OVERSIGHT OF FINANCIAL MANAGEMENT PRACTICES AT THE HEALTH CARE FINANCING ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, AND TECHNOLOGY

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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OVERSIGHT OF FINANCIAL MANAGEMENT PRACTICES AT THE HEALTH CARE FINANCING ADMINISTRATION

FRIDAY, MARCH 26, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn, Biggert, Ose, and Turner.

Staff present: J. Russell George, staff director and chief counsel; Bonnie Heald, director of communications; Mason Alinger, clerk; Paul Wicker and Kacey Baker, interns; Faith Weiss, minority counsel; and Earley Green, minority staff assistant.

Mr. HORN. The quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order. Today's hearing is the third in a series of hearings to examine the results of financial statement audits of selected Federal agencies.

On March 1, we heard from the Internal Revenue Service. Unfortunately, that agency was unable to sustain the progress it had made in 1998. Last Thursday, we discussed the serious problems confronting the Department of Justice and the Federal Aviation Administration. Today we'll hear testimony focusing on the financial management practices of the Health Care Financing Administration [HCFA], part of the Department of Health and Human Services.

The Health Care Financing Administration is responsible for funding Medicare and Medicaid, the two most extremely important Federal programs for millions of our citizens. In 1998 these programs provided over $290 billion worth in health care to our most vulnerable citizens, the elderly and the poor. $298 billion represents nearly 18 percent of all Federal spending last year. It's an enormous cost and one that analysts predict will skyrocket during the next decade. The Congressional Budget Office projects that by the year 2009 the cost of these two entitlement programs will more than double to a soaring and sobering $689 billion. We cannot allow any portion of that money to be wasted.

Two previous financial audits of the Health Care Financing Administration identified serious problems at the agency, including

an estimated $40 billion worth of improper payments in the Medicare program during 1996 and 1997. Problems were also found with the Health Care Financing Administration's ability to collect money that is owed to the agency and with its inability to provide adequate security for its computer systems.

Medicare is critical to the health and well-being of millions of elderly Americans. Likewise, Medicaid is the lifeline for America's low income and chronically ill. I understand that we will hear today that the Health Care Financing Administration has made some progress in improving its financial management. I sincerely hope that is true because we need dramatic improvement in the way these programs are managed.

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

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"Oversight of Financial Management Practices at the Health Care Financing Administration"

March 26, 1999

OPENING STATEMENT
REPRESENTATIVE STEPHEN HORN (R-CA)
Chairman, Subcommittee on Government Management, Information, and Technology

A quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order.

Today's hearing is the third in a series of hearings to examine the results of financial statement audits of selected Federal agencies. On March 1, we heard from the Internal Revenue Service. Unfortunately, that agency was unable to sustain the progress it had made in 1997. Last Thursday, we discussed the serious problems confronting the Department of Justice and the Federal Aviation Administration.

Today, we will hear testimony focusing on the financial management practices at the Health Care Financing Administration, part of the Department of Health and Human Services.

The Health Care Financing Administration is responsible for funding Medicare and Medicaid, two extremely important Federal programs.

In 1998, these programs provided over $290 billion in health care to our most vulnerable citizens – the elderly and the poor.

That $290 billion represents nearly 18 percent of all Federal spending last year. It is an enormous cost, and one that analysts predict will skyrocket during the next decade.

The Congressional Budget Office projects that by the year 2009, the cost of these two entitlement programs will more than double to a soaring and sobering $689 billion. We cannot allow any portion of that money to be wasted.

Two previous financial audits of the Health Care Financing Administration identified serious problems at the agency, including an estimated $40 billion worth of improper payments in the Medicare program during 1996 and 1997. Problems were also found with HCFA's ability to collect money that is owed to the agency, and with its inability to provide adequate security for its computer systems.

Medicare is critical to the health and well-being of millions of elderly Americans. Likewise, Medicaid is the lifeline for America's poor and chronically ill.

I understand that we will hear today that HCFA has made some progress in improving its financial management.

I sincerely hope that is true, because we need dramatic improvement in the way these programs are managed. I welcome our witnesses today and look forward to their testimony.

Mr. HORN. I welcome our witnesses today and look forward to their testimony, but first I'd like to yield to my colleague, Mr. Turner of Texas, who is the ranking member on this committee. Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman. It's a pleasure to participate in this ongoing series of oversight hearings on Federal financial management. I want to thank you, Mr. Chairman, for your leadership in this area and for the bipartisan way in which you proceed to examine the agencies of the Federal Government.

Congress recognized as early as 1990, with the passage of the Chief Financial Officers Act, that the Federal Government should maintain reliable financial information that could be audited. The Chief Financial Officers Act directed 10 Federal agencies to conduct independent financial audits, and in 1994 Congress expanded the requirement to all 24 major Federal agencies. Today we are going to have the opportunity to discuss some of the tangible results of this process and the third consecutive audit of the Health Care Financing Administration's financial statements.

I want to welcome the Inspector General of Health and Human Services and the Deputy Administrator of HCFA, who are here to discuss the results of the fiscal year 1998 audit.

In the first HCFA audit, fiscal year 1996, the Inspector found that HCFA's financial information was so unreliable that the Inspector General could not finish the audit nor draw any conclusions about the agency's financial statements. In the audit conducted last year, HCFA received a qualified opinion which, as I understand, means that while the financial statements were generally reliable, inadequate documentation existed for certain amounts.

This year the audit again resulted in a qualified opinion. Although HCFA has made progress in resolving its financial management weaknesses, the Health and Human Services Inspector General raises serious concerns which we will hear about today.

As we all know, Medicare is a very important Federal program. It provides health insurance for over 39 million elderly or disabled citizens. Without Medicare, many of these Americans would be deprived of adequate medical care. Medicare provides Americans with the security that, as they grow older and increasingly more vulnerable, they will have access to sound health care without bankrupting them or their families.

It is surprising to note that the Medicare program processed over 900 billion Medicare claims last year and paid out more than $210 billion in benefits. We can see Medicare's importance. That's why we must ensure that it runs well.

Clearly the program is susceptible to fraud, abuse, and overpayments. Over this last year, however, HCFA demonstrated a significant reduction in the total amount of estimated Medicare overpayments. In fact, HCFA has reduced the error rate by 50 percent and has been actively trying to reduce the amount of improper or inappropriate payments made by the Medicare program. The results of these efforts are beginning to show, and HCFA must continue to reduce these overpayments as aggressively as possible.

In closing, I would like to commend the Health and Human Services Inspector General and HCFA's leadership in working to combat fraud and abuse in the Medicare program, and I look forward to the hearing and to hearing from each of our witnesses.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Jim Turner follows:]

Opening Statement of The Honorable Jim Turner
GMIT: "Oversight of the Financial Management Practices at HCFA"
March 26, 1999

This Subcommittee is holding a series of oversight hearings on Federal financial management. To date, we have reviewed the financial management practices of the Internal Revenue Service, Department of Justice, and the Federal Aviation Administration. Today we will turn our attention to the Health Care Financing Administration. I would like to thank Chairman Horn for his active oversight of financial management at federal agencies and for the bipartisan manner in which he consistently conducts his hearings.

Congress recognized, as early as 1990 with the passage of the Chief Financial Officers Act, that the federal government should maintain reliable financial information that can be audited. The CFO Act directed 10 Federal agencies to conduct independent financial audits, and in 1994, Congress expanded the requirement of an audited financial statement to all 24 major agencies. Today, we have the opportunity to discuss some of the tangible results of this process with the third, consecutive audit of HCFA's financial statements.

I would like to welcome the Inspector General of HHS and the Deputy Administrator of HCFA who are here to discuss the results of the audit for fiscal year 1998.

In the first HCFA audit (for fiscal year 1996), the IG found that HCFA's financial information was so unreliable that the IG could not finish the audit nor draw any conclusions about the agency's financial statements. In the audit conducted last year, HCFA received a "qualified" opinion, which means that while the financial statements were generally reliable, inadequate documentation existed for certain amounts. This year, the audit again resulted in a "qualified opinion." Although HCFA has made progress in resolving its financial management weaknesses, the HHS IG raises several serious concerns, which we will hear about today.

As we all know, Medicare is an important federal program. It provides health insurance for over 39 million elderly or disabled citizens. Without Medicare, many of these Americans would be deprived of adequate medical care. Medicare provides Americans with the security that, as they grow older and increasingly more vulnerable, they will have access to the sound medical care without bankrupting them or their families. Last year, the Medicare program processed over 900 billion Medicare claims and paid more than $210 billion in benefits.

We can see Medicare's importance. That's why we must also assure that it runs wells. Clearly, the program is susceptible to fraud, abuse, and overpayments. Over this last year, however, HCFA demonstrated a significant reduction in the total amount of estimated Medicare overpayments. In fact, HCFA has reduced the error rate by 50% and has been actively trying to reduce the amount of improper or inappropriate payments made by the Medicare program. The results of these efforts are

beginning to show, and HCFA must continue to reduce these overpayments as aggressively as possible.

Additionally, the IG audit indicates that the procedures and practices of the Medicare contractors, those who are responsible for processing claims, prevent HCFA from producing more reliable financial information. These Medicare contractors are the point of contact between the agency and the providers, and it is their responsibility to assure that Medicare claims are paid appropriately.

In closing, I would like to commend the HHS IG and HCFA's leadership in combating fraud and abuse in the Medicare program, and I look forward to this hearing and welcome our witnesses.

Mr. HORN. Thank you very much for that thoughtful statement.

Let me note the procedures here for some who are not familiar with it. Once we introduce the witnesses, your statement is fully put in the record—by your leave or without objection, et cetera.

No. 2, this committee is part of the full Committee on Government Reform, and all of our witnesses are sworn in on the oath. So, if the three witnesses this morning would stand and raise your right hands, just affirm the testimony you're about to give this subcommittee is the truth, the whole truth, and nothing but the truth.

[Witnesses sworn.]

Mr. HORN. We will note for the record that all three witnesses have affirmed, and we will start with the Honorable June Gibbs Brown, Inspector General of the Department of Health and Human Services. She has a very rich background, as we all know, having been Inspector General of the Department of Defense from 1987 to 1989, and she's held numerous other positions. She's won probably every award that can be given to a career civil servant.

And it's always good to see you. We know you run a tight shop. I've never asked you, is Defense easier than HHS or is HHS easier than Defense? You're not about to tell, right? Remember, you're under oath.

Anyhow, go ahead. Obviously if you want to summarize, fine. If you want to go into exhaustive detail, we're all with you because we've got the whole morning.

STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JOSEPH E. VENGRIN, ASSISTANT INSPECTOR GENERAL FOR AUDIT OPERATIONS AND FINANCIAL STATEMENT ACTIVITY

Ms. BROWN. Thank you, Mr. Chairman. I'll summarize. I'm pleased to report to you on our fiscal year 1998 audits of the Medicare fee-for-service payments and the Health Care Financing Administration's [HCFA] financial statements.

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

I'd like to begin by acknowledging the cooperation and support we receive from the Department, from HCFA, and from the General Accounting Office. HCFA's assistance in making available medical review staff and the Medicare—at the Medicare contractors and the peer review organizations was invaluable. We also work closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government.

My statement today will focus first on the notable reduction in Medicare payment errors this year and then on HCFA's financial reporting. Our review included a statistical selection of 5,540 medical Medicare claims from a population of $176.1 billion in fiscal year 1998 fee-for-service claims expenditures. Payments to providers for 915 of these claims did not comply with Medicare laws and regulations.

By projecting these sample results, we estimated that fiscal year 1998 net improper payments totaled about $12.6 billion nationwide or about 7.1 percent of the total Medicare fee-for-service benefit payments. This is the midpoint at the 95 percent confidence level

of the estimated range of $7.8 billion to $17.4 billion, or 4.4 to 9.9 percent.

As in the past years, the improper payments could range from inadvertent mistakes to outright fraud and abuse. It should be noted that medical personnel detected almost all of the improper payments in our sample. When these claims had been submitted for payment to Medicare contractors, they contained no visible errors.

We are very encouraged by the reduction in payment errors this year. This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion, a 45 percent drop. We attribute this improvement to several actions on the part of the administration, the Congress, and the health care provider community.

To provide just two examples, the Medicare Integrity Program, under HCFA's direction, provides resources to expand contractor safeguard activities, while the Health Insurance Portability and Accountability Act has provided both HCFA and my office with a stable funding source for Medicare payment safeguards and fraud and abuse prevention activities for the next several years. That is fraud and abuse prevention activities.

Chart one, which is to the side here and is also attached to my written testimony, demonstrates the reduction in improper payments by the major type of errors found over the last 3 years. The red error indicates documentation errors where we saw the most dramatic reduction. The blue indicates errors due to a lack of medical necessity, a continuing problem. The yellow, incorrect coding, which is also a concern. The green, errors due to noncovered services. And finally, the purple, which is all other types of errors.

