do here is to make sure that how the codes and ultimately how the payment is handled is consistent with the rules that have been established.

And because there are so many rules, it's a finite number but a large number, and because those rules keep changing and because the codes keep changing, it's very difficult for physicians. I can tell you as a physician myself, it's impossible to remember all of these. And so there's great value in being able to bring together various experts who will review this, identify the rules and then ultimately translate that into software that can then be available to everybody. In effect, what the software does is make experts out of the entire system. And so there is tremendous value in that.

Just one other part of it in terms of the issue of what happens to how physicians bill for their services and what the consequences are. A question that was raised earlier this morning was: How much of this is, if you want, misunderstanding or ignorance of the rules and how much of this is abuse and how much of this is outright fraud?

Oftentimes, it's very difficult to sort that out and, frankly, part of the benefit of this kind of software is it doesn't need to ultimately make that distinction. What it can do is to make the right decision, what are the right code combinations; change the codes as presented so that the payment is fair, without fully coming to grips with the issue of whether this is simply ignorance, which is what we believe most of the time is the case, or whether it's abuse or whether it's fraud.

Mr. HORN. Give me a feeling for how a private insurance company, a large HMO, with national scope, a large hospital system with maybe 20, 30 hospitals, as well as HCFA, deals with these changes. Do they have professional advisory committees by discipline that discuss some of these, advise them?

Is the private sector different in its handling of this, of listening to people, than HCFA? Or is HCFA ahead of them in listening to people? How does the process work? You have had a pretty good vantage point to say that.

Dr. KELLY. I think several points, Mr. Chairman. First of all, before organizations such as ours were available, every single delivery system had to have a way of coming to grips with this. So oftentimes, the organizations would have a medical director or a medical policy committee or certain consultants that would help them and advise them. And then add to it, when claims would come in, they had to have a process for reviewing them.

Initially, a good bit of that was handled manually. Subsequently, it was handled in an automated way. Part of the challenge is because the coding system keeps changing. One of the problems which those organizations faced was that it took a significant amount of time and resources to be able to stay on top of this, to be able to address that.

What has happened over time has been that those organizations have typically turned to private sector organizations such as ours, and we are not the only one. There are others that do similar—developed similar tools and do so in a way which is similar to what we do. And what those, whether it's a large insurer, a large HMO or a hospital system or a group practice, what each of them have found is that it makes sense to turn to experts who devote their attention fully to this and who then develop tools which they can license and use that; in effect, provide them the benefit of this expertise.

Absent doing that, they would have to, in effect, recreate the same kind of process that we have in place, and so the benefit that we provide to them, why these kind of tools have been used in so much of the private arena, as well as in the Medicaid, as well as in the CHAMPUS, is, in effect, we are able to bring all of this expertise and then to translate it into a relatively easy, automated way, that can be inserted relatively effortlessly into their payment systems.

You may choose to ask some of the other participants here as to how easy it is and how readily this can be transferred into the Medicare Program, the same kind of tools that they are using in other parts of their business.

Our concern then as far as the Medicare Program is concerned and as far as HCFA is concerned, is that they are not moving rapidly enough or not taking advantage of some of the kinds of technology which is available today, widely used today, not developmental but, in fact, readily available. And our belief is that the Medicare Program would benefit in the same ways as the rest of the health care system is currently benefiting from this kind of technology.

Mr. HORN. What do the various academies in medicine, surgeons, family practice, or whatever, do? Do they have committees that deal with this type of matter in terms of agreeing on coding, agreeing on the various processes that are best practiced processes at this point in time? And how does that information get to the insurer, the nationwide HMO, the nationwide hospital system and HCFA?

Dr. KELLY. Well, Mr. Chairman, what happens is the following: Is that, first of all, there's the process which the American Medical Association has in place, which is developing the coding system, the CPT coding system and developing the various rules and providing guidelines regarding payment policy. That's a major activity and an important activity.

Many of the medical specialty societies, such as the American Academy of Dermatology or the American Academy of Orthopedic Surgeons or the American College of Cardiology, will have input into that process and so provide influence there. At the same time, they will oftentimes communicate with their members and provide guidance regarding payment decisions, how they should bill, how they should code for particular services.

Typically, this is conveyed through books or educational programs. The difficulty, of course, is that the number of codes is large. The number of rules are complex and how particular rules,

oftentimes very general rules, how they should apply in a particular decision may not always be clear.

And I can tell you that what we find is that when we take the codes that have been developed and the rules that have been generated, whether by the American Medical Association or one of the medical specialty societies and then we look at how it should apply with the particular set of codes in dealing with a particular claim. Oftentimes decisions have to be made which are not fully provided for by those policies or by those rules, and so there needs to be that kind of very careful evaluation and input.

And then—and so what then happens is that can then be turned into a set of decisions because of ultimately the general policies helping form this, but in the final analysis, in claims payment, the issue is how do you handle a particular claim for a particular patient, with a particular grouping of codes? And so that's really where a significant amount of activity needs to occur.

I should tell you that we and other organizations like our own look to the AMA. We talk to them regularly about what a particular policy is, what it means, how it should be interpreted. We talk to the numerous members of various medical specialty societies, work with their leadership. And as Mr. Owens indicated, we have over 200 physicians who work with us on a consulting basis who provide guidance to us.

And then what we also have is that we have an 800-number and regular contact back so that if there's ever any question, whether it be from a medical director or even going down to an individual physician, about how a particular rule or decision was made and what it means, then we provide a response to that and then we also use that kind of input to help review and update our various rules and modify them as necessary.

Mr. HORN. How do you interface then, after all of that, with HCFA, the Health Care Financing Administration? And how do they interface with you and any other groups around the country?

Dr. KELLY. Well, I think that at—as the primary arenas in our tools are being used, are in the private sector, the CHAMPUS Program and in the Medicaid Program and typically on the Medicaid Program we deal with State organizations that are overseeing those programs. So we do not typically interact directly with HCFA over how these particular tools might be—might apply to the Medicare Program because, as you know, they have not made an affirmative decision in that regard.

We have met with them. We have obviously indicated our view, that's reflected in the General Accounting Office's recommendations, that these kinds of tools will be beneficial. Obviously, we would be very eager to continue to meet with them to help identify ways in which these kinds of tools could be transferred into that program, because we see that they have tremendous positive benefit.

Mr. HORN. Would any of the executives of these different firms want to comment on this dialog and add some dimension to it that you see that we haven't brought out?

Mr. RUDIN. I would offer, Mr. Chairman, that I believe in 1989, our company did an analysis of firms that do comparable functions to GMIS. We basically chose them as a best-in-class, best-practice

activity. We are one of their larger customers. We use their products in a number of settings in the private sector, in a number of our Medicaid States that we have responsibility for, and have found very, very positive results.

And as we talk more about high-impact projects, if we go back to the GAO report this morning, talking about wanting to get down to more specifics on scope and cost and timeframes and benefits, these are classical examples of the kind of projects that can be installed in basically any kind of legacy system to create high impact with very reasonable short timeframes to install.

I am sure I am being very conservative when I would say that the benefits are at least 10 times to 1 what the costs are to put these things in. And I mean, I can find no reason why you wouldn't want to be pursuing these types of things under the Medicare Program.

Mr. HORN. Mr. Huntzinger.

Mr. HUNTZINGER. Thank you, Mr. Horn.

Also, I would like to add that we are in the business of developing proprietary solutions for the managed care industry, so we developed application software similar to your MTS initiative. We are doing that for the commercial sector, and we do not have all the expertise in our shop to develop all the specialty functions and technology that need to go into a complete integration effort.

We have also done the same thing and evaluated the market and we have developed intelligent interfaces to products that we are talking about today. Our customers have gained—I believe, significant benefit from their use, and as was mentioned previously, there are other competing market—products on the market and we have taken a path where we have developed intelligent hooks to a number of those products and have not endorsed any one in particular.

I agree with what was said in that there is significant gain in benefit that can be realized, and I think it was very appropriately stated, by the way.

Thank you.

Mr. HORN. I think we have learned years ago in many areas of rapidly changing technology that we all know it's out of date the day the system starts and that another generation is coming right behind it.

In that time spread they gave us, where it really won't be fully implemented until 1999, did you have any reactions on what you saw? Do you think we are buying an Edsel from the fifties and putting a lot of money in it? Will there be something coming right behind it or that you are already doing, that they haven't taken advantage of?

Mr. HUNTZINGER. Well, Mr. Chairman, I have been in the information technology business since 1969, all on the applications development side of the fence. I have not had the opportunity to evaluate the work that has been done to date, so I cannot really comment on that. I can only speak from experience, and I can relate it to an example.

We have been in the application sciences or application software side of the business since 1977. We developed some of the first initial managed care software that's been—that went on the market

at that time. We have revised that a number of times and came out with replacement products.

The last 2.5 years were spent in an R&D lab developing our newest client-server product called Meridise, and Meridise is now currently in beta site. I will not talk about the two customers because we are under nondisclosure there.

Suffice to say, one is a large managed care environment that consists of about 400,000 lives and a mix of HMO, PPO, and traditional indemnity health insurance business. It took us 2.5 years to take it from the design stage to the actual beta site and it just started and went into beta site last month. It's going to be in beta site—actually, it's going to be in two beta sites for probably around 9 months.

