INSPECTOR GENERAL AUDIT OF HEALTH CARE FINANCING ADMINISTRATION FINANCIAL STATEMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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INSPECTOR GENERAL AUDIT OF HEALTH CARE FINANCING ADMINISTRATION FINANCIAL STATEMENTS

THURSDAY, JULY 17, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:08 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 3, 1997
No. HL–14

CONTACT: (202) 225–3943

Thomas Announces Hearing on Inspector General Audit of Health Care Financing Administration Financial Statements

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Inspector General of the Department of Health and Human Services' (HHS) Report on the Financial Statement Audit of the Health Care Financing Administration (HCFA). The hearing will take place on Thursday, July 17, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The Report will be released to the public at the time of the hearing.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Office of the Inspector General of the HHS recently completed its first full-scale audit of the HCFA Medicare financial statements and accounting procedures, as required by the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994. The audit found that HCFA has a 14-percent error rate in paying Medicare fee-for-service claims, amounting to $23 billion in net annual payments that were made improperly during fiscal year 1996.

The Inspector General, June Gibbs Brown, will testify at the hearing on her review of the first year audit of HCFA's financial statements. With expenditures of approximately $300 billion, assets of $175 billion and liabilities of $50 billion, HCFA is the largest component of HHS. Because of the high-risk nature of health insurance reimbursement, the Office of Inspector General undertook a comprehensive review of claim expenditures including medical records review. This is the first time that a statistically valid national error rate for fee-for-service claims has ever been developed.

In announcing the hearing, Chairman Thomas stated: "During the 104th Congress, the House conducted the first-ever financial and operational audit of the House of Representatives. We kept our word by auditing our books and developing programs to save money and improve efficiency. We need to make sure that HCFA is similarly accountable to the taxpayers. The Inspector General's audit shows that billions of dollars are being wasted every year by Medicare because of fraud, abuse, shoddy accounting practices, and improper payments. I believe the American people would benefit from a full public airing of the Inspector General's findings and hope we can work together to address these problems, as well as assuring Medicare beneficiaries and taxpayers that Medicare funds are being spent in the most prudent and cost-effective manner possible, in accordance with sound accounting principles."

FOCUS OF THE HEARING:

The hearing will examine the details of the Inspector General's audit, focusing on the magnitude and cause of the incorrect payments made by HCFA. It will also focus on the accounting and financial reporting problems uncovered by the Inspector General.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text format only, with their name, address, and hearing date noted on a label, by the close of business, Thursday, July 31, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 7, 1997
No. HL–14–Revised

CONTACT: (202) 225–3943

Time Change for Subcommittee Hearing on Thursday, July 17, 1997, on Inspector General Audit of Health Care Financing Administration Financial Statements

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Inspector General of the Department of Health and Human Services' (HHS) Report on the Financial Statement Audit of the Health Care Financing Administration (HCFA). The hearing will take place on Thursday, July 17, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The Report will be released to the public at the time of the hearing.

All other details for the hearing remain the same. (See Subcommittee press release No. HL–14, dated July 3, 1997.)

Chairman THOMAS. The Subcommittee will come to order. Find a seat, please.

This is the Health Subcommittee hearing on the Inspector General's audit of HCFA's financial statements. I believe this is the official release of the audit. We have heard others making comments on the other side of the Capitol. There was a press conference.

My colleague, the gentleman from California, was interviewed on a television program, and they apparently had an advance copy and asked a question of him. And since he was the first of the Members to comment on it, I think it's appropriate that he be the first to make a statement.

The Chair would be pleased to recognize the gentleman from California, Mr. Stark.

Mr. STARK. I thank the Chairman. I was so surprised to know that we could get this information before the official release that I was caught a little short in preparing a lengthy opening statement worthy of this audit.

But I thank you for holding this hearing so promptly or so contemporaneously with the release of the audit, which evidences your interest and the interest of some of our guests here today who are with the Oversight Committee. I would even hope that this hearing and the general information that the audit provides would help us to strengthen the antifraud provisions that we include in this year's budget reconciliation bill. To the extent we can help solve this problem, the sooner the better.

I am, as most of us are, I'm sure, appalled, though not shocked, at the results of the audit. We have all been talking about fraud and abuse in broad terms for a number of years. Despite the knowledge of fraud and abuse and the workload piled on HCFA, last Tuesday the House actually cut the Medicare administrative budget below last year's budget. It seems to me that that can only guarantee us more waste and abuse than we'll save in the administrative budget.

The number $23 billion has been out and about as being paid out improperly. We don't know how much of that was criminally paid out and how much of that was mistakes. Those are things that I think the Chair and the rest of the Subcommittee will want to determine.

I would like to suggest that I feel HCFA has been taking aggressive action in investigating health fraud cases. The Columbia HCA issue is in the press regularly. This has been instigated, I am sure—although they may not admit it—by the actions of HCFA and perhaps by its Inspector General. This is a big, extensive problem, and I'm guessing that we have a very small number of people within Health and Human Services who are able to devote full time to it.

I have asked Attorney General Reno to initiate a RICO investigation concerning Columbia. I think that if, in fact, that proves to be the proper statute, we will get a lot more effort from the private sector to comply. While many may say that the audit indicates that the government can't do anything right, and remind us of $600 toilet seats, I would like to point out that the beneficiaries of all this fraud and abuse have not been the government or the public instead they've been the private sector physicians, hospitals and claim processors who have received money to which they are not entitled.

The net result is that we have been less able to provide extended benefits to the beneficiaries and, indeed, there's enough money in here to have bought health insurance for every poor child in this country and a host of other things that we struggle to do.

Twenty-three billion is the amount that we're working on in conference, Mr. Chairman, to save over the next 5 years. Nobody suggests that if that is the accurate figure in fraud, waste and abuse, we could recover it all, or stop it all. But it sure would be the biggest item on our agenda if we could get a small piece of that and make all of our lives easier. You know, we could build a new rural hospital in every congressional district in this country with this kind of money.

So it is not insignificant, and it is not easily solved. There is no reason to think it is a partisan problem, and it's a problem that I hope HCFA will tell us or suggest to us today how we can help

them solve it, recover what money is recoverable, and prevent the continuation of this kind of inefficiency in the program.

Thank you very much.

Chairman THOMAS. I thank the gentleman.

The reason for the hearing is fairly obvious. There has already been much speculation and, unfortunately, most of the examination of the audit has been of the usual "road kill" variety. That is, they take the dollar amount, talk about waste, fraud and abuse, and then exclaim how horrendous that is.

The reason I wanted to move as quickly as we did for an audit is because I believe the audit deserves a full airing opportunity, a presentation as complete as we can, as soon as we can, with appropriate comments from the individual who heads the administration for which the audit was done.

Bruce Vladeck has been with us a number of times in front of the Subcommittee, and this may very well be his last time. If both of us had an opportunity to time, it probably would not have been under these circumstances. But I do want to tell you, Bruce, I have appreciated your openness and frankness and for the contributions that you have made, and that you will make.

The other reason that I wanted to move as quickly as possible is because another hat I wear in this institution is Chairman of the Committee on House Oversight, which was the Committee that conducted the first ever independent audit of the House of Representatives. I full well have shared the experience of reading an audit, which was not the kind of audit you would like. We knew full well that would be the case because we had never been completely audited—We had never been audited before. In this instance, it was a more complete audit, notwithstanding the fact that there were some problems with the earlier audits in 1993, 1994 and 1995.

But the process of audits and oversight is rarely enjoyable. They normally don't spend a lot of time applauding what you've done. You have to appreciate when you read the audit that their focus is criticism. There are a lot of good things that could be said, but their job is not to do that. Their job is to examine critically. It's not always pleasant. It is necessary, and it is an integral part of a process to ensure program integrity.

If we're going to protect and preserve the Medicare Program, we need to do this in as open a way possible, so that we can examine where we are not as good as we would like to be, and then work together to be better. I do look forward working with the administration and others, especially since this audit occurs before we had the full ability to look at the Health Insurance Portability and Accountability Act changes that we had made, and we'll be asking questions about whether or not that will be useful and can we point it in that direction for additional help, or what other directions can we take. We will shortly pass a balanced budget act that contains additional tools—and the President and the administration has offered additional tools as well to fight fraud and abuse.

I look forward to today's testimony. I look forward to hearing about the proposed action taken by HCFA and, frankly, want to spend as much or more time talking about where we want to go in a prospective way rather than dwelling on the problems or mis-

takes of the past. But obviously, we need to have a full understanding of how we got to where we are so that we can make sure that the steps that we take are the appropriate ones. I think that is the fundamental underpinning of an audit.

With that, I would ask the Inspector General of the Department of Health and Human Services, June Gibbs Brown for her testimony—if she has written testimony, of course, that will be made a part of the record. You may address us in any way you see fit to adequately inform us, and then I'll ask Dr. Vladeck to respond to, since he has received the audit, the administration's or HCFA's response to the audit prior to going to any questions by Members. Similarly, the written testimony of Mr. Vladeck will be made a part of the record and he will address us in any way he sees fit.

Ms. Brown.

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY JOSEPH E. VENGRIN, ASSISTANT INSPECTOR GENERAL, AUDIT OPERATIONS AND FINANCIAL STATEMENT ACTIVITIES

Ms. BROWN. Thank you, Mr. Chairman.

I am June Gibbs Brown, Inspector General of the Department of Health and Human Services. I am pleased to report to you on our audit of the Health Care Financing Administration's fiscal year 1996 financial statements. This is the first comprehensive audit of HCFA's financial statement that has been done.

With me this morning is Joseph Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

Before beginning my testimony, I want to acknowledge the cooperation and support we received during this audit from both the Department and from the Health Care Financing Administration. A review of this magnitude and complexity could not have been carried out without HCFA's assistance and that of medical reviewers at the Medicare contractors and peer review organizations.

Also, I would like to point out that this audit was performed in close cooperation with the General Accounting Office, due to HCFA's significance in the consolidated financial statements of the Federal Government that GAO has the responsibility to audit. The GAO participated extensively in various segments of the audit and provided significant contributions.

We undertook this audit as part of our implementation of the Government Management Reform Act of 1994, which requires audited financial statements. My statement today will focus first on the extensive Medicare claims testing and then on concerns with several multibillion dollar accounts.

The Medicare Program has 38 million beneficiaries, 800 million annual claim payments, complex reimbursement rules, and decentralized operations. Further, health care consumers may not be alert to improper charges. As a result, the Medicare Program is inherently at high risk for payment errors. Because of this high risk, and the $168.6 billion in fiscal year 1996 expenditures for Medicare fee-for-service claims, we embarked on a comprehensive review of claims expenditures and supporting medical records.

Our review included a statistically valid sample of 5,314 Medicare claims. Payments to providers for 1,577 of those claims did not comply with Medicare laws and regulations. By projecting the sample results nationwide, we estimate that improper payments for fiscal year 1996, at a 95-percent confidence level, are $17.8 billion to $28.6 billion, or 11 to 17 percent. We used the midpoint of this range, $23.2 billion, or 14 percent of the total Medicare fee-for-service benefit payments.

These improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributed to fraud.

It is important to note two major points. Specifically, 99 percent of the improper payments were detected through medical record reviews, coordinated by the Office of Inspector General in conjunction with medical personnel. When these claims had been submitted for payment to Medicare contractors, they contained no visible errors.

Second, Medicare, like other insurers, makes payment based on standard claims forms. Providers are not required to submit supporting medical record documentation with each claim, but they are required to maintain such documentation to justify the necessity of the services billed. However, a significant portion of the payment errors occurred because providers did not submit any documentation, or submitted inadequate documentation, when requested to do so during the audit.

I have some charts with me today, which you will find attached to my written testimony and are on display here.

The first chart shows the errors we found. Most of these errors fell into four categories: Insufficient or no documentation, lack of medical necessity, net overpayments due to incorrect coding, and noncovered or unallowable services.

The most pervasive error type was insufficient or no documentation, which accounted for $10.8 billion, or approximately 47 percent of the $23.2 billion in improper payments. Medicare regulations specifically require providers to maintain sufficient documentation to justify diagnoses, admissions, and other services.

A lack of medical necessity was the second highest error category. It accounted for $8.5 billion, or 37 percent of the $23.2 billion in improper payment. In determining whether the medical records supported these Medicare claims, medical reviewers found that the services, as billed, were not medically necessary.

The third highest category in our sample is incorrect coding, which accounted for $2 billion net of undercoding, or about 8.5 percent of the $23.2 billion in improper payments. For most of these errors, the medical reviewers determined that the documentation submitted by the provider supported a lesser reimbursement code.

Finally, unallowable services accounted for $1.2 billion, or about 5 percent, of the $23.2 billion in improper payments. Unallowable services are those that Medicare will not reimburse because they do not meet reimbursement rules and regulations.

Moving to the second chart, we can further analyze these errors. As you see, 88 percent of the $23.2 billion in improper payments occurred with six provider types. First, inpatient prospective payment system; second, the physician; third, home health agency;

fourth, outpatient; fifth, skilled nursing facility; and sixth, laboratory.

Mr. CHRISTENSEN. Mr. Chairman, would the speaker either bring the chart up closer or point to where it is in the testimony, what page?

Chairman THOMAS. I would tell the gentleman that in the Inspector General's testimony, on page 6—the first chart was on page 3 of the Inspector General's written testimony, and this chart is on page 6. And then you follow through and there will be a series of charts. At the end, if she continues, there will be full chart pages.

Ms. BROWN. Thank you.

On this chart we have highlighted the section of the chart for you, because these provider types present the target of opportunity for corrective action.

Mr. Chairman, HCFA uses numerous prepayment and postpayment safeguards to prevent or detect improper Medicare fee-for-service benefit payments. For instance, prepayment edits help ensure that billed services are paid accurately and timely, but they do not always detect the improper claims that we have identified, such as upcoded, medically unnecessary, or underdocumented services.

In addition, HCFA's postpayment reviews are generally effective for identifying abuse due to overutilization, payments for unsubstantiated, medically unnecessary, and noncovered services. However, funding limitations have significantly constrained postpayment reviews. Currently, only about three of every thousand providers are subjected to these most extensive reviews.

Even the best developed prepayment and postpayment controls at the contractor level may not be sufficient to prevent or detect material Medicare Program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA needs to consider stronger deterrents to reduce improper benefit payments and to protect the solvency of the Medicare Trust Funds.

Stronger oversight by HCFA is also needed to ensure provider compliance with Medicare reimbursement rules and regulations. Our report contains a number of recommendations for enhanced oversight.

We have a disclaimer of opinion on HCFA's financial statements, for several reasons, and I would like to now focus on HCFA's financial reporting. We are unable to reach conclusions on several billion dollar accounts in HCFA's fiscal year 1996 financial statements. The auditing term is a "disclaimer of opinion." This basically means that we're not able to gather sufficient evidence on the validity or reasonableness in the following four areas.

On the third chart you will see that Medicare accounts payable, as of September 30, 1996, reported Medicare accounts payable totaling $36.1 billion, and comprised 71 percent of the total liability. The Health Care Financing Administration did not provide adequate support for this estimate, and we couldn't find support for $18.3 billion of that accounts payable amount.

Turning to our last chart now concerning our disclaimer, the second account shown is supplementary medical insurance review, which are part B Medicare premiums. Because this review has not been audited, and because we lack the statutory authority to audit

the Social Security Administration, we were unable to determine the validity and completeness of $18.9 billion of the SMI revenue account, as well as the $61.7 billion Federal match.

Third is Medicare accounts receivable, or overpayments to providers owed to HCFA. We could not determine the validity of $2.68 billion in accounts receivable because Medicare contractors did not maintain adequate documentation.

Finally, our disclaimer relates to cost report settlements, the Medicare process for determining final payments to 38,000 institutional providers. Due to the limited scope of contractors' audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $3 billion in prior-year cost settlements reported in the financial statements.

To briefly summarize, Mr. Chairman, unnecessary or improper benefit payments continue to plague the Medicare Program. To ensure provider compliance with Medicare reimbursement rules and regulations, stronger oversight by HCFA is needed. Also, claims must be subjected to medical review. I am pleased to say that HCFA is aggressively working on a corrective action plan addressing our concerns.

Finally, I would like to note that we have already started to audit HCFA's fiscal year 1997 financial statements.

I thank you for the opportunity to appear before you today and welcome your questions.

[The prepared statement and attachments follow. The Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 is being held in the Committee's files.]

Statement of Hon. June Gibbs Brown, Inspector General, U.S. Department of Health and Human Services

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services (HHS), and I am pleased to report to you on our audit of the Health Care Financing Administration's (HCFA) Fiscal Year (fiscal year) 1996 financial statements. With me this morning is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

My testimony today will focus on our extensive review of the correctness of Medicare payments and the reliability of HCFA's financial reports. Further details are provided in our report which is being released at this hearing.

Before beginning my testimony, I want to acknowledge the cooperation and support we received during this audit from the Department and HCFA. A review of this magnitude and complexity could not have been carried out without HCFA's excellent cooperation and assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO). We look forward to working with them again on the fiscal year 1997 audit. Also, I would like to point out that this audit was performed in close cooperation with the General Accounting Office (GAO) due to HCFA's significance in the consolidated financial statements of the Federal Government, which GAO has the responsibility to audit. The GAO participated extensively in various segments of the audit and provided significant contributions.

We undertook this audit as part of our implementation of the Government Management Reform Act of 1994 which requires audited financial statements. As you know, the intended purpose of financial statements is to provide a complete picture of agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the reliability of such statements. While we issued audit reports on portions of HCFA's financial statements in previous fiscal years, this year maral statement audit of HCFA.

MEDICARE CLAIMS TESTING

The HCFA is the largest single purchaser of health care in the world. With expenditures of approximately $300 billion, assets of $175 billion, and liabilities of $50 billion, HCFA is also the largest component of HHS. Medicare and Medicaid outlays represented 33.2 cents of every dollar of health care spent in the United States in 1996.

In view of Medicare's 38 million beneficiaries, 800 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and health care consumers who may not be alert to improper charges, the Medicare program is inherently at high risk for payment errors. Medicare, like other insurers, makes payments based on a standard claims form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, Medicare regulations specifically require providers to retain supporting documentation and to make it available upon request. Because of the high risk in health insurance reimbursement and its dollar magnitude in relation to financial statement impact, i.e., $168.6 billion in Medicare fee-for-service claims, we embarked on a comprehensive review of claims expenditures and supporting medical records.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with prescribed Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

This is the first time in the history of the Medicare program that a comprehensive, statistically valid sample of Medicare fee-for-service claims has ever been taken to determine the correctness of payments. The results of our claim testing corroborate past program findings that the Medicare program is inherently vulnerable to improper provider billing practices.