Documentation errors dropped from $10.8 billion in fiscal year 1996 to $2.1 billion this year. These errors had represented the most pervasive problems in 1996 and 1997, even though Medicare regulations specifically require providers to maintain sufficient documentation to justify diagnosis, admissions, and other services.

As shown in chart 2, the overall category of documentation includes two components this year: insufficient documentation for medical experts to determine the patient's overall condition, diagnosis, and extent of services performed; and no documentation to support the services provided.

Last year we included an additional component to identify situations in which providers were under investigation and the OI could not obtain medical records to support billed services.

This year, in contrast, we obtained all medical records on claims under investigation. A lack of medical necessity was the highest error category this year, and the second highest for both 1996 and 1997.

As noted in chart 3, these types of errors in inpatient prospective payment system [PPS] hospital claims, shown in red, have been consistently significant in all 3 years. Decisions on medical necessity were made by medical staff who followed their normal claim review procedures to determine whether the medical records supported the claims.

Incorrect coding is the second highest error category this year, as illustrated in chart 4. Physician and inpatient PPS claims ac-

counted for over 80 percent of the coding errors in fiscal years 1996, 1997, and in 1998. For most of the coding errors, medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code.

Clearly, Mr. Chairman, progress has been made in reducing payment errors, and we are heartened that providers are doing a better job in documenting their services, but we caution that diligence is needed to sustain the apparent downward trend. In short, our audit results from the 3-year period demonstrate that the Medicare program remains inherently vulnerable to improper and unnecessary benefit payments.

To ensure continued progress while keeping abreast of continuing changes in the health care area and adequately safeguarding the Medicare trust fund, we've made a number of recommendations to HCFA.

Turning to our audit of the fiscal year 1998 financial statements, we're pleased to report that HCFA has continued to successfully resolve many previously identified financial accounting problems. For example, substantial progress has been made in improving Medicare and Medicaid accounts payable estimates, as well as estimates of improper payments included in cost reports of institutional providers.

However, our opinion on the 1998 financial statement, as mentioned by Mr. Turner, remains qualified because of continuing documentation problems. Most significantly, we could not determine if the report of $3.3 billion Medicare accounts receivable balance, that is, what Medicare providers owed to HCFA, was fairly presented because contractors did not maintain sufficient documentation to support the reported activity.

Our report also discusses our concern that contractors do not have uniform accounting systems to record, classify, and summarize financial information, or adequate controls over the electronic data processing environment.

To briefly summarize, I'm pleased that HCFA is progressively pursuing a corrective action plan to address our concerns. As part of that plan, we're working closely with HCFA to establish an adequate internal control structure for Medicare accounts receivable.

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

[The prepared statement of Ms. Brown follows:]

FY1998
Financial Statement Audit
Health Care Financing Administration (HCFA)

Testimony of
June Gibbs Brown
Inspector General

Hearing Before:
House Committee on Government Reform,
Government Management, Information and
Technology Subcommittee

March 26, 1999

Office of Inspector General
Department of Health and Human Services

June Gibbs Brown
Inspector General
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, and I am pleased to report to you on our audits of Fiscal Year (FY) 1998 Medicare fee-for-service payments and the Health Care Financing Administration (HCFA) financial statements. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

The Office of Inspector General (OIG) recently issued its third annual estimate of the extent of fee-for-service payments that did not comply with laws and regulations. As part of our analysis, we profiled all 3 years' results and identified specific trends, where appropriate, by the major types of errors found over the 3 years and the types of health care providers whose claims were erroneous. As required by the Government Management Reform Act of 1994, we also issued our third comprehensive financial statement audit of HCFA. The 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 statements.

My statement today will focus first on the notable reduction in Medicare payment errors we have found and the problem areas where further effort is needed. Then I will briefly highlight the significant findings of our financial statement audit.

Before I begin, I would like to acknowledge the cooperation and support we received from the Department, HCFA, and the General Accounting Office (GAO). HCFA's assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO) was invaluable in reviewing benefit payments. Also, I want to point out that we worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government. The Department is one of the most significant agencies included in these Governmentwide statements.

MEDICARE PAYMENT ERRORS

Overview

The HCFA is the largest single purchaser of health care in the world. With expenditures of approximately $310 billion, assets of $181 billion, and liabilities of $40 billion, HCFA is also the largest component of the Department. Medicare and Medicaid outlays represent 34.2 cents of every dollar of health care spent in the United States in 1998. In view of Medicare's 39 million beneficiaries, 860 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the Medicare program is inherently at high risk for payment errors.

Like other insurers, Medicare makes payments based on a standard claim 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.

As part of our first audit of HCFA's financial statements for FY 1996, we began reviewing claim expenditures and supporting medical records. We did this because of the high risk of Medicare payment errors, the huge dollar impact on the financial statements (e.g., $176.1 billion in FY 1998 fee-for-service claims), and our statutory requirement to report on compliance with laws and regulations. This year, for the first time, we issued the results of our claim testing separately from the financial statement audit report.

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 Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Sampling Methodology

To accomplish our objective, we used a stratified, multistage sample design. The first stage consisted of a selection of 12 contractor quarters during FY 1998 (10 from the first, second, and third quarters and 2 from the fourth quarter). The selection of the contractor quarters was based on probabilities proportional to the FY 1997 Medicare fee-for-service benefit payments. The second stage consisted of a stratified random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,540 claims valued at $5.6 million for review.

For each selected beneficiary during the 3-month period, we reviewed all claims processed for payment. We first contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response, we made numerous follow-up contacts by letter, telephone calls, and/or onsite visits. Then medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and PROs assessed the medical records to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on previously identified improper 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.

Sample Results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during FY 1998, we found that 915 claims did not comply with Medicare laws and regulations. **By projecting these sample results, we estimated that FY 1998 net improper payments totaled about $12.6 billion nationwide, or about 7.1 percent of total Medicare fee-for-service benefit payments.** This is the mid-point of the estimated range, at the 95 percent confidence level, of $7.8 billion to $17.4 billion, or 4.4 percent to 9.9 percent.

Medical review personnel detected 90 percent of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors we found.

As in past years, the 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. We have, however, quantified the estimated provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded, or noncovered. These were the major error categories noted over the last 3 years.

Reduction in Error Rate

This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion--a 45 percent drop. While we do not have empirical evidence supporting a specific causal relationship between the error rate decline and corrective actions, we attribute the decline to several factors:

- The Medicare Integrity Program, under HCFA's direction, provides resources to expand contractor safeguard activities, including increased medical reviews, audits, and provider education. For instance, HCFA directed its contractors to conduct extensive prepayment reviews of certain types of physician claims that we had identified as vulnerable to improper payments.

- Fraud and abuse initiatives have had a significant impact. Operation Restore Trust placed greater emphasis on more in-depth reviews of home health claims. Also, the Health Insurance Portability and Accountability Act has provided both HCFA and OIG with a stable funding source for Medicare payment safeguards and fraud and abuse activities for the next several years. Through the Health Care Fraud and Abuse Control Program, a nationwide effort was established to coordinate Federal, State, and local law enforcement activities on health care fraud. Other critical efforts include industry guidance, corporate integrity agreements with providers that settle allegations of fraud, beneficiary education, and pursuit of legislative changes.

- Virtually all major provider groups, including physicians, inpatient and outpatient services, and home health agencies, had significant error reductions since FY 1996. The provider community has been working aggressively with HCFA to ensure proper billings for services rendered, thereby ensuring compliance with Medicare program reimbursement rules.

- Finally, HCFA and OIG outreach efforts and HCFA's corrective actions were pivotal in reducing documentation errors.

Chart 1 demonstrates the reduction in improper payments by major error categories: documentation, medical necessity, coding, and noncovered services. While the drop in documentation errors is especially encouraging, errors due to the lack of medical necessity and incorrect coding remain matters of concern.

Significant Drop in Documentation Errors

Documentation errors dropped from $10.8 billion in FY 1996 to $2.1 billion in FY 1998. These errors represented the most pervasive problems in our samples for both FYs 1996 and 1997, despite Medicare regulation, 42 CFR 482.24(c), which specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments, and continued care.

We believe that documentation has improved primarily because of:

- ***HCFA and OIG outreach efforts.*** With the release of our FY 1996 report, OIG and HCFA together briefed providers on the audit results and Medicare documentation requirements. For example, HCFA hosted informational meetings with major professional organizations representing various physician specialties, the home health care industry, skilled nursing facilities, hospitals, and other providers.

- ***Implementation of HCFA's corrective action plan.*** Since our FY 1996 audit, HCFA has developed and initiated several corrective actions designed to reduce Medicare payment errors. For example, in FY 1998, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. In addition, HCFA asked contractors to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation. The HCFA dedicated approximately $14 million to increase the level of claims review in accordance with its corrective action plan. An additional $10 million was focused on medical reviews and audits of a provider group with aberrant billing practices.

For FY 1998, as seen in chart 2, the overall category of documentation includes two components: (1) insufficient documentation for medical experts to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. In FY 1997, we included an additional component to identify situations in which providers were under investigation and the OIG could not obtain medical records to support billed services. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. In contrast, working

with our Office of Investigations and the Department of Justice to satisfy legal concerns, we obtained all medical records on FY 1998 claims under investigation.

Some examples of continuing documentation problems follow:

- **Physician.** Medicare paid a physician $871 for 40 hospital visits. The medical records, however, supported only 18 visits. Therefore, payment of $479 for the 22 visits without supporting documentation was denied.

- **Home health.** A home health agency was paid $64 for skilled nursing visits. Because the medical records contained no documentation to support the provision of services, the medical reviewers denied payment.

Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries or the extent of services performed. It should be noted that HCFA subsequently upheld almost 99 percent of prior-year overpayments and recovered approximately 94 percent.

Medically Unnecessary Services

The lack of medical necessity was the highest error category this year and the second highest for both FYs 1996 and 1997. As noted in chart 3, these types of errors in inpatient prospective payment system (PPS) hospital claims have been significant in all 3 years (FY 1996 - about $3.3 billion of the total $8.5 billion; FY 1997 - about $2.3 billion of the total $7.5 billion; and FY 1998 - about $2.8 billion of the total $7 billion).

In the case of outpatient services, we noted a major shift of errors this year from the documentation category to medically unnecessary services. For example, in FY 1996, errors in outpatient claims totaled an estimated $2.8 billion, of which $2.3 billion was attributable to documentation concerns. For FY 1998, errors in outpatient claims totaled $1.7 billion, of which $1.2 billion was for medically unnecessary services.

This error category covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the claims, as illustrated in the examples below:

- **Hospital inpatient.** A beneficiary was admitted to an acute care hospital for a trachea resection surgical procedure. The beneficiary was discharged without having the procedure, and the hospital was paid $15,625. The beneficiary was subsequently readmitted to the same hospital, and the procedure was performed during the second admission. Based on a review of the medical records, the PRO concluded that the procedure should have been completed during the initial hospital stay and that the beneficiary was prematurely discharged at that

time. As a result, the second admission was determined not medically necessary and the total payment of $21,284 for that admission was denied.

- **Community mental health center**. A community mental health center was paid $21,421 for a beneficiary who received services under the partial hospitalization program. This program is designed to treat patients who exhibit severe or disabling problems related to acute psychiatric/psychological conditions. The medical reviewers determined that the beneficiary had already achieved sufficient stabilization and did not meet the definition of one who would otherwise require in-patient services. The services provided were therefore medically unnecessary, and the entire payment was denied.

- **Skilled nursing facility**. A skilled nursing facility was paid $10,428 for a 51-day skilled nursing stay. However, the patient's medical records documented that the patient received only maintenance-level (nonskilled) nursing home care, such as routine occupational therapy and the continuation of routine medication. Because Medicare does not reimburse for nonskilled services, the entire payment was denied.

Incorrect Coding

Incorrect coding is the second highest error category this year, representing $2.3 billion, or almost 18 percent, of the total improper payments. As illustrated in chart 4, physician and inpatient PPS claims accounted for over 80 percent of the coding errors in FYs 1996, 1997, and 1998.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical review staff determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which we offset against identified upcoding situations.

Some examples of incorrect coding follow:

- **Hospital.** A hospital was paid $33,380 for performing a partial thyroidectomy to remove part of the patient's thyroid gland. Based on the medical records, the surgical procedure actually performed was a less complex partial parathyroidectomy to remove small glands and tissues located near the thyroid gland. The PRO's correction of the procedure code produced a lesser valued diagnosis-related group (DRG) of $19,695, resulting in denial of $13,685 of the payment.