Mr. HORN. I think for the viewer and the reader we need to translate beta site. This is essentially the second site after you have proved it works?

Mr. HUNTZINGER. Actually, no. It is—a beta site, in our definition of it, is we have developed the system in-house. We have tested it and put it through rigorous internal testing.

Now we are ready to take it to a real customer and someone who is also going to put it through a very rigorous, intensive acceptance test, and upon completion of that acceptance test will migrate a segment of their business over to that product and monitor it very closely.

We at that time put a swat team, per se, around it, making certain that anything that—any problems that are identified are corrected. That's a beta site.

Once we are all done with that and the customer has actually used it in an ongoing production mode under close supervision; then we believe, and after we have corrected all of the problems that were identified at that time, we then make it commercially available.

And beta sites are—it's a way of—I think there's reference to model office work. It's not a model office environment. It's taking actual live customer involvement.

Mr. HORN. It is fully operational?

Mr. HUNTZINGER. It is fully operational, on small scale.

Mr. HORN. You have gone from the laboratory. You have tested it. You think you have got something that works but you are not—really don't know until you are out in the real world.

Mr. HUNTZINGER. That's correct.

Mr. HORN. So it goes through the basic research, the applied research, the developmental research and you are there.

Mr. HUNTZINGER. Right.

Mr. HORN. I have learned long ago, don't be the alpha site. That I know. I have been through that. You can make headlines that way.

But do you have any comments, Mr. Rudin.

Mr. RUDIN. Yes, Mr. Chairman. When you stand back and take a look at the conversations this morning I compare it to your analogy about the Edsels back in the fifties and frowning upon legacy systems; when I stand back and look at MTS, we are basically spending close to 10 years to replace one series of transaction systems, the nine that are in place today, with one much larger trans-

action system, that makes the assumption that life stands still. I don't think it does.

As we listened to the testimony from Mr. Owens and Dr. Kelly talking about the things that are available, if we had a chance to quickly go across the private sector across many industries in this country today, I think we would find that in most all environments, there are many legacy systems running all over the place. Now, why is that? No one can afford to totally replace legacy systems.

Mr. HORN. We found 50 in the Pentagon earlier this week. They should have done it in 1947. Now they don't know what has happened to $15 to $28 billion. Actually they got the $28 billion down now to $15, all because nobody thought that through.

Mr. RUDIN. Yes. But people don't totally replace legacy systems because the business case is not there.

Now, I think there's a lot of wisdom in the GAO report this morning as they were talking about, you know, getting to definable projects with clear scopes, clear costs, clear benefits, very specific details. What goes on in the private sector is a tremendous scrutiny of projects, and what you typically find is an abundance of smaller projects, 12, 18, maximum 24 months long, that have very definable scopes, very definable costs, very definable timeframes, very definable benefits of when they are going to occur, that allow the executive committee of that firm to understand exactly what the cost-benefit analysis is, the return on the investment, and the net present value of the investment to go forward.

As you analyze any major large systems that would be comparable in size, to what we are talking about with Medicare, I think the financial industry probably has many of them, you would see an ongoing evolution of many projects and the upgrading of these large systems, to continually keep tuning them with very measurable paybacks that come from these things.

So I would——

Mr. HORN. Don't mind democracy at work.

Go ahead. I am going to leave in 10 minutes so don't worry. I will be back.

Mr. RUDIN. OK.

Mr. HORN. It might be evening, but I will be back.

Mr. RUDIN. So I think the point is, I would make recommendations that there are many, if I can call them, plug and play activities. There are many things that can be done to deal with the current systems in Medicare, and I would encourage you to look at strategies that would look to consolidate perhaps some of the Medicare systems that are out there today.

Don't worry about replacing the transaction systems. Move forward toward looking at some common data formats of how to extract the massive data out of these remaining systems, how to build the data warehousing that's available, to leverage that data, and to get it toward knowledge.

When you start applying the right decision support systems to it, then if you followed the conversation this morning when they were talking about $25 or $28 billion of estimated savings, to work on that $25 or $28 billion, you need to leverage the data that already exists and that's where the projects should be focused, not on reinventing another transaction system.

Mr. HORN. Right. Let me ask you on some of the points that you have both raised and Dr. Kelly raised it. Based on your experience, how much of a payback should be expected from investing in a new health care automated system? In other words, for every dollar spent, how much of a savings should be generated? How quickly should that be realized? What is your experience with that?

Mr. RUDIN. Across different industries, different organizations use different measurements. I have been in organizations that look for 14 or 18 month paybacks for their investments. Many organizations will look at the net present value of the investment, which tends to encourage you again to go to these shorter term projects because you can't get a positive net present value unless they have got a reasonable timeframe, you know, to get in. So I think those are two measurements.

Mr. HORN. I must say the experiences I have had here, as well as on the West Coast, usually the people that are selling the hardware and the software are very optimistic and it never comes true. They can't get a system working in the time they claim they could get a system working. So has that been your experience?

Mr. RUDIN. I think there's a lot of things that come up very much on time and I think in many cases due to some innovation there are some things that don't come up on time but, again, I think that's what leads to the focus of smaller sized projects.

Mr. HORN. Yes. That is certainly a good argument for them to try to incrementally do this.

Let me ask you all a couple of questions just to get it on the record. Based on the robust activity occurring in health care information technology, would you try to design a single system today that would be the state-of-the-art in the year 2000? That is what we are talking about. I mean, I take it the answer is, no, am I wrong, from most of you?

Mr. RUDIN. I would offer for you that at the rate things are changing right now, it's very difficult to exactly predict the state of technology in the health care industry in the year 2000. Both the health care industry and technology are changing so fast. I don't think anybody has the ability to identify the rate at which the Internet and public networks are starting to move forward. There are already many massive pervasive private networks. You know, you basically have a national information infrastructure existing today. You don't need to wait for the super information highway.

Mr. HORN. Right.

Mr. RUDIN. It is all out there right now and things are changing so fast it is almost a blur. So to try to predict the year 2000 I think is a little bit dangerous. I think you want to keep going along as fast as you can incrementally applying what is best and most available to you and continually just keep improving the activities that are going on.

Mr. HORN. At least be able to add on or transfer easily the data.

Mr. Owens, do you want to add anything to that?

Mr. OWENS. Simply, Mr. Chairman, that I have to agree with that. We have noticed in the private industries that when they start to address replacing their claim systems, they get all hung up on what the design should be, given the amount of change. And what they have realized is through the incremental changes that

Mr. Rudin was talking about, they can realize very significant savings. And as the GAO report points out, with the kinds of systems that are in the private sector today that deal with billing abuses, they estimate $640 million in savings to the Medicare Program. We think that's conservative and underestimated. But clearly, for the amount of investment, estimated again at $20 million, to get a return like that, I can tell you anybody on Wall Street would love anywhere near that return, even half or a third or a tenth of that return.

There's very significant things that can be done. And to try to design a system today that will meet all of those needs, unpredictable needs in the future is a very dangerous undertaking.

Mr. HORN. Do you have a comment?

Mr. HUNTZINGER. Yes. I would like to add something to that, and I am going to take an opposing point of view. We have been, as I said, in the information systems development business, especially on the health care side, for a long time. You can continue to enhance, and I agree with both of the gentlemen, that you can continue to enhance something for a certain point in time, but you reach a point where technology changes so radically and you can through a paradigm shift in technology where now it's time to rewrite, reinvent, to fully take advantage of the technology that's in hand.

Also, health care itself is rewriting and changing itself at the same time and you cannot continue to always patchwork something to get the full efficiencies. You need to take a look at the entire business and try and build a system or a solution that anticipates change and builds flexibility into the solution that you are developing so that you are using the most current technologies to take advantage of the capabilities that are at hand today.

I think also, and I would like to add, that the focus here has been for the most part on the administrative side of the equation. We are missing a very significant part by focusing on the administrative side solely. You need to focus more significantly on the delivery side, the medical side of the equation. If you look at the equation itself, 78 to 85 cents of every dollar is going to medical costs; 12 cents is going to administrative costs and that's on the average. A few cents are dropping to the bottom line.

A 5-percent improvement on the medical side is a radical change and big benefit. There are technologies available today that can be added to your legacy applications to help you drive down the medical cost side of the equation or at least control it a little bit better than it's being controlled today, in addition to working on the administrative side, and coming up with a unified system that better serves the needs of the industry today.

Mr. HORN. I completely agree with you. The administrative side in a system is obviously peanuts compared to where the real money is going, to the hospitals, the doctors, and so forth and so on.

Dr. Kelly, do you have anything to add to that?

Dr. KELLY. I agree, Mr. Chairman. There are tremendous opportunities to improve the delivery of health care. Physicians are clearly looking for that.

I think that also what we have heard today is that there is a tremendous number of very practical solutions that are, in fact, avail-

able, that can be used. And I think that the Medicare Program that, as you know, is likely to continue to undergo changes, clearly should be taking advantage of those various solutions that are available rather than trying to independently come up with a—with a solution that doesn't take advantage of all the tremendously positive developments going on elsewhere in health care.