We estimate that during fiscal year 1996 net overpayments totaled about $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 99 percent of the improper payments were detected through medical record reviews coordinated by the Office of Inspector General (OIG) in conjunction with medical personnel. When these claims had been submitted for payment to Medicare contractors, they contained no visible errors.

REVIEW METHODOLOGY

To accomplish our objective, we used a multistage, stratified sample design. The first stage consisted of a random selection of 12 contractor quarters during fiscal year 1996, and the second stage consisted of a random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,314 claims for review. The population from which the sample was drawn represented $168.6 billion in fee-for-service payments.

We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and PROs who regularly assess medical records to determine whether services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations. We asked the Medicare contractors to send a letter to each provider in our sample to obtain copies of all medical records supporting services billed. In the event that a response was not received, a second letter was sent, and in most instances additional telephone calls were made. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy.

Concurrent with the medical review, we made additional detailed claims reviews, focusing on past incorrect billing practices, to determine whether: (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Projecting the 1,577 claims not meeting Medicare laws and regulations to the total fiscal year 1996 fee-for-service Medicare benefit payments, we estimated that

the range of improper payments at the 95-percent confidence level is $17.8 to $28.6 billion, or 11 to 17 percent. Therefore, we used the midpoint of this range, or $23.2 billion (about 14 percent of the $168.6 billion in processed fee-for-service payments) as the projected estimate of improper payments. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This information is being provided to HCFA in order that appropriate corrective action can be taken. Also, this estimate of improper payments does not take into consideration waste (excessive pricing) and numerous kinds of outright fraud, such as phony records or kickbacks.

TYPES OF ERRORS FOUND

As shown in the following chart, most of the errors we found fell into four general categories: (1) documentation, which includes both insufficient and no documentation; (2) lack of medical necessity; (3) incorrect coding; and (4) noncovered/unallowable services.

Estimated Amount of Improper Payments

(By Type of Error)

Type of Improper Payment	Estimated Dollars In Improper Payments (in millions)	Improper Payments as a Percent of Total
Documentation:	$10,846	46.76
Insufficient Documentation	7,596	32.75
No Documentation	3,250	14.01
Lack of Medical Necessity	8,529	36.78
Incorrect Coding	1,97	88.53
Noncovered or Unallowable Services	1,219	5.26
Other	620	2.67
Total	$23,192	100.00

Lack of Documentation

The most pervasive error type in our sample is insufficient or no documentation, which accounts for $10.8 billion, or approximately 47 percent, of the $23.2 billion in improper payments. This can be further broken down between insufficient documentation totaling $7.596 billion (33 percent) and no documentation totaling $3.250 billion (14 percent). As previously indicated, if providers failed to submit documentation or submitted insufficient documentation, the contractors generally requested supporting medical records at least three times before determining the payment to be improper. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care.

Some examples of documentation problems follow:

- Skilled Nursing Facility (SNF). A hospital-based SNF was paid $9,365 for a 25-day skilled nursing stay even though the medical records did not support the need for skilled care.
- Physician. A physician who was paid $523 for 10 hospital visits could support only 2 visits, resulting in a $386 overpayment.
- Clinical Laboratory Services. One clinical laboratory billed Medicare $64 but could not provide the doctor's order authorizing the service.

Lack of Medical Necessity

A lack of medical necessity is the second highest error category, accounting for $8.5 billion, or 37 percent, of the $23.2 billion in improper payments. Medical reviewers followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. Their findings showed that in these cases, based upon the "look behind" review of the medical records employed in our audit, the services as billed were not medically necessary.

Some examples include:

- SNF. A SNF was paid $15,362 for 61 days of care even though the medical records clearly documented that the individual did not need this level of care.
- Home Health Agency (HHA). An HHA was paid $11,790 for skilled physical therapy, skilled nursing care, and home health aide services when the medical records clearly indicated that the patient had no functional diagnosis requiring physical therapy or skilled nursing care. Another HHA received payment of $1,528

for home health services which were not medically necessary because the services entailed custodial care (care to assist patients with daily living or meeting personal needs) rather than skilled nursing care. Therefore, the medical reviewer disallowed the entire claim.

Incorrect Coding

Incorrect coding is the third highest category, accounting for an estimated $2 billion, or about 8.5 percent, of the $23.2 billion in improper payments. The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical reviewer determined that the documentation submitted by the provider supports a lesser reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Examples of incorrect coding follow:

• Inpatient Hospital. One beneficiary had three separate hospital inpatient admissions during a 3-month period. Medicare paid $8,533 for each admission under one diagnosis-related group (DRG). Based on the medical records, the medical reviewer concluded that all three claims should have been paid under a less extensive and less costly DRG that paid $6,290, resulting in a total overpayment of $6,729.

• Physician. A physician billed Medicare for a hospital emergency room visit for "treatment of a medical problem of high severity that requires urgent evaluation by the emergency room physician" when the medical records support only treatment for problems of moderate severity.

Another physician billed Medicare for subsequent hospital care requiring "a medical decision of high complexity by the provider" when it should have been for medical care "that is straightforward or of low complexity."

Noncovered/Unallowable Services. Unallowable services account for an estimated $1.2 billion, or about 5 percent, of the $23.2 billion in improper payments. Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations.

Following are some examples of noncovered or unallowable services identified during our review:

• Physician Claims. A physician billed Medicare for an electrocardiogram and various laboratory tests. After reviewing the provider's medical records, the medical reviewer concluded the billed services should be denied because the services were performed as part of the beneficiary's routine yearly physical examination, which is not a Medicare-covered service.

• Hospital Outpatient. A patient was evaluated for foot orthotics, and impressions were taken to make soft arch supports. Arch supports are not covered by Medicare. Although the patient signed a hospital form acknowledging that arch supports were not covered by Medicare, the claim was billed as though it were a Medicare-covered service.

• SNF Services. Most of the errors occurred when the SNF billed Medicare separately for various routine services already included in its flat-rate reimbursement.

A further analysis of the errors, as illustrated in the chart herein, shows that 88 percent of the $23.2 billion in improper payments occurred within 6 provider types: (1) inpatient prospective payment system (PPS), (2) physician, (3) home health agency, (4) outpatient, (5) skilled nursing facility, and (6) laboratory.

We believe that it would be prudent for HCFA to focus corrective action in these specific provider groups. We have provided HCFA a detailed list of certain procedure codes that have a high frequency of error.

CONCLUSIONS AND RECOMMENDATIONS: CLAIMS TESTING

The HCFA uses numerous prepayment and postpayment safeguards to prevent or detect improper Medicare fee-for-service benefit payments. For instance, prepayment edits help ensure that billed services are paid accurately and timely, but they do not always detect the improper services that we identified, i.e., undocumented, medically unnecessary, or upcoded services. The HCFA's postpayment medical review is generally effective for identifying abuse and overutilization and for detecting payments for unsubstantiated, medically unnecessary, and noncovered services. However, funding limitations have significantly constrained medical review to the extent that currently only about 3 of every 1,000 providers are subjected to postpayment medical review audit.

Due to limited funding, resources devoted to prepayment and postpayment review have not kept pace with the increase in claims or questionable billing practices by providers. However, even the best developed prepayment and postpayment controls at the contractor level may not be sufficient to prevent or detect material Medicare

program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA needs to consider stronger deterrents to reduce improper benefit payments and to protect the solvency of the Medicare trust funds.

As our results indicate, a significant opportunity exists for providers to: (1) bill for services that are excessive or not medically necessary; (2) bill for services that are unsubstantiated by the beneficiaries' medical records; and (3) improperly code services to obtain higher Medicare payment than the appropriate code would permit. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers.

Estimated Amount of Improper Payments

By Type of Error/Provider

Type of Provider	Types of Error (in millions)					Total	Percentage of Improper Payments
	Insufficent/ No Documentation	Lack of Medical Necessity	Incorrect Coding	Non-covered/ Unallowable Service	Remaining Errors		
Inpatient PPS	$1,040	$3,301	$900	.....	($2)	$5,239	22.59
Physician	2,756	614	1,070	$329	258	5,027	21.68
Home Health Agency	1,684	1,935	.....	.....	31	3,650	15.74
Outpatient	2,286	356	1	85	82	2,810	12.12
Skilled Nursing Facility	1,056	1,365	.....	.....	3	2,424	10.45
Laboratory	1,173	146	(14)	30	2	1,337	5.76
Subtotal	$9,995	$7,717	$1,957	$444	$374	$20,487	88.34
Other Providers	851	812	21	775	246	2,705	11.66
Total	$10,846	$8,529	$1,978	$1,219	$620	$23,192	100.00
Percentage of Improper Payments	46.76	36.78	8.53	5.26	2.67	100	.....

To ensure provider compliance with Medicare reimbursement rules and regulations, stronger oversight by HCFA is needed. Among the more important issues HCFA faces in the immediate future is preserving the solvency of the Medicare trusts strategic plan to safeguard these funds, we recommend that HCFA:

- Develop a system that objectively and periodically estimates improper payments and disclose the range of such overpayments in its financial statements.
- Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.
- Enhance prepayment and postpayment controls by updating computer systems to better detect improper Medicare claims.
- Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.
- Direct contractors to make followup evaluations of specific procedure codes we identified with high error rates and consider whether identified providers should be placed on prepayment medical review.
- Ensure that contractors adjust their Medicare accounts for improper payments we identified, initiate recovery from the identified providers, and follow up with the providers to correct deficiencies and to determine whether other systemic problems need to be corrected.

DISCLAIMER OF OPINION ON HCFA'S FINANCIAL STATEMENTS

Lastly, I would like to focus my testimony on HCFA's financial reporting. We were unable to reach conclusions on several billion dollar accounts in HCFA's fiscal year 1996 financial statements. This does not mean that these numbers are incorrect; rather, they are not supported by current accounting or audit data. The auditing term is a "disclaimer of opinion," which means that we were not able to determine if HCFA's financial statements were fairly presented because the documentation was not adequate or available to support the reported financial statement amounts. Specifically, we were not able to gather sufficient evidence on the validity or reasonableness of the following:

- Medicare Accounts Payable—services provided at year end but not yet paid. As of September 30, 1996, reported Medicare accounts payable totaled $36.1 billion and

comprised 71 percent of total liabilities. These payables represent HCFA's estimate of actual or potential claims for services provided to beneficiaries but not paid at the end of the fiscal year. The HCFA did not provide adequate support for this estimate. Additionally, we were unable to determine, through alternative audit procedures, if the September 30, 1996, Medicare accounts payable balance was fairly presented. Specifically, we could not find support for $18.3 billion of the accounts payable amount using historical claims data adjusted for costs associated with interim payments to providers and settlements from providers' cost reports. Moreover, using expenditure trends to assess the reasonableness of the payables estimate, we noted that Medicare expenditures increased 16 percent while the accounts payable increased 64 percent. Historically, when compared with expenditures, the payables had erratic and inconsistent changes which HCFA could not explain.

• Supplementary Medical Insurance (SMI) Revenue (Part B Medicare). The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the SMI trust fund each month. Because the SMI revenue has not been audited and because we lack statutory authority to do this work, we were unable to determine the validity and completeness of the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion.

• Medicare Accounts Receivable—overpayments to providers owed to HCFA. We could not determine the validity of the $2.68 billion Medicare accounts receivable balance because Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. For example:

• Some Medicare Part A providers are paid on an interim basis using prior claims activity and related costs (referred to as the periodic interim payment (PIP) method of reimbursement). Some contractors used inconsistent accounting procedures to calculate receivables and payables resulting from the PIP reimbursement process. One contractor, for instance, incorrectly included $700 million as a receivable when in fact all but $32 million was a payable. Also, four contractors did not record either PIP receivables or payables. One additional contractor included a $25 million PIP payable, rather than an $80 million PIP receivable.

• At another contractor location, approximately $7 million could not be reconciled to reported amounts.

• Cost Report Settlements—HCFA's process for determining final payments to certain institutional providers. About 38,000 institutional providers are paid interim amounts throughout the year and subsequently file a cost report to reconcile actual costs to the interim payments received. The HCFA's cost report audit process is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of contractors' audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $3 billion in prior-year cost settlements reported in the fiscal year 1996 financial statements.

CONCLUSION

I appreciate the opportunity to appear before you today and to share our report with you. As demonstrated in our review, unnecessary or improper benefit payments continue to plague the Medicare program. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers. Our review has also demonstrated the need for stronger oversight by HCFA to ensure provider compliance with Medicare reimbursement rules and regulations and the necessity of subjecting claims to medical review. I am pleased to say that HCFA and the Department's Chief Financial Officer are aggressively working on a corrective action plan addressing our concerns.

Finally, I would like to note that we have already started our audit work on HCFA's fiscal year 1997 financial statements. As in fiscal year 1996, we will be performing comparable fee-for-service claims testing. I welcome your questions.

Analysis of Medicare Accounts Payable

FY	HCFA's Actuarial Estimate (in billions)	Claims History (in billions)	Difference (in billions)
1993	$14.1	$11.2	$2.9
1994	24.9	13.4	11.5
1995	22.0	13.7	8.3
1996	36.1	17.8	18.3

Concerns Resulting in Disclaimer

NAME OF ACCOUNT	PROBLEM
Medicare Accounts Payable ($36.1 Billion): estimated amount medicare owes providers	• Questionable claims support • Actual claims data could not support $18.3 billion of the payables estimate
SMI Revenue – Medicare Part B Program ($18.9 Billion, $61.7 Billion Federal Match): amount of premiums collected from beneficiaries and matched by contributions from the Federal Government	• No audit work performed outside of HHS/OIG • HHS/OIG lacks authority to audit other Federal agencies
Medicare Accounts Receivable ($2.68 Billion): amount of overpayments due from providers	• Incomplete accounting records • Millions could not be reconciled to reported amounts • Reporting procedures not being followed, resulting in unreliable financial information
Cost Report Settlements ($3.0 Billion): amounts paid during the year for settlement of cost reports	• No process in place to complete an audit • 37,700 cost reports filed annually • Unable to determine if amounts paid for final cost settlements meet medicare guidelines

Chairman THOMAS. Thank you, Ms. Brown.

As a preface to Mr. Vladeck's testimony, any Member who believes they should fill out a form for three units of accounting credit by the time we're through with this, feel free. But as Members of the Ways and Means Committee, we're familiar with a number of firms that are going through the change from cost accounting to

accrual accounting, and we do need to familiarize ourselves with the various auditing terms as we go through.

Ms. Brown, you mentioned a number of specific dollar figures. All of us understand that any specific dollar figures were based upon a guesstimate from a range that was available, off of a sample which was taken. If we keep that in mind as we deal with these figures, I think we put them in the proper perspective.

With that, Bruce, proceed.

STATEMENT OF HON. BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman, Members of the Committee. Mr. Chairman, I appreciate your kind words in your introductory remarks.

Obviously, we have submitted a complete statement for the record, including a discussion of some of these accounting terms. Let me try very briefly to focus, as I think is appropriate, on the steps we have taken and, most importantly, propose to take as a result of these audit findings and our continuing ongoing work with the Inspector General and her staff.

As the Inspector General noted, this was the first comprehensive audit of our financial statements and related systems. As she suggested at the very end of her statement, in which she noted the work has already begun on the 1997 audit, it is sometimes useful to view this more as a continuing process than as one of a series of discontinuous steps.

I want to underscore our commitment to making sure, insofar as is humanly possible, that every dollar in the Medicare Program is well spent, and that our goals of increased efficiency and cost effectiveness protect the quality of health care for our beneficiaries. We are committed to making sure that our funds are accounted for in a businesslike manner. I would like to spend a few minutes just to tell you about some of the steps we are taking to address some of these concerns, particularly since I think you've had an excellent overview of the audit and its findings.

We have made fighting fraud and abuse an important priority. In conjunction with Members of Congress, notably including the leadership of this Subcommittee, we have taken a number of important steps in recent years. We have some progress to show for that, which helps to provide the basis for moving forward.

As an example of where we are at the moment, in fiscal year 1996, the year discussed in the audit, our total expenditures for all of the activities in our budget that we describe as payment safeguards were $441 million, and they produced savings of approximately $6.2 billion. This is a cumulative return on investment of about 14 to 1. Although this high rate of return is encouraging, it makes one a little nervous in the sense of, if you can produce rates of return of 14 to 1 with existing dollars, what kind of actual dollar returns could you produce if you were spending more money on that activity? So we began 4 years ago to seek additional resources for these activities.

Thanks to the work of this Committee and other Members of Congress, we did include in last year's Health Insurance Portability and Accountability Act, in HIPAA, provisions to establish a stable

funding base for the Medicare Integrity Program. However, actual increments in funding for our activities will not begin to take effect until October.

In addition, working very closely with the Inspector General on Operation Restore Trust, since it was announced by the President in 1995, we have established and institutionalized a set of relationships between ourselves, the Inspector General, our contractors, State Medicaid Program agencies and survey agencies, and fraud control units and law enforcement activities to seek out and stop fraud, waste and abuse. We have identified in specific Operation Restore Trust specific activities, more than $187 million in fines or recoveries or audit disallowances that were owed to the government on incremental expenditures, of under $5 million over a 2-year period. As a result, we are expanding some of the specific Operation Restore Trust Activities to 12 additional States.

We have also, and this is detailed in my written testimony, made a lot of investments in various kinds of technologies. Some, such as our unbundling and correct coding software, are already in use, and others are being tested. Still being tested are some of the off-the-shelf software and the pattern recognition fraud detection methods for which we have contracted with the Los Alamos National Laboratory.

In that regard, we see the specific findings of the audit that is being released today as the latest effort in helping us to better understand the dimensions of the issues with which we're dealing and to better target our activities.

The discussion of the appropriateness of claims payment as a result of this audit, has raised the central issue of the adequacy of our focus on medical review activities. Medical review is a very resource-intensive activity because it requires our contractors to collect additional medical documentation from the providers. It is also a very paper intensive process.

Over time, we have decreased the proportion of actual claims that we subject to medical review because, in an era of highly constrained expenditures, we found that we were able to produce a higher rate of return on our investment by very highly focusing our medical review activities. Over the last 8 years, for example, the proportion of all claims that have been subjected to medical review has fallen by almost half, from 16 percent in 1989 to the current level of about 9 percent. However, the return on investment from this activity has increased from 6 to 1 in 1989 to about 14 to 1 in 1996.