- **Physician.** A physician was paid $103 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the medical review staff determined that the provider's documentation supported a less complex, expanded problem-focused history, expanded problem-focused examination, and straightforward medical decisionmaking. As a result, $46 of the payment was denied.

- **Physician.** A physician was paid $108 for a hospital visit which included a detailed interval history, a detailed examination, and medical decisionmaking of high complexity. The

medical review staff determined that the level of service actually provided supported a lower level procedure code of focused interval history and decisionmaking of moderate complexity. Because the provider should have billed a lower level of care, $30 of the payment was denied.

Noncovered/Unallowable Services

Errors due to noncovered or unallowable services have consistently constituted the smallest error category. For the last 2 years, the majority of errors in this category were attributable to physician and outpatient claims.

Unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. For example:

- **Outpatient.** An outpatient provider was paid $56 for laboratory work which, according to the medical records, was part of a routine physical examination. Since Medicare does not cover such examinations, the payment was denied.

- **Physician.** A physician was paid a total of $34 for two claims for treating a beneficiary. Medical review follow-up determined that the treatment involved bioelectric medicine. Since this procedure is considered experimental and is not covered by Medicare, the total payment was denied.

Conclusions and Recommendations

We are most encouraged that actions on the part of the Administration, the Congress, and the provider community have contributed to a reduction in payment errors--and particularly that providers are doing a better job in documenting services to Medicare beneficiaries. But we caution that diligence is needed to sustain the apparent downward trend. In short, our audit results for the 3-year period clearly demonstrate that the Medicare program remains inherently vulnerable to improper and unnecessary benefit payments. We still have an unacceptable $12.6 billion estimated loss from the Government's coffer, and the FY 1998 improper payments relating to medically unnecessary services ($7 billion) and improperly coded services ($2.3 billion) are of significant concern.

Additionally, a number of issues could negatively affect future error rates:

- ***Substantial Year 2000 initiatives.*** More than 100 claim processing systems are being renovated/changed to comply with millennium requirements.

- ***Instability of Medicare contractors.*** The HCFA has experienced a record number of contractor terminations and consolidations.

- ***Legislative requirements.*** Additional requirements resulting from the Balanced Budget Act of 1997 must be implemented and enforced.

To ensure progress in reducing past problems while keeping abreast of continuing changes in the health care area and adequately safeguarding the Medicare Trust Fund, we recommended, among other things, that HCFA:

- enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare payments and

- continue to direct that the Medicare contractors and PROs expand provider training to (1) further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare, and (2) identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews.

We believe these types of reviews are critical to reducing improper Medicare payments and ensuring continued provider integrity.

The HCFA generally concurred with these recommendations. We expect that HCFA's testimony today will address the specific corrective actions being taken.

FINANCIAL STATEMENT AUDIT

We are pleased to report that HCFA has continued to successfully resolve many previously identified financial accounting problems. For example, substantial progress was made in improving Medicare and Medicaid accounts payable estimates, as well as estimates of potential improper payments included in cost reports of institutional providers. However, our opinion on the FY 1998 financial statements remains qualified. In accounting terms, a qualification indicates that we still found insufficient documentation to conclude on the fair presentation of all amounts reported.

Medicare Accounts Receivable

Most significantly, Medicare accounts receivable (i.e., what providers owe to HCFA) were not adequately supported. The OIG previously reported that Medicare contractors did not have adequate internal controls over these receivables. Specifically, they used various ad hoc spreadsheets and periodic financial reports in lieu of entry and tracking in a more formal accounting structure, such as dual-entry recordkeeping and having subsidiary accounting records for each provider. The contractors reported over $22.9 billion of Medicare accounts receivable activity during FY 1998, resulting in a reported gross accounts receivable of approximately $5.8 billion and net accounts receivable of $3.3 billion, which represents approximately 90 percent of the $3.6 billion of total Medicare accounts receivable at yearend.

We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors in our sample. Some contractors were unable to support the beginning balances, others reported incorrect activity, including collections, and finally others were unable to reconcile their reported ending balances to subsidiary records. We also found that substantial amounts of receivables had been settled with insurance companies but were still presented as outstanding

accounts receivable. As a result of these problems, we could not determine whether the Medicare contractors' accounts receivable balances and activities were fairly presented.

Material Weaknesses

Material weaknesses are serious deficiencies in internal controls that could lead to material misstatements of amounts reported in the financial statements in subsequent years unless corrective actions are taken.

The FY 1998 report on internal controls notes three material weaknesses:

1. As discussed above, significant improvements are needed in Medicare contractors' development, collection, and reporting of accounts receivable.

2. Financial reporting remains a material weakness because Medicare contractors have not adequately reconciled expenditures reported to HCFA. Also, the process for preparing financial statements is manually intensive.

3. The HCFA central office and Medicare contractors continue to have material weaknesses in electronic data processing controls relating to security access and application development and change controls.

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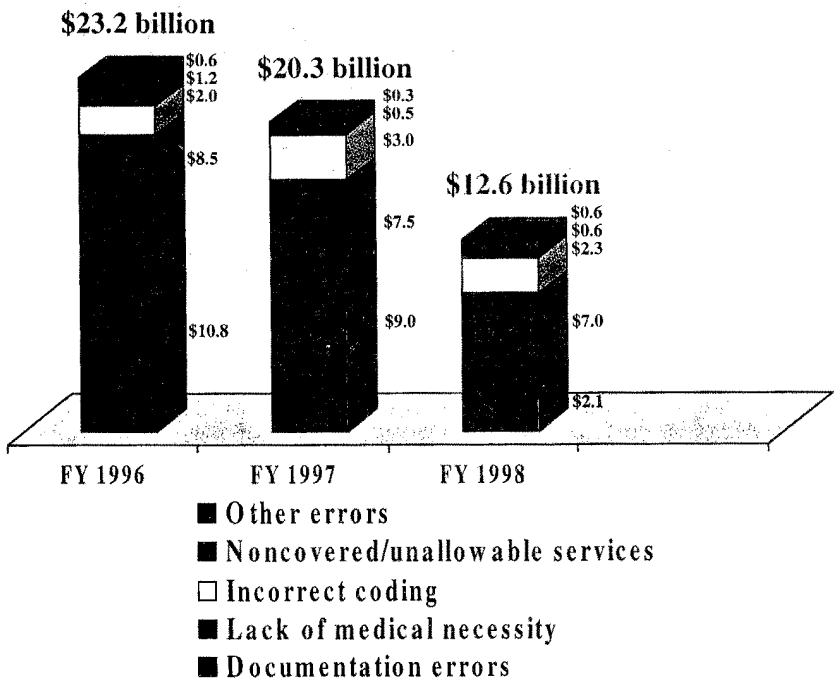
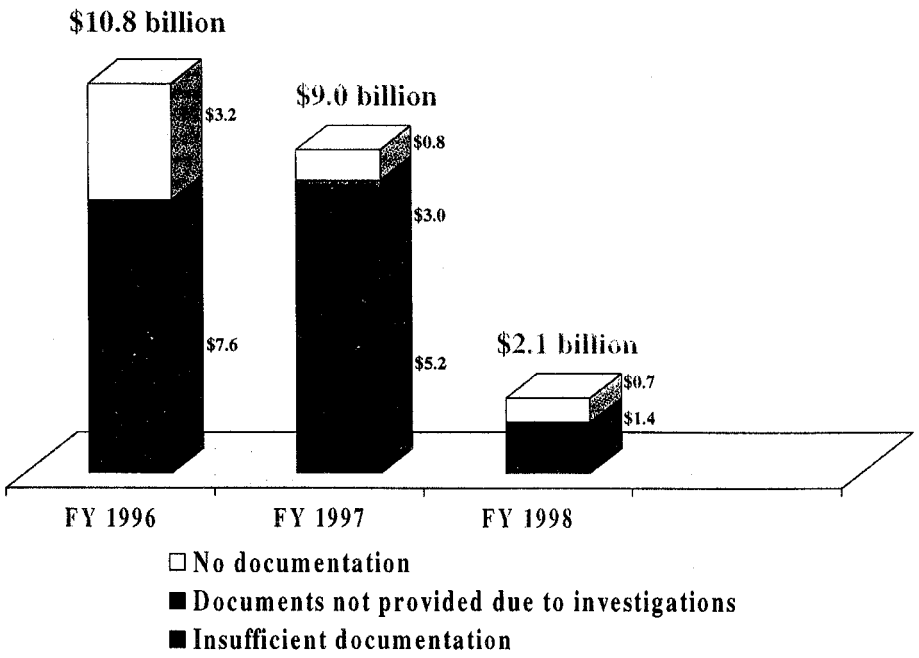
I appreciate the opportunity to appear before you today and to share our reports with you, and I will be happy to answer any questions you may have.

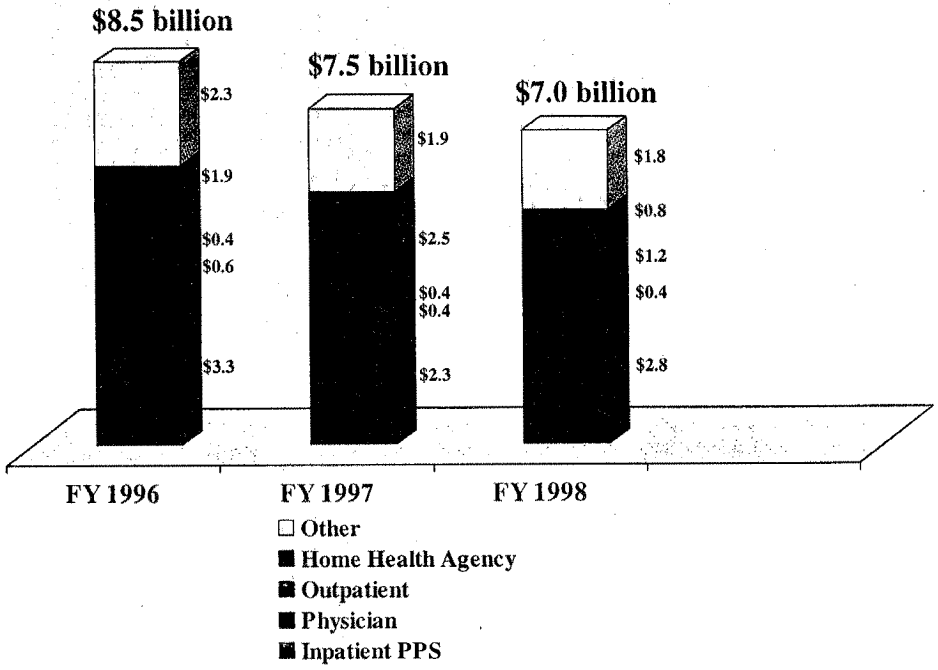
Estimated Improper Payments by Type of Error
(Dollars in Billions)



Documentation by Error Category
(Dollars in Billions)

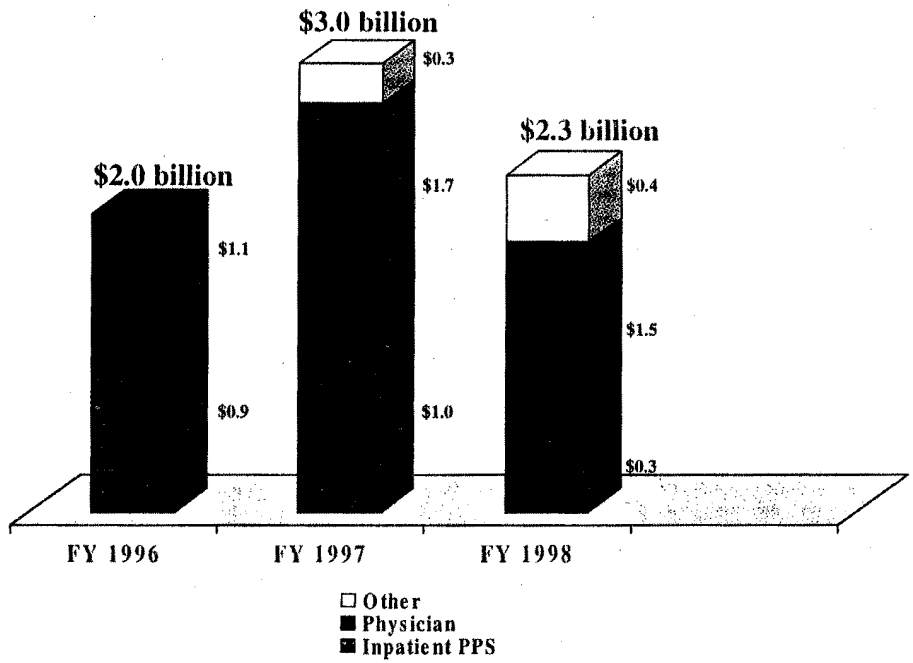


Errors Due to Lack of Medical Necessity by Provider Types (Dollars in Billions)



4

Errors Due to Incorrect Coding by Provider Types (Dollars in Billions)



Mr. HORN. Thank you very much for that very helpful statement.