Mr. HORN. I remember in the time—I was on the Hill in the times of the McNamara Pentagon—when they wanted to have one universal plane for the Navy and the Air Force. Well, after everybody got done, it could barely get off the ground. I don't know that it ever did.

If you had a single advice for HCFA on MTS, what would it be that you haven't already said?

Mr. HUNTZINGER. I don't believe I would add anything else. I am not that familiar.

Mr. HORN. OK. Mr. Rudin, anything else to add on that?

Mr. RUDIN. I would just reemphasize going to shorter term, high impact projects, to start having some impact on these things that you are concerned about.

Mr. HORN. OK. Mr. Owens, anything else on that?

Mr. OWENS. Nothing to add.

Mr. HORN. Dr. Kelly.

Dr. KELLY. No, thank you, Mr. Chairman.

Mr. HORN. OK. What savings could HCFA expect if it implemented fraud detecting software like claim check? Have we had enough experience with claim check to really see what the results are?

Mr. OWENS. Our experience in the private sector, and we don't have any reason to believe that the experience can't be replicated in the public sector because it has been replicated in Medicaid programs and is being implemented now in the CHAMPUS Program, is that the savings would be somewhere close to 5 percent of professional payouts. That's a very significant amount of money.

The issue that I think is obfuscating some of the facts around the implementation in Medicare is really that we are talking about the same coding system used both in the private sector as well as in the public sector, the same coding guidelines being applied to that coding system and the same misinterpretation of those guidelines by a provider, whether it's for Medicare or for some other form of insurance. And given the fact that those guidelines should be interpreted uniformly, regardless of payment type, I think that the savings estimates that have been realized on the private side are easily replicated on the public side.

Mr. HORN. I am going to have to recess this for about 20 minutes. We have this vote and then a 5-minute vote immediately follows. So go have a coke or whatever and see you in about 20 minutes.

[Brief recess.]

Mr. HORN. The hearing will resume. It is now 2:30. We have a couple more questions. We have culled them down from 15 to 50 we were planning to ask you.

Drawing upon your experience with the claims processing contractors, is the development of MTS discouraging these contractors from developing new software and technology strategies which

could improve Medicare claims processing before MTS itself is ready?

Mr. RUDIN. I believe, if I understand your question, Mr. Chairman, that moneys for changes to the current systems have pretty much come close to a halt during MTS. So I think things have greatly slowed down as far as changes during this time period.

Mr. HORN. So we have a transition period problem?

Mr. RUDIN. Yes. I think we have a great slowdown during this period.

Mr. HORN. Where is that slowdown occurring, primarily?

Mr. RUDIN. I think its source is just in the funding of changes. I think there's actually a little bit of shrinkage in the amount of money available for technology projects, and I am not sure—I am not the right expert to comment on the—where the moneys are appropriated for the funding of the administrative and technology portions of Medicare versus the trust funds and the 97 percent, but I think there's some lock up in that area during the course of the development of MTS.

Mr. HORN. Dr. Kelly, did you want to add something to this?

Dr. KELLY. I think, Mr. Chairman, what we see is that the exact same organizations that are doing processing, claims processing, for Medicare, who are not investing in certain of these solutions in that part of their business, in fact, are making tremendous investments on their private side or in the managed care side or even what's going on in the Medicaid side which they are serving. So we are seeing a tremendous investment on that side to great benefit. Obviously, we are not seeing the transfer of those same kind of capabilities into the Medicare, where we believe that similar benefits could be achieved.

Mr. HORN. Anybody else like to comment on this?

OK. Would you agree with the assessment that with MTS there seems to be a strategic decision to take more control of claims processing from contractors? How do you feel about that? Does that make any sense or is that baloney?

Mr. RUDIN. I think from the testimony I listened to this morning, I think that definitely was the implication taking place there. I think if you want to fully deploy the creativity of the private sector to help out with Medicare, I think the more that you are deploying the administrative activity of the program and to engage all of the many companies and organizations that want to come forward can help with programs like this, I think that competition and that interest and involvement only more and more facilitates competition, and a very centralized singular system probably does deter from competition.

Mr. HORN. Well, competition is a very good word for it. I am drawing an analogy between the debt collection legislation I have offered and the arguments I have listened to in pursuit of that. The Federal Government has never had a systematic way to collect debt, and we have—$100 billion that has been written off by the Internal Revenue Service over the years. There is still about $60 to $70 billion to collect. And the rest of the Government has about $60 billion to collect. And what we are saying is, hey, folks, you get the first crack at it since they have got their own in-house bill col-

lectors, and after 6 months we want that to be turned over to private collectors.

I think there is no question that we will, through that competition. One of the incentives we have is to give the agency that is collecting part of the action to spend in their budget. Whether that finally goes through the various appropriations committees, I don't know, but we are starting with 5 percent. If they collect $1 billion out there, the agency earns 5 percent.

But the competition is the key and because other people are involved you can test out who are the sleepers and don't give them anymore of the business. You can know statistically and keep everybody on their toes.

So that is why that competition question is here. I think it is a good idea. Now, some people don't. Some people say big government knows all. The current majority does not feel that way, needless to say, especially when we see $100 billion written off by IRS. That doesn't please me, as the Commissioner knows. So we will have a hearing on that, maybe a date like April 15, which might stay in everybody's mind.

What incentives do current Medicare contractors have to update their systems while HCFA develops MTS? Are there any incentives that you are aware of?

Mr. RUDIN. I would think that the most effective way to instill the right set of incentives in this system would be to look toward more activity in the privatization of the program and more outsourcing of the functionality of the program that would cause more and more continual upgrading and competitiveness of the whole activity and process.

Mr. HORN. Anybody want to add anything to that?

What concerns does EDS have about reverse engineering as it may relate to copyright infringement? Any feelings on that?

Mr. RUDIN. Offhand, I don't think I have got a clear view of how that would apply in this case. I am sorry. I would have to check with some other people.

Mr. HORN. Let me ask you this, then: Are data processing companies reluctant to do business with HCFA out of fear of copyright infringement? In other words, if you have got a system going are you concerned about doing business with HCFA? We know we are in an age where intellectual property is regularly stolen by some of our friends and enemies and allies.

Mr. RUDIN. I think that if we look at the Medicaid Program as an example, I believe that we have gone through an evolution over the years in Medicaid, you know, where there's access to all the systems in the marketplace, if you will, so they don't remain proprietary, if you will. So I think we have already paved the way in some of the Medicaid areas to already deal with this entire issue.

Mr. HORN. OK. I think we might have a few more questions, but if you don't mind, we will submit them in writing, and if you would be good enough to share your experience with us, we would like to put them in the record at this point. So I thank you all for coming.

Mr. HORN. Yes, do you have a question?

Mr. DAVIS. I am sorry.

Mr. HORN. No, that is great. This is the gentleman from Virginia, Mr. Davis.

Mr. DAVIS. Let me just ask some questions. EDS has a big complex out in our area and I am familiar with a lot of things they are doing. What is your reaction to HCFA's earlier statement that they are ready to implement 1990's technology?

Mr. RUDIN. If you look at the whole nature of global competition, which does not deal in just the private sector but I think also has to do with the public sector as well, there is no organization in private business that could possibly deal with implementing technology that's 10 years old and think they are going to stay in business in the global competitive environment that we are headed into.

I think the same analogy basically works with the Government as well.

Now, that doesn't mean you take undue risk, but with the rapid rate of development of technology in the health care industry, you have got to be actively moving with smaller size projects, trying to actively leverage and deploy as quickly as you can the greatest advancements in technology in the health care industry as soon as possible in the major programs like this.

Mr. DAVIS. Anybody else have a reaction to that? Anyone else want to take a stab at that?

Mr. HUNTZINGER. I commented earlier on that, I believe. I guess I would just add that in developing information systems, and as I said earlier, it's important to capitalize on the technology that's available. There have been significant technological changes over the last couple of years. I am not familiar with the program that's being developed for HCFA and what technology platforms are being deployed.

I agree with what was stated earlier in that in order to really get a full gain out of technology being deployed, you have to capitalize on the current technology at hand. It's very difficult to deploy it in a big bang theory. However, a common system is an important thing. I mean, you have to operate in a standard mode. Things have to work and link seemlessly together so that you are not administering systems under two different standards and there is commonality in whatever it is you are bringing to market.

Technology can be an enabler for change. It can help if you use the technology properly. It can help you deliver significant change not only on the administrative side but on the medical side of the equation. It can position you properly. If you combine technology innovation with re-engineering, and process redesign, you can get significant improvement and benefit by looking at the whole system, not just the technology side of the equation.

Mr. DAVIS. OK. Thank you. Let me just conclude and start with you again, Mr. Rudin. Do you disagree with the basic vision of MTS or are you more concerned about HCFA's approach? I think you touched on that earlier.

Mr. RUDIN. My problems are not with the vision of HCFA regarding MTS. I think that's pretty much right on target. I think the issue really deals with the approach and the idea of doing a project over a 10-year period with all the things that are changing that should be broken down into many successive projects, that can have high impact and can start to affect all the multitude of things that can be brought to bear to deal with the issues.