Nonetheless, the findings of this audit provide us with information that makes it necessary to rethink some of our strategies. In formulating a corrective action plan we have been working very closely with the Inspector General and her staff. We have tried to balance two competing goals: to more systematically scrutinize provider bills and to require the medical community to substantiate bills with appropriate documentation. At the same time, we must not swing the pendulum too far from the increased emphasis in the current budgetary environment on streamlining operations and requiring less paperwork from the American people.

We think we are able to create a balance and walk the line through the following kinds of activities: First, just to reassure ev-

eryone, all of the overpayments or inappropriate payments identified by the auditors in the course of the audit are being actively pursued for overpayment. We are going to continue to work with our contractors on more aggressive systems, not only for getting the accounting straight on the amount of dollars to be recouped in the process, but on the techniques and effective ways in which they can do that.

We will continue to maintain and reinforce the provision that providers who bill the Medicare Program are accountable for documentation to support the payment of the claim. In making such requirements, we are just requiring that providers follow the norms of good medical practice, which requires careful documentation of health services. Nonetheless, every time we undertake these sorts of efforts, we get a fair amount of complaining and objection. Our most recent experience in this regard grows out of the work the Inspector General has led, in which we found serious program integrity problems in clinical laboratory billings for the Medicare Program.

A number of our carriers have begun to address some of those problems by requiring a diagnostic code on all laboratory orders submitted by physicians. We have had quite an amount of controversy about that, but we have persisted, and we are committed to working very closely with the provider community to recognize that there is additional work associated with increased documentation, to find waste in as straightforward and unburdensome a way as possible and to work collaboratively on a variety of education and other kinds of activities. We have already scheduled a series of meetings with particular provider associations to acquaint them with the findings of this audit activity and to begin to work cooperatively with them on addressing some of the issues that have been raised.

We are going to simply increase the level of claims review that we undertake. Obviously, if you applied to every Medicare claim we receive the kind of scrutiny that the sample of claims received, we could over a period of time reduce the error rate to very close to zero. However, the reality is that the processing of 800 million claims a year makes 100 percent review unfeasible, cost ineffective, and not entirely rational. While we clearly need to do a more intensive medical review of claims than we are now doing, we clearly aren't going to get to 100 percent. We are working with analysts and statisticians to find the number of claims review that will give us the most return for our claims review expenditures.

In the meantime, we are going to undertake certain additional steps. In fiscal 1998, all of our Medicare carriers will be conducting random prepayment reviews of physician claims for evaluation and management services, the most commonly billed physician services, and claims which involve issues of documentation and appropriateness of coding. We hope that this particular initiative will not only identify overpayments in those areas, but will give us much greater insight into what the optimal level of medical review and prepayment ought to be. We hope it will also permit us to focus our future medical review activities.

We are going to much more systematically scan Medicare billings for evidence of unnecessary admissions, and we will target specific reviews on leads generated from that process.

We are about to implement a sampling methodology for part A claims, to estimate overpayments to part A providers. We will use that sampling methodology as the basis for defining recoveries of overpayments.

We are in the process, through the legislative process, again with the help of Members of this Subcommittee, and other Members of Congress and activities we can undertake administratively, to substantially raise the standards for provider admission into the Medicare Program. We are working with you on legislative proposals to require disclosure of employer identification numbers, taxpayer identification numbers and Social Security numbers, and to both limit the folks who can enter the program and facilitate certain kinds of provider exclusions. We also are moving ahead with implementation of a national provider identification system, as required under HIPAA, that will help us prevent providers from obtaining multiple billing numbers and/or playing games of distributing their bills across different contractors. That provider identification system will permit us to track and monitor the complete billing pictures of providers more effectively.

We are going to learn from this first-ever substantive claims review testing process as we move forward. The Inspector General will conduct parallel or similar kinds of activities in their audits of our financial statements for fiscal years 1997 and 1998. By October 1 of next year, we will have in place our own internal system for substantive testing to establish performance measures, to do some degree of random review, and to have continuous measures of the appropriateness of the levels of review we are conducting and the relative cost effectiveness of the various kinds of review activities that take place.

We will need to evaluate both the short-term effects, in terms of the number of erroneous claims we identify from which we make recoveries, and the longer term effects in terms of the sentinel or deterrent effect on inappropriate or incorrect billing.

All of these initiatives and corrective actions are designed to improve our record in future CFO audits, and, in accordance with the Government Performance and Results Act, to strengthen our ability to monitor and track our efforts.

But more importantly, they will help us reassure ourselves, Members of this Committee, and members of the general public, including our beneficiaries, of the financial soundness of Medicare operations.

The work of this Committee and other Members of Congress has already contributed significantly to improving our ability to protect the integrity of the Medicare Program and to safeguard beneficiary interests. The lessons and experience we have gained from our efforts in the last few years will guide us as we put some of these new legislative and administrative tools to use. By effectively utilizing the kinds of solid partnerships among State and Federal agencies, the public, and private health care organizations, of the kind I think were reflected in our work with the Inspector General on this financial statement audit, we will be able to significantly

strengthen and protect the Medicare and Medicaid Programs for future generations.

Again, I appreciate the opportunity to be here today. I appreciate your having called this hearing, and obviously, I am happy to answer any questions you might have.

[The prepared statement follows:]

Statement of Bruce C. Vladeck, Administrator, Health Care Financing Administration

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am very pleased to have this opportunity to discuss with you the findings of the recently completed Fiscal Year (FY) 1996 Chief Financial Officers (CFO) audit by the Department of Health and Human Services Office of the Inspector General (OIG), and our plan to respond to issues raised by the CFO audit and improve our performance. The Clinton Administration has a long record of efforts to strengthen program integrity and contractor activities and have had successes such as Operation Restore Trust (ORT) and the Medicare Integrity Program (MIP). For the past few years, the OIG has performed audits of selected accounts at the Health Care Financing Administration (HCFA). The FY 1996 audit, which was the first comprehensive audit of HCFA's financial statements and related systems, alerts us to additional improvements that are needed. We are already working to address the concerns noted in the audit.

What is the CFO Audit?

In order to understand the CFO audit findings, it is necessary to describe briefly what the CFO audit is, why it was conducted, the separate components of the audit, and the audit findings.

The CFO Act of 1990 (Public Law 101–576) requires HCFA to prepare financial statements that fully disclose its financial position and the results of operation in a manner consistent with financial reporting standards that have long been employed in the private sector, but which differ significantly from prior Government practice. The objective of the Act is to improve systems of accounting, financial management, and internal controls throughout the Federal Government to help reduce waste and inefficiency, and to provide to Congress complete, reliable, timely, and consistent information on the financial status of the Federal Government. The CFO Act and the Federal Financial Management Improvement Act of 1996 require HCFA to comply with Federal accounting standards. For example, financial reporting must be on the accrual basis of accounting (expenses are recognized when incurred, revenues are recognized when earned) rather than on the cash basis of accounting (expenses are recognized when cash is paid and revenues when cash is received). Like other Government programs, Medicare and Medicaid have historically used a cash accounting basis for all budget and reporting purposes. We are currently in the process of making a transition to the accrual basis of accounting.

In 1994, the CFO Act was enhanced by the Government Management and Reform Act requiring Government-wide and Department-wide financial statements. This legislation required the Government Accounting Office (GAO) to audit the Government-wide financial statements and the OIG to audit the Department-wide financial statements. Including both the Medicare and Medicaid programs, HCFA is among the four largest Federal agencies in terms of outlays, thus highly influencing the audit opinion on the Government-wide financial statements.

Since this process is new to all of us, it may also be useful to spend a moment on the terminology auditors employ. In public accounting terms, the purpose of an audit is to permit the auditors to issue a report as to whether the financial statements are presented fairly in conformity with generally accepted accounting principles. For Federal agencies, generally accepted accounting principles are the Federal accounting standards as recommended by the Federal Accounting Standards Advisory Board (FASAB) and issued by the Office of Management and Budget. There are four types of auditor's report: 1) unqualified opinion which means the financial statements are fairly presented; 2) qualified opinion which means the financial statements are fairly presented *except for* the effects of a matter or matters as described in the auditor's report: 3) adverse opinion which means the financial statements do not present fairly; and, (4) disclaimer of opinion which states that the auditor does not express an opinion on the financial statements and gives all the substantive reasons for the disclaimer.

FINDINGS OF THE CFO AUDIT

In the FY 1996 CFO audit, the OIG raised concerns and issued a disclaimer of opinion on HCFA's financial statements and systems. This is not necessarily an uncommon occurrence for first-year audits. Briefly, the CFO audit findings identified five areas of concern: the actuarial methodology for estimating Medicare accounts payable; the lack of a review of the Supplemental Medical Insurance (SMI) premiums; the substantive testing error rate reflecting improper payments; the records for Medicare accounts receivable; and the retroactive settlement process which was not reviewed by the OIG and caused them to issue a disclaimer. I will discuss each area in the order of the OIG report and later I will outline our corrective action plan.

For MEDICARE PAYABLES $36 billion was disclaimed. In other words, the OIG has expressed concern with the methodology used by HCFA's actuaries to estimate payables as well as the lack of a validation process. In FY 1997, OIG contracted with Ernst and Young who provided actuarial auditors to review the Office of the Actuary (OACT) methodology for estimating accounts payable. The Ernst and Young auditors identified several areas where improvements could be made. The current HCFA estimating process is a byproduct of the overall process used by our actuaries to make Trust Fund projections. One of the chief concerns is that it is difficult for the auditors to validate, since the payables represent benefits incurred but not yet paid and some of these payments will be made as much as 2 years later. This creates a data set that is very volatile in the short term. However, it should be noted that the payable estimate is used only for financial statement purposes rather than for determining actual payments; our actuaries have traditionally made estimates for other purposes such as the Trustees' Report. HCFA will be working with Ernst & Young to develop a revised process that can be validated.

For SUPPLEMENTAL MEDICAL INSURANCE or MEDICARE PART B PREMIUMS $80.6 billion was disclaimed. The Social Security Administration (SSA) is responsible for withholding premiums from Social Security checks of Supplemental Medical Insurance (SMI) beneficiaries and transferring these funds to the Part B Trust Fund each month. Since the number is material to HCFA's financial statement, specific auditing of SSA must be done. Because the OIG was not able to audit the SSA process this year, the OIG disclaimed the $18.9 billion in Part B premiums, as well as the $61.7 billion Federal matching funds (representing about 75 percent of Part B costs). The OIG has assured us that the issue is resolved and that this Social Security function will be audited for FY 1997.

For SUBSTANTIVE CLAIMS TESTING, the OIG found that the majority of our systems and controls are effective. However, the Substantive Claim Testing audit demonstrated that contractor controls were not adequate to detect the types of errors identified in the audit, especially in cases where medical necessity existed but the provider had not maintained the required documentation. These findings are not necessarily a criticism of HCFA's or our contractors' processes but an indication of the fact that providers may not be fulfilling their responsibilities to provide adequate documentation. I will discuss this area in detail at the end of this section.

For MEDICARE RECEIVABLES, $2.7 billion (net) was disclaimed. Much of Medicare's financial record-keeping is done by our contractors, under reporting and accounting rules that do not fully meet requirements of the CFO Act. Without an integrated general ledger and accounts receivable system maintained by the Medicare contractors, the OIG and their contract auditors had difficulty reconciling receivable data, as the contractors use many different systems for the tracking and reporting of receivables. The OIG has found that, contrary to HCFA instructions, many contractors do not reconcile the financial reports with their accounts receivable data reflected on the Provider Overpayment Report (POR), which reflects overpayments resulting from the cost settlement process, and the Physician Supplier Overpayment Report (PSOR), which is used to record most overpayments found by carriers. Difficulty following the "audit trail" is partly due to some contractors failing to save the documentation required to support the reports.

For the COST REPORT SETTLEMENT PROCESS, $3 billion was disclaimed. The OIG was unable to determine an appropriate methodology to audit the cost settlement process, since this activity involves a fiscal intermediary (FI) audit of cost reports submitted by providers. The FIs conduct desk reviews of all cost reports, and also audit some providers' cost reports, using either a full or limited scope approach. HCFA's position has been to focus the limited scope audits on those providers that have a greater potential for overpayment in order to recover misspent Medicare funds and to provide a sentinel effect on all providers. The OIG has not challenged the quality of the current process and, in fact, has recognized its high cost-savings ratio.

Government audit standards would allow the OIG to rely on HCFA's provider audit process if it were based upon a methodology that would select a representative sample of cost reports to be audited. Presently, it is not possible for the OIG to review a sub-sample of the HCFA audits and develop a statistically valid national error rate, or to ensure that the number reported on the financial statement is "fairly represented" as an accurate reflection of HCFA's liability. HCFA plans to work with the OIG to determine how to make the process auditable, and to implement that process.

Findings of the Substantive Claims Testing Audit

Appropriately enough, most of the attention surrounding the CFO audit has focused on Substantive Claims Testing. These findings, however, do not impact HCFA's overall FY 1996 audit opinion. First of all, the Substantive Claims Testing audit demonstrated that contractor controls were adequate to: 1) ensure beneficiary and provider Medicare eligibility, through actions such as confirmation of the Provider Identification Number; 2) ensure that payment for claims was appropriate based on information submitted; and 3) ensure that services billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors identified in the audit which originated at the provider level. Medicare, like other insurers, makes payment based on standard claim forms and validates the information submitted only in limited circumstances.

Numerous allegations of high rates of fraud and abuse in health care programs prompted the OIG to review in detail the supporting medical documentation accompanying a sample of claims. We want to note that this is the first time that this type of audit has been done. To the best of our knowledge, no other audit either in the private or public sector has included such a comprehensive review as was done by the OIG in this audit. Since these reviews must be performed by medical personnel from the contractor or PRO, it is costly and time-consuming.

The OIG report on the CFO audit also included an assessment of HCFA's compliance with laws and regulations. The good news is that the CFO audit findings tell us that most of our systems and controls are working. The audit demonstrated that based on the information provided on the claim, payment was correct. However, in a number of cases sufficient medical documentation did not exist to support payment of the service. In fact, the OIG found that 99 percent of improper payments were detected as a result of the look-behind review and were not the failure of our system or controls.

Of the 5,314 claims audited, which were taken from a statistically valid sample, roughly 30 percent were found to be incorrect. From this limited sample, the actual dollars in error were approximately $440 thousand. When these audit findings were extrapolated to the set of all existing claims, the total dollars paid in error were projected to be $23.2 billion, which is approximately 14 percent of the $168.6 billion in adjudicated fee-for-service payments reported by HCFA. Based on the precision of the sample, this estimate could vary from 11 percent ($17.8 billion) to 17 percent ($28.6 billion). Eighty-eight percent of incorrect payments, or approximately $20 billion of the projected dollars in error, occurred in six provider types of services roughly in proportion to total Medicare payments by provider type. The six types of service are: Inpatient Hospital, Physician, Home Health Agency, Outpatient, Skilled Nursing Facility, and Laboratory.

Almost half the errors identified resulted from insufficient or lack of documentation from providers, and one third of the documentation errors were associated with providers who failed to respond to repeated requests from the OIG to submit documentation. These percentages, however, cannot be extrapolated to the entire Medicare program, because the sample was designed only to yield the overall payment error. This lack of response from the medical community raises some important questions, for which we must find the answers:

- Why don't providers document the reasons for health care services? And why did one third of them ignore repeated requests for medical documentation?
- Was the care in fact reasonable, but poorly documented, in which case it would still not be reimbursable by Medicare? Or, did we pay when we should not have? The results of this audit should serve notice to the medical community, to document as they were trained or face delayed or denied claims, or other actions.

This is new information for HCFA, and will be key to our future program integrity strategy. It is important to note that the errors reported by the OIG were not evident on the face of the claims, meaning that the error determinations were only made through the "look-behind" review of medical documentation. For example, an incomplete medical history and/or diagnosis may cause the treatment prescribed to be viewed as unnecessary or improper, thus giving the appearance of error or fraud. Because of the significant expense involved in this type of review, the total amount

of overpayments might not necessarily be recouped, after the cost of the review is considered.

The Substantive Claims Testing audit findings are extremely disturbing and require HCFA's immediate attention. We have carefully reviewed these deficiencies, and a corrective action plan has been initiated to improve our financial controls.

CURRENT PROGRAM INTEGRITY INITIATIVES

This Administration has already taken action and implemented a number of important initiatives to improve the management of the Medicare program. The OIG has been empowered by the President and the Secretary to implement reforms that will help improve this program. Since the President took office, he has implemented initiatives which have saved billions of dollars. The President's first budget in FY 1993 closed a number of loopholes in Medicare and Medicaid, tightening up on fraud and abuse. Under the President's leadership, the Justice Department has also made this a major priority, dramatically increasing health care fraud investigations, criminal prosecutions, and civil recoveries.

The FY 1998 budget contains a number of new initiatives, including cracking down on abuses in home health services and skilled nursing facilities. CBO has estimated that the fraud and abuse savings in the budget will be worth about $9.7 billion over ten years. In March, the President announced yet another series of anti-fraud initiatives. Some of the initiatives in the President's budget and subsequent legislation have been included in the House and Senate budget proposals. We are working to ensure that all of these provisions are included in the final Balanced Budget proposals. We want to work with the House and the Senate in this regard.

Our current payment safeguards are already paying dividends in cost savings. These safeguards comprise a comprehensive system which attempts to identify improper claims before they are paid, to prevent the need to "pay and chase." HCFA's current strategy for program integrity focuses on prevention and early detection. Some of our payment safeguard activities include: Medicare Secondary Payer, medical review (MR), cost report audits, and anti-fraud activities.

The results of our current strategy have been substantial. In FY 1996, total administrative costs for all payment safeguard activities were $441.1 million, with an identified savings of $6.2 billion equally distributed between pre-payment and post-payment safeguard activities. This resulted in a projected ROI of $14 dollars saved for every dollar spent on payment safeguard activities (ROI = 14:1).

- For Medicare Secondary Payer, our contractors spent an estimated $109.3 million, producing identified savings of approximately $3,308.6 million, resulting in a projected ROI of $30 dollars saved for every dollar spent (ROI = 30:1).
- For Medical Review activities, our contractors spent an estimated $128.3 million, producing identified savings of approximately $1,864.1 million, resulting in a projected ROI of $14 dollars saved for every dollar spent (ROI = 14:1).
- For Audits, our contractors spent an estimated $152.3 million, producing identified savings of approximately $1,017.6 million, resulting in a projected ROI of $7 dollars saved for every dollar spent (ROI = 7:1).
- For Anti-Fraud, our contractors spent an estimated $51.2 million on payment safeguard activities. The ROI is not applicable to this area of the program because cases are turned over to law enforcement, and recoveries often require several years, while there is no quantitative estimate of deterrence effects.