Before we open to questions, we will call on the Deputy Administrator of HCFA, Mr. Michael Hash. He has a very rich experience in health care problems, including several years on the House Committee on Commerce dealing with the health issues that come before the Congress. So, we look upon you as suitably initiated, having worked on the Hill, and we obviously wish you well. That's one of the toughest jobs in this city. So please proceed.

STATEMENT OF MICHAEL M. HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HASH. Thank you, Mr. Chairman.

Chairman Horn, Mr. Turner, Mrs. Biggert, we're very pleased to have this opportunity to discuss the fiscal year 1998 Chief Financial Officer's audit of HCFA. As the Inspector General just mentioned, this is the third such comprehensive audit by her office. We are grateful for the valuable insights which this audit process has provided to us, and we believe that we are making substantial progress and improvements because of them.

In just 2 years we have been able to cut the error rate in half, from 14 percent to 7 percent. However, this year's audit shows that the Medicare payment error rate is still too high. We want to especially thank, for progress that we have made, physicians and other providers, because they have made efforts by improving their claims processing submissions and their documentation. They have greatly helped in reducing the error rate, and we have new provider education initiatives under way to build on this success.

The 7 percent error rate represents about $12.6 billion in taxpayer funds, which we all agree is simply unacceptable. We must be diligent in sustaining and increasing the improvements that we've made. To do that we have a number of initiatives under way, and we have developed a comprehensive program integrity plan to make sure that in fact we pay right the first time.

Thanks to the work of this committee and the Congress, we now have more tools to continue this improvement. The Health Insurance Portability and Accountability Act [HIPAAA], for the first time created a stable source of funding for program integrity activities. In the current fiscal year we have about $560 million available for our program integrity initiatives. And the Balanced Budget Act helped close some important, significant loopholes, and tightened controls on problem providers.

President Clinton's fiscal year 2000 budget also includes several new proposals to build on our success in fighting health care fraud, waste and abuse. These measures would save an additional $2 billion in Medicare expenditures over the next 5 years and, we believe, help to extend the life of the Medicare trust funds. We look forward to working with you to secure passage of these important proposals.

Through additional tools that were provided by HIPAA and the BBA, our comprehensive program integrity plan, plus the President's new proposals and your continued support, I'm confident that we will continue to reduce the payment error rate.

We are also pleased that this year's audit found that only one remaining area, contractor accounts receivable, prevents us from receiving an unqualified opinion, which is our goal. We are working with the Inspector General to develop a short-term solution to the accounts receivable documentation problem. However, a full remedy of this problem involves systems changes that must be delayed until we have cleared the year 2000 computer challenge.

These audits provide a valuable road map directing us to areas that need attention. The findings in previous audits helped us correct problems with our accounts payable, with our Social Security Administration receivables, and other problems that the audits have identified and the Inspector General referred to. They have also helped us in our aggressive efforts to improve our computer systems security. While we have a lot of work that needs to be done to improve the results of the CFO audit, we are pleased with the pace of our progress.

With your continuing help and support, we will continue to do everything in our power to fight waste, fraud, and abuse, and to ensure that the Medicare program pays it right. We will also continue to improve our financial reporting and management of the Medicare trust funds.

I want to thank you again for holding this hearing today, and I'd be happy also to respond to any questions that you or other members of the subcommittee may have. Thank you, Mr. Chairman.

[The prepared statement of Mr. Hash follows:]

Statement of

MIKE HASH

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Before the

HOUSE COMMITTEE ON GOVERNMENT REFORM

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,

INFORMATION, & TECHNOLOGY

on the

FISCAL 1998 CFO AUDIT OF HCFA

March 26, 1999

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Testimony of
MIKE HASH, DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
on the
FISCAL 1998 CHIEF FINANCIAL OFFICER'S AUDIT OF HCFA
before the
HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, & TECHNOLOGY
March 26, 1999

Chairman Horn, Congressman Turner, distinguished Subcommittee members, I am pleased to have this opportunity to discuss the findings of the fiscal 1998 Chief Financial Officer's (CFO) audit of the Health Care Financing Administration by the Department of Health and Human Services Inspector General. This is the third such comprehensive audit, which looks at our financial statements and whether we pay claims properly. We are grateful for the valuable insights these audits provide and are making substantial improvements because of them.

This year's audit shows that the Medicare payment error rate is still too high. We are pleased that we have cut the error rate in half in just two years, from 14 percent to 7 percent. However, that 7 percent represents some $12.6 billion taxpayer dollars, which we all agree is simply unacceptable. We must be diligent in sustaining and increasing the improvement. To do that, we have a number of initiatives under way and have initiated a comprehensive program integrity plan. We look forward to your continued support in these efforts.

We would not have come so far without the support of this Committee and Congress. We are particularly grateful for the steady program integrity funding provided under the Health Insurance Portability and Accountability Act (HIPAA) that allows us to plan and maintain comprehensive program integrity efforts. The Balanced Budget Act also provided essential tools to protect program integrity and fight fraud, waste, and abuse.

We are also pleased that this year's audit found that only one remaining problem area, contractor accounts receivable, prevents us from receiving an unqualified opinion. While we are working with the Inspector General's office to develop a short term solution to put in place for next year's audit, a full remedy involves systems changes that must be delayed until we have cleared the Year 2000 computer challenge.

The audit was conducted with our full cooperation and we welcome the Inspector General's findings. These audits provide a valuable roadmap directing us to areas that need attention. The findings in the previous audits helped us improve our accounting systems and highlighted areas in which our operations could be strengthened. As a result, we have cleaned up our accounts payable and Social Security Administration receivable problems and made other necessary corrections.

Paying Right

Since the Clinton Administration took office, the Department of Health and Human Services has taken numerous steps to implement a "zero tolerance" policy for waste, fraud and abuse. To do this, we must assure that we pay the right amount, to a legitimate provider, for covered, reasonable and necessary services for an eligible beneficiary. Achieving this goal is one of our top priorities at HCFA. With help from Congress, providers, beneficiaries, and our many other partners, we have achieved record success in assuring proper payments. We have also made considerable progress in fighting fraud by increasing investigations, indictments, convictions, fines, penalties, and restitutions.

In February, we released a Comprehensive Plan for Program Integrity. Its development began one year ago when we sponsored an unprecedented national conference on fraud, waste, and abuse in Washington, D.C., with broad representation from our many partners in this effort. The bulk of the conference consisted of discussions on how we could build on the highly successful Operation Restore Trust demonstration project, in which we increased collaboration with law enforcement and other partners to target known problem areas. Groups of experts from private

insurers, consumer advocates, health care provider groups, state health officials and law enforcement agencies were invited to share successful techniques and explore new ideas. Their discussions were synthesized and analyzed to determine the most effective strategies and practices already in place, and the new ideas that deserve further exploration. The result is a Comprehensive Program Integrity Plan with several clear objectives. These objectives include:

Increasing the Effectiveness of Medical Review and Benefit Integrity Activities. Medical review activities, where physicians review medical records to ensure that claims are correct, include all actions taken by contractors to determine whether a particular service was medically necessary and was appropriately provided. Benefit integrity activities, such as data analysis and complaint investigation, allow us to identify and pursue improper billers. The first initiative under our Comprehensive Plan includes:

- Tightening the performance standards for, and evaluation of, contractor medical review and benefit integrity units;
- Conducting training by the HHS Inspector General's office for 500 HCFA and Medicare contractor staff to improve the quality of information included in any referrals of cases of suspected fraud by HCFA contractors to the Inspector General.
- Engaging independent contractors to evaluate key medical review processes.

Implementing the Medicare Integrity Program. This allows us to hire special contractors who will focus solely on program integrity, as authorized under the Health Insurance Portability and Accountability Act. We are now reviewing public comments on a proposed regulation for how these contracts will work. Until now, only insurance companies who process Medicare claims have been able to conduct audits, medical reviews, and other program integrity activities. Under the new authority, we can contract with many more firms who can bring new energy and ideas to this essential task. We expect to have four new types of contractors:

- Payment Safeguard Contractors will focus on medical review, fraud case development, cost report audits and related program safeguard functions as needed;
- a Coordination of Benefits Contractor will consolidate all activities associated with

making sure Medicare does not pay for claims when other insurers are liable;

- a Statistical Analysis Contractor will provide a comprehensive on-going analysis of trends, utilization data and other information which helps detect fraud, waste, and abuse; and,
- Managed Care Integrity Contractor(s) will target the issues that are unique to health plans.

We have already issued one Program Safeguard Contract solicitation to establish a multiple awards contract for these activities, and expect to have a schedule of approved contractors shortly. Once established, the multiple awards contract will allow us to issue Task Orders for any or all program integrity activities. This way we can have a pool of contractors available to undertake the work before we solicit proposals for specific contractors' workloads. This lets us experiment with various configurations of program integrity activities, and provides flexibility that will help mitigate risk related to the Year 2000 issue and other challenges. We also will be able to turn to these contractors when various situations arise, such as the appearance of new scams or the departure of another contractor.

Proactively Addressing the Balanced Budget Act. This law created several new programs, benefits, and payment systems which all create new vulnerabilities. We are acting to address potential program integrity problems before they occur for:

- diabetes self-management, mammography screening, prostate cancer screening, and osteoporosis screening benefits;
- reimbursement changes for physicians assistants and nurse practitioners;
- the prospective payment system for skilled nursing facilities; and
- the Children's Health Insurance Program.

Promote Provider Integrity. We intend to make clear that we do not simply pay bills, but enter into agreements to do business with providers. To do so, we will:

- step up efforts to educate providers on how to comply with program rules;
- increase the number of unannounced onsite visits; and
- publish a proposed regulation to establish clear enrollment requirements, including conditions under which we will deny or revoke billing privileges.

Prepare for the Year 2000 Computer Issue. We have special work groups exploring how the millennium problem could affect program integrity efforts. They are evaluating the function, value, and Year 2000 risks for each of our efforts, and are developing a plan to mitigate or circumvent any problems if they do arise.

Target Known Problem Areas. These include inpatient hospital care, managed care, congregate care (delivered in settings such as assisted living facilities), nursing homes, and community mental health centers.

- *Inpatient Hospital Care.* We will step up efforts to investigate, correct, and prevent problems documented in audits of Medicare, such as providing unnecessary or uncovered services, failing to properly document care, and coding claims incorrectly.
- *Managed Care.* As mentioned above, we will hire a special program integrity contractor to focus on managed care, where fraud, waste, and abuse are more likely to involve inadequate care, avoiding enrollment of high-cost patients, and misrepresenting data on which payment rates are based. We expect such contractors to verify data, review beneficiary appeals to ensure that access to care is not denied inappropriately, and monitor plan compliance with Medicare rules.
- *Congregate Care.* Beneficiaries in nursing homes, assisted living centers or adult day care facilities are easy targets because there is easy access to large numbers of beneficiary billing numbers. Unscrupulous providers conduct "gang visits" in which all beneficiaries receive a service or supply whether they need it or not, or they submit bills for every beneficiary without furnishing anything at all. They also submit duplicate bills to both Medicare and other payers for services that only one payer should cover. We will mount Operation Restore Trust style projects to fight these types of scams. We also will work to anticipate shifting incentives for congregate care fraud, waste, and abuse as we move to more prospective payment systems.
- *Nursing Homes.* As one of our original Operation Restore Trust focus areas, much is already underway to fight fraud, waste, and abuse and improve the quality of care. We will continue our initiative, announced by the President this past summer. Last month, we

announced a number of steps that build on the President's initiatives to promote quality care for 1.6 million elderly and disabled Americans in nearly 17,000 nursing homes. These steps include a new regulation that subjects nursing homes with problems to tougher fines; instructions to states to investigate complaints about harm to nursing home residents more quickly; a national campaign to prevent neglect and abuse of nursing home residents; and a website link at www.medicare.gov aimed at getting comparative information about nursing homes to families. We will continue to develop Operation Restore Trust style projects targeted on specific nursing home fraud, waste, and abuse problems.