As we talked earlier about the estimated $25 to $28 billion of potential savings in the benefits areas, there are lots of things that exist out there today that if we work with them and start putting them in the program and not wait for many years, will have a lot of impact very quickly if we just move on it.

Mr. DAVIS. Thank you. I yield back.

Mr. HORN. Just for the record, since our next panel is from HCFA, have all of your firms made your interests known to HCFA, that you have the software, the experience, the systems and so forth that could maybe help solve some of their problems? I mean, what is your involvement with HCFA? Have you posed the availability of your experience?

Mr. RUDIN. I would think that HCFA is well aware of all the capabilities of our company, being the large scale contractor that we are in Medicaid and Medicare. So I suspect they understand all of our capabilities.

Mr. HORN. To your knowledge, was there ever a meeting that they called of people that are likely to solve their problems prior to the development of this MTS system? Did they ever ask for advice from the private sector, to your knowledge?

Mr. HUNTZINGER. If I may answer the question a couple of different ways. We are currently a contractor for HCFA, and I head up the commercial sector for CSC. We are not integrated as a company from a government/commercial sector perspective.

My organization was not contacted from the standpoint of what we might be able to do from an information systems perspective with COTS, or commercial off-the-shelf software. I think it's appropriate and based on what I have learned today, that we should take some initiative on both sides of the fence to see what other opportunities might be available to help the Government in reducing costs, on both the administrative and medical side of the equation.

Mr. HORN. How about you, Mr. Rudin?

Mr. RUDIN. Yes, Mr. Chairman. We provided input into shared systems and processing initiatives but not a single system. We, as we stated in our written testimony, did respond to the RFP on MTS, and we are involved in conversations around it.

Mr. HORN. Any comments, Mr. Owens?

Mr. OWENS. Our involvement has been not—we have had some direct involvement with HCFA on the issues of the technologies that we can provide, but our involvement has been more directly with the Office of Inspector General of HHS who used us as a subcontractor to quantify the problem in the Medicare Program in Medicaid, as well as the Government Accounting Office used us to validate the savings that they determined in the study that was presented in May.

Mr. HORN. Is that development for the Inspector General for review of claims on a spot check basis or what?

Mr. OWENS. Yes. They did a nationwide study, initially starting with one State and then rolling it out to eight additional States, back, starting in 1991 and completed it in 1994, looking at the costs to the program of not utilizing technologies of this sort. But more importantly, just what is the magnitude of the problem within both of these programs? The Government Accounting Office did

an independent study using the same technology to derive essentially the same results.

Mr. HORN. Well, unless anybody has anything else to say, I simply want to thank you for spending the time. It has been most helpful. You have had a lot of experience and I am delighted you could share it with us.

So thank you for your patience in the various votes we have had to leave for.

Mr. RUDIN. Thank you, Mr. Chairman.

Mr. HUNTZINGER. Thank you, Mr. Chairman.

Mr. HORN. Our last panel will be Carol Walton, Director of Bureau of Program Operations, Health Care Financing Administration, and she is accompanied by Jared Adair, who is, the MTSI program manager for HCFA.

So welcome and we will swear you in.

[Witnesses sworn.]

Mr. HORN. Well, we will start with Carol Walton, Director of Bureau of Program Operations, Health Care Financing Administration. Please proceed. As you know, we put your prepared statement in the record at the time of introduction. So we would like you to summarize it as best you can, although you are the last panel and we can have a lot of leeway.

Ms. WALTON. I did not bring a prepared statement and was not going to make remarks.

Mr. HORN. All right.

Ms. WALTON. Bruce Vladeck, the Administrator of HCFA, presented the prepared statement this morning, and I was hoping to be able to be here to answer any questions that came out of the day as best I could.

Mr. HORN. Sure. Well, you heard all the testimony. Let's just have your reaction as you listened to it.

STATEMENT OF CAROL WALTON, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIDED BY JARED ADAIR, MTSI PROGRAM MANAGER, HCFA

Ms. WALTON. Well, I did not hear all of the testimony, but I did listen to the last panel. If I had to just summarize a couple of points about the Medicare Transaction System, I would say that what we are building is a technical platform for the 21st century. We are trying to build a platform that provides for a flexible, scalable system with open architecture so that we can have an investment that allows us to have a Medicare Program that we see changing quite a bit. We think you have to have a modular approach and certainly support using as much off-the-shelf software in a plug-and-play mode, but on the base of a modern information systems platform.

The second thing I would like to point out is that the investment for the system is the very key to being able to support the Medicare choices that I think we see emerging. The history of Medicare for about 30 years has basically been overwhelmingly that of a fee-for-service program, and our systems today are truly for claims processing. What they are actually fairly good at is getting a claim in,

attaching a price, and pushing a check out the back door. That is not the technology that the program needs today.

So finally, in addition to supporting the Medicare choices and the different insurance benefits that I think will be available for beneficiaries in the future, the MTS is a strategic move to go from claims processing to an information systems platform that watches for fraud and abuse and manages the program dollars instead of concentrating on pushing the check out the back door on a claim-by-claim basis.

Mr. HORN. Just give me an idea of the process the agency went through in selecting this route. Was this something that just grew over several years? Did people say we have got to look at this a different way; times are changing? How did that all develop?

Ms. WALTON. I think that, just sort of a thumbnail sketch of history is, perhaps maybe in about 1991, the administration did feel like the system was big, inefficient, very expensive to change. When legislative change would come out, Reconciliation Act would cost sometimes $40 million, $50 million just to change multiple systems. It was clear that it was an old, batch-oriented technology, and even as early as 1991 there was a sense that technology was advancing.

The administration leadership met with outside groups. I thought it was interesting that you asked the last panel that, because, indeed, that was something that Administrator Wilensky did. She met with outside groups on technology. She met with providers. She met with some oversight agencies. There was quite a bit of consultation before deciding on the direction for the system.

Step two was to do an alternatives analysis to decide, so, if you need a new technology, what do you do? The alternatives analysis looked at basically variations on two different themes. One was to build on or fix up the current systems, and the other one was to refresh the technology and start from a new platform. And then within both of those there were a couple of alternatives evaluated. And from the benefit side of meeting overall program goals for the future and achieving maximum savings and enhanced control of the program payout, the alternative selected was the direction we have under way. Next was a competitive procurement to select an outside company.

Mr. HORN. To what extent were existing processes in software, hardware, and operations looked at as a possible alternative along the line you are talking about, of having an open architecture and being able to add on things? If we found something that worked, was there any thought to a pilot program that could determine if they could handle the Medicare situation? Were alternatives already in use for insurance companies, hospitals, HMO's, you name it considered?

Ms. WALTON. Well, the current Medicare systems were examined for this, and the current technological platform was found not to be sufficient to handle the managed delivery programs and the different benefit structures. We did not dismiss the fact that there might be insurance systems commercially developed that would meet some of these needs. That is why the decision was for a modern platform and a modular approach to the system so that we could take advantage of commercial products off the shelf or per-

haps even especially developed modules that would work. You might need a managed care module. You might need an accounting module. The analysis of the current system argued against trying to fit them into the old batch technology.

Mr. HORN. You are familiar with the social HMO concept that was authorized by Congress, where they took a group of senior citizens and they compared it with what they pay on Medicare claims with maybe 100,000 people and give them 95 percent or whatever it is of what that would be.

Ms. WALTON. Yes.

Mr. HORN. There were several experiments, California among them.

Ms. WALTON. Yes.

Mr. HORN. I am just curious, on the handling of those payments. It would seem to me it is very simple, whether you paid it on a monthly basis or a quarterly basis or whatever, we are talking about a lump sum and then it is up to the HMO to manage within that. And as I remember, they made money on the contract.

Ms. WALTON. Yes.

Mr. HORN. So the fact is, it meant to any of us looking at it, that Medicare could be done for 10 percent cheaper than it has been done when you look at those experiments and you assume a preventive care model. But did that create any extra type of problems for Medicare in terms of the billing and the paying and all the rest of it or was that pretty simple to handle?

Ms. WALTON. I don't recall the way that was handled at the time. In planning for the future, what has been our model is that we need maximum flexibility to handle beneficiaries choosing a PPO where we might have——

Mr. HORN. Sure.

Ms. WALTON [continuing]. Varying co-pays depending on whether beneficiaries are in or out of a network. You might have, perhaps, a system where the payment to the plan, the insurance company, is based on a competitive bid. We have tried to build those kinds of variations into the system.

Mr. HORN. Well, I wonder, you might want to file for the record how you did handle this at this point.

[The information referred to follows:]

QUESTION:

Can Medicare save by using the Social HMO (SHMO) program? And did you have any billing and paying problems with SHMOs? [Transcript pp. 158 and 159.]

ANSWER:

An evaluation was completed covering the first five years of operation of the Social HMO I demonstration sites -- 1985 through 1989. The four sites established a long-term care benefit package that could be marketed in a competitive market and have consistently built enrollment in their communities. Due to data systems difficulties, findings related to expenditures were limited to two years in the sites' operation (1987 and 1988). Therefore, we cannot draw conclusions regarding savings from this evaluation.

- Case management was found to be successful in managing the long term care benefit, and provision of formal case management and long-term care services did not detract from the provision of informal care by family members.

- There appeared to be favorable enrollment and disenrollment.