Last year's Health Insurance Portability and Accountability Act (HIPAA), which the President signed into law, contained provisions establishing a mandatory funding base for the Medicare Integrity Program (MIP). This legislation will help provide us the tools to address the concerns raised in the CFO audit. This audit, however, covers a period prior to the implementation of those new provisions. In FY 1997, which is the first year of MIP funding under HIPAA, the total allocations for program safeguard activities are $440 million, with projected savings of $5.3 billion.

HCFA'S Current Medical Review Strategy

Our payment safeguard strategy has focussed on areas where we receive the biggest return on investment (ROI). These activities are funded out of HCFA's discretionary and mandatory funds. We have streamlined our medical review strategies to increase our ROI. The specific components of HCFA's current medical review strategy are:

Medical Review of Claims: Since 1989, administrative funding for medical review and the percentage of claims reviewed has decreased. In 1990, 16 percent of claims were reviewed with an ROI of 7 to 1. In 1996, the percentage of claims reviewed decreased to 9 percent, yet the ROI increased to 14 to 1. This performance stems

from increased efficiency in the use of resources that we have available to target and correct outstanding problems.

• Currently, about 9 percent of all 800 million claims, representing about $70 million, are reviewed each year on either a pre-payment or post-payment basis. Ninety-seven percent of current medical review savings come from pre-payment reviews. Whenever possible, review is automated to avoid the costs associated with manual documentation review. Many errors, however, cannot be discovered without documentation or some other form of manual review external to the claims. Documentation is not routinely received with the Medicare claims, but instead is submitted on request.

Education: HCFA's contractors "educate" the provider billing community, including hospitals, physicians, home health agencies, and laboratories. This education covers current payment policy, documentation requirements and coding changes through quarterly bulletins, fraud alerts, seminars, and, more importantly, via local medical review policy. These efforts offer providers information and guidance that enable them to bill correctly.

Use of Data and Innovative Technology: Analysis that leads to the efficient use of resources is critical to our strategy. HCFA and its contractors continue to pursue ways to make available data usable by invoking innovative technology in a number of ways:

• HCFA's willingness to fund new technology has driven private industry to develop and market software that our contractors use to profile providers, compare utilization trends and patterns and identify claims review priorities. Some of this software utilizes sophisticated methods such as neural netware or fuzzy logic to mine the data for what may not be obvious, thereby enhancing surveillance of fraudulent and abusive practices. HCFA has chosen not to endorse any specific software, but has funded contractors to purchase software so that competition continues and the best state-of-the-art software is produced.

• We are also utilizing a dedicated statistical analysis contractor to support Durable Medical Equipment (DME) Regional Carriers, who are responsible for payment safeguards in the area of DME, prosthetics, orthotics and supplies. The statistical analysis contractor works closely with the four DME Regional Carriers and produces ongoing analysis of utilization trends, impact of carrier policy and pre-payment review strategy, and unusual payment patterns at the national and regional levels. As a result of this comprehensive examination of utilization, duplicate billing and other aberrant billing practices have been quickly identified and addressed. The continued success of this concept will shape future contracting strategy.

• At the national level, HCFA is developing and continuing to support the HCFA Customer Information System (HCIS), which provides rapid access to national, provider and beneficiary level data.

• To prepare for the future, HCFA is also pursuing research and development of long range strategies for data analysis with the Los Alamos National Laboratories that will employ mathematical, computer-based methods to efficiently identify potentially fraudulent or abusive providers and claims on a pre-payment basis.

• HCFA has been working with the Lewin Associates to develop a methodology for determining a provider compliance rate that will complement the CFO Audit. This rate will indicate the percentage of providers that comply with Medicare rules and regulations and will include review of the documentation supporting the claim. For FY 1998, we will continue to develop this methodology and pilot this prepayment initiative.

Current Efforts for Collaboration and Cooperation with Partners: Under the Operation Restore Trust (ORT) initiatives, HCFA and its contractors worked closely with the Office of the Inspector General, the Federal Bureau of Investigation, State Medicaid and State Survey Agencies to seek out and stop fraud, waste and abuse. This two-year demonstration project, which was launched by the President in May 1995 and concluded on March 31, 1997, was designed to demonstrate new partnerships and new approaches in finding and minimizing fraud in Medicare and Medicaid. As a demonstration project, ORT targeted four areas of high spending growth: home health agencies, nursing homes, DME suppliers, and hospices. Because more than a third of all Medicare and Medicaid beneficiaries are located in New York, Florida, Illinois, Texas, and California, ORT efforts were targeted at these five states. Since its inception, Operation Restore Trust has produced returns of $10 for every $1 spent.

HCFA plans to continue the relationships established during ORT. Using monies made available through the Fraud and Abuse Control Account, established in HIPAA, we expanded our successful ORT efforts nationwide using the State survey agencies to be our "eyes and ears" in the field and to report back to the contractors whether providers are meeting Medicare billing as well as quality requirements. In

1997, home health agencies and skilled nursing facilities remain a focus of ongoing reviews done in collaboration with HCFA's partners. Currently, we are developing projects for FY 1998 that will focus on the areas identified in the CFO audit. Seventeen States will participate in a total of 26 HIPAA-funded projects, allowing us to survey approximately 300 providers for both certification and reimbursement issues.

Medicare Integrity Program (MIP): The Medicare Integrity Program was enacted to strengthen the Secretary's ability to deter fraud and abuse in the Medicare program in a number of ways. First, it created a separate and stable long-term funding mechanism for program integrity activities. Second, by permitting the Secretary to use full and open competition rather than requiring that we contract only with the existing intermediaries and carriers to perform MIP functions, the Government can seek to obtain the best value for its contracted services. Third, MIP permits HCFA to address potential conflict of interest situations. We will require our contractors to report situations which may constitute conflicts of interest, thus minimizing the number of instances where there is either an actual, or an apparent, conflict of interest.

We are currently developing regulations and scope of work to implement the competitive contracting portion of MIP. As we transition work from one of our contractors, Aetna, which is terminating its Medicare work, we are testing a new contracting relationship in several western States that will separate out and consolidate payment integrity activities from claims processing. This will give us valuable experience as we prepare to implement MIP.

OUR CORRECTIVE ACTION PLAN

The Administration will take immediate action to respond to the concerns raised by the CFO audit. Our preliminary corrective action plan outlines changes and improvements to HCFA's payment safeguard program. We recognize that a level of tension will be created by a program that scrutinizes provider billing and requires the medical community to substantiate billing with medical documentation. At the same time, the Federal government is promoting efficiency, less red tape, and less regulation. These two constraints could be difficult to resolve. Many of the actions listed below will in fact be incorporated into the scope of work of our MIP contractors.

Increase the amount of payments recouped: Our contractors have denied improper claims and are seeking overpayments for these improper claims identified in the audit. We will also instruct contractors to evaluate the providers identified in the report for more extensive review. For example, we will look more closely at the skilled nursing facility that was paid $15,000 for respiratory and other services that could not be substantiated by medical documentation.

In FY 1997, HCFA will continue working with the contractors to ensure compliance with accounting conventions for proper reconciliation of receivable and payables. These efforts will be supplemented by a review of internal controls in six contractors using the American Institute of Certified Public Accountants' Statement on Auditing Standard Number 70 (SAS–70), Reports on the Processing of Transactions by Service Organizations. Other contractors will be asked to review and certify the existence and operation of their internal controls, particularly in the area of financial reporting. Also, HCFA will hold a training session in 1997 to ensure that contractors understand the reconciliation process in order to correctly recoup funds. We have begun an analysis of the Intermediary, Carrier, and DMERC shared systems as well as the Common Working File to determine how accounting and reporting processes can be incorporated into these systems. A longer-term corrective action planned for FY 1998 and FY 1999 will be to further implement a single integrated accounting system for the tracking and reporting of receivables as part of the broader process of developing the Medicare Transaction System (MTS).

Develop and implement a Substantive Claims Testing Program: The OIG will conduct the substantive testing activities and issue a report in FY 1997 and FY 1998. Pursuant to an agreement with the OIG, HCFA will have a substantive testing program fully operational by October 1, 1998. The program will establish performance measures, employ some level of random review, and include metrics to monitor outcomes. HCFA will replicate the OIG methodology used in the previous audits for the FY 1999 audit. This will allow for consistency and comparison with previous audits.

This corrective action plan will re-engineer our medical review workload and strategy. We are in the process of understanding the required resources to implement this plan. As we work through this corrective action plan and implements its components, we will focus our efforts on the random prepayment review of claims and adherence to medical standards for documentation, which validate the medical necessity and reasonableness of the provided services. We will closely evaluate the

successes gained through a reduced national error rate and the correct payment of claims, versus any short term impacts on our ROI. Most importantly, we will make every effort possible to ensure that paid claims are appropriately documented.

Increase the Level of Claims Review: If we could look at every claim and the associated documentation, we could achieve the ideal error rate of zero. However, the reality is that the processing of 800 million claims a year makes a 100 percent review unfeasible and cost-prohibitive. This initiative will go a step further than the OIG's substantive testing activities by establishing a control system that provides reasonable but perhaps not absolute assurance that payments are made properly. At a minimum, the cost of reviewing 100 percent of claims would be a tenfold increase in medical review cost. Increasing the level of review and requiring documentation with initial claim submissions could have an impact on our ability to process claims in a timely manner. While the audit findings clearly argue for increased and intensified review levels, determining how to attack this problem is an issue which HCFA must, and will, resolve. Some level of review—between the current 9 percent and the unattainable 100 percent—will most effectively resolve this problem. Finding the right number is our challenge.

The most commonly billed physician services are the evaluation and management codes. In 1992, in conjunction with physician payment reform, the AMA issued new CPT codes for evaluation and management services. The interpretation and use of these new codes were questioned by the medical community and the carriers, resulting in HCFA instructing the carriers to cease review until documentation could be developed. In 1994, the AMA and HCFA jointly released documentation guidelines and embarked on an educational program. With the completion of the first round of provider education seminars, carriers were given discretion to conduct medical review of evaluation and management codes beginning in September 1995.

In FY 1998, our Medicare contractors will be instructed to conduct a random prepayment review of evaluation and management claims. A detailed implementation plan, including instructions to our contractors, will be developed in the fourth quarter of FY 1997, for implementation in October of 1998. Our plan will include monitoring the effectiveness of the review process and further action will depend on the findings of this random review. We will instruct the contractors to make changes accordingly. Based on analysis of the CFO audit report and analysis of the data, HCFA will expand the scope of services subject to prepayment review of medical documentation.

Continue Initiative Requiring Documentation: Despite anticipated controversy and protest, we will maintain and continue to reinforce the position that those providers who bill the Medicare program are accountable for the documentation to support the payment of a claim. We are requiring that providers follow standard medical practice, which requires careful documentation of health services. This requirement includes entities that bill for services that are ordered, referred or otherwise certified by physicians (e.g., clinical labs, skilled nursing facilities). Critical to this initiative is our ability to require diagnostic information on the claim.

Increase the Number of Contractor Medical Directors: Contractor Medical Directors (CMD) are a critical component of all medical review and educational activities. To expand payment safeguard activities in FY 1997, we required CMDs at all carriers and regional home health intermediaries. We will increase the number of Medical Director full time equivalents (FTEs) by 15 percent for the fiscal intermediaries with funding under MIP.

Use Sampling to Project and Collect Overpayment: We are working on detailed methodology to develop and enhance cost-effective, yet fair, ways to estimate and collect overpayments to providers. This method involves post-payment review of a statistically valid sample of a provider's claims where results are extrapolated to the entire spectrum of claims. While our carriers have been active in using this approach, the fiscal intermediaries will begin this process when instructions are released later this summer. This methodology is a new tool for fiscal intermediaries that creates stronger deterrents to reduce improper payments.

Review Inpatient Hospital Claims: Although peer review organizations (PROs) are not conducting random review of individual cases, PROs continue to perform mandatory review of a limited number of cases which include: assistants used in cataract surgery, beneficiary complaints, higher-weighted DRG adjustments, beneficiary requests for immediate review of continued stay notices of noncoverage, concerns identified during project data collection, dumping violations, and referrals from HCFA, OIG, and intermediaries. Work has begun on a system to scan Medicare billings for evidence of unnecessary admissions, which will be supplemented by a narrowly targeted review process to follow up on any leads generated. PROs will use these and other appropriate data to perform surveillance analyses to monitor patterns, trends, and variations in health status and care among Medicare bene-

ficiaries, to identify sentinel events or clusters of events that may indicate less-than-optimal care and to identify, prioritize, and act upon opportunities for improvement. The implementation of the Health Care Quality Improvement Program in 1993 shifted the focus of the PRO program from its emphasis on identifying individual (and often isolated) clinical errors to helping providers and practitioners improve the mainstream of medical care. However, PROs continue to perform mandatory review of a limited number of cases.

Engage the Provider Community: HCFA cannot combat fraud and abuse alone. We will continue to seek the help of national organizations and the provider community to take more responsibility for identifying and eliminating widespread fraud and abuse. Although providers have been understandably reluctant to welcome the additional work associated with maintaining and submitting documentation, HCFA is working to facilitate provider documentation, via increased education programs that promote correct coding and documentation. In addition, we have scheduled meetings with professional provider organizations who will be invited to participate in an educational briefing to explain the audit findings and enlist their assistance in addressing the audit's identified problems.

Correct Coding Initiative: In 1994, HCFA began the Correct Coding Initiative by awarding a contract to AdminaStar Federal for the development of correct coding policy for all physician CPT codes. This contract resulted in more than eighty thousand claims processing edits that bundle services prior to payment. Implemented in 1996, this enhanced pre-payment control and associated software update resulted in savings of about $217 million in its first year.

In FY 1998, HCFA will continue to develop coding policy and edits with a focus on new CPT codes with the potential for high utilization. This project includes ongoing evaluation of the utilization and associated pairing of CPT codes to ensure that all significant CPT codes are included in this initiative.

Strengthen Provider Enrollment Safeguards: Due to the often covert nature of illegal acts, a review of documentation provides no assurance that illegality will be detected. HCFA will impose stricter standards, requirements and post application investigation to prevent those illegitimate providers, bent on fraud and abuse, from admission into the Medicare program in the first place. In FY 1998, proposed legislation will support this ongoing activity by requiring providers to disclose Employer Identification Numbers (EINs), their Social Security Number (SSN) and prohibiting entry into the Medicare or Medicaid Program to individuals or entities convicted of felonies. We are developing a Notice of Proposed Rule Making (NPRM) that would establish much stricter standards for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Among other things, this NPRM will establish a requirement that each DMEPOS supplier obtain a surety bond as a prerequisite for participation in the Medicare program.

Implementation of the National Provider Identifier (NPI) is also well underway. This initiative will prevent providers from obtaining multiple billing numbers and distributing billing across contractors. One provider identifier will allow HCFA to track and monitor the complete picture of a provider's billing practice. As these NPI numbers gain universal use and acceptance, we will be better able to identify and, more importantly, track abusive providers who have had numerous billing numbers in the past. A Notice of Proposed Rulemaking (NPRM) will be issued shortly on the NPI.

Improve Use of Technology and Data: In FY 1998, HCFA will continue developing and refining the HCFA Customer Information System, which provides rapid access to national provider and beneficiary level data. Proposed additions for FY 1998 designed to enhance identification of abuse include expanded cost data, beneficiary profiles, and detailed HCPCS (HCFA Common Procedure Coding System) and Revenue Center code level analysis.

- In FY 1998, HCFA is planning a contract for a National Statistical Analysis Contractor. This initiative is modeled after the success of a similar contractor for the DME Regional Carriers, which improved contractor identification of abusive and fraudulent providers. The proposed statistical analysis contractor will also have a new capability to combine Part A and Part B claims data to develop comprehensive beneficiary profiles.
- Los Alamos National Laboratories (LANL)—As mentioned earlier, LANL is currently investigating new sophisticated statistical methods for HCFA that combine both provider and beneficiary profiles for development of algorithms based on patterns of care that could potentially identify providers at risk for submitting fraudulent and abusive claims. LANL has developed sophisticated computer pattern-recognition programs that quickly spot new types of fraud and abuse, before the claims are paid. LANL methodology will "look at unusual data clusters" and refer suspect claims for our analysis. We expect this research to translate into methods

that can be incorporated into our claims processing systems to enhance the efficiency of claims review and proactively identify providers for review.

CONCLUSION

The initiatives and corrective actions described in this testimony are designed to improve HCFA's record in the future CFO audits, and, in accordance with GPRA, strengthen our ability to monitor and track Program Integrity efforts. However, the degree to which these efforts will influence the error rate is unclear at this time. As we gain experience, these actions will be monitored, evaluated and adjusted in future years to ensure effectiveness.

The work of this Committee and other Members of Congress has been vital to increasing our ability to protect the integrity of the Medicare program, and to safeguard the interests of our beneficiaries. Most importantly, the lessons and experience gained from our efforts in the past few years will guide us as we put our new legislative and administrative tools to use. By effectively utilizing the solid partnerships between State and Federal agencies, the public, and private health care organizations, we will preserve Medicare and Medicaid for future generations.

Chairman THOMAS. Thank you, Mr. Vladeck.

I want to mention that we have with us Members of the House Oversight Subcommittee. The Chairman of that Subcommittee is the gentlewoman from Connecticut, Mrs. Johnson. She is also a Member of this Subcommittee, but we wanted to make sure that Members of that Subcommittee would participate.

Also, the gentleman from Washington, Mr. McDermott, although I don't believe is currently a Member of either Subcommittee, is a previous Member of the House Subcommittee and, as a practitioner, would obviously show interest. I am pleased to have him here as well.

I think, in part, we need to begin our questioning with the understanding that, with the Government Management Reform Act of 1994, we have the ability to look behind the other audits, and that has produced some of the more "sensational" findings of waste, fraud and abuse. But you did have a limited scope audit authority and did so in 1993, 1994 and 1995.

My first question would be to that portion of the audit which was like the previous audits. That is, my understanding is that this audit was not significantly different from the audits in the area that had been looked at in 1993, 1994 and 1995; is that correct, Ms. Brown?

Ms. BROWN. Yes, sir, that's correct, as to accounts payable and accounts receivable.

Chairman THOMAS. So you had discovered weaknesses, if you will, noncompliance over a period of time, but obviously, based upon Mr. Vladeck's testimony, they have been attempting to implement changes.

Do you have any feeling now, looking at it from a historical perspective, of making the same auditory comments without significant change, as to why what is attempted to be instituted has been so ineffective?

Ms. BROWN. A couple of things—there had been other priorities—health care reform and so on—going on during that time. Also, funding was not adequate to make some of the changes. That's at least a partial reason, I'm sure. With the HIPAA Act, which was

passed last year, there will be additional funding both for our work and also for HCFA in doing their control work and monitoring.