Community Mental Health Centers (CMHCs). As another of our earlier Operation Restore Trust focus areas, much is already being done to stop abuses in this area, as well. We have a 10-point action plan underway which first and foremost ensures that beneficiaries who need intensive psychiatric services get them from qualified providers. We are doing so through coordination with other agencies, providers, and advocacy groups. This beneficiary protection is essential as we terminate the worst offenders and work aggressively to bring others into compliance with all rules and regulations. We are increasing claims review and developing a prospective payment system that will eliminate incentives for inappropriate, unnecessary or inefficient care. We also are increasing scrutiny of new applicants and requiring site visits nationwide to ensure that they meet all of Medicare's core requirements. Already this year we have denied Medicare participation to more than 100 applicants because they failed to provide all the required services. President Clinton is seeking legislation to strengthen CMHC enforcement activities by: authorizing fines for falsely certifying a beneficiary's eligibility for partial hospitalization services; prohibiting partial hospitalization services from being provided in a beneficiary's home or other residential setting; and authorizing the Secretary to set additional requirements for CMHCs to participate in the Medicare program.

AUDIT FINDINGS

In conducting the CFO audit, the Inspector General found that our contractors paid the vast majority of claims correctly based on the information submitted by providers on claims. The estimated error rate was determined by visiting HCFA contractors, requesting supporting documentation from providers, and reviewing the medical records of 5,540 fee-for-service claims paid in fiscal 1998 for 600 beneficiaries. Of these, 915 should not have been paid. The error rate identified in the audit could only be found by manually reviewing supporting documentation and medical records from providers. This is a very expensive, labor intensive process, and we do not have resources for such extensive investigation of every claim.

In the case of the 915 erroneous claims, the auditors found that the providers had not demonstrated that the claim was in accordance with Medicare laws and regulations. By projecting these results to the entire universe of Medicare claims, the Inspector General arrived at a midpoint estimate of $12.6 billion in improper payments nationwide or about 7.1 percent of the total Medicare fee-for-service benefit payments. Due to the limited size and variance of the sample, however, the true level of improper payments could range from 4.4 to 9.9 percent.

Documentation Errors represented the most dramatic improvement in this year's audit. They had been the single largest factor in our error rate in past audits, and have declined by almost 80 percent from fiscal 1996 to fiscal 1998. They now account for approximately 17 percent of the claim errors. Documentation errors occur when the records are not sufficient to justify a claim. The drop is primarily attributed to HCFA's enhanced claims review activities; and HCFA and Inspector General outreach efforts. As part of that, I would especially like to thank the provider groups with whom we have worked to educate their members on the importance of documenting and filing claims correctly.

Lack of Medical Necessity is the largest factor identified as resulting in improper payments in fiscal 1998. Over one-half of the erroneous claims fell into this category, which covers situations in which the medical records contained sufficient documentation to allow professional medical

review staff to determine that the services were, in fact, not medically necessary. Even here, however, we have shown improvement - a nearly 20 percent decline in erroneous payments due to medical necessity between fiscal 1996 and fiscal 1998.

Incorrect Coding is another problem identified by the CFO audit. These types of errors accounted for approximately 18 percent of the claim errors. Incorrect coding errors occur when the documentation provided supports a lower level of service than is billed. Medical professionals who reviewed the documentation determined that the service was not as complex as the provider claimed, and that Medicare had therefore paid too much. These errors have decreased by 24 percent since last year.

Noncovered Services is another payment error problem. The Inspector General noted that a small percentage of improper payments were for services not covered by Medicare. Such claims were for services that fee-for-service Medicare by law does not cover, such as routine physical examinations, routine ear and eye examinations and most routine foot care. This type of improper payment has declined by 50 percent since fiscal 1996.

CORRECTIVE ACTIONS

Almost 80 percent of the incorrect payments found in the fiscal 1998 audit occurred in five areas: inpatient hospital services (26 percent), physician services (25 percent), home health agencies (13 percent), and outpatient hospital services (13 percent). The remaining 20 percent were made in other categories. Several initiatives in our Comprehensive Plan for Program Integrity address these specific findings and we are zeroing in on these key areas.

Bolstering Provider Education. First and foremost, we want to ensure that providers understand our coding and documentation rules. Most providers who make billing errors have no intent to do anything wrong, but simply make mistakes. Still, these mistakes are costly both to the provider and to the taxpayer, and they must be stopped. We are bolstering our provider education efforts to make sure that happens.

Last year we piloted, in thirteen states, a multi-faceted provider education project developed by Blue Cross/Blue Shield of Florida. We will be expanding the project this year. Its first component is a seminar on proper documentation and coding under Medicare. The seminar is aimed at hospital billing agents and other providers and their employees responsible for billing Medicare. We broadcast the seminar via satellite, and in one broadcast alone, we reached over 10,000 people at hundreds of sites in hospitals and other providers across the Southeast. Combined with 44 live seminars that we also conducted, our seminars reached more than 19,000 people this year alone. And we know that they work. We tested participants' knowledge of Medicare rules both before and after the seminars, and found a big improvement in test scores.

We have also targeted medical schools, to reach medical residents just as they are about to start their own practices. Last year, we taught over 6,000 residents, almost one-quarter of all of the residents that graduated nationally, about setting up their practices to bill Medicare correctly.

And, we have turned to the Internet to advance our cause. We now have training modules on the web that can be used by any physician, office clerk, hospital employee, or anyone else with Medicare billing responsibilities. The site is www.medicaretraining.com, and I invite any of you to log on and take one of our online courses. I must warn you that there is a pre-test and a post-test, so we can see how you do, but you will have plenty of company. In 1998, over 15,000 of these courses were completed.

The last component of our provider education effort is a special duplicate claims reduction program. It has two components: an edit for electronic claims that rejects duplicates and a set of provider training materials. This program was particularly popular with doctors, who often pay billing agencies by the number of claims they file, and thus save money themselves by reducing duplicates. We piloted the program last year at Blue Cross/Blue Shield of Texas, implementing the edit and sending the training materials to the 250 providers who filed the most duplicate claims. The result was a reduction in duplicate claim volume of 170,000 claims, resulting in an estimated savings of $7.40 for each dollar spent. We expect that the program will save the Texas

contractor over $1 million in administrative costs next year.

Improving Medical Review. While trying to reduce the number of errors made by providers, we are engaging in a variety of efforts to catch errors that are made by improving our contractor's medical review processes. We have tested a protocol for an outside contractor to verify and validate all contractor medical review practices and to recommend necessary corrective action. We will also be hiring an outside contractor to evaluate local medical review policies to identify policy similarities, differences, and gaps, and to assure compliance with national coverage policy.

Inpatient hospital claims are especially important since they are the most expensive claims we pay, and we will be implementing an aggressive plan to lower the error rate in inpatient claims. Among the types of analyses we may use are changes in patterns of DRG coding, prevalence of readmission of the same patient to the same facility on the same day as discharge, and changes in patterns of very short stay admissions. We are also working with our Peer Review Organizations to develop and test new ways to ensure the medical necessity of inpatient hospital claims.

With respect to physician payments, we are conducting thorough prepayment reviews of documentation on a random sample of physician office visit claims and are developing a testing process. That process will help us determine whether services are actually rendered and medically necessary, allow for projection of a national claims error rate, and help to spot areas for improvement.

Enhancing Contractor Evaluation. A key component of these efforts is managing our contractors. We are improving our assessment process to better gauge the effectiveness of contractor medical review and benefit integrity activities. This will ensure that we obtain the most from our contractors and will give the contractors solid guidance as to where improvements are needed.

Using Technology. We are always looking for ways to use technology to help us "pay it right." To assure we are taking advantage of the latest in anti-fraud technology, we have begun cataloging and evaluating fraud detection technologies for use by Medicare contractors. This is an ongoing process allowing us to keep abreast of developments in the field.

An example of our successful use of technology is the Correct Coding Initiative, a package of more than 93,000 automated edits we have required contractors to use since 1996. This initiative has saved hundreds of millions of dollars since its inception, and we continue to improve on it with new edits being tested and added regularly. Similarly, the HCFA Customer Information System enables us to view provider or service utilization data at the national, State, contractor, provider type, or individual provider level. As a result, audits or reviews can be focused, rapidly and inexpensively, on a particular level.

Implementing the Medicare Integrity Program. As discussed earlier, HIPAA gave us new authority to hire specialized contractors to perform program integrity functions. This will be a key part of our efforts to reduce the payment error rate in the future. There will be at least three types of program integrity contractors. Program Safeguard Contractors will perform the standard program integrity functions that are currently part of the claims processing handled by carriers and intermediaries. This new contracting authority allows us to contract with different entities to perform these tasks, and will give us new flexibility in managing and evaluating these functions. We expect to begin hiring these types of contractors shortly.

Collecting Overpayments Identified by the Inspector General. We have already recovered almost all of the overpayments identified in this year's CFO audit, and we have intensified payment recovery efforts overall. In addition, we have instructed our contractors to evaluate providers identified in the CFO audit report for more extensive oversight.

RECENT LAWS AND LEGISLATIVE PROPOSALS

Thanks to the work of your committee and this Congress, we now have more tools we need to fight fraud and abuse. These tools from the Balanced Budget Act let us:

- exclude providers convicted of felonies or health related crimes;
- levy new civil monetary penalties on hospitals who contract with providers who have been excluded from Medicare;
- levy civil monetary penalties on providers who take kickbacks;
- require provider applicants to provide Social Security numbers and employer identification numbers so we can check the applicant histories; and
- tighten eligibility and close loopholes for home health services.

The Health Insurance Portability and Accountability Act also for the first time created a stable source of funding for program integrity activities -- in fiscal 1999, $560 million. It also gave us authority to contract with special program integrity contractors. Under HIPAA, $630 million will be available for program integrity functions in fiscal 2000.

President Clinton's fiscal 2000 budget also includes several new proposals to continue our success in fighting health care fraud, waste, and abuse. These measures would save an additional $2 billion in Medicare expenditures over five years and preserve the Medicare Trust Funds. The proposals include:

- eliminating excessive Medicare reimbursement for drugs;
- ending overpayments for Epogen, a drug used to treat anemia related to chronic renal failure;
- preventing abuse of Medicare's partial hospitalization benefit;
- ensuring Medicare does not pay for claims owed by private insurers;
- empowering Medicare to purchase cost-effective high-quality health care; and
- requesting new authority to enhance contractor performance.

We look forward to working with you to secure passage of these important provisions.

Through additional tools provided in the BBA and HIPAA, our Comprehensive Program Integrity Plan, our corrective action plan, the President's new proposals, and your continued support, I am confident that we will continue to make progress in reducing the payment error rate.

FINANCIAL STATEMENTS

A second function of the CFO Audit is to determine whether HCFA's internal accounting mechanisms are in order. In public accounting terms, the purpose of an audit is to permit the auditors to render an opinion as to whether the financial statements are presented fairly and in conformity with generally accepted accounting principles.

There are four types of audit opinions: 1) an unqualified opinion, which means the financial statements are fairly presented; 2) a qualified opinion, which means the financial statements are fairly presented except for the effects of specific matters as described in the auditor's report; 3) an adverse opinion, which means the financial statements are not presented fairly; and, 4) a 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. We received a qualified opinion, which is a significant step above an adverse or disclaimer of opinion but represents that we still have work to do to achieve an unqualified opinion.

I am also very pleased to say that since fiscal 1996 we have resolved two major financial statement shortcomings, we have worked with the auditors to satisfy their concerns with two other shortcomings, and we are making progress on remaining areas of concern.

In response to the fiscal 1996 audit, we responded to concerns regarding Medicare accounts payable ledgers to the satisfaction of the external auditors. In addition, we funded an audit of the Social Security Administration process for withholding Supplemental Medical Insurance premiums that did not disclose any material weaknesses. In response to the fiscal 1997 audit, we were able to clarify our handling of cost reports and the Medicaid payables and receivables to the auditors' satisfaction, and we have made progress in each of the remaining areas of concern to the auditors.

Accounts Receivable

The one remaining issue that prevents us from obtaining a clean audit is accounts receivable. The auditors could not be sure the receivable number was correct due to the lack of general ledgers and other documentation at most Medicare contractors. Concerns were also expressed about internal controls. Finally, because States use different accounting systems, their reporting of Medicaid receivables is inconsistent.

Our goal for the long run is to standardize contractors' claims processing systems so we can have an integrated accounting system. However, this will require extensive system changes which will not be possible given the priority that we and our contractors must place on ensuring all systems are Year 2000 compliant. In the meantime we will focus on using the contractors' existing subsidiary systems to improve the quality of data, and to identify and document the audit trails necessary to support and validate the data reported to HCFA.

We also have two efforts underway in 1999 toward resolving the accounts receivable qualification. First, we are currently reviewing our policies for determining the Medicare Secondary Payer (MSP) receivables at 15 Medicare contractors that comprise 80 percent of all Medicare contractor receivable activity to improve procedures to ensure that FY 1999 accounts receivable data are adequately processed and documented. This determination may enable us to significantly reduce the amount of accounts receivable that remain on the books and to obtain a clean opinion for next year's audit.

We intend to improve our internal controls for assuring that transactions are properly recorded and accounted for, safeguarded against loss, and in compliance with laws and regulations. For example, we are updating financial reporting instructions and requiring components to clearly identify controls.