- There were no significant differences between individuals in the Social HMO versus the fee-for-service group assessed on the basis of case-mix standardized mortality rates.

- The service delivery system has continued to evolve over time to address the health and long-term care needs of individuals enrolled.

We are refining the design for a second generation SHMO demonstration. Refinements include changing the payment methodology so that it more appropriately pays for those who are low risk compared to those who are high risk for health care use. We are also changing service delivery patterns to more geriatrically oriented care. We anticipate savings from the refined payment combined with service system changes.

There were no real billing and payment problems and there have been no provider complaints. Systems changes were needed to refine our HMO payment methodology to accommodate specific long-term care considerations.

Mr. HORN. I am going to yield time such as he would like to consume to Mr. Davis who has other commitments.

So, Mr. Davis, the gentleman from Virginia.

Mr. DAVIS. Just a couple of quick questions.

HCFA's testimony projected about $200 million in annual administrative savings after 1999 as a result of MTS. According to the GAO, you have not updated since 1992 your MTS cost projection of $151 million and that old number never included many of HCFA's own internal costs. Could you furnish the committee and GAO with your most recent breakdown of the anticipated cost of MTS and the potential savings?

If a further analysis by the GAO demonstrates that MTS as currently constituted would not save as much as alternatives, would you be willing to re-examine your decision to proceed with the current plans with MTS?

Ms. WALTON. I didn't understand the last piece. Did you say that GAO has——

Mr. DAVIS. No, if.

Ms. WALTON. Oh, if——

Mr. DAVIS. If they have analyzed, if they updated the cost—if they analyzed it at that point and they find that you would not save as much—the MTS as currently constituted wouldn't save as much as alternatives, would you then re-examine your decision to proceed with the current plans?

Ms. WALTON. The $152 million estimate for building and implementing and bringing up the operating sites is still the current estimate. Until we make the design decision at the end of the year and do some of the cost-benefit decisions that come with that decision, we have not updated that estimate because we think that's still an accurate number.

If evidence were that a great more could be saved with a different strategy, of course, it would be important to look at that.

Mr. DAVIS. So you would be willing to look at that point?

Ms. WALTON. Yes.

Mr. DAVIS. Let me ask you another question. We had in our packet a copy of an article from Health Systems Review that you wrote on the Medicare Transaction System. Now, it listed a number of the priorities for MTS, including uniformity in operations and efficiency in administration. But detecting waste and fraud is hardly mentioned at all. How important is fraud detection for MTS?

Ms. WALTON. Well, it's certainly one of the main strategic goals. The goals have been—I think what may have—have caught—not been clear in that article is what we called it was better management of the program dollar or the benefit dollar, the idea being that our goal is never to pay out less of the benefit dollar if, indeed, it's accurate but not to pay out one extra dollar if, indeed, it was inaccurate or fraudulent. So that might have been a little bureaucratic way of saying that we wanted to be tougher on fraud and abuse.

It's really a basic strategic area. The background of Medicare coming from such a claims processing mentality to our systems, they have not had the data basis, the information systems that allowed us to do the kind of job on fraud and abuse prepay. Most of

the systems, the data warehousing and the analysis to date happens postpay, after the data is paid, because our systems are such outdated claims processing systems. So this is a pretty basic strategic mark for us.

It's extremely important. The idea is to not only have prepay identification of incorrect payments or patterns that are fraudulent, but to also have the modules and the pieces of the system integrated so they talk to each other and they update one another.

My recollection is in Mr. Vladeck's testimony he talks about the fact today when a Medicare card is stolen and that's reported, there is no way for an automatic update to a file. So when a claim comes in against that card number that someone is aware that that's a stolen card, and can look into that in an automated fashion, if bills are being paid for on some kind of spiffy medical equipment that would mean there should be physician bills of a certain type showing up, those kinds of things are not automated today, basic things for the future. It's a very key point to look for these.

Mr. DAVIS. OK. Mr. Chairman, I have got to run. Thank you very much.

Mr. HORN. Well, we thank you very much.

Let me go through a few things that relate to the GAO report. I take it you have had an opportunity to read it, have you?

Ms. WALTON. I have looked at it briefly.

Mr. HORN. OK. According to GAO, your own independent verification and validation contractor has warned you against selecting your system design before defining the system requirement. Your own independent verification and validation advisor has also criticized your process for controlling requirements as lacking discipline. Are they wrong? Are you heeding their advice? If so, what has changed?

What do you think about that, those statements? Are they in error?

Ms. WALTON. Actually, I would be very surprised at the first one. The IV&V contractor has actually been encouraging us not to get into the documentation of the requirements in full detail as a precursor to moving forward on the design. So I actually think there might be some confusion in a discussion with the IV&V. They have been a catalyst for us to what they call stay out of the weeds, to know your business and your requirements at a high level. Look for those important flexible requirements and move on with your architecture. So that one—that surprises me.

Mr. HORN. So you are saying you have defined the system requirements?

Ms. WALTON. Yes, sir.

Mr. HORN. Yes.

Ms. WALTON. Yes, sir.

Mr. HORN. And so, in essence, you are saying you don't think that is a fair charge because you are trying to define them in advance of selecting particular processes as a way to solve those requirements?

Ms. WALTON. That's correct.

The second part of the question, I think that I agreed with IV&V, but I can't remember, that we needed to improve something.

Mr. HORN. Well, the question was, your own independent verification and validation advisor has criticized the process for controlling requirements as lacking discipline.

Ms. WALTON. They have asked us to put together a control board to manage that, and we have done that. We have just established that. Ms. Adair has just put the management group in place to be that—that is a change control board, yes.

Mr. HORN. How does that work? How do you select people for that board? Ms. Adair.

Ms. ADAIR. What we did is that we have a management group which has an intercomponent reflection of HCFA that we have people of midlevel executives from across the agency sitting on that group, and we will be asking them to take a look at requirements that would be included in releases and modifications that need to be made.

Mr. HORN. And are there any people from the outside of HCFA or are these all within HCFA?

Ms. ADAIR. We do have participating in the group a representative from our IV&V contractor and from also our design contractor.

Mr. HORN. Have you searched out for advice of consultants while you are doing this? Have the best in the private sector been brought into it in any way?

Ms. WALTON. For this particular piece of the change control, no. For the system, absolutely. We have talked to several outside companies looking for the best in its class. We talked to NationsBank because they had done a consolidation of systems when the bank had done some consolidations, and they were in multiple States. We have contacted Wal Mart because they are doing a systems modernization of their computer room. So we are trying to really take advantage of other outside experts. It's interesting how much similarity we find between our application and that of an outside company.

The NationsBank, for example, they were very concerned about many of the same things we were doing. They were integrating what had been previously multiple systems. They were very concerned about testing and making it transparent to the user. So this has been useful. It's something GAO encourages us to continue, and you bet we will.

Mr. HORN. I noted—I put in the record maybe before you arrived some of the various attachments, such as the MTS executive committee, which you chair, Ms. Walton, and you got some fairly high-powered people there. How often does that group meet to review what is happening on MTS?

Ms. WALTON. We meet once every 2 weeks for an hour and a half. We have been known to meet more often if there is a need or a request from Ms. Adair. But we do meet once every 2 weeks.

Mr. HORN. What sort of things do you discuss? Is there an agenda prepared in advance and circulated so people can get all the input they can from their particular part of the Health Care Financing Administration?

Ms. WALTON. Sometimes it's an electronic mail agenda. Other times, there would be a quick discussion at a senior staff meeting.

Yes, we do have an agenda. We tend to start with the status of the system and how things are going, and we find ourselves looking at other areas that need attention.

We do planning. We consider ourselves advocates for the project; focus on resources for the agency. As a board, we think that if Jared has a problem, that that takes priority for our meeting. We have set up techniques to keep Administrator Vladeck informed. We try to keep our finger on the pulse of the project and take a corrective action or encourage a corrective action when needed.

Mr. HORN. Now you have got a subset of the MTS executive committee, that is the MTSI management group. Do they meet in the interim, or how does that work?

Ms. WALTON. The MTS management group is the group that Jared was just describing, the midlevel executives. And I am not sure how frequently they meet. I will ask her.

Mr. HORN. Well, as I understand it, the MTSI program management team no longer exists and the functions of that group have been incorporated into the office lead structure and the functions of the MTS management group. And so then we have here the Bureau of Data Management and Strategy Group with the various subgroups of systems management, information systems, resources management, computer communication services, program manager, and so forth. And then the Bureau of Program Operations has its people under your leadership, starting with the MTSI program manager, who is here with us today, Ms. Adair, and then again your subgroups.

I take it the people that are actually running the MTS program day to day sit with these committees when they meet so you have the direct feedback and there can be an interchange in questions?

Ms. WALTON. The line management is Jared. She is responsible for the day-to-day management of the MTS project, and she does have dedicated staff.

Mr. HORN. That is Ms. Adair?

Ms. WALTON. Yes. And she works for me.

Certainly, it is a HCFA-wide project, and there is coordination across the agency. One of the things that all of the outside experts tell you is that changing your software, the information technology, alone is not nearly sufficient to get all of the advantages. You have to change the environment and the processes around which you use the system. So all of the agency has activities to do. And so the coordinating of those activities—the line responsibility to the component is with that office lead. The coordinating activities happen with Ms. Adair's management group or at my MTS management board. So we maximize line responsibility but still can make it an agency-wide project.