Chairman THOMAS. So what we did in the HIPAA Act, providing funding and focusing on waste, fraud and abuse, you see as a very useful tool?

Ms. BROWN. Extremely useful. I think it was a giant step forward.

Chairman THOMAS. I'll come back to you in terms of whether you've had enough experience with it to make any kind of meaningful comments, and if you've had an opportunity to look at the budgetary aspects.

I am especially concerned about what I hope is not an ongoing problem, because in 1993, you indicated in your report that the Office of the Actuary did not provide the IG with sufficient documentation and, according to your report, you were informed by HCFA officials that HCFA actuaries were involved in the President's health care reform initiative and, therefore, were not available to provide sufficient information to audit the details of the actuarial estimate of the payables. That's a statement that you made, in fact. I believe in your testimony you stated that.

What does that mean and what were the consequences for the audit?

Ms. BROWN. Those earlier audits were of a much smaller scope, and we were trying to do some testing in order to prepare for this audit. One of the things we wanted to look at was the actuarial work. At the time, HCFA did not make that available to us. I think you can detect a high level of annoyance there. But we did not expect it to be as far off as what it was this year when we were able to do a complete study of that work.

Chairman THOMAS. And the actuaries have been cooperating with you more fully now?

Ms. BROWN. Yes, this year——

Chairman THOMAS. So you believe it was simply because they were preoccupied with the President's proposal that they did not work with you, or is there some kind of a working relationship problem?

Ms. BROWN. You know, in retrospect, it's hard to know what they were thinking, but it did seem to be plausible at the time that they were extremely limited in their time and resources. That portion of it was an estimate and not a high priority with us at that time.

However, that estimate does affect what we consider to be spent on Medicare each year, because it shows what payables are left at the end of the year, and if it's $18 billion off, it looks as if a lot more was spent in, say, fiscal year 1996 than was actually owed and eventually paid.

Chairman THOMAS. You mentioned in your testimony on page 8 that you didn't look at the part B beneficiary payment structure because that's in the Social Security area and you don't have the statutory power for that.

I did want to ask you a question about the structure of the IG under Health and Human Services, in looking at the largest area of HHS's involvement, HCFA. I wanted to ask you to either be qualified as a comfort level question, or perhaps even a legal struc-

ture question; that is, we know that the Social Security Chief Actuary is structured differently than the actuaries in HCFA.

Is that a model that we might look to that would resolve the problems—that is, an independent or separate structure for the actuary arrangement—or do you have a comfort level now that it was the need to work on the President's proposal and it wasn't necessarily a structural problem, that it was simply a time problem and their demands were called for by the President and they couldn't devote the time to working with you? Is it structure or—Would it help as if we looked at the Social Security structure as a model?

Ms. BROWN. No. I believe they are structured fairly similarly. I don't believe there's a real difference.

Joe Vengrin, who did these audits, is here with me. Could you comment on that, Joe?

Mr. VENGRIN. Mr. Chairman, we looked into that issue, and I believe they are very similar.

Chairman THOMAS. So that would not be a help to us; it mainly is a working relationship, time-focused problem, that I think the Department is now sensitized to, or at least it will not occur again.

Mr. VENGRIN. No, sir. We had total access to the Actuaries' Office this year.

Mr. STARK. Was there anybody in the office?

Mr. VENGRIN. I'm sorry, sir?

Mr. STARK. Were there actuaries in the office?

Mr. VENGRIN. Yes, sir, there were.

Chairman THOMAS. The gentleman from California has some questions along this line as well, because we're concerned about the department working cooperatively to produce the best possible product. If there are demands on time, which they feel they need to respond to, we were thinking there might be an ability to create an independence there that would allow a time use that would not be similar to the 1993 experience.

Mr. Vladeck, in February we spent all day in Baltimore going through the new operation there, and we were talking about the planned integration of the managed care structure. Some time was spent in your presentation on the Medicare transaction system. One of the focuses of the presentation was that it would improve the control of the Medicare Expenditure Program and that, in fact, it was going to be a tool that would assist the department in waste, fraud and abuse.

That response, I think, would have—and I accepted it at the time, under the old auditing system, which obviously showed a 99-percent failure to detect what went on in this audit. I guess I would be willing to give you a little time to respond, as to whether or not you think the MTS system really is something we should continue to plow the amount of millions that we've plowed into it, on the assumption that it would be a useful tool in dealing with waste, fraud and abuse.

Mr. VLADECK. Well, let me begin my comments by saying that, if you look at the history of the audit reports over the last 4 or 5 years, and some of the recommendations and corrective actions we committed to, I think, in hindsight, we may have put too many

eggs in that basket of how that was going to solve all our problems. And let me speak to a couple of those at the moment.

Clearly underlying the audit findings relative to both Medicare payables and receivables, and a number of other issues that have been raised, is the reality that we do not have an integrated financial accounting system for the Medicare Program that even comes close to meeting the requirements of contemporary accounting or audit standards. That's because the program grew up over a period of time with much of the financial recordkeeping responsibilities in the hands of the individual contractors, and in an era in which the expectations were different and the standards of performance were different.

We have always viewed the development of an integrated, CFO-Act-compliant, accounting system as one of the central components of the Medicare transaction With some of the setbacks we've had in the development of the MTS, it has become clear to us in the last number of months that we can't wait for full-scale implementation of the MTS in future years to have that kind of adequate financial reporting and accounting system. So when we are back consulting with you in the next few months about our revised MTS strategy, you will see that one of the pieces will be to move ahead on a separate track, with the development of a contemporary, CFO-compliant, Medicare accounting system.

Chairman THOMAS. My concern was that maybe we set up a system to go in the wine cellar and count the bottles, but nobody ever checked to see if there was any wine in them.

On that basis, do you think that a healthy dose of random audits would be a way to get at it? I know it's intensive and expensive, but based on the results that we found, I don't see how you can't have a random audit, in depth structure built in.

Mr. VLADECK. Mr. Chairman, I think your point is exactly correct, and it very much reflects what we have learned as a result of this audit process.

As payment safeguard dollars became tighter and tighter over the years, in the context of an ever-increasing claims volume, we did move away from random testing of a variety of kinds of efforts to focus testing on higher yield kinds of activities.

I think what the audit results show us is that it's imperative that you maintain some level of random review. I do think that, in part, because of the additional resources we'll be getting as a result of HIPAA's establishment of a dedicated fund for these activities, and as a result of what we learned in the course of this audit, we will have to get back to trying to find an appropriate level of random testing as well. We will begin doing that at the very beginning of the next fiscal year.

Chairman THOMAS. Then briefly, in terms of the testimony, I just have a couple of questions because of the statements that were made and my inability to fully understand them in the testimony—and I know my other colleagues are anxious to ask questions as well.

On page 3 of your testimony, Ms. Brown, you indicate that "this estimate of improper payments does not take into consideration waste [excessive pricing] and numerous kinds of outright fraud,

such as phony records or kickbacks.'' Yet in the chart in the next section on the same page, you have 100 percent as the total.

Is it reasonable to assume that the phony records, for example, might likely fall under the documentation category of no documentation, or insufficient documentation, or would this be an entirely separate area and that the 100 percent in no way takes into consideration—and if that's the answer, I don't understand how it relates to the numbers that you have here.

Ms. BROWN. It was 100 percent of the sample. The sample itself was just on fee-for-service claims. So of those claims, we looked for medical backup. That's what the figures that are on the chart refer to.

Chairman THOMAS. But when you use the term ''phony records,'' and you have a category of ''insufficient documentation''——

Ms. BROWN. If somebody were forging records in some case, that wouldn't have been detected here. In fact, there would be documentation then because they would have those falsified records.

Chairman THOMAS. OK. So we have the first level of never looking behind at the actual claims and we were paying whatever was shoved over the transom; you now go behind and look at it to see if there's documentation to determine whether or not it was appropriate.

Ms. BROWN. Yes.

Chairman THOMAS. This is the first audit that we've seen doing that.

Ms. BROWN. That's true.

Chairman THOMAS. But we still haven't looked to see, even if they laid out full documentation, whether it was totally phony or not.

Ms. BROWN. Well, that's true. And in a lot of our other work, in our investigative work and so on, we recognize that kickbacks or people who are submitting false records, things like that, are whole other categories of fraud.

Chairman THOMAS. Were the tools that we gave you in HIPAA more useful to get at that kind of behavior than you've had in the past, or do we need additional tools for that?

Ms. BROWN. I believe those tools that we got during HIPAA, and those that are being considered under the Budget Reconciliation Act now, will give us the things that we really need to keep this system as clean as possible.

Chairman THOMAS. For example, on page 6, in referring to the coding difficulties, and the chart that identified the six particular areas in terms of the types of difficulty, including coding, you say, ''We have provided HCFA a detailed list of certain procedure codes that have a high frequency of error.''

Is it possible to briefly describe the high frequency of error? That is, are they difficult to use accurately, or are they easy to misuse in terms of upcoding, or are there a variety of uses under the ''high frequency of error'' term that you use?

Mr. VENGRIN. Mr. Chairman, we highlighted codes with a frequent incident of error. For example, as Dr. Vladeck was talking about the E&M codes, they had a very, very high error rate. Also—

Chairman THOMAS. When you say error, what type of error?

Mr. VENGRIN. Both with respect to documentation problems and medical necessity, in the area of home health agencies.

Chairman THOMAS. So they were listed as a higher category than would have been appropriate, or they were upcoded?

Mr. VENGRIN. Both.

Chairman THOMAS. Both.

Mr. VENGRIN. In medical necessity, too. We said to them that the area of home health agency had overall a very high frequency of error.

Chairman THOMAS. Bruce, in your testimony—and let me see if I can find the page—you say on page 4 that, in terms of the kinds of reviews that must be performed by medical personnel from the contractor or the PRO, the second paragraph on page 4, it is costly and time consuming.

Given the potential cost of $18 to $29 billion, my assumption is that that statement is a relative one, and that, in all probability, if we did more of this, there would be a net savings?

Mr. VLADECK. No question, Mr. Chairman. This is exactly the issue, that HIPAA begins to address. Over many years while the total size of the program grew, estimates of potentially erroneous payments grew. There was a fixed dollar amount with which do to all of our payment safeguard activities. And so clearly, if you're running returns on investment of 12 to 1, 14 to 1, you could invest substantially more and it would still be an intelligent investment Not until HIPAA did we begin to have the opportunity to do so.

Chairman THOMAS. Right. On page 5 you say, "did we pay when we should not have?" You went into an examination of how you try to recoup money that maybe was paid out. My argument is we need to look at a system that doesn't pay out first and then determines whether it was accurate later.

Finally, in reviewing the suggested changes, I was somewhat amazed that there wasn't a real emphasis on changing the payment methodology as much as I thought there might be, if PPS is significantly different than the fee-for-service, and I believe reduces the possibility of waste, fraud and abuse, and again significantly left out of suggested conclusions was a significant role for the beneficiaries, in terms of their participation through education and information, and the need for computerized patient records, not only for smart buying but for clear comparison, which I think on a comparative basis you could detect patterns that otherwise wouldn't be there, all of these tools, things that we've been trying to move forward with.

I guess what I did when I read your conclusions, it looked too much like the head of a very large bureaucracy that's just had an audit, that turned inward to try to figure out how you could do a better job inside the bureaucracy, instead of saying the way we can solve a lot of these problems is to realize that the system doesn't make a lot of sense and that we ought to fundamentally change the system, both in terms of who helps us detect waste, fraud and abuse, and the way in which we pay our bills.

Mr. VLADECK. Obviously, you're entirely correct, Mr. Chairman. If I could just make one specific point in that regard, because we and you and our staffs have worked so hard on it for so long. We are, whatever else may occur, going to have prospective payment

systems for home health and skilled nursing facilities in law very soon. If you look at some of these numbers, particularly the audit findings when you're no longer paying on a cost basis, the nature of these problems changes very dramatically. At least we will have new wars to fight, and we will eliminate the old wars on some of these.

Chairman THOMAS. But as a final statement, notwithstanding our ability to put those into effect, it's clear that we need people watching carefully, and some very real tools in punishing those who, removing errors, clearly appear to be actively involved in fraudulent behavior. And when you look at the dollar amounts involved from a projection, it is serious business for us to get to the bottom of.

Mr. VLADECK. Absolutely.

Chairman THOMAS. The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. Ms. Brown, it's good to see you here, and Bruce. Is this the last time you'll be here?

Mr. VLADECK. It depends on the Chair's intention about additional hearings. [Laughter.]

We are always prepared to appear whenever the Chair desires.

Mr. STARK. If it is your last time here, I wish we had a more suitable forum for celebrating your past service and saying we will miss you, Bruce.

Bear with me a minute while I try and get in focus some of the understanding of the problems in auditing, Ms. Brown. I want to draw a parallel here with banks. When I was a banker, I had to deal with several audits, so I have a lot of experience in that area.

It does seem that we're out of whack here about the same amount that we lost in the savings and loan scandal. That cost taxpayers about $130 billion, and we think that over 5 years, at this rate, we could get to the same amount in Medicare.

Also, in auditing a bank, when the examiners first roar in and take control, they count up the money—and perhaps Mr. Vengrin has never done this—but that is not rocket science. You count up the money, count the change, count the vault cash, add up all the debits and credits, and it ought to come out right. The key is basically finding out what is the value and integrity of the assets. There's a lot of subjective judgment in that.

I presume that it is similar in auditing a provider. You can pretty much add up the number of bills they submitted, and you can look to see if the code was the right code. But the key question is: was that code right? Was there a patient there, was it pneumonia grade one, two or three? Those are very subjective or often can be defended on a subjective basis. So you may need to take an auditor trained to analyze more than just the empirical data, but also the subjective data underlying it.

Am I going down the right path here in what the problems are? Why not then follow what was done when we had the scandals of Thomas Jefferson and Penn. They decided, as part of their penance, that they would set up compliance audit plans with outside auditing firms, or law firms, who would annually review the institution's policies and activities in compliance.

Why would this not be a good condition of participation for our providers and, indeed, intermediaries? Let them pay to have an

outside audit to make sure that their system, at least, is one that would lend itself to be audited, and to enhance compliance? Would that be a useful tool?

Ms. BROWN. I think it would be very useful. Currently, the plans that you were speaking of, the integrity plans, are something that we imposed. It was part of the settlement, that providers had to follow these types of plans.

We're in the process now of working with the industries to put out model compliance plans that they could voluntarily adopt, that would contain these things.

Mr. STARK. How about requiring them to adopt the plans?

Ms. BROWN. Well, the problem is that there is so much variance from one provider to another—large hospitals, small, and things like that, that we——

Mr. STARK. Wasn't there enough consistency in the types of mistakes you found that it wouldn't make any difference what kind of provider it is. Upcoding is upcoding, isn't it?

Ms. BROWN. That's true. In the coding area, it could be pretty consistent. I think some areas would——

Mr. STARK. Could I suggest a second tool that the Comptroller of the Currency uses that has a very meritorious effect on financial institutions. That is that when examiners go into an institution and go through the loan portfolio, they stay there until the documentation is completed. They stay there at the expense of the financial institution. When a bank is audited or examined, the bank pays for the examiners.

Ms. BROWN. I see.

Mr. STARK. Why should we not charge the providers for having the auditors come in? If they're good and they're clean and they keep the records the way they should, the auditor would go through there very quickly. Also, the cleaner they are, the less frequently you would audit them anyway.

It's the "bad actors," who would have our resident examiners. If they don't have the paperwork, we'll do it for them at their expense. I would like you to consider that, because instead of thinking that we've got to go and appropriate more money all the time to help Bruce get more staff, maybe what we ought to be doing is having some of these offenders paying.

I suspect there weren't many prosecutable criminal cases that came up because of the intent problem, is that fair to say?

Ms. BROWN. Not out of this audit, yes.

Mr. STARK. So I'm just suggesting that maybe we could tighten this up. Senator McCain and I have a bill in saying, "Make these guys pay fees when they don't repay what they should fast enough." They're using us as a bank. They draw out money through in their interim payments, and then after we find out they owe us money back, they take forever to pay us back. That's fine if we charge them real tough fees to make that an unattractive alternative.

I'm suggesting these ideas in hopes that you all will think about them and see if there are areas in which you might ask us to legislate.

There is a guy who does seminars for providers out in La Mesa, California. He held ten seminars in June throughout California on

how to get the maximum payments out of Medicare. He tells providers that you can scan their E&M codes, as a tip off to possible fraud. This guy runs seminars based on your screening. He shows people how to upcode within acceptable ranges so you won't catch it as an outlier outside the bell curve.

Now, why don't we just send somebody from your staff to these seminars to take down the names of everybody that's there and audit them first. [Laughter].

I can tell you, that's where you'll find problems.

Finally, the American Hospital Association treats this, as they usually do when we ask them to do something good, as something to whine and complain about. They have asked Ms. Reno and Secretary Shalala for a 6-month moratorium on hospital audits, I suppose so they can steal more money. But is there any reason to postpone the audits on upcoding? I mean, why, now that we know upcoding is there, why cave in to the pressures of the industry and give them time? They've had years to try and voluntarily comply and haven't. We've all seen how JCAHO gets sloppy and we have to remind them.

Let's get tough now and keep auditing. That would be my plea to you and to Bruce. This is not a time when we suddenly have found it's the providers that are not doing their job, either through incompetence or through greed. They've been doing it all along but it isn't because of any problems we're creating for them. So I would hope that you would look very much askance at giving them any kind of moratorium on going after them through audits, because a 6-month moratorium means $11.5 billion lost to fraud.

Ms. BROWN. Yes, sir. We have not agreed and——

Mr. STARK. Good.

Ms. BROWN. It certainly isn't something we're considering, that we would withdraw——

Mr. STARK. I would love to hear from you and from Bruce's department, about in what we could do to put much of the burden on the providers to get their records in shape and make it very expensive for them if they don't. Because the expense to the taxpayers, this $23 billion, is Medicare funds that aren't going to provide health care to other people who need it. That's a pretty nasty indictment of the providers.

Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly.

The gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

This is, indeed, a very interesting hearing. It's a little unbelievable to me that this is the first time we've ever had a comprehensive audit of this system. It started in 1965, and that's a long time to go without really knowing what's happening.

Ms. Brown, is there any chance that there are billions of dollars out there not being claimed? Is there any chance that doctors or hospitals or clinics are doing work for elderly patients and not filing their claims?