We are also working to improve security in electronic data processing. We have introduced a systems security initiative to aggressively address vulnerabilities found through the Inspector

General's and our own reviews. Our goal is to be able to maintain the tightest security as the business environment in which we operate changes, and to integrate security into every aspect of our information technology management activities.

CONCLUSION

While we have work to do to improve the results of the CFO audit, we are pleased with the pace of the progress we have made in reducing the estimate of improper payments and getting our financial statements in order. With your help and support, we will continue to do everything in our power to fight fraud, waste, and abuse; to ensure that the Medicare program "pays it right;" and to ensure that our financial reporting is sound and the Medicare Trust Funds are well managed.

# # #

Mr. HORN. Well, we thank you, and enjoyed reading your statement. The way we're going to operate on the Q and A is each of us will rotate in 5 minutes. I'm going to ask Mrs. Biggert, the gentlewoman from Illinois, to take my first 5 minutes and question the witnesses, and then it will be Mr. Turner, and then it will get to me, and we'll just go around until either we're worn out or you're worn out, one or the other.

I yield my 5 minutes for the purpose of questioning to the gentlewoman from Illinois and vice chairman of this committee. And by the way, if you had an opening statement, we'll put that at the beginning, without objection.

Mrs. BIGGERT. Thank you, Mr. Chairman.

You have the work done in managed care or Medicaid. HCFA had total program expenses of $308 billion in 1998 and these expenses were broken down to Medicare fee-for-service payments which was 57 percent, $177 billion; Medicare managed care payments, $33 billion, 11 percent; and Medicaid payments of $98 billion for 32 percent.

It's my understanding that the testing is done to arrive at the estimate for improper payments of $12.6 billion solely on—is done solely on the $177 billion Medicare fee-for-service payments. Is my understanding correct? I'm sorry, I'm addressing this to the Honorable Ms. Brown.

Ms. BROWN. Yes, that's true. This is the fee-for-service area where we're making this estimate.

Mrs. BIGGERT. Then what level of testing is done on the remaining $131 billion?

Mr. VENGRIN. We, in conjunction with the General Accounting Office, in all three fiscal years have examined the managed care area. We attempted to project it back but we have no material findings at this time to really report on the managed care. With respect to the $90 billion or so for Medicaid, we are relying on the work of the single audit. That is at the State level, and we certainly do not want to duplicate that effort.

We are aggressively working with three or four States to develop an error rate comparable to what we're doing here in Medicare, but because it's not mandated, it's a very difficult process. The States complain that they do not have the money to do this, but we're confident that an error rate does exist in Medicaid and we're working very diligently with them to develop that.

Mrs. BIGGERT. How many States? Is that all States?

Mr. VENGRIN. We're working—again because it's not a requirement either by Medicaid or the OMB through the compliance supplement on the single audit, it's on a voluntary basis. Currently we're working through the national intergovernmental audit forum with the State auditors to develop this.

Mrs. BIGGERT. And about how many States——

Mr. VENGRIN. We're aggressively working in four States.

Mrs. BIGGERT. Four States?

Mr. VENGRIN. Yes, ma'am.

Mrs. BIGGERT. Is there any evidence of improper statements in these areas?

Mr. VENGRIN. Yes, ma'am, there is. Again, we did meet with a State auditor. They did make a first attempt at this process. We

went out and visited those particular States and found some need for improvement in the thoroughness of the medical review, plus the statistical sampling had some concerns. We're working again with these States to develop a plan, a methodology, so it can be replicated in other States.

Mrs. BIGGERT. Does this involve the Medicare Plus Choice issue at all?

Mr. VENGRIN. No. Basically this again would involve the fee-for-service at the State level.

Mrs. BIGGERT. Thank you. Then to Mr. Hash, it sounds like you're having success in reducing the amount of improper payments, from the testimony, but that there still is a great deal of work that remains. Can you explain a little bit more about the area "lack of medical necessity" in your chart?

Mr. HASH. Yes, I'd be glad to. Also perhaps my colleagues here would want to elaborate too, who conducted the audit. This refers to a determination of the appropriateness of a covered service for a given individual with a given condition or diagnosis. What the audit does is evaluate the documentation, generally in the form of the medical record of the patient, to see that it appropriately supports the need, the appropriate need of the patient for the service that's being paid for. This is an area where we have been stepping up our efforts very dramatically to improve and strengthen medical review by our contractors.

Mrs. BIGGERT. It seems that the amount in the area has stayed very constant. Is this an area where it's harder to achieve progress? If you look at the area of documentation error, it seems like this is harder to achieve any change for the lack of medical necessity. Is there any reason for that, or what actions have been taken in that area to try and change them?

Mr. HASH. Medical review is a difficult area but I'm happy to report that the audit does show, I believe, that we've actually reduced by 20 percent the amount of error since 1996 that's attributable to medical necessity problems. So we are actually making steady progress, I think, at reducing it, but it remains a significant portion. In fact, about half of the errors are attributed to medical necessity problems.

What we've done by way of strengthening medical review is that we have hired an outside contractor that is actually working with the carrier medical directors, the physicians, and their staff who are charged with the responsibility of reviewing claims for medical necessity, and we are giving them assistance in overseeing their work much more closely. And second, we are working with the peer review organizations [PRO], who are composed of locally based physicians, to assist also in the review of medical necessity activities. And we have stepped up our prepayment review; that is, before we actually pay, we're doing medical necessity reviews of services in a more intensified manner.

Mrs. BIGGERT. Thank you.

Mr. HORN. I thank the gentlewoman from Illinois.

I now yield to the ranking member, Mr. Turner of Texas, for the purposes of questioning, 5 minutes.

Mr. TURNER. Thank you, Mr. Chairman.

Let me make sure I understand. You have to bring me up to speed here, but as I understand it, all of the Medicare payments that we make are actually handled by private contractors; is that correct?

Mr. HASH. Not quite, Mr. Turner. The fee-for-service payments are made by contractors, 40 of them around the country, which are private organizations. But the managed care payments, the capitated payments that are made to managed care plans, are made by the Health Care Financing Administration.

Mr. TURNER. What's the trend in terms of the percentage of your funds that are paid through managed care? I assume that has been on the rise?

Mr. HASH. It's rising. I think the Inspector General just indicated that about $210 billion of our total expenditures are related to fee-for-service payments and an additional—I don't have the figure in front of me—about $33 billion for managed care payments, and that number is rising.

Mr. TURNER. This audit seems to be, and the sampling—I'm glad to see you sampling here, Mr. Chairman—sampling seems to——

Mr. HORN. Touche.

Mr. TURNER [continuing]. To be directed solely at the fee-for-service side. Doesn't there need to be some kind of audit work done on the managed care side, even though those payments obviously are set and the managed care company has got to make do with what they get, but isn't there some necessity for looking at that side as well?

Mr. VENGRIN. We are, Mr. Turner. As I mentioned, we did sample those and we did not come up with any deficiencies to project back that would be material to the financial statements this year.

Mr. TURNER. When we're talking about managed care, what are we looking for? What's your objective when you take a look at the managed care side?

Mr. VENGRIN. Whether we have an eligible beneficiary, whether we have a correct payment. There are localities that adjust the payments. We want to make sure the beneficiary is in fact in that particular area that is used to compute the rate. So we are looking at all factors there for the computation of these payments.

Ms. BROWN. The incentives are much different in the managed care area. So, separately from the financial statement audits, we're doing a lot of other work there to see whether or not services are being identified; whether there's some form of preselection, where that's possible because it is 100 percent managed care to get healthier patients in; whether they're driving out patients that have chronic conditions that would make it difficult for them. We're looking at all those kinds of things. We can't project an error rate at this point, but we are looking at those situations and investigating where we have indicators that there is unfair influence there.

Mr. HASH. If I might add a footnote, Mr. Turner, we also have concerns about integrity of our managed care contractors as well. And as a part of our Medicare integrity program, we are going to be contracting with, again, an outside contractor for the purpose of reviewing the appropriateness of the submissions that the managed care plans make to us that are used for purposes of determining payments to them. So we think an oversight from an integrity

point of view is also an appropriate component of our overall comprehensive fraud and abuse plan.

Mr. TURNER. We have heard a lot recently about managed care companies dropping their patients. What basically has been, from your perspective, the cause of that disruption?

Mr. HASH. I think the answer to that is a complicated one. For the most part I think managed care plans that withdrew from Medicare did so because of business decisions that pertained to the markets that they were in.

A closer look at what happened and in the withdrawals last fall would suggest in some of the markets where plans left they had very small penetration. They were otherwise very competitive marketplaces. Clearly some of the factors that influenced their withdrawal had to do with an expectation or projection of what the Medicare payment rates would be in the future. But altogether, I think the withdrawals had more to do with business and market conditions than any single factor.

Mr. TURNER. Is there anything that we should be doing to try to create more stability? I mean, I think most of us agree that managed care is here to stay and is probably here to stay in the Medicare field, but it doesn't seem that we can endure the disruptions that we've been seeing in the last several months.

Mr. HASH. I think there are some things that are under way now, that we started, that will bring a greater stability to this marketplace. For one thing, the rates that are being forecast for next year are going to be significantly raised from what they have been in the past 2 years, so I think that will go a long way toward stabilizing the market for contracting by these plans.

I think also we're trying to take account of suggestions and recommendations from the health plan community about ways that we can streamline our program and make it less burdensome from their point of view. So we are trying to work with the managed care community to in fact stabilize participation in the Medicare program.

Mr. TURNER. Are there audit tools available that can allow one to verify that managed care is saving money over fee-for-service?

Mr. HASH. That's a tough question, Mr. Turner. I think there is some evidence—first of all, the Medicare payments themselves, as you may know, are roughly based on the average cost for Medicare beneficiaries in fee-for-service discounted by 5 percent. In other words, we figure out what the average is and pay the plan roughly, on average, 95 percent of the cost of fee-for-service. So there is an expectation that there is saving right off the top from the payment system.

On the other hand, as you look at the characteristics of individuals who have enrolled in managed care plans, there's considerable evidence that they have less than average health care costs. In other words, while we pay on an average basis, their actual experience is that the enrollees tend to be healthier and younger and therefore there is potential—not only a potential but I think substantial evidence that confirms—that we have overpaid managed care plans.

The BBA and other steps we've taken I think are bringing payments more in line to the expected costs of the enrollees. A signifi-

cant part of that strategy is the implementation of a risk adjustment payment methodology which we announced just recently.

Mr. TURNER. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Thank you. I am going to use just a little bit of my time and yield 5 minutes to Mr. Ose.

Let me just refer to your chart, Inspector General, documentation by error, to category dollars in billions. Down there on the blue schedule under fiscal year 1997, we're talking about $3 billion, documents not provided due to investigations. What happened to those investigations? How many did we win, in brief?

Mr. VENGRIN. There were roughly around 151 claims last year. When we went back to pursue and obtain the medical reports, because there was an active investigation by the Department of Justice or Office of Investigations, we were precluded from obtaining those medical records. We really did not go back and followup to determine the disposition of the particular claim.

Mr. HORN. So, are we to say that $3 billion went down the drain?

Mr. VENGRIN. No, sir. Typically the investigation covered 2 or 3 past years ago. We were auditing 1997. We really can't say that those claims were improper, sir.

Mr. HORN. What's the length in the statutes as to how long you have to look at it, probably prosecute it? You'd have to turn it over to Justice, or the U.S. Attorney in each area? How does this system work in terms of any fraud and abuse you find?

Ms. BROWN. When there is fraud, there are different statutes depending upon the particular issue, and then there are some where there are continuing issues like the RICO statutes. If it's conspiracy or something of that nature, there is a continuing problem; so you can go back much further. It varies in the individual cases, but certainly all of these cases were followed up. And I don't have the resolution of them with me, but they're either still in process or they are on an individual basis making the appropriate collections.

That's a separate thing from our analysis of what the error rate is. Because the audit process of the error rates didn't delve into it further doesn't mean those cases weren't pursued. In fact those were the ones where there was a concentrated effort to find out exactly what happened and recover any losses.

Mr. HORN. In whose jurisdiction are the documents? Are they under Medicare right now? Are they over in Justice? Are they in the Inspector General's office? Where are the documents that are reflected here under "documents not provided due to investigations," $3 billion, fiscal year 1997?

Ms. BROWN. They were in more than one place. However, we have worked out an arrangement so that we were able to get information this year on documents, even though investigations might be in process, enough information anyway to consider in the error rate. So that wasn't a constraint, as it had been in the past, where we just couldn't work out the arrangement in time to do the audit.

Mr. HORN. Now, do you have lawyers on your own staff that can take a look at these and say they conform to the law in terms of time as well as substance?