We have just shifted to this structure because we are moving from the analysis phase, where we kept a more separate team, to the development cycle, where we need more line responsibility in areas like procurement and other areas like that.

Mr. HORN. Well, is the focus of this system really on the direct Health Care Financing Administration people out there making services available, one form of organization to the other? With the current Medicare bill, this will substantially change things in terms of how money is allocated, which I wonder if it is being ade-

quately planned but that we will get to later. It seems to me there has got to be a focus on the primary mission of the agency.

What worries me, when I see everybody's uncle represented, is what happened in several administrations I can think of, is that so many people want to use, "the system," whatever it was, for meeting their prime needs, that somebody has to make some tough decisions and say, wait a minute, what's our basic mission? Where are our customers? They are the taxpayers and the senior citizens that are expecting timely services, as well as the providers.

And I just wondered, to what degree is the focus there on the customer outside the agency and not simply the customer inside the agency who might want a few bells and whistles added?

Ms. WALTON. That's an excellent point. Fortunately, Administrator Vladeck had us do a strategic plan a year ago, and what we figured out as an agency is the primary customer is the beneficiary. The reason I am here is because of the Medicare beneficiary, and the main purpose of the system is to serve the beneficiary.

So in planning new requirements for Medicare, one of the first things we did was to get out and have focus groups with beneficiaries and ask them what was working in the Medicare system today; what was not; what other needs they have. So we have been able to keep that focus on the system as it will serve the beneficiary. It's very important.

Mr. HORN. Were these groups held in different regions of the country so you got sort of a feel?

Ms. WALTON. Yes.

Mr. HORN. We have heard testimony that apparently practices do differ in some of these regions, and I am sure you see that.

Ms. WALTON. Yes. That's absolutely right. One coast to the other. There was one in California, there was one in New York, and they were across the Nation, yes, sir.

Mr. HORN. It seems to me the key to this is, if the agency sorts out what it is they think their mission is and then the rest of this is simply implementation. The basic hard decisions have to be made on where is the organization headed and who do we work with and so forth.

Now, with what is going on in the Congress, in terms of keeping traditional Medicare as one option but providing choice for people on several other options, be it the HMO, health maintenance organization option, the provider support organizations, Medisave, whatever, is there a planning group now that is monitoring that and thinking through, what are we going to do when that becomes law?

Ms. WALTON. Yes, sir. A lot of the new requirements are around managed care and new choices, and we have built for maximum flexibility. It's one of the advantages of going for the open architecture and the flexible module. You think you have thought of everything, but if there is anything we have always said about Medicare, something is going to change. And I think that will continue. So the modular approach is just key.

Mr. HORN. Yes. Well, that is good and I congratulate you and the administrator for doing that, because once Congress passes a law, people say where is it? And we all know that it is very difficult to be geared up——

Ms. WALTON. They want it fast.

Mr. HORN [continuing]. Geared up to implement any change in the law. It takes time. You are a massive agency dealing with probably more citizens than any agency but Social Security as a whole, who has some people under 65 and 62.

So that is helpful to know that.

How many of the nine existing automated systems does the health care financing system or GTE have a license to use or incorporate into MTS? Do you have any thoughts on that, how many of these you have the authority to use them and incorporate them, if you wished?

Ms. WALTON. The plan for the system is not to be limiting on that. GT——

Mr. HORN. I am just saying of the nine existing ones, is there a reason——

Ms. WALTON. Oh, I am sorry.

Mr. HORN. In other words, how many of the nine existing automated systems does your agency or GTE, the contractor, have the license to use or incorporate into MTS? I am not saying they should be or they shouldn't be.

Ms. WALTON. I see.

Mr. HORN. I am just saying, if you wanted to use those systems and you thought they were effective, successful systems, do you have access rights to them under your current contracts?

Ms. WALTON. OK. Of the nine systems, let's see, probably about half of them would be in the public domain, and maybe a little bit more. I was trying to think, it might be about 60 percent of them are public domain, but at least two are proprietary. Probably all of the part A system——

Mr. HORN. The top of the——

Ms. WALTON [continuing]. Are CWF and probably half of the part B.

Mr. HORN. You might want to do this for the record so you can go back and ask your staff.

Ms. WALTON. OK.

[The information referred to follows:]

QUESTION:

How many of nine existing automated systems does your agency or GTE, the contractor, have the license to use or incorporate into MTS? [Transcript page 172.]

ANSWER:

There are nine standard systems, three Part A systems and six Part B systems. We have the rights to two Part A systems and two Part B systems that are in the public domain. They are:

Part A — Arkansas UB82 System, maintained by Arkansas Blue Cross Florida Shared System, maintained by Florida Blue Cross

Part B — CFA Part B Standard System (HPBSS), maintained by The Travelers Pennsylvania Blue Shield Part B System (PBSPTB), maintained by Pennsylvania Blue Shield

The remaining five systems are proprietary. They are:

Part A — Advanced Claims Processing Systems (ACPS), maintained by Policy Management Systems Corporation

Part B — Optimum Systems Inc. (OSI/Shared Arkansas System (SAS), maintained by Arkansas Blue Shield Multi-Carrier System (MCS), maintained by Electronic Data Systems-Federal (EDSF) GTE Medicare System (GTEMS), maintained by GTE Data Services VIPS Medicare System (VMS), maintained by Viable Information Processing Systems (VIPS)

Mr. HORN. Because the other questions would be: How many of these systems do you have documentation for? If you or GTE do not have a license or documentation, how would you be able to incorporate the best features of each system into the MTS? That is where we are leading here.

Ms. WALTON. Well, obviously, GTE has documentation for the part B system that they currently operate, and for the ones that are public domain, we do have documentation.

The best features are usually more conceptual than meeting the actual documentation. I think even if there were a best feature in a proprietary system, it certainly would be understandable enough to be able to migrate to a new platform. That would be doable.

Mr. HORN. Is that the same as reverse engineering, a current term of art? What are we thinking about?

Ms. WALTON. I am not up-to-date on those current terms.

Mr. HORN. We hear about the best features bit. We hear a lot of that out of NPR and so forth and that is sort of the current management jargon. But I just wonder, where is the line between reverse engineering and copyright infringement?

Ms. WALTON. I was listening to that discussion from the last group. I actually think there has been a lot of honoring the proprietary systems in the Medicare Program. I don't think that EDS is running around accusing anybody of stealing their part B system. I don't think anyone is running around—GTE is not doing that. I have not seen that problem in our program, where they think we have taken it or they think any of their business competitors have done so. It's not to say it couldn't creep up there somewhere, but it's not been a problem for us, to date.

Mr. HORN. In their complete written testimony, GMIS raises their concern about the intellectual property protection of their proprietary software. Given the Health Care Financing Administration's intention to reverse engineer software, if they are, should not health care software companies be cautious in doing business with the Health Care Financing Administration out of fear of copyright infringement? You are saying you don't think it is a problem; is that correct?

Ms. WALTON. I was saying it had not been—to date, it has not been. The GMIS system has a special wrinkle to it because part of their software is tied to medical policy, and previously, because we are a public program, we have felt it's important to not only understand what the medical policy was, but to make sure the physician community was aware of it. So they are more nervous about this.

And this is a new issue for us to deal with in looking at the off-the-shelf software, because we have previously tried to be as open with the physician community as possible. You do not want providers or Medicare beneficiaries getting surprise denials. We need clarity about the coverage and the expectations in a public program. So that is a new challenge for us to deal with that.

Mr. HORN. Speaking of surprise denials, what is the internal mechanism of the Health Care Financing Administration to make those decisions that involve medical practice that might be changing, technology that might have come in? How does your system work to deal with it? Is it a question of somebody trying something

new on billing that causes people to say, what is this, and go out and investigate it?

And to what degree are the various academies that we talked about earlier, be it family physicians or surgeons, to have them involved in explaining this? How does the Health Care Financing Administration deal with that?

Ms. WALTON. If it's a new technology, a new medical device——

Mr. HORN. Yes.

Ms. WALTON [continuing]. Then it needs approval, it needs a medical code. Then we become the agency or one of our contractors would be aware of it and it would be checked out.

If what I am doing as a physician is something new in my office but I am still billing it as an office visit, I think that is not the kind of thing that the Medicare Program would be aware of.

Generally speaking, either at the local level, the carrier medical director would look at new technology or new devices, check the literature, check with his colleagues in the community, consult with a local committee and try to figure out if it were a standing medical practice and should be covered. Once something is a big national issue, that would happen at a national level.

It's an area where the MTS will continue to support some local differences with an overarching national program behind it.

Mr. HORN. If that decision was made, that this is an accepted practice, to what degree would the Health Care Financing Administration retroactively make payments on those bills? Or does it start from the day that your approval system recognizes it as a practice?

Ms. WALTON. You are probably asking less than the top expert on this topic.

Mr. HORN. Why don't you just say we will file an answer for the record?

Ms. WALTON. Great. I will be glad to do that.