Ms. BROWN. There is a certain amount of that. What we usually do when we're looking at coding errors—for instance, in the PATH audit that was referred to in looking at the coding errors, if we found there was a range of errors that went in what you would con-

sider a normal curve, some undercoded, some overcoded and so on, we offset those. If it was within a reasonable amount, we didn't consider that something that we were going to go after and even get any of the penalties.

Dartmouth, for instance. When we gave them a pass and said that they did not have any substantive errors, it wasn't that they didn't have errors. It's just that there was an understandable amount.

When we go in and we find that virtually all the errors go in one direction, and that they're very heavily in favor of the provider of the services, then we feel there has been some kind of philandering here. It would depend upon the degree, and we look at how people do their coding, what are their instructions, a lot of other things, to determine just why that happens. That's where the more severe penalties will be placed.

Mr. MCCRERY. So let me get this straight. In the course of your audit, you did find that there were instances where providers would undercode or perhaps not even claim work that was done?

Ms. BROWN. Yes. We netted those. For purposes of this audit, where we did the sample, we netted the undercodes against the overcodes to get the rates that we're looking at here. We do all kinds of audits, so the coding is one of the things that we typically would audit in a variety of different forums.

Mr. MCCRERY. Considering that the net figure is, what, $23 billion in overpayments are we to assume that the frequency of undercoding and not filing claims is probably less than the frequency of upcoding and filing more claims?

Ms. BROWN. It's extremely low. In the claims that we tested, it was certainly extremely low; and it was a sample from which we could project for the universe.

Mr. MCCRERY. Why do you think that is? Why do you think there is so much more overcoding and filing of additional claims than there are the reverse?

Ms. BROWN. Well, I think people are trying to optimize their profitability, and that if there haven't been any types of examination audits and so on for a long time, they get more and more aggressive and tend to optimize——

Mr. MCCRERY. So the system gives them the opportunity to——

Ms. BROWN. Yes. It's a very complicated and a huge system. It is certainly one we would consider a high risk system.

Mr. MCCRERY. Yes. We're now at over $200 billion of claims being paid by the Medicare system. That is a huge system.

Ms. BROWN. Yes.

Mr. MCCRERY. I think that's an understatement.

Mr. Stark earlier referred to the $200 toilet seats and things like that, and that was in the Defense Department, which also spends $200 billion plus. Any time you've got that much money out there, it's going to be difficult, if not impossible, to prevent some fraud and abuse from occurring.

Ms. BROWN. Sir, I also served as Inspector General of the Defense Department for some time——

Mr. MCCRERY. So you're the one that cleared up the $200 toilet seats. Good. [Laughter].

Ms. BROWN. We did a lot of clearing up.

Improper payments by Medicare is a far more difficult thing to control than the types of fraud we were finding with the Defense Department.

Mr. MCCRERY. Why is it more difficult?

Ms. BROWN. Because there is such an enormous number of providers of various types of services, of beneficiaries. This is something——

Mr. MCCRERY. In fact, I think you said there was 800 million claim payments per year?

Ms. BROWN. That's right.

Mr. MCCRERY. Eight hundred million instances of claims being paid.

Ms. BROWN. That's right. So there is enormous room for——

Mr. MCCRERY. That's more than the Defense Department?

Ms. BROWN. Well, yes. I mean, in Defense we basically——

Mr. MCCRERY. By several times?

Ms. BROWN [continuing]. 300 major contractors. It was a different type of work.

Mr. MCCRERY. That's the point that I wanted to make, that this problem is even more difficult than the $200 toilet seat or the Defense Department fraud and abuse, which we know has been and still is and forever will be with that much money out there.

But this problem is even more difficult, and it will remain more difficult as long as we have 800 million points of payment out there, as long as we provide that much opportunity for a single individual or a corporate individual to abuse the system, or even to game the system.

Ms. BROWN. Yes.

Mr. MCCRERY. I notice that you did not audit the managed care operations, only the fee-for-service part of Medicare. Why is that?

Ms. BROWN. Managed care companies are paid a certain amount per patient, regardless of how much usage that patient has. So for purposes of this audit, that was not an area where we had this kind of concern. They're given—I believe it's 95 percent of what, on average, the fee-for-service patients would be——

Mr. MCCRERY. So the opportunity for fraud and abuse and waste or error is less in the managed care operations than it is in the fee-for-service operation?

Ms. BROWN. I have to say that the incentives are completely reversed. Abuses could be in underutilization rather than overutilization. We have different incentives. Managed care is fairly new for Medicare at least, and we still need to do a lot of work in that area to find out if the people are getting the services they need and other things. But for purposes of this audit, we did not find problems in that area.

Mr. MCCRERY. Thank you very much for your testimony, and Dr. Vladeck for your testimony.

Mr. Chairman, my time is up. But I want to conclude by saying that I think this audit points to the fact that this system is so broken it cannot be fixed, that fraud and abuse and waste in this system will forever be with us, as long as we have this open-ended, fee-for-service, 800 million point of contact system. We need to drastically change it if we are going to stop this kind of error rate

and have a program that is responsible and the kind of program that Americans expect for their tax dollars.

Thank you.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Maryland, Mr. Cardin, wish to inquire?

Mr. CARDIN. Yes. Thank you, Mr. Chairman. I, too, want to thank you for holding this hearing in such a prompt way. Obviously, a 14-percent overpayment, or unjustified payment, is unacceptable and we need to get a handle on that.

I want to follow up on Mr. McCrery's questions, but from a different angle.

It's interesting that we do pay the managed care operators 95 percent of the average cost under the fee-for-service program, but if there is a 14-percent overpayment in the fee-for-service program, can we then draw a conclusion that 95 percent is really paying a significant overpayment to the managed care programs?

Dr. Vladeck, I would appreciate your observation, or that of Ms. Brown. Is that 95-percent payment an overpayment to the managed care program?

Mr. VLADECK. I think one can say more generally, Mr. Cardin, that any aspect of the fee-for-service system, whether it's erroneous payments or fraudulent payments or excessively high unit payments for certain services that occurs in a fee-for-service system, does indeed get built into the rate determinations for managed care plans.

Mr. CARDIN. It's interesting to point out that in our budget that we're working through in conference, we're trying to correct some of those inherent problems of using a formula tied to the fee-for-service. But it does point out that it can cause an overpayment to our managed care providers.

Ms. Brown, I don't know if you have a view on that or not, was that part of your audit in any way.

Ms. BROWN. That wasn't one of the things we were auditing, but obviously, any of these things are going to affect all the decisions that are based on the totals used in Medicare.

Mr. CARDIN. It is an inherent problem in fee-for-service, where you have to rely upon the providers' good faith submission of claims. They are supposed to have certain medical records to back up what they're doing, and you have shown in your audit that they, in fact, have not done that.

I'm curious as to whether there's any information you have about any of the private fee-for-service plans, either now or historically, as to whether audits have been done and whether there's any contrast or comparison as to whether the 14 percent that we have found is somewhat typical, or is high or low, on a fee-for-service plan?

Mr. VLADECK. We have had a number of conversations with folks in the private insurance business, many of whom, of course, are contractors. I think their general response to the questions is one of astonishment, that when you have activities that are producing rates of return of the kind that our program safeguard activities have been, that you don't expand them.

The notion that is an artifact of the Federal budgetary process, that you have benefit spending over here and administrative

spending over here, and you can't trade off between them, is a hard concept for many of them to comprehend, and when they comprehend, they have some questions about its underlying sanity.

So I think their belief is that their level of problems is significantly lower than ours, but that is in part because their expenditures on the safeguard activity relative to benefit payments is higher than ours.

Mr. CARDIN. Medicare, being such a large part of the medical reimbursement in health care, has certain advantages. And I want to follow up on Mr. Stark's point. Should we have some type of compliance audit requirements from certain participants as a condition of participation in the Medicare system? We may very well wish to either make that a condition of large providers, or providers who your audits have shown have had problems in this area, in order to make it administratively feasible and cost effective.

Do you have the legal authority to require some form of a compliance audit from providers, or is that something that Congress needs to be able to give you additional authority, in order to get better compliance to the rules of Medicare?

Mr. VLADECK. I think that probably varies by category of provider. I think, for most part B providers, we probably do not. I would emphasize the relative small size as economic entities of many part B providers as we think about that.

We do get audited financial statements from all hospitals, for example, participating in the Medicare Program, and——

Mr. CARDIN. But they're not compliance audits.

Mr. VLADECK. They're not compliance statements, that's correct. But I believe we could probably, for part A providers, generate such a requirement without statutory change. But I would have to check into that.

Mr. CARDIN. I would appreciate if you could get back to me, Bruce, on that. And I'm not necessarily suggesting that for every provider that there be an annual compliance audit. It may well be that, depending on size and depending upon their history, and depending upon your audits, and depending upon the areas that we've had problems, that we could have a game plan, a selective process, for requiring compliance audits on a periodic basis for those providers that have a history of poor performance. It seems to me that could save a lot of money.

I agree with Mr. Stark. In those cases, it seems to me that the provider should be responsible for the cost and it should not come out of HCFA's budget.

Mr. VLADECK. Certainly when cases are pursued to formal litigation, either civil or criminal, the Inspector General has made it a practice, in the resolution of many of those cases, to require continued compliance plans and so forth. But we should probably look at making that more general.

Mr. CARDIN. Thank you.

Thank you, Madam Chairwoman.

Ms. BROWN. If I could add to that, sir, there are several things we feel are very important that are now under consideration in the Budget Reconciliation Act, things like the Social Security number, so that we can track the individuals—because many of them work for a number of different firms; ways of keeping people who have

a criminal record out of the program so that they don't get in in the first place; not allowing them to discharge their obligations in this area under bankruptcy.

These are the kinds of problems that we have seen abused over and over again, and I would be glad to talk to any Members or their staffs about what we have found and why some of these things might be very important.

Mr. CARDIN. Thank you.

Mrs. JOHNSON [presiding]. Thank you.

I want to make a couple of comments. First of all, for several years the trustees of Medicare have reported that the system is in significant trouble and, indeed, is catapulting itself toward bankruptcy. As Chairman of the Oversight Subcommittee of Ways and Means, we have now, for all 3 years that I've chaired that Subcommittee, have reports from the executive branch that Medicare was one of the few high fraud programs, highest fraud programs, in the Federal Government. Every year they pick out the top high fraud programs and report to us on them. It is, at a fundamental level, really outrageous that, given the importance of Medicare to seniors in America, given the seriousness of its financial situation, and given the concerns we had about it, that we should only now be coming to this information.

The good news is that we're coming to this information. The really outrageous news is that it has taken us so long to get here. I am pleased to know that the tools that we gave you a year ago are helping, and that the tools we're finally putting in this budget reconciliation, this Medicare reform bill, will be helpful.

But I think we have to look at the comment that Mr. McCrery made. Is it possible to manage all this information? That's where I want to focus my questioning in the time that I have.

It doesn't appear to me that the lack of information is the problem. What appears to me is that we don't look at it. Now, one of the things that you say in your testimony, both of you in different ways, one of your disclaimers has to do with the auditing of hospitals, home health agencies and so on, and that you are working now on an audit process for 1997 that you will both agree on.

Now, if there is a group of providers from which we've been getting detailed cost reports, it's certainly the home health industry. Frankly, many of us have wondered whether anybody ever looked at that stuff. So I wonder, as you go through this audit issue, are you looking at what information are we collecting—because it all has a cost—and are we using that, has it been helpful, and is one of the messages we're getting from this is that we're asking for the wrong information? So I want to hear about that in the home health.

But I would have to say, if there's anything we've been looking at, we certainly have been looking at coding, so it strikes me as truly outrageous that 8.5 percent of the $23 billion are coding errors. That's not hard.

Even the documentation. We've known what the documentation requirements were. Wasn't anyone looking to see if the fiscal intermediaries were asking for documentation? Twenty-three billion dollars in documentation errors, in coding errors, things like that

known, simple. That's more than anyone has ever proposed saving any year, and would easily have solved the problems of Medicare.

So while I understand we're never going to be to zero, I think this report is an absolutely startling, dramatic condemnation of this government-run health care program. It raises fundamental issues, as Mr. McCrery pointed out, about our ability as a bureaucracy to assure an honest system that pays for appropriate health care.

But to return to some of the narrower issues that we might try to sort through, I would like to hear you both talk about the cost reports that are already in the agencies and why they weren't more helpful, why you have to now go back and find an audit process you can both agree on when we had cost reports, we had audit processes, presumably, and they aren't working for us.

Mr. VLADECK. That's not what the report says, Mrs. Johnson. Let me try to clarify that, because I think the Inspector General's audit showed that there are very substantial recoveries as a result of our auditing of the cost reports.

What it also found, however, is the cost of the limitations on the amount of auditing we perform, which is directly a function of the budgetary limitations for those procedures. We don't have a nationally valid sample from which an auditor can project the potential savings or the potential overpayments across all audit activities.

We know, for every dollar we spend on auditing cost reports for Medicare providers, we save the program $7. What we don't know is how much in total could be saved, because we don't have enough audit funding to provide a statistically reliable sample of all the audit activity we have. Is that a fair——

Mr. VENGRIN. That is fair.

Mr. VLADECK. So, in fact, the audit process is extremely useful. There just isn't enough of it.

Mrs. JOHNSON. If the audit process then is not at issue, then why does there have to be a disclaimer?

Ms. BROWN.For instance, in asking for all the backup documentation, HCFA in the past was only able to go through that type of process for 3 out of 1,000 providers.

Mr. VLADECK. No, that's the medical review estimate.

Ms. BROWN.The medical review, I think, is one of the things you're talking about; that is, having people do those kinds of medical reviews before Medicare agrees to pay, or shortly afterward, so that they can reconcile those overpayments. There hasn't been enough funding that HCFA has gone through and done that on a more frequent basis. Certainly if it was done, maybe 3 percent or something, people would be careful.

Mrs. JOHNSON. Let me clarify something here.

They go through this reconciliation process of accounts every year, for every provider.

Mr. VENGRIN. That's correct.

Mrs. JOHNSON. Are you saying that that's not an accurate process?

Mr. VENGRIN. We're saying they don't do enough of them, ma'am. Of 38–40,000 cost reports, the maximum they can do is selective line items. They cannot cover all the providers out there. So while they recover an enormous amount of money back from those that

they review, we know that there's still a major population that gets no review.

Mrs. JOHNSON. I think I'm asking a slightly different question.

Mr. VENGRIN. OK.

Mrs. JOHNSON. Every year, in order to reconcile accounts with agencies—in other words, the difference between the prepayments and the final payments——

Mr. VENGRIN. Yes, ma'am.

Mrs. JOHNSON [continuing]. They do reconcile a lot of bills. I mean, they review tons of material.

Mr. VENGRIN. Yes.

Mrs. JOHNSON. I mean, they have to. Otherwise, they can't decide how much money to pay that agency.

Mr. VENGRIN. Correct.

Mrs. JOHNSON. What is the quality, what is the accuracy, of that process? Because we're putting lots of money into that, provider specific, action by action, bill by bill. What is the quality of that process, in your estimation?

Mr. VENGRIN. I can only talk about the cost reports. Now, when we went out there and interviewed, the individuals reviewing the actual cost reports themselves, they will tell you that there is still a major population out there that they absolutely do not review at all.

In terms of the claims reconciliation, I'm not too sure that they're covering that. Again, they only have resources to look at selective cost centers or line items. But again, some of these things can be 11 or 12 inches thick. They do not have resources to validate various line items. That is the problem. We cannot be sure that the amount they are ultimately selling for, approximately $3 billion, is the correct amount. Stated another way, they could be settling on costs that are inflated.

Mrs. JOHNSON. I appreciate that. I don't think that you can make a determination about how to solve the system without understanding whether or not that basic reconciliation process that goes on in an agency-specific level—I mean, surely that ought to be capable of looking at coding, looking at appropriateness of care, and looking at documentation.

The forms these agencies fill out, and the stuff they're sending to the government, is voluminous. So I guess we're not going to solve this here. But I would say that this report really challenges us all to deeply rethink the system, not just to make superficial changes. I will be interested to see whether the provider number, which we could have done several years ago—it was in the recommendations, I think, in our original Medicare reform bill—helps. But I think Mr. McCrery's point is one that we've got to be far more serious about.

So I have taken my time and I will recognize now Mr. Lewis.

Mr. LEWIS. Thank you, Madam Chair, but I think other Members were here before me, Mr. Becerra.

Mrs. JOHNSON. Excuse me. I guess next is Mr. Becerra. My mistake. Following him, Mr. Christensen.

Mr. BECERRA. Thank you, Madam Chair. I thank my colleague, Mr. Lewis, for that courtesy.

Let me see if I can ask a couple of questions with regard to our remediation efforts on the whole issue of fraud and abuse, and recognizing that the findings in this audit don't necessarily reflect 100-percent fraud or abuse.

Can either of you give me some sense of, say, over the past couple of years, the last 2 years, how many cases of criminal prosecution have been instituted by HHS to try to address the issue of intentional fraud or abuse?

Ms. BROWN. We have between 1,500 and 2,000 in a year. I can get you the accurate numbers and I will submit that for the record.

Mr. BECERRA. Out of how many prosecutions? It's 1,500 to 2,000 convictions. How may prosecutions?

Ms. BROWN. These are for just the health care area. We only have about 150 convictions in the year, but we have about 650 civil settlements.

Mr. BECERRA. OK. Let me make sure I'm distinguishing here. We're talking criminal and civil prosecutions here, or are we talking only criminal prosecutions?

Ms. BROWN. OK. Frequently, if somebody is going to be prosecuted criminally——

Mr. BECERRA. They settle on something else, civil charges?

Ms. BROWN. They settle in a civil settlement. So it's very hard to draw the line. There is some overlap there.

Mr. BECERRA. So then let's be clear.

How many actual convictions, criminal convictions, did you have, and over what period?

Ms. BROWN. About 150 a year.

Mr. BECERRA. A year.

Ms. BROWN. A year.

Mr. BECERRA. OK. And you mentioned the figure 650 settlements.

Ms. BROWN. That's true.

Mr. BECERRA. And they settled on civil grounds?

Ms. BROWN. Yes.

Mr. BECERRA. And it could have included criminal complaints, but——

Ms. BROWN. There may be a few of those as well in there, and many of the civil settlements were—we could have gone either way. In each case we analyze whether or not this entity should be able to continue providing service. We exclude them, and the figures I mentioned about the 2,000 were for those we exclude from participating in the program.

Mr. BECERRA. How many actual prosecutions or initiations of actions against providers in a year do you normally see occur?

Ms. BROWN. You mean how many investigations are ongoing?

Mr. BECERRA. Investigation doesn't always lead to some form of action or prosecution. Why don't we first talk about how many—Well, how many investigations in a year do you typically perform?