Ms. BROWN. Yes. In the Office of Counsel to the Inspector General, there are about 60 attorneys and support staff. Of course we

work in prosecution closely with the Department of Justice. We work closely with U.S. Attorneys as well as the AGs from the various States when that's appropriate. So we work in combination with others on almost all of our work before it's concluded.

Mr. HORN. I know this is a tough question for you to answer, but are there situations where the U.S. Attorney says, "Hey, this doesn't matter to me, isn't significant enough either in dollars or anything else. I haven't got the time for it." How much of that goes on?

Ms. BROWN. I can't give you a percentage. There certainly are those situations. There are a few things we've done to resolve them. We have an executive level fraud group including the Deputy Attorney General and myself. We have someone from HCFA represented, someone from the FBI, someone who represents the U.S. Attorneys, and we talk over these cases and look at national projects. They can establish a national protocol so that there's more consistent enforcement throughout the United States on certain types of cases. That's helped a lot. They also can get in touch with U.S. Attorneys if any single decision seems to go against what the national prerogative might be.

I might mention, too, there's a lot less turning down cases because there is additional money provided to the Department of Justice also out of the HIPAA legislation for enforcement efforts, and they've been very aggressive and quite successful in this. We've more than doubled our enforcement and our settlement activity.

But even saying that, when they decline a case, we have, you might say, a third bite at the apple. Where criminal and then civil declination has occurred, we have civil monetary penalty authority, so we can still use that. Say something doesn't meet the dollar criteria, which would be the most typical, we could take selection actions based on that CMP authority. So there is a variety of tools available to us, where people aren't just slipping through the cracks once we have developed some material on them.

Mr. HORN. Well, I'm going to ask both the minority and majority staff to look at this and ask some questions for the record, and without objection, the answers will be put in at this point.

Ms. BROWN. Be glad to do that.

Mr. HORN. Mr. Ose, you have less than 10 seconds on my time, but you have your own 5 minutes.

Mr. OSE. Thank you, Mr. Chairman.

Mr. HORN. Do you have an opening statement?

Mr. OSE. I do not have an opening statement. Just questions.

Mr. HORN. OK, good.

Mr. OSE. For the Inspector General, on page 8 of your submitted comments, the bottom paragraph talks about "deficiencies in nearly all facets . . . of the 12 contractors in our sample." With great respect to my colleague, Mr. Turner, I don't care to debate the sampling question today but if that is the case, if there are gaps in the underlying data that the contractors are using to report to HCFA, how is it that we have any reliability in the numbers in the first place?

Ms. BROWN. On page—are you talking about the accounts receivable in particular?

Mr. OSE. Yes, Medicare accounts receivable.

Ms. BROWN. Let me let Mr. Vengrin, who actually conducted the audit, go into a little more depth.

Mr. VENGRIN. We did find, sir, in all 3 years discrepancies in the various reporting systems that the contractors used. Typically there are multiple data bases tracking the same number. Since fiscal year 1996 we noted millions of dollars in discrepancies in these various data bases. Last year HCFA, in trying to streamline this process and get one set of records, issued instructions to their contractors to better maintain their receivable information and in one set of books, but unfortunately this year we went out there on a test basis and still found millions of dollars in discrepancies.

There's a form called a 751 that tracks the accounts receivable. When the contract auditor went back to try to find support for that, on virtually every line from the beginning balance to the current receivable activity to collections, we found in one case $144 million was plugged to agree to the ending balance. Another one of the lines on claims transferred was plugged so it would balance. Right now the reported information is just unreliable.

Mr. OSE. This gets to my basic question, and that is that the contractors who are providing the service to HCFA and perhaps the service providers themselves are unclear on the rules that govern how to classify and assign different services. I'm curious whether or not there is a clear understanding on behalf of the people actually doing the coding in the field, for instance, or the collections in the field as to how to deal with these situations.

Mr. VENGRIN. Sir, this is one where I would certainly have to side with Health Care Financing. Our office has participated in numerous training exercises with HCFA staff where they repeatedly told the contractors how to record this information. But I must tell you all, saying that information—as Mike Hash was saying, we have a claims processing system out there. It was kind of an afterthought to have a financial component to that, so where the contractor pays claims in an expedited, expeditious manner, tracking some of this accounting information is coming kind of late in the game. They processed 860 million claims and millions of dollars of offsets.

I don't want to leave you with the impression that they're losing $20 billion on this receivable. There are billions of dollars, as for example on the Part B side, if a doctor has been overpaid $100, the next time that physician submits a claim, that $100 is offset and grabbed so there's no outstanding amount. So the problem still is with the recordkeeping.

Mr. OSE. I would appreciate if I could submit this particular question in writing and have some suggestions as to how we can more closely correlate this information. I don't know if it's possible but I also understand the closer we can correlate it time-wise, the better off and more accurate our numbers are.

Mr. VENGRIN. I believe we can correlate it. We're working with HCFA this year to go back in 1998 and do a reconstruction on that ending balance. The bulk of this overpayment is attributable to particular transactions: One, cost report settlements, and second, for periodic payment adjustments where HCFA has given a particular provider too much money in setting up accounts receivable.

Well, these particular categories lend themselves to tracking even on a Lotus spreadsheet. I think we can track this, and I'm convinced that we can go back out there and find supporting information. So part of this is going to be a reconstruction effort, and explicitly telling the contractors yet again what type of information they need to maintain.

Mr. OSE. I think the education process is probably going to have to be constant, just because those of us on this side of the dias probably issue too many rules and then we get regulations and they change constantly. I encourage that almost on a constant basis.

I have one other question, Mr. Chairman. The HCFA statement shows amounts due of about $7.5 billion, of which about $3.8 billon is estimated to be uncollectible. For the moment ignoring the $3.8 billion deemed to be uncollectible, what's the status of the other $3.7 billion? If it's not uncollectible, that means it is collectible. What are we doing to collect it?

Mr. HASH. I believe this is in regard to the errors that have been identified in the audit process. We've actually been making progress in the collection of that. From the 1996 audit we've now collected, we believe, 100 percent of the identified overpayments. From the 1997 audit I'm told that we have collected about 53 percent of the identified overpayments. And obviously we just got the 1998 audit, and we're beginning to institute collection efforts for that money as well.

Mr. OSE. May I ask the chairman's indulgence for one final question or observation?

Mr. HORN. Is this followup?

Mr. OSE. It is followup. The reason I ask that question is in my district we have a system that identified, through its own compliance effort, an overcollection on their part. In other words, they had been paid too much. They voluntarily reported it back to the contractor and returned the money. They refused to take it. And there have been subsequent legal inquiries as to the provider's veracity.

This is a provider that has identified on its own that they have collected too much, they have proffered it back. They have been told no and then they have been in the initial steps of sanctions. I've got to tell you, that's why I ask these questions.

Mr. Chairman, thank you.

Mr. HORN. You also wanted, a portion of the previous question, to have the data brought in. And without objection, that would be put in where you raise the question, and I'd like to ask both the Inspector General and the Health Care Financing Administration to give the answers to the question. So if there's a policy question versus an audit question, we'd like to have it in the record.

Let me just on nobody's time get on the record how the providers are designated by HCFA. A lot of people don't really know that. They think you're one vast bureaucracy and everything is operated out of Washington and all that. But when the law was written, there was an aim to not have that and so providers were chosen to sort of decentralize operations around America, and I know it poses some problems and the Administrator and I have chatted about those.

So maybe just for the record, since you're Deputy Administrator, how do they get picked? What are the concerns that HCFA, Health Care Financing Administration, has here in Washington, if any, with regard to providers? I got into it because of the year 2000 problem. So why don't you just lay it out for the record?

Mr. HASH. I would be happy to, Mr. Chairman. As you know, we have for the last, I think, 5 or 6 years submitted legislation to the Congress to consider reforming the methods that we use for contracting with private organizations to process claims and pay bills. The current arrangements for the contracting with private entities are to some degree different between whether we're talking about the fiscal intermediaries who are responsible for paying claims that are covered under Medicare and what we call the carriers——

Mr. HORN. Just for the record, put "Part A" in. A lot of people don't know it unless they're aficionados of this.

Mr. HASH. Part A refers to that part of the Medicare program that covers inpatient hospital services, the services of skilled nursing facilities and home health agencies, for the most part.

Mr. HORN. Which was in the original law.

Mr. HASH. That is correct, from 1965. And those contractors that we call fiscal intermediaries or FIs, their selection is actually governed by very specific statutory provisions that include the right of providers within the geographical area that may be served to nominate the actual entities with whom we can then contract. So there is, how shall I say, not a lot of discretion on the part of the program or the Health Care Financing Administration to actually engage in any sort of competitive competition for fiscal intermediaries because of the nomination process that is written into the statute.

On the carrier side, which is the organizations that process claims for services covered under Part B of Medicare, which includes primarily physician services and other outpatient services covered under the program, we do contract. But there again, we are restricted by the statute to contracting with organizations that meet certain criteria, including being in the business of insurance, demonstrating that kind of experience, and we think there are a broader array of organizations out there who would be capable of and interested in contracting with us to process claims and to administer the Medicare program, and we would like to have greater flexibility and discretion in that area.

Mr. HORN. That is very helpful. Do you want to add anything, Ms. Brown?

Ms. BROWN. Only that I heartily endorse HCFA's initiative in this area. Among those who we have had huge settlements with are many of the contractors, where they have misused their authorities and overcharged in some way or defrauded in some cases.

Mr. HORN. On that point, when that happens, can you decertify them?

Ms. BROWN. Yes. They can be excluded, or HCFA can take an initiative and not contract with them any longer. However, there is such a limited number of people they can contract with, it puts HCFA in the dilemma of making sure that the services are still performed.

So even when it might be appropriate to withdraw, there is a great dilemma as to how to get the job done. So, contractors who

might not otherwise be chosen are still allowed to persist in the business or get back into the business or assume business in another area, because we just don't have others who are eligible to perform that service.

Mr. HORN. Let's just put in the record for the last 2 years how many contractor providers have been decertified.

[The information referred to follows:]

Mr. HASH: Several Medicare contracts have ended in the past two years, either at the initiative of the contractor or at our initiative for various reasons. Following is a list of the contractors who have non-renewed, the date of the action, and the action along with the reason for the non renewal where applicable.

Contractor	Date of Action	Action/Reason
Xact Medicare Services	Various Dates 1997-1998	Partial Non Renewal/ Integrity
Blue Cross and Blue Shield of Delaware	March 1998	Not Renewed
Health Care Service Corp. (Part A)	September 1998	Not Renewed/ Integrity
Health Care Service Corp. (Part B)	September 1998	Not Renewed/ Integrity
General American Life Ins. Co	December 1998	Not Renewed
Wellmark, Inc.	January 1999	Not Renewed
Hawaii Medical Association	September 1999	Not Renewed
Minnesota Blue Cross	September 1999	Not Renewed
Anthem Blue Cross Blue Shield Connecticut	September 1999	Not Renewed/ Performance
Trigon Insurance Company	September 1999	Not Renewed

Mr. HASH. I will be happy to do that.

The Inspector General is correct. We are faced often with a very challenging set of circumstances about transitioning work to another contractor, which can in the best of circumstances still be disruptive from the point of view of both the beneficiaries and the providers who are affected by those transitions. On the other hand, with help from our law enforcement colleagues in the Federal Government, we have made important strides on cracking down on behavior that is criminal and unacceptable and we have excluded those contractors.

Mr. HORN. We are now going to start the next round again with Mr. Turner.

Mr. TURNER. Just to followup, are the States under the same restrictions that HCFA is under with regard to the selection of their contractors for the Medicaid program?

Mr. HASH. Mr. Turner, I am not familiar with their contracting laws under the Medicaid program, but I would assume that they have more flexibility than we do. But my presumption is that each and every State has contracting laws that are comparable to what we have in the Federal Government, the so-called FAR regulations for contracting, and I think States have comparable laws. But I am not aware that they have in their State statutes very narrow prescriptive language about the selection of contractors to administer the Medicaid program, and some States administer their Medicaid programs directly, with State employees.

Mr. TURNER. What was the political motivation for the restrictions that you have been discussing when they were put into the law initially?

Mr. HASH. I confess that I was not around in 1965, but from reading about the debates that took place at that time, the philosophy was, as Medicare was being launched, to select a process that would not create a Federal, as you will, bureaucracy for the purpose of processing claims; but rather to use the claims processing expertise in the private sector. There was experience in the insurance world of processing claims and paying bills.

In the early years of the program the majority of the contractors were Blue Cross and Blue Shield plans around the country, and many continue to serve the program to this day. But essentially the philosophy at that time, in order to launch the program quickly, was to use the expertise on this area that existed in the private insurance company world.