Mr. HORN. I don't want to put you on the spot. When we send you all of this stuff, you can steer it to the right part of the agency. And if you can't find them, why that is a comment, too, on the size of agencies.

[The information referred to follows:]

QUESTION:

(regarding coverage of new technology) If the decision was made, that this is an accepted practice, to what degree would the Health Care Financing Administration retroactively make payments on those bills? [Transcript, page 177.]

ANSWER:

Medicare coverage policies usually have a prospective effective date and are administered in a way that enables them to apply to all claims submitted on or after a certain date. For example, our recent regulation concerning the payment status of certain investigational devices had a prospective effective date and would apply to device claims submitted on or after that date. Claims for devices submitted before that date would be evaluated under existing policy at the time the claims were submitted. These policies are contained in program instructions and are know to the providers.

Depending upon the issues, however, our policy applicability may differ. Sometimes a policy clarification may apply to all new claims as well as all claims for which appeals are made after the date the policy is issued. We frequently use this approach when a policy clarification is issued as a result of confusion over the circumstances of coverage. In such cases, it makes sense to apply the new policy to claims that are in the appeals process. Often, the providers raising these questions are then able to appeal the disputed claims and an equitable resolution is reached.

Mr. HORN. What pilot projects is the Health Care Financing Administration engaged in to test the potential software modules for incorporation into either MTS or your existing system? What are we looking at here in pilot projects?

Ms. WALTON. Several things are being piloted. One of the customer service features of the new system is a Medicare summary notice that, like a Visa card statement, summarizes the charges. We have done focus groups with beneficiaries, but we want to make sure that we have it right.

It's one of those things, when you have 38 million people, that you don't want to have that be your test; so we are actually running two pilots this coming year, 1996, two pilots as control groups and two pilots with the summary notice. We are doing pilots—actually, we are prototyping the user screens. Both providers and the customer service reps at the carriers are going to have some advantages of integrated data from the MTS. So the way systems are built today, it is not that the programmers sit back in their closets and decide what the screens will look like; they actually work with the customer, the user, to prototype the screens. That is also happening in 1996.

Mr. HORN. So this is a Windows-type system, in essence, and you want the consumer, the beneficiary, to be able to come into an office or what and use it, or is it a customer service representative?

Ms. WALTON. The consumer in this case would be the provider or the physician checking the eligibility of the insurance, or it would be the customer service representative taking a telephone call where someone was asking a question about something.

Mr. HORN. Well, the next part of that question was that the private sector has been moving toward online real-time processing systems. Do you have any pilot projects for that aspect? As my counterpart and colleague, Subcommittee Chairman Christopher Shays of Connecticut, when this has come up, has said, hey, why don't they look at Home Depot. They for example, have immediate information about transactions anywhere in the country and tie it into inventory renewal and all of that? And as you know, when you walk into something like Target, Home Depot and Office Supply, it is amazing, you know, how their information systems work. And this is nationwide.

But anyhow, where are we on that? Do you have that type of pilot project under way, too?

Ms. WALTON. Actually, I am not as familiar with Home Depot. The one I usually think of is the airline reservations, but it just goes to show you, I am not as good at the home improvement lines.

To have a real-time and online system for the Medicare insurance file, right now, when a beneficiary signs up in an HMO it's very slow. Sometimes the managed care company doesn't hear back for weeks. If they wanted to drop out or change, it's a batch process. It takes weeks and weeks.

With the coming managed care choices, and actually talking to customers, to not only beneficiaries, but providers and managed care companies, one of the main things they asked for was real-time updating of insurance eligibility. So that is something that we are working on and hoping to get piloted late next year.

Mr. HORN. In other words, there would be different access codes and all the various parts of the Medicare communities, if you will, could access those common data to know what the situation is on the beneficiary, and all the rest if case fraud was being committed.

Have you experienced any fraud to any degree on that? We have it in the Social Security Program where you can have 20 people on the same number and they seem not to have been able to check it or didn't want to. Have you had similar problems on Medicare?

Ms. WALTON. We know that there have been situations where Medicare cards have been purchased from senior citizens and then used for submitting fraudulent bills. Stolen cards have been used for submitting fraudulent bills.

Mr. HORN. Is there a system you have to detect that by simply seeing either unusual use in different areas where that person lived the last time you knew, or what? How do you get on top of that issue because I think it is probably more common than you and I believe.

Ms. WALTON. The system today does not have an artificial intelligence that systematically looks for unusual activity. The MTS is very basic to have. The annotation of the card has been reported stolen or missing.

Finally, one of the key areas we have is tips from the beneficiary when Explanation of Benefits comes back to the senior saying they got an exercise bicycle and retractable bed and they are really sure this didn't happen. We are hoping that the summary notice on a single statement will be an improvement for that. Some of those processes clearly exist today, and we think in the MTS they will be stronger and more systematic at stopping that kind of fraud.

Mr. HORN. And you are testing those reports that go back to your customer and beneficiary to see if anyone can read them other than an accountant?

Ms. WALTON. Absolutely.

Mr. HORN. I have had that experience with my private insurance and went to see the senior partner and he couldn't understand it either. Then he called in the junior partner who had been on the national committee that created this form, and he couldn't understand it either. So I am dubious about the degree to which the average citizen can understand it.

Ms. WALTON. I agree. I always say it is good intentions I have and good intentions won't cut it. The program is complex, and we will have to do a lot of testing and piloting with the beneficiaries to get it right.

Mr. HORN. What investigations or reviews of automation technology currently in the marketplace has the Health Care Financing Administration taken? Have you got somebody that is an ex-nerd in high school that really loves this kind of thing and runs around to see what is happening? That is what you need.

Ms. WALTON. Actually, we do have a systems manager that we just brought on board. We said this was one of our internal weaknesses that we didn't have the ex-nerd, so we have just brought someone onto staff to provide that systems expertise.

We do rely a lot on outside help for that. It is the kind of expertise that is difficult for the Government to keep. We have a group called the Gartner Group, which is quite well respected and recog-

nized for information on the leading edges of technology, and we have a contract with them to give us advice, put us in touch with experts, and they even do training at a level like mine to come in to talk about what serves over clients and what are the leading technologies so we can stay a little bit more on board.

From a little less technical area, we have been spending time with private companies on how they are handling the choices of their insurance, because the future in Medicare looks a lot more like the way large employers handle their insurance today where employees make choices. So we visited companies like IBM and talked to them about the way they manage both current employees and retirees, they have a large base of insurees, to talk about how they handle the service, enrollment, what kinds of data they use. We have been doing that at a more executive level, again, for the less technical people like myself.

Mr. HORN. Does your Gartner consultant sit in on some of these meetings so they can get a feel for what the concerns of the management group are?

Ms. WALTON. They have not been sitting in on the management board meetings, although the IV&V contractor sits in on some of those, but they are working with the management group and Miss Adair's group, yes.

Mr. HORN. HCFA does not have its own Inspector General, right, or do you? Are you part of Social Security's Inspector General, or HHS?

Ms. WALTON. Part of HHS.

Mr. HORN. Inspector General Brown. She mentioned to me a few weeks ago that they collected $8 billion in health care, primarily Medicare/Medicaid fraud and abuse. I am sure your people have helped bring that in.

Ms. WALTON. We like to see it as a team effort, yes, sir.

Mr. HORN. She certainly would acknowledge that.

But to what degree is the Inspector General's people in these meetings so they can help think about how do we discover this fraud that we know about and that we have detected around the country, and are we building that into the system?

Ms. WALTON. This past year when we were preparing the future requirements, the new functionality we would like the system to have, we had a series of work groups and the Inspector General's staff participated in whichever of those work groups were appropriate to the kind of activities they were doing, whether debt collection or fraud and abuse. So they participated fully in identifying new requirements.

Additionally, in preparing the requirements, we combed through the reports for the last 5 years from both IG and GAO to look at deficiencies that have been pointed out. I am actually very pleased to say that the Inspector General's office just quite recently came out with a report on the MTS quite complimentary of the requirements addressing the deficiencies that have been pointed out.

Mr. HORN. If I were the manager of any program and I was developing a new one, I would have the Inspector General's representative right there. Better to have them inside, because you never know when something will come up that is not on the agenda

that you could use some good advice from someone who has been out there working the trade, if you will.

Ms. WALTON. I think that is an excellent point.

Mr. HORN. Let me finish and then yield to the ranking minority member. She can take as much time as she likes.

GAO reports in its testimony that despite the changes in GTE's work assignments and delays in meeting deadlines for MTS, there has not been an adjustment in the test and implementation deadline. Is that true?

Ms. WALTON. That is true.

Mr. HORN. Wouldn't delays in meeting initial deadlines for MTS require an adjustment of the two final deadlines, if you are lagging behind now? Are we talking about the year 2002, when we balance the budget, and not 1999?

Ms. WALTON. No, sir; actually, we do believe we can still meet the date. It seems to us an important enough investment to be ready to support Medicare choices and be able to enhance fraud, that it is an important project to try to push as aggressively as we safely can.

Right now, we do believe that we will still be able to bring the system up in 1997. We are not going to turn anything on if we are not 100 percent sure that it is tested and running well.