Ms. BROWN. OK. Excuse me. There are about 750 ongoing investigations, and some of them overlap years, though. But they would yield these results. And over time, you would say, of the 750 or so going on, you would get about 150 convictions a year, and you get settlements of about 650. I can give you that information in a more accurate form.

Mr. BECERRA. It sounds like what you're telling me is that, if you initiate some 700 to 800 investigations, that in most cases you end up with either a settlement or a prosecution.

Ms. BROWN. Yes.

Mr. BECERRA. So it doesn't look like, in most instances, you're engaged in any kind of "fishing expedition." You've got some pretty substantial evidence to have you go forward.

Ms. BROWN. Yes, sir. I have been Inspector General for five agencies, and one of the things we ordinarily did in all of the other agencies where I served was a lot of work trying to find vulnerable areas and looking for places where fraud could exist.

We have so much available that we're picking those that are the best cases and that we know we can get some kind of resolution.

Mr. BECERRA. That tells me then that you're picking, of all the information you've received, you're picking those that you think are most likely to lead to some form of action, that you can have success on them.

Ms. BROWN. That's true. In fact, the Secretary's initiative is to get a real handle on the fraud, waste and abuse and, of course, the Congress has seen fit to pass the HIPAA legislation last year, which will fund a lot more of this work, so that we can do a better job.

Mr. BECERRA. So that leads me to conclude from what you're saying that there are a number of investigations that you don't undertake, whether it's because of resources or other reasons that you don't undertake, that could also be fruitful——

Ms. BROWN. That's true.

Mr. BECERRA. Could you use more money for the purpose of investigations?

Ms. BROWN. We certainly can.

Mr. BECERRA. How would you propose to collect on some of the overpayments that you've discovered in this audit that you've just performed, and how much would it cost to do so?

Ms. BROWN. In the audit performed, those things that were in the sample and where we found errors, we have turned those over to HCFA and they will look at them to see where overpayments can be collected, or an exception is appropriate, and start the collection action.

Perhaps Bruce would want to comment on that.

Mr. BECERRA. Mr. Vladeck, can you tell us how much it's going to cost you to do that, and do you have the resources to do the collection?

Mr. VLADECK. No, we haven't looked at that.

Let me just say two things about that. One is that the recoveries are a gross figure, not a net figure, relative to collection costs. But we have not estimated that.

The second is that it's not clear that we will recover in every instance. Ordinarily, particularly on denials of medical necessity, providers whose claims we deny appeals rights. In the appeals process on medical necessity claims, we lose about half the time. So none of the instances found in this audit were post appeals process. They were all the determinations we would make. So whatever the dollar estimates are, they are not necessarily an estimate of recoverable dollars.

Mr. BECERRA. Madam Chair, if I could be indulged for one last question.

Give us a sense, if you can today—We have an audit that says an estimated $23 billion was overpaid by the system to providers. Some of that you're telling me we will not be able to collect because in some cases the providers acted legitimately and they would win on appeal. In other cases perhaps it would be difficult for us to prove up that we're owed the moneys.

But there is a pot of money out there that we're fairly sure was overpaid. How much would it cost us to go collect it and are you going to try to collect it?

Ms. BROWN. If I could comment, the $23 billion is the result of a sampling technique. It's a valid sample that is projectable and so on.

Mr. BECERRA. Understood.

Ms. BROWN. All we have is those in the sample. So we have a little over 1,500 claims that we can go back on. But that would be a small portion of the amount of money identified. I don't think that we'll ever collect that money back. There will be a small portion of that that can be collected, but we do want to be sure that it doesn't continue to happen in the future.

Mr. BECERRA. Madam Chair, if I could be indulged—They're raising more questions than I think answering.

What percentage did the sample represent of all the various claims that were submitted by providers? What percentage are we talking about, the sample?

Mr. VENGRIN. The sample was not segregated by provider type. We selected it from the contractors. Otherwise, to do that we would have had to review maybe 60,000 or 70,000 claims.

Mr. BECERRA. Well, you extrapolated and told us there was about $23 billion out there that was overpaid.

Mr. VENGRIN. Yes, sir.

Mr. BECERRA. What was the actual amount you found to be overpaid?

Mr. VENGRIN. $400,000.

Mr. BECERRA. $400,000. So you have extrapolated to what degree?

Mr. VENGRIN. We projected the individual overpayments back to the population that we drew from, which was $168 billion.

Mr. BECERRA. What I'm trying to get a sense of is your actual sample is what percentage of the full universe.

Mr. VENGRIN. We reviewed 5,000 claims. It would be 5,000 out of 800 million claims.

Mr. BECERRA. Out of how many?

Mr. VENGRIN. 800 million.

Mr. BECERRA. 800 million claims, and you examined 5,000?

Mr. VENGRIN. Yes.

Mr. BECERRA. OK. So clearly, what you have found in terms of actual overpayment reflects only a very tiny, infinitesimal sample, and you've been able to, using statistical methodology, extrapolate that we would have about $22 billion overpayment.

Mr. VENGRIN. I would just like to insert one caution. Population is not a major factor in our sampling.

Mr. BECERRA. That's fine.

Mr. VENGRIN. It's the variability in the population.

Mr. BECERRA. What I'm trying to find out is, given that we used a small sample to come up with this overall estimate of $23 billion, we know some specific cases of overpayment through the sampling——

Mr. VENGRIN. Yes, sir.

Mr. BECERRA. We're now estimating the entire amount of overpayment for the entire system.

Mr. VENGRIN. Yes.

Mr. BECERRA. In order to ever collect that $23 billion, we have to go out and examine all the files, all the claims, to find out where the overbilling took place——

Mr. VENGRIN. Absolutely.

Mr. BECERRA [continuing]. Which would cost you enormous amounts of money and enormous amounts of time. So we're looking at $23 billion in projected overpayment.

But what is the chance that we're ever going to be able to collect what you have estimated to be a $23 billion overpayment?

Ms. BROWN. I would say it's far less than 1 percent. Nobody is attempting to do that.

Mr. BECERRA. So it seems to me that we had better find a better way to prevent the overbilling from occurring, because collecting it is virtually a nil possibility. So some of the ideas that were suggested by Mr. Stark and others, to try to make sure that we encourage providers not to make mistakes, is probably the best way to go.

I thank the Madam Chairwoman for the extra time.

Mrs. JOHNSON. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

Not to go overboard in terms of the last question, I think the Congressman's question was very good—exceptional, as a matter of fact. The one thing I do want to ask, though, is this $8.5 billion on the lack of medical necessity.

When you were looking at the testing in these areas to determine lack of medical necessity, what were some of your findings and what were the various parameters that you set up to determine lack of medical necessity?

Ms. BROWN. First I would like to comment that we had doctors doing this work, medical specialists, that were very familiar with these things. We used both some of the medical people that worked for the HCFA contractors and the PRO's to do this examination. So HCFA actually did a major portion of that work; or it was through HCFA that we got that done.

As far as the parameters, Joe, do you have a comment?

Mr. VENGRIN. The medical review staff followed the same methodology that they did when they were out there performing the services as part of the contractors.

What are types of examples? Skilled nursing facility. When we requested the medical documentation, and when it was submitted and provided to the medical review staff, they went into the records, and it generally did not support the level of care billed. There has to be documentation. That's a requirement under the Federal regulations, to clearly document the need in the case record.

When the medical reviewers went to do that, many instances—for example, in the skilled nursing facility, it showed that the patient was receiving a lesser level of care.

Mr. CHRISTENSEN. Of the 5,000 cases that you've analyzed, were all of them also looked at for each of these various categories, incorrect coding, lack of medical necessity——

Mr. VENGRIN. Yes, sir.

Mr. CHRISTENSEN [continuing]. Or was there a separate pool that just specifically dealt with lack of medical necessity?

Mr. VENGRIN. No, sir. Each of the 5,000 claims that we reviewed all included a medical review, plus I had an audit program that covered every aspect of the claim—eligibility, provider eligibility, and what have you.

Mr. CHRISTENSEN. I wanted to ask Bruce, how far along are we in the national provider identifier system and what phase have we reached in that system, regarding the first page in the Chief Financial Officer's report?

Mr. VLADECK. I think there's really two elements to that, Mr. Christensen. One is the updating of HCFA's own provider records to conform to the national provider identification system, and sort of in parallel to that is the adoption of a rule under the provisions of HIPAA for essentially an all payer national provider system.

We will have the proposed, HIPAA rule, out within the next couple of months. It will have an effective date of some time in mid-1998. Our systems will be in conformance with it by that time. So we're progressing and we're within less than a year, I think, of bringing our own records in to conformity with the national provider identification system and of trying to establish a norm so that the private sector over the following years will also come to use the same system.

Mr. CHRISTENSEN. To what degree do you think the national provider identifier system will help in deterring fraud and abuse?

Mr. VLADECK. It will help enormously, I think, in fraud cases where there is real intent to deceive and to steal from the programs, I think it will be, based on the experience we've had in Operation Restore Trust and other cases, I think it will be enormously helpful. For the kind of overpayment issues that we're talking about, I don't think it will be as critical.

Mr. CHRISTENSEN. Ms. Brown, have you looked at this system yet? Have you looked at the national provider identifier system?

Ms. BROWN. Well, we've got somebody that is working with them to finalize the system, and our input is being used in all of the decisions.

Mr. CHRISTENSEN. I think Ms. Johnson said earlier we're not going to begin to solve all the problems at this hearing.

But I do believe, if you look at the $8.5 billion in the lack of medical necessity that the Inspector General has documented here through her sampling, it points to a larger, problem, and the fact that people are not don't have a financial interest in the system, means that they unintentionally use the system.

That's why I think we have to move away from the current system. We have to go to a system where people have a financial interest, every time they go to a doctor, they have an opportunity to share in the expenses of that, and they have a second chance to

think about whether or not they want to use the system in that manner.

I believe, until we get to a system where people have to dig into their own pocket a little bit deeper, to make the decision on whether or not they're going to invoke the Medicare system, we're going to continue to experience this lack of medical necessity, and the kind of money that we're spending, 37 percent of the $23 billion documented here is outrageous.

I would like to say, frankly, there are very few companies—maybe the top 100. I don't know what the top 100 corporations in the country, in terms of net sales are, but I would say that $23 billion is equivalent to the earnings of at least one of the top 100. Unless we have a fundamental shift in the way the Medicare system is operated, and construed by the beneficiaries, we're going to see this year in and year out. I would just applaud the Chairman for holding this hearing, but hopefully we can move on to a fundamental in Medicare of where we're going to take the program to the 21st century.

Mrs. JOHNSON. Thank you, Mr. Christensen.

Mr. Lewis.

Mr. LEWIS. Thank you, Madam Chairperson. I will be rather brief.

Ms. Brown, on page 7 of your testimony you make six recommendations for improving HCFA accounting practices. Could you explain the first two a little further?

Ms. BROWN. OK. I'm going to let Joe——

Mr. LEWIS. The first two recommendations.

Ms. BROWN [continuing]. Go into a little more detail on the recommendations.

Mr. VENGRIN. Yes, sir. We feel, since this is the first nationwide error rate that has ever been established for the program, that HCFA should continue with that process. As Dr. Vladeck indicated, I believe by fiscal year 1999 they have agreed to develop that.

They need that for a couple of purposes, not only to determine where to prioritize their attack on the claims process, but also in terms of the financial statement implication. Because as I mentioned, the fee-for-service is $168 billion. They need to reflect what part of that for financial reporting does not meet the current Medicare laws and rules.

Mr. LEWIS. Do you have any sense of how easily these recommendations can be implemented?

Mr. VENGRIN. I think that, as everyone has probably testified here today, this is a most complex problem. It's not one that is easily resolvable today, but certainly documentation is 47 percent of the problem, and certainly one attack that they need to focus on is making sure that the providers understand that this is a problem. So I think the outreach effort, which may not cost, you know, billions of dollars, is certainly critical here.

Mr. LEWIS. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS [presiding]. I thank the gentleman.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you,

Mr. Chairman.

Chairman THOMAS. Thanks for being with us.

Mr. MCDERMOTT. I want to ask a pragmatic question here. You did 5,500 audits of 5,500 claims. Where did you select those claims from, in HCFA or out in the field at various State intermediaries?

Ms. BROWN. They were at the contractor's site. The claims selected were from the contractors, claims they had paid.

Mr. MCDERMOTT. Where did you do these?

Mr. VENGRIN. We first started, sir, with a selection of the contractors, and then we reconciled the actual pay claims back to reported amounts——

Mr. MCDERMOTT. But, in which States did you do these audits, which contractors did you audit?

Mr. VENGRIN. The first cut on the statistical selection was of the contractors, so it was across the country.

Mr. MCDERMOTT. So you went and looked at completed claims in the contractor's file?

Mr. VENGRIN. That they processed, yes, sir.

Mr. MCDERMOTT. You didn't go up to the HCFA level and get what had been submitted from the contractor?

Mr. VENGRIN. We pulled the sample at the contractor site of processed claims, yes, sir.

Mr. MCDERMOTT. Now, if I understand correctly, when I used to practice medicine, I filled out a form and I sent it to the intermediary in my State. It would be Blue Cross or Blue Shield or Aetna, one of the major insurance companies that had a contract with HCFA to administer at the State level; is that correct?

Mr. VENGRIN. Yes.

Mr. MCDERMOTT. That's still the process today?

Mr. VENGRIN. Yes.

Mr. MCDERMOTT. Now, if there is an error of either no documentation or poor documentation, it should have been picked up at that level, shouldn't it?

Mr. VENGRIN. Not necessarily, sir. When we went back to the medical records, that's where the problem was. On the surface, the bill, as submitted, was correct.

Mr. MCDERMOTT. So you went one step back. You took the document that they had said for a peptic ulcer or something, and you went back then and pulled the hospital chart?

Mr. VENGRIN. Yes, sir.

Mr. MCDERMOTT. In the hospital itself, or did you use some kind of data access system?

Mr. VENGRIN. We mailed out a letter to the specific provider and asked that that documentation supporting the claim be sent to us.

Mr. MCDERMOTT. And so what they did was they xeroxed the pages out of the hospital chart, or their office files or whatever, and sent it in to you as documentation?

Mr. VENGRIN. Yes, sir. In some instances, they did not send in documentation.

Chairman THOMAS. Would the gentleman yield?

Ms. BROWN. We did go back to them at least three times, and they knew that on that particular claim they would have to reimburse us if they did not submit the documentation and backup for it. So there was great incentive for them to do so, if it was available.

Chairman THOMAS. Incentive. But what was the general feeling of cooperativeness about what you were doing, since you had never done this sort of thing before?

Mr. VENGRIN. Well, it's kind of hard to read from that, since in a high incidence there was no documentation provided. As the Inspector General points out, the letter clearly indicated that if this information was not provided, a disallowance would be taken. And then we went back the second time with a follow up formal letter saying the same thing.

Chairman THOMAS. I thank the gentleman.

Ms. BROWN. And then a third time with phone calls or in a few cases, letters a third time.

Mr. MCDERMOTT. So if there's a problem here, it is that the intermediaries, not HCFA, not public employees, but private sector contractors who have a contract with the government have not been following up and actually looking for the documentation. Is that a fair assessment of where the problem actually exists?

Mr. VENGRIN. No. I think it goes back further, sir. It's at the provider level. Typically under Medicare, as with most insurance systems, they do not submit backup medical files when they process a claim.

Mr. MCDERMOTT. So, the contractor is not requiring providers to send in sufficient information; is that what you say the fundamental problem here is?

Ms. BROWN. The system is built on a trust, that there will be documentation in the medical records, and people are aware of the fact that we can request that at any time. But it is seldom requested, and I think there was carelessness in the best instance, and perhaps some pushing the system by claiming things that weren't actually procedures performed.

Mr. MCDERMOTT. Mr. Vladeck, Is there anything, Mr. Vladeck—When you negotiate a contract with one of these intermediaries, do you require them to do any kind of compliance auditing? Is there anything in the contract that requires them to do so, or do they just accept the responsibility? If they say the claim is OK, that means there's documentation somewhere, some place in a file?

Mr. VLADECK. Let me try to clarify this, because I think it's important and it's at the heart of the issue of the corrective action plan.

Intermediaries and carriers are required to do several things. One of the things they are required to do by law is to pay a so-called "clean" claim within 30 days of the time they have received it. Another thing they are required to do is to provide as much incentive as possible for providers to submit claims electronically, because the only way we've been able to afford to maintain claims payment, with the volume increases and a flat budget, is by moving from a paper system to an electronic system.

They are also required to do a detailed review of the backup documentation for medical necessity, of a sample of all the claims for all of the providers they deal with. However, they are on cost-based reimbursement contracts with a budgeted cap for those activities in the course of their fiscal year.

So we will say to a particular contractor, you have an approved budget for this year of $18 million, with which you have to do the

following things, including devote a certain amount of time and effort to doing these look-behind reviews, but your budget for payment safeguard should not exceed $*x*.

What the audit found, in fact, was that the contractors were extremely compliant with our requirements on them, and that the activities they undertook in audit and medical review, among other things, were done extremely well. But the amount of resources devoted to these sorts of activities, relative to the total claims volume, is very, very small.

Mr. MCDERMOTT. So you actually set two requirements a disincentive to an incentive. One is they're supposed to look back, but the other is you can only use $50 to do it, which made it impossible for them to do the kind of look-back process that you anticipated?

Mr. VLADECK. Again, when they do the process, they do it well. The problem is they don't do nearly enough of it, and that's because they don't have the money to do it.

Mr. MCDERMOTT. Their sample is too small.

Mr. VLADECK. That's correct.

Mr. MCDERMOTT. So out in the field, where Mr. Stark heard of these seminars, they told people how to avoid the look-back process that's being done by the local intermediaries? Is that a fair description?

Mr. VLADECK. We have gotten to a process, I think, where the intermediaries and carriers are very sophisticated about using statistical data, to make it hard to predict who they're going to look at and what they're going to look at from 1 year to the next. So some of the value of these seminars is relatively short lived.

But the underlying fact is, again, that the number of claims on which we do this sort of detailed look behind as a proportion of the total claims volume or the total dollar volume is clearly just way too small.

Mr. MCDERMOTT. So it's sort of like the IRS audit. You know that you can slide pretty much if you don't get too far out, because they only audit a very small number of people. It's the same thing operating here. Doctors or the professions would know that there were very few audits actually occurring and the likelihood of getting caught was small.

Mr. VLADECK. I think the average doctor with a large Medicare practice, who submits a lot of Medicare bills, finds very few instances in which somebody comes and looks at a chart.