Mr. TURNER. And so the decision, in part, on selection of contractors is left in the hands of the providers because they have the option?

Mr. HASH. In part. On the Part A side, correct.

Mr. TURNER. One of the recommendations in the President's budget for fiscal year 2000 is a request for new authority to enhance contractor performance. What is encompassed in that recommendation, and are those the matters that you've been discussing?

Mr. HASH. It does refer to the increased flexibility in terms of contracting with private organizations, enlarging the pool of potential contractors to include organizations that have the capability,

the resources, the electronic data processing capabilities to actually take on these responsibilities.

Mr. TURNER. So the problem that you were discussing, at least there would be more flexibility if the President's recommendations were adopted?

Mr. HASH. That is correct, Mr. Turner.

Mr. TURNER. A moment ago we were talking about the accounts receivable. Are we approaching a situation with home health care agencies, many of which are going out of business, where we are going to have a large number of accounts receivables that are uncollected from home health agencies that have failed?

Mr. HASH. That is a factor in what the audit shows, an increase in the cumulative net amount of receivables. I think the figure is now $3.6 billion, rising from last year I think $2.6 billion. And a good part of that increase in receivables we think is attributable to an increased auditing function that is associated with launching the new payment systems for home health agencies, so we had to establish a base year and more thoroughly audit the cost reports for agencies of that year.

Second, in that process, now that we have new limits in the home health payment system, we have identified a number of overpayments. Those add to the accounts receivable.

And then last I would say, in terms of the accounts receivable number, we are experiencing an increase in the number of bankruptcies in providers in general, and that also contributes to the accounts receivable number.

Mr. TURNER. Many of our home health agencies experienced a great deal of financial difficulty adjusting to some of the recent changes in their reimbursement rates. I somehow wonder, and I don't know if you would comment or have an opinion on it, but I wonder if we have not made adjustments so rapidly and harshly for the home health agencies, our home health agencies, that many of them are going to be forced to go out of business, which is going to result in a lot of uncollectible accounts receivable from those agencies. Have we been too harsh?

Mr. HASH. We have been very concerned about what is happening with the home health agencies in light of the changes in the payment system that were put into motion by the Balanced Budget Act. I think it is fair to say that at this point we are still trying to analyze the data and get better information about the financial status of organizations. We are trying to determine whether or not there is developing any sort of access problem. That is to say, are Medicare beneficiaries having difficulty being referred appropriately to a qualified home health agency?

As of now we don't have any evidence that is a systematic problem, but there is no question that there are many home health agencies who have demonstrated that financially they are having a very difficult time. I think that has to do with the fact that the new limits in effect require home health agencies to manage their delivery of services in a more efficient manner, and that is a transition that is difficult to make.

I think many of them are making it. I have seen some reports that some of the chain organizations in home health have actually adjusted to the new payment system, while others are still strug-

gling with it. We need to carefully monitor the impact of these payment changes, because in the end we are responsible for assuring that our beneficiaries do have access to appropriate home care providers, and it is something that we are monitoring very closely.

Mr. TURNER. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Let me just pursue the home health care bit for a minute. In 1965, when this was all being patched together, I happened to be a big advocate at the staff level for my mentor on home health care, and we only knew of Detroit at that time as having a very good operation.

One thing that has intrigued me in the last few years, is that home health care providers come to the houses, make a phone call when they arrive or when they leave so that the record would show that they made that visit of 1 hour's length. I gather that is where some of the abuse was, in terms of what are they putting in for hours when they might have just given the person 5 minutes or something.

So, could you explain a little bit how you are working on that, because as I look on the "Errors Due to Lack of Medical Necessity by Provider Types," dollars in billions, we can see that the outpatient situation has really been much greater in terms of the $7 billion there, versus the very small amount under $7.5 billion the preceding fiscal year, and the fairly small amount of the outpatient area at the $8.5 billion. So, it would look like, just looking at that chart, that the home health care agencies have been squeezed a little in terms of the medical necessity, and the outpatient area seems to be maybe a similar problem to what home health care was at one time. Is that just chance in the money trail here, or what is your feeling on that?

Mr. HASH. Well, I think that—I am not certain that the sample for the audit, although I would defer to my colleagues here, is looking at an individual provider category that we have necessarily a representative sample, at least on an individual provider basis. But I think it is fair to say that we have been taking a much more close look at the compliance of home health agencies with our coverage requirements.

As you know, Mr. Chairman, home health under Medicare is only covered if a patient meets all of three conditions. They must be home-bound, they must require a skilled level of service, and they must be referred to home health by a physician.

In terms of the actual visit by a skilled professional or by a home health aide, which is actually the largest number of visits, they are made by home health aides as opposed to registered nurses, physical or occupational therapists or the skilled health care professionals. In the case of visits, we pay now on the basis of a visit. And of course the issue for us is if the visit is very long, then in fact the cost of the visit can rise very dramatically as opposed to a briefer visit. So since the duration of the visit is largely determined by the health care professional, we are trying to track more closely the timeframes associated with visits to make sure that the costs for that period of time are reasonable.

Mr. HORN. Does the Inspector General want to add something to that?

Ms. BROWN. Yes. This particular benefit grew astronomically and far faster than any projections in a very short period of time. We found it was one of the most abused areas in health care provisions. I literally can show you pictures of rooms as large as this full of boxes of documentation that was created in a very specific manner, with people being paid so much a page of documentation, created for patients who were never seen by anybody and yet they were being charged for regular home health visits, with literally millions of dollars going out.

There are others where tens of millions of dollars were paid monthly by HCFA, where the companies went bankrupt immediately and never paid the money back because they were protected under bankruptcy laws. They were being paid for home health visits, most all of which, virtually all of them, were never even performed. So, along with wanting to provide this service, we must recognize that this was an extremely vulnerable area.

Mr. HORN. I agree with you completely on that, even though it should be a worthwhile service.

In the room full of documentation that you are referring to, does this mean that the—I'm trying to get at the documentation there. Does this really mean that when these persons that ran that particular home care firm, when they were caught, for want of a better word, and then took bankruptcy, have we followed them to see if they have reopened this kind of an operation somewhere else? And do you really have to accept them if they have taken bankruptcy, or are we stuck there?

Ms. BROWN. We have a number of convictions that have already taken place and a number of indictments. There are more pending. We are going after both the individuals and the organizations. If there is a conviction, there is a mandatory exclusion where they cannot come back into the business.

There are some refinements we are concerned about, like whether they have relatives that they put in as a front and so on. We are trying to propose some things to HCFA, and they have done a great deal, particularly in excluding some of these people who have not really got any qualifications for getting into the business in the first place.

Mr. HORN. Can you exclude them forever?

Mr. HASH. If I may, Mr. Chairman, I want to make two points about this.

One is, with regard to the enrolling of new providers into the Medicare program, including home health agencies, we now have in place a series of requirements that must be satisfied that are considerably more rigorous than they were in the past.

For example, a home health agency now who wants to come into the Medicare program must demonstrate a certain minimal level of capitalization. They must demonstrate a certain patient load indicating, before they start serving our patients, they have actually demonstrated the capability of providing home health services. And so we have really been tightening up on the process for getting into the Medicare program as a home health agency and being able to bill.

The other point I should have made about the visit issue which I think is important, when the Congress designed the new payment

system, the interim payment system under the Balanced Budget Act, they inserted into that payment system a new payment limit that is an aggregate limit for each individual who has served—it is actually an average limit for the patient served. And what that means is that now under that limit agencies have an incentive to be very economical and proficient in the provision of visits, because otherwise they will run afoul of this per-beneficiary limit that is imposed by the BBA. So we now have a kind of payment system that creates incentives to reduce inappropriate visits or visit lengths.

Mr. HORN. As I look at this chart, "Errors Due to the Lack of Medical Necessity," the big money still out there is the "other" category. As we look at that "other" category, are there any particular types of real abuse within that that maybe ought to be put into another category? Mr. Vengrin, do you have any thoughts on that?

Mr. VENGRIN. Mr. Chairman, it goes to all of the other types of providers, and we really don't have statistical information that we can say one is more aberrant than the other. Right now it is still the big provider groups, the inpatient services, and I think home health agencies have in fact made tremendous progress in billing more correctly. I believe statistically there is about $2 billion less in expenditures this year. So I think there has been improvement there, but the biggest story is the inpatient side.

Mr. HORN. It is clear on your chart that the home health agency category seems to be really dwindling compared to the other 2 fiscal years. What is getting out of control is the outpatient as well as the inpatient, and that is where it looks like the big billions are to collect in some way.

Mr. VENGRIN. One of the biggest factors in the outpatient area was partial hospitalization. There were substantial dollars questioned because of the improper nature of those particular claims.

Mr. HORN. On that, let me bring up what was quite a hullabaloo around here 2 years ago. Under the Medicare law, one goes into the hospital and is in a ward and says, "Wait a minute, I have some money in my banking account which I have been saving for my health, I would like to move to a single room." As we all know, apparently some language was put in at the end of the session. A lot of that end-of-the-session language does lead to trouble, and presumably it was going to be repealed and I don't think it was ever repealed. What is the philosophy of Medicare on the patient upgrading their place in the hospital? I think it was in the original act, wasn't it?

Mr. HASH. Yes, sir. I am not completely familiar with this, I confess, and I would be happy to supply for the record——

Mr. HORN. Let me give you another example. Let us say a dermatologist is allowed certain reimbursement under Medicare for certain types of surgery and the patient says, "Wait a minute, I have this other thing that is bothering me."

And the doctor says, "I'm sorry, Medicare doesn't cover that."

"That's OK, I am willing to pay you."

Apparently that is a violation of Medicare regulations?

Mr. HASH. I do know what you are referring to now, Mr. Chairman, and the matter is as follows, as I understand it: If a Medicare patient, a beneficiary, is asking for a service that is a noncovered

service under Medicare, that is excluded, an annual physical or plastic surgery or a hearing aid or eyeglasses or any number of items that are not covered under Medicare, there is no limitation on that beneficiary's ability to purchase that service or those items with their own funds at whatever cost the transaction results in. So there is no imposition of a Medicare requirement in that circumstance.

The issue that you are referring to is a service which is an otherwise covered service, but for the case of the individual who is seeking it there is a question about whether it is medically appropriate or medically necessary for that individual, that in fact in those circumstances Medicare provides special rules which require that a claim be submitted to make a determination about the medical necessity; and that if in fact a claim is denied because it is not medically necessary, then it becomes a noncovered service and the individual may purchase that service out of their own funds if they so desire.

Mr. HORN. There is no inhibition against that. Well, let us take some of the plastic surgery. Obviously there is a national epidemic on breast cancer and there are also those people marred in the face and whatnot, and I would think part of the healing there psychologically for that person would be to have plastic surgery. What are the ground rules on that?

Mr. HASH. There is a new provision in law that deals with the Health Insurance Portability and Accountability Act [HIPAA], which I believe requires coverage for reconstructive surgery following a mastectomy. So I believe that now is a covered service.

Mr. HORN. So that is no longer a problem?

Mr. HASH. I want to qualify it only because I would like to check to make sure that I am absolutely correct.

Mr. HORN. Fine.

Mr. HASH. But I believe it is.

Mr. HORN. Without objection, we will have the answer from the Health Care Financing Administration.

[The information referred to follows:]

Mr. HASH: Medicare has paid for the surgical reconstruction of the breast on which the mastectomy has been performed since 1980 and for surgery of the other breast to produce a symmetrical appearance since 1997. The Omnibus Appropriations Bill for FY 99, which was passed by the Congress in 1998, amends the Employee Retirement Income Security Act of 1974 and Title XXVII of the Public Health Service Act, the title created by the Health Insurance Portability and Accountability Act of 1997, to require similar coverage under group health plans or individual health insurance policies that cover medical and surgical benefits in connection with a mastectomy.

Mr. HORN. Mrs. Biggert.

Mrs. BIGGERT. Thank you. Within the audit report there have been disclosures across all aspects of computer security, and one particular section of the report is very alarming to me. The report reads that "We were able to penetrate the security and obtain access to sensitive Medicare data at 5 out of a sample of 12 contractor locations." Simply stated, auditors acting as computer hackers were able to easily access confidential medical data.

My question to you, Mr. Hash, is why can't HCFA guarantee the confidentiality of this medical data, and what steps are being taken to secure these systems?

Mr. HASH. You are absolutely correct that the protection of this information is critical, and it is our responsibility because the privacy of the American public is certainly the highest priority, and we take our responsibilities very seriously in this regard. In addition to what is in the Inspector General's audit report, our own Chief Information Officer has been conducting similar tests of vulnerability of contractor data systems, and we as a result of that have also identified vulnerabilities.

We have taken a series of steps that involve new technology that is now in place with our contractors