There is no reason to take any risk for disruption to the beneficiary or the provider community, and we are certainly not going with the big bang theory where every single thing changes at once. We are going with staged releases, a very controlled environment; so 1997 will be a controlled release and we think we can still make the date, yes.

Mr. HORN. You heard the testimony of some of the private vendors here. In a sense, aren't they already doing what you want to have done? Is it just a matter of scale rather than learning how we do it? In a sense, aren't they already doing it out there?

Ms. WALTON. It seems to me that they were generally supporting what we are doing, that they seemed to be for the staged releases. There seemed to be some question on whether we needed a new platform. One gentleman from EDS seemed to think we could simply improve today's old technology of the batched system. I would disagree. I think there was a sense for some that you needed a new platform modular approach, lots of plug-and-play, and that is precisely the plan we are following.

What I disagreed with was the idea that this is a 10-year project based on the idea that the technology will be outdated. Certainly we started thinking about it in 1991, but the requirements are completed right now. The technology and the architecture for the platform will be a competitive procurement for this 1996 year. We will start with the staged releases in 1997, and I think we have opportunities, because it is modular, for refreshing the technology. It is our intention to build something that can be refreshed because the technology is changing so quickly.

Mr. HORN. So GTE would remain the overall contractor or are they on a part phase to reach the goal of 1999, and are you giving separate contracts along the way?

Ms. WALTON. Their contract is a 6-year contract. When that expires, we would recompete the maintenance of the system, one

maintenance contractor, but using lots of commercial software. That is the goal.

Mr. HORN. As I listened to the GMIS, both Chairman Owens and Dr. Kelly, who has had a lot of overview nationally on these things, it seemed to me, maybe I am optimistic, that they are already doing what you are aiming to do by 1999. I wonder am I completely off base there and, if so, tell me where?

Ms. WALTON. Dr. Kelly certainly does not have a Medicare operating system. There are not commercial packages that would manage or operate Medicare choices, fee-for-service, capitated payments.

What Dr. Kelly's software package does is it edits coding on claims and rebundles them according to coding rules. You have different parts of a system. There is not a system out there today other than the nine fee-for-service systems and our HCFA internally homegrown managed care system. So I think that the discrepancy is as to whether it handles all the functions. It is one piece; it could be one module.

Mr. HORN. That piece you have already taken care of or is that somewhere down the line?

Ms. WALTON. The coding rebundling; we have had coding rebundling in our system nationally since the physician payment reform. Because of the Inspector General's report that we needed to do more, we had a competitive contract with a commercial company to refresh and update the rebundling codes, and several thousand new ones are going into place the first of the year.

Mr. HORN. My last question; you mentioned the Inspector General's report. We have had discussion here, and you are well aware of the GAO report. Do those reports in draft form come to you for correction, criticism, suggestion before they are issued, or do they just go out and issue them?

Ms. WALTON. They generally come to us when they are in draft for comment. My recollection is that the one on the coding did come to us.

Mr. HORN. Do you feel the Inspector General report and the GAO reports fairly portray the situation as you know it from the inside?

Ms. WALTON. I am not an expert in coding rebundling. I think that there is probably some difference of opinion on the appropriateness of coding software that might not have made perfectly clear to the public what the medical policy is. So I think there is probably some difference of opinion between GAO and ourselves on the kinds of research and look behind on the software you need.

Mr. HORN. How would you pull that together and describe the differences? State your approach to it and what do you think their approach is?

Ms. WALTON. I hate to speak for GAO but I think some believe——

Mr. HORN. Perception is reality. Reality is not reality.

Ms. WALTON. The coding rebundling package is something that you can purchase, plug it in, and start denying claims immediately.

In a public program, we have looked at these packages and we find that much of the saving is in the medical policies that go behind the rebundling of the codes. It is our practice, first of all, to make sure that the policies were, indeed, Medicare policies, and we

would, second, want to be sure that the physician community was aware of them. So there are extra steps that would take more time in a public program.

In fact, we talked to our colleagues at the CHAMPUS because they bought the GMIS software in 1993, and they have still not brought it up because of these issues. That is not to say that it is still not an important piece of software to study, to analyze, do a cost-benefit analysis and implement. I just didn't want you to think it is a magic pill for us, because I think it is not.

Mr. HORN. I am delighted with your testimony. I think you have been an excellent witness and I thank you for sharing the operational views, which is what I am interested in, that is where the real work is done in the agency.

I recognize my ranking minority member, Mrs. Maloney.

Mrs. MALONEY. I thank the Chair for yielding to me.

Ms. Walton, the secondary payer problem has plagued HCFA for a number years and most efforts to recover these dollars have not been successful. How will the proposed MTS program solve the secondary payer problem?

Ms. WALTON. One of the tenets of the MTS is to move the program safeguards to the front end and try to pay claims right in the first place. So particularly with MSP, we are using this as an opportunity to try and get the beneficiaries' insurance files correctly annotated so the payment can be tracked correctly.

One of the things we have started doing today to get ahead of the curve is an initial enrollment questionnaire so that when seniors first become eligible for Medicare, we send a questionnaire, ask about their insurance, explain the importance of keeping their insurance record up-to-date. That is just getting started, and it's working very well. We are going to reinforce that with the MTS, with our Medicare summary notice.

Using the analogy of the Visa bill summary statement, along with billing the Medicare activity, we are going to use this as an opportunity to say has your address changed? Check this box or call this number. Has your insurance changed? And use the summary notice as an opportunity to confirm with the senior, the working agent, or the spousal insurance or whatever, just like my charge card confirms my address, et cetera. So we are making an investment in getting it right on an insurance record.

Mrs. MALONEY. Thank you. What is HCFA doing to address the criticisms that were raised by the GAO?

Ms. WALTON. The criticisms from today?

Mrs. MALONEY. From their report and from today.

Ms. WALTON. Because we don't have a report and I glanced very quickly at the testimony——

Mrs. MALONEY. They questioned if you were going to stay on schedule. They questioned if you were going to be effective. Are you going to stay on schedule?

Ms. WALTON. We are certainly going to try. We met with GAO a few days ago to talk about some of their findings and there is quite a bit of agreement between us. We made some commitments to talk about some of the areas. They feel the SIM practices of talking to outside companies and how they approach them—one of the things they had suggested that also our IV&V contractor has also

recommended is to improve our project management's plan so that instead of just having deliverables, include processes along the way so we can measure progress better. We are improving that. We are actually incorporating as many of their ideas and suggestions as we can.

Mrs. MALONEY. They questioned your ability to meet the 1999 deadline. Do you think you will be able to meet that deadline?

Ms. WALTON. It looks like we can. We are certainly going to start with staged releases so we can take advantage of the benefits of the new system in a modular form so we don't have to get into the big bang theory. We are certainly still going to do contingency planning, for if it takes a little longer to get everything turned on and everybody up how we will handle that.

Mrs. MALONEY. I wasn't here for the testimony, but in reading their remarks, the GAO cited the lack of adequately specified requirements as the main problem. Are you being more specific in what your requirements are?

Ms. WALTON. There is a little bit of confusion about the definition of requirements here. It is probably a difference in the level of detail. The current requirements for Medicare, we certainly do have those well-defined.

We operate a national program. The future requirements for the MTS, for the new system, for as much flexibility, we have defined those. We got customer inputs. We looked at old reports for deficiencies. We looked at all the managed care choices and the ideas for the future, and we put together a data base of 1,600 future requirements that try to give as much flexibility to the system as we can.

And, third, we have put together requirements for performance of the new system, what kinds of volumes, what kinds of security, what kinds of service; so those requirements are known.

The requirements documentation that GAO studied involves taking these thousands of current and future requirements and reducing them to actually tens of thousands of mini specs, really documentation that has the data flows and the data decisions and the data values, the detailed structured documentation. That is called a requirements document. In the way modern computer systems are built, you have this very structured, very detailed documentation of the requirements. If it is robust and accurate, it is very quickly coded. So that is the piece that we have just reengineered, the process to improve it and make it more efficient.

So the basic requirements, current and future, yes, ma'am, we have those. We know those. Detailed documentation of the requirements, an important tool for building a new system, is what we are working on.

Mrs. MALONEY. I thank you very much and good luck. Thank you, Mr. Chairman. I have no future questions.

Mr. HORN. I thank you, and I, again, thank the witnesses.

Before we close the hearing, I want to thank all of the staff that have been involved. The majority staff starting with the Subcommittee on Human Resources and Intergovernmental Relations, Larry Halloran, staff director and counsel; Kate Hickey, professional staff member; Bob Newman, professional staff member, and Tom Costa, subcommittee clerk.

From my subcommittee, the Government Management, Information, and Technology, J. Russell George, staff director and counsel; Mark Uncapher, the prime organizer of this hearing, professional staff member and counsel; Tony Polzak on loan as a legislative fellow from the Department of the Army. This is his last hearing. He has held three this week. Did we do 27 this year? And our able subcommittee clerk, Andrew G. Richardson.

Minority staff, David McMillen, professional staff member; Cherri Branson, staff member; and our two official reporters Mindi Colchico and Donna McCalley. We thank you for a fine effort.

With that, this hearing is adjourned.

[Whereupon, at 3:50 p.m., the subcommittees were adjourned.]