Mr. MCDERMOTT. Let me ask one more question, and this is one that I think, Mr. Chairman, at some point probably needs another hearing of its own, and that's the whole question of medical privacy. In the back of the audit from the Inspector General is this whole section detailing your ability to invade the privacy of medical records. It sounds like you were able to get into the entire system without very much trouble. It sounds like there was little if any resistance to your going in and finding any information that was stored in the electronic system. Is that correct?

Ms. BROWN. We, as members of the Inspector General Office, have the right to go in and look at those records. But one of the things we looked at was whether or not the system was secure from others going in.

Mr. MCDERMOTT. And your answer, basically, is a whole page of "noes." This system is not secure. Isn't that a fair assessment?

Ms. BROWN. There were some problems in that area.

Mr. MCDERMOTT. It seems to me that, under the Kennedy-Kassebaum bill, you have a requirement now that everyone's medical information be put into an electronic data system. That issue, I think, is going to be a huge problem, at least that's my assessment.

Is it your assessment from your audit that there is the potential, at least as we go to a national data system, where all medical records are put into the same data base, that we will have that difficulty of medical record confidentiality?

Ms. BROWN. I think those problems that were identified were corrected already, and that there is a great consciousness here of the necessity for protecting medical records. So it's something we will continue to look at and put emphasis on, and I believe also that HCFA is very much aware of that and is taking precautions.

Mr. MCDERMOTT. You're saying that right now it's not as easy to get into the system as it was when you did the audit; is that correct?

Ms. BROWN. That's true.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Without objection, a statement and questions from the gentleman from Pennsylvania, Mr. Coyne, will be made a part of the record.

[The prepared statement of Mr. Coyne follows:]

Statement of Hon. William J. Coyne

In March of this year, the Oversight Subcommittee held hearings on programs deemed by the U.S. General Accounting Office to be "high risk" programs—those programs highly vulnerable to waste, fraud, abuse, and mismanagement. The Medicare program, the nation's second largest social program, has been on the GAO's list of high risk programs since 1992 and remains there today. It is my hope that the information we will receive today will give us a better idea of the true scope of problems faced by the Health Care Financing Administration (HCFA) in preventing erroneous Medicare overpayments to providers. I commend Chairman Thomas and Ranking Member Stark for holding today's hearings on this exceedingly important issue.

In its high risk report, the GAO estimated that the costs of fraud and abuse in the Medicare program range from 3 to 10 percent. The HHS Inspector General's audit reveals that this number is actually closer to 14 percent—or approximately $23 billion in erroneous payments in fiscal year 1995. At a time when the Congress is considering dramatic changes to the Medicare program in order to protect it from insolvency, we cannot afford such staggering losses to the program from overpayments to providers. I look forward to hearing from the Inspector General and from the HCFA Administrator as to their ideas and recommendations for safeguarding the Medicare program against the problems that we will hear about today.

Chairman THOMAS. I know of the gentleman's interest in the privacy of records and the confidentiality. I made a statement earlier that we may need to move into the computerized patient records area. But clearly it would be with sufficient safeguards for confidentiality, and I believe the gentleman shares the general understanding. Perhaps how and when it's done might be different.

The gentlewoman from Florida. We're hopeful that we can conclude the hearing prior to having to go to vote.

Ms. THURMAN. I thank the Chairman. I will be brief.

Ms. Brown, let me ask a question, because in the course of some of the questioning earlier—I hope I misunderstood but I may not have—that you believed, with the Kennedy-Kassebaum and with what's happened this year in the budget reconciliation, that you might have all of the tools you need to fight fraud?

Ms. BROWN. Well, I certainly could identify others, and we can certainly use more money. But I think it has given us a substantial increase to the tools that we have available to us. The funding that HCFA has to perform their oversight functions is also increasing. For a 7-year period we will get substantial increases every year, which were probably calculated on the basis of what they thought we could absorb.

Ms. THURMAN. On the other side of that, though, let me remind you of a letter that you sent to Chairman Archer that dealt with some areas of advisory opinions for antikickback law, the intent standard change for civil money penalties, and the expanded exceptions for managed care under antikickback law, and basically thought that they were standing in the way of prosecuting health care fraud.

I'm just curious. Are those no longer needed, or should we be continuing to look at these issues? Are these some of the other tools that we still need to be looking at?

Ms. BROWN. Yes. The President submitted a bill this year that had many of the tools that we need. I know that in budget reconciliation, both the House and Senate versions, contained many of the things that we have been requesting and felt would be very helpful in fighting this battle.

Things change quickly in that environment, as you well know, and we were planning to work on a continuing basis with the Committees to supply any kind of backup information so that they could make the decisions on which ones they would put into law.

Ms. THURMAN. I would just hope that, as this conference goes through, while I know there are some provisions in the bill—and I thank the Chairman for the surety bond issue—but I am still very concerned. I think on the heels of this report that we have some way to go, and that I hope we continue to keep this in the front so that people feel like we are not wasting dollars out there.

Ms. BROWN. I don't think this will be, you know, an instant fix or anything, but as we continue to work, we will continue to provide that information so that—I'm sure many decisions will have to be made before we have a clean system.

Chairman THOMAS. No, but I do think it's important to underscore the fact that this is not 1993, it is 1997, and in those 4 years there have been fundamental changes. We've gotten off the political arguments.

One of the really useful things that an audit does is focus issues in positive ways, notwithstanding the pain that's involved in the positive ways, and concrete ways. Instead of pontificating about the way the world ought to be, you get some very specific focus on what you should or should not do.

I began by saying that this is a painful process, but it is absolutely integral to us being able to make meaningful responses. There's a lot of dollars out there being wasted. What we're focusing on are ways in which we can reduce that waste, and there are, sad

to say, people engaged in fraud. It's like any white collar crime area; the chances of getting caught are so small that the odds are that you, in essence, are willing to run the risk.

Our job is to provide a structure within reasonable costs to minimize all of those. We're never going to eliminate them, but audits are absolutely crucial as tools for us to identify whether we're moving in the right direction and, to a certain extent, at what speed we should be moving.

So I want to underscore the positive aspect of the audit. I am pleased to know that the IG has a comfort level in going forward into 1997 and beyond. We're receptive to any tools that may be necessary.

Mr. Vladeck, once again I want to apologize on the part of all the Subcommittee, and if this is the last appearance in front of this Subcommittee, we will remember all the other times as well as this one.

[The following questions and answers were subsequently received:]

QUESTIONS SUBMITTED BY HON. WILLIAM J. COYNE, RANKING MINORITY MEMBER, TO HON. JUNE GIBBS BROWN

1. What, in your opinion, are some of the most cost-effective efforts that the Health Care Financing Administration (HCFA) can undertake in the very near future to start to reduce the amount of Medicare overpayments?

Answer: In the short term, HCFA could direct its contractors to make follow-up evaluations of specific procedure codes we identified with high error rates and consider whether identified providers should be placed on prepayment medical review. The HCFA can direct its contractors to emphasize to providers the importance of maintaining sufficient documentation and the penalties for not doing so. Since 99 percent of claims that come to the contractors appear, on their face, to be correct, it is very difficult for the contractors to do a better job of identifying overpayments in the near future without implementing improved processes and systems. Their overpayment reduction efforts should be targeted initially to high-risk areas and to making providers understand that "mistakes" that result in a pattern of overpayments will not be taken lightly.

2. Since HCFA has already invested nearly $100 million in the Medicare Transaction System (MTS), do you have any recommendations about the implementation of this system? What are some issues that HCFA ought to take into consideration when planning for making this system operational, in light of your findings?

Answer: Regarding the cost of MTS, there have been a lot of numbers quoted in the press lately. At the beginning of 1997, we estimated that HCFA would spend $102 million for MTS contracts. Meanwhile the contract was terminated, and the contractor incurred about $45 million. Of that, HCFA paid about $41 million. Several tangible products came from that investment, including a system design to meet the needs of a completely redesigned managed care and fee-for-service transaction system and a high-level set of requirements (what the system must do) for the entire Medicare environment, including both fee-for-service and managed care, covering both current and future capabilities. The work that was done to develop system requirements will be useful to HCFA in whatever way it proceeds.

The HCFA states that as a result of the MTS development effort, it will consolidate existing contractor systems into standard Part A, Part B, and durable medical equipment (DME) systems by the year 2000. To date, 20 Part A intermediaries have been transitioned to a shared system and the remaining 20 will be transitioned by next August. Three of the four DME contractors are using a standard system now, and the transition for the fourth will be completed by July 1998. Eight Part B carriers are using a standard system now, and the remaining 24 will be using the same system by August 2000. While this does not fulfill the original goal of housing all information on beneficiaries, providers, payments, and services on a single shared database, it is a workable alternative and another step in the direction of a fully integrated system. A fault of the MTS plan was attempting to do too much in one initiative. The incremental enhancements that are going on now have a better potential for success. In moving toward an integrated system, we continue to rec-

ommend that HCFA build in adequate computer edits, internal controls, and related safeguards as described in OIG and General Accounting Office reports.

3. I understand that the focus of your audit was the fee-for-service side of the Medicare program. In your opinion, is it possible that such significant problems also exist in the managed care side of the program? We know from the GAO's high risk report that Medicare payments to HMOs are excessive, and we know that HCFA has historically not been very effective at ensuring that managed care companies play by Medicare's rules. Do you have any plans to undertake a similar audit of the Medicare managed care program?

Answer: Yes, although the focus of our CFO audit for fiscal year 1996 was on the Medicare fee-for-service side, we did conduct some limited testing on the managed care side. As managed care increases (as is expected) we will plan more testing, accordingly. Since managed care providers have a financial incentive to control costs, it would seem they would be less likely to provide medically unnecessary or unallowable services. Billing errors and coding problems associated with fee-for-services claims would likely be significantly diminished or eliminated in the managed care setting. However, rate setting methodologies for risk-based health maintenance organizations (HMOs) are based on expenditures in Medicare's fee-for-service program. We are concerned that abusive practices which drive up costs in the fee-for-service program are included when the HMO rate setting methodologies are applied. This is especially disconcerting when considering payments to HMOs are expected to increase throughout the decade as more beneficiaries opt to join HMOs.

Also, the GAO believes Medicare may be overpaying managed care providers by at least $2 billion a year because some HMOs substantially avoid the chronically ill. Our work related to the profit margins of Medicaid managed care plans is consistent with the GAO findings. The OIG has conducted a number of audits and inspections of the managed care environment in recent years and will continue to do so. Several managed care projects are slated to begin in fiscal year 1998.

4. In your opinion, do some of the provisions included in the Health Insurance Portability and Accountability Act (HIPAA)—like advisory opinions, anti-kickback rule exceptions, and weak false claims standards—present problems in combating the types of erroneous payments you identified in your audit?

Answer: It may be too early to assess the impact of specific provisions. Most fraud cases take several years to resolve. At any given moment, we are opening new cases, managing field investigations, initiating court or administrative proceedings, and wrapping up prosecutions or settlements of older cases. The resources made available under the HIPAA have enabled us to attack all phases of fraud fighting with renewed effectiveness. After passage of HIPAA, we moved expeditiously to form a new unit with primary responsibility for issuing advisory opinions. We worked diligently to ensure that the regulations and resources needed to respond to such requests were in place in advance of the statutory deadlines. We have received and responded to several advisory opinion requests, and are educating the industry about advisory opinion procedures through presentations to interested trade association and bar groups. In addition to advisory opinions, the new law requires the Secretary to provide industry guidance by soliciting proposals for modifications and additions to the so-called Safe Harbors, i.e., regulatory provisions which establish conditions for business structures or practices deemed to be non-abusive. Such arrangements will not be investigated or prosecuted under the Anti-kickback Statute. We anticipate that in the next several months we will be able to finalize eight proposed safe harbors and clarifications.

5. As you know, yesterday a multi-departmental investigation continued into the Medicare billing practices of Columbia/HCA in several states. From press reports it appears that the investigation is focusing on many of the same problems as your audit—upcoding, lack of medical necessity, etc. I notice that your report did not distinguish between overpayments to for-profit health care institutions versus those not-for-profit institutions. Is that information that you would be able to provide to the Subcommittee?

Answer: As to the Columbia/HCA investigation, we are actively involved in an official investigation with various other Federal agencies and cannot comment at this time. Regarding the second part of your question, we would generally agree that the causes for overpayments to hospitals do not differ substantially between for-profit and not-for-profit institutions.

6. The IG's review demonstrated "weaknesses in Electronic Data Processing (EDP) general controls through a system penetration test in which the IG obtained access privileges necessary to read or modify sensitive Medicare enrollment, beneficiary, provider and payment information." How widespread is this problem, and what needs to be done to insure the protection of confidential and sensitive Medicare data?

Answer: The specific vulnerability to which the quotation above refers was immediately corrected. To say that the problem is "widespread" would imply that many unauthorized individuals are penetrating the various subsystems of the Medicare network. We believe the possibility for abuse was present, and the fact that we were able to penetrate is a concern that must be addressed. There were several vulnerabilities. We found that access controls did not adequately protect data from unauthorized modifications or destruction. Application developers were allowed update access to production data for many sensitive applications in a manner that would bypass audit trail controls. In addition, access control software was configured so that it did not adequately protect HCFA's 400,000 tapes. Furthermore, the use of sensitive utilities that could bypass access controls was not monitored. All of these weaknesses could allow users to modify production data without detection.

We also identified serious application development and change control weaknesses. In addition, EDP functions were not adequately separated to prevent one individual from controlling key aspects of computer related operations; controls over operating system software were ineffective; and service continuity controls had serious weaknesses.

As HCFA consolidates its systems, we expect the vulnerabilities will be eliminated. We will, nevertheless, continue testing HCFA's controls in the future to ensure the privacy, integrity, and safety of Medicare data and will report our findings to the Congress as needed. The HCFA is now well-aware of the critical importance of system security and is working to build adequate controls into its protocols.

7. During the Oversight Subcommittee's March 1997 hearing on "high risk" federal programs, the GAO provided extensive testimony on Medicare claims fraud. Among other findings, the GAO concluded that:

- Medicare fraud and abuse was in the range of $6 to $20 billion annually;
- problems in funding program safeguards and HCFA's limited oversight of contractors continue to contribute to fee-for-service program losses; and
- the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs with which it contracts.

Do you have any comments on these GAO findings?

Answer: Regarding GAO's estimate of fraud and abuse, we now believe that $6 to $20 billion annually may be a fairly conservative number, particularly if you consider improper claims to be a form of program abuse. We projected a mid-point of $23 billion and a range of $17.8 billion to $28.6 billion that HCFA would not have paid in fiscal year 1996 if the Medicare contractors had been able to do pre or post payment reviews of the medical files. We would not venture to say how much of that is fraud because our review was limited to determining whether the claims in our sample were proper and supported.

Regarding funding of program safeguards and HCFA's limited oversight of contractors, we believe the resources provided by the Health Insurance Portability and Accountability Act will greatly strengthen these activities. One of the most significant provisions of HIPAA was the Medicare Integrity Program (MIP). This program authorizes the Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out program integrity activities such as audits of cost reports, medical review, and payment determinations. The MIP provides a stable source of funding for HCFA's program integrity activities, and provides it with the authority to contract for these activities with any qualified entity (not just those insurance companies who are currently fiscal intermediaries or carriers). A dependable funding source allows HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It will help HCFA to shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

We agree with the GAO that the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs with which it contracts. Payment rates appear to be inflated because HMO rates are driven by inflated fee-for-service expenditures and HMOs tend to recruit healthy beneficiaries, avoiding the costs of caring for the chronically ill. There are other systemic challenges as well, including HMO insolvency and difficulty in recovering overpayments made to HMOs. We encourage HCFA to communicate actively with its resource partners within the Government and the private sector to strengthen its monitoring and management of the program. The OIG is undertaking a number of audits and inspections in fiscal year 1998 to study a cross-section of managed care issues.

QUESTION SUBMITTED BY HON. PETE STARK TO HON. BRUCE C. VLADECK

Question: I would love to hear from you (OIG) and from Bruce's department, in what we could do to put much of the burden on the providers, to get their records in shape, and make it very expensive for them if they don't.

Answer: It is HCFA's position that all providers who bill the Medicare program are accountable for the documentation to support payment of each claim. Careful and appropriate documentation of health conditions and services is an integral part of good medical practice.

HCFA's Corrective Action Plan includes a commitment to reduce the errors identified in the CFO audit. To do this, HCFA will "put the burden on providers to get their records in shape" as follows:

• Providers must submit underlying documentation, which must be reviewed prior to payment or denial. Failure to submit such documentation will make it more expensive for providers by delaying their payment or denial of their claims.

• HCFA's prepayment medical review will be increased to approximately 10 percent of the total claims processed and will include requests for additional documentation. Where problems are found, the effort will be intensified. This will slow reimbursement somewhat and increase providers' awareness that documentation of all services is required for timely reimbursement.

Our contractors have denied claims and are seeking overpayments for the improperly filed and paid claims uncovered during the OIG's fiscal year 1997 CFO Audit. In addition, the providers identified in that report will be evaluated by HCFA's contractors as to the need for more extensive review.

QUESTION SUBMITTED BY HON. BENJAMIN CARDIN TO HON. BRUCE C. VLADECK

Q: Mr. Cardin asked whether there shouldn't be some type of compliance audit requirements from certain participants as a condition of participation in the Medicare system and about whether HCFA had legal authority to require some form of compliance audit from providers. He said, maybe we should request audits on a periodic basis from providers with a history of poor performance and, in those cases, make the provider responsible for the cost, not HCFA's budget.

Bruce Vladeck agreed to check HCFA's authority to require such audits.

Answer: HCFA has broad audit authority to assure that proper payments are made in both Medicare Part A and Medicare Part B as follows:

• For Part A, 42CFR Subpart B, Section 413.20(d) describes continuing provider recordkeeping requirements including that:

"(1) The provider must furnish such information to the intermediary as may be necessary to (i) Assure proper payment by the program, including the extent to which there is any common ownership or control between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports; and... (iii) Satisfy program overpayment determinations."

"(2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due."

• For Part B, Section 1842(a)(1)(C) of the Social Security Act authorizes the Secretary to enter into contracts with carriers to..."make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part."

HCFA's fiscal intermediaries and carriers monitor billing patterns and do focused medical review. When they identify problems, they may suspend payment of claims, perform total prepayment review of all claims for a given provider, as well as monitor and question problem providers.In addition, the OIG has required continued compliance plans in cases that have been pursued to formal litigation.

Chairman THOMAS. The Subcommittee stands adjourned.

[Whereupon, at 1:20 p.m., the hearing was adjourned.]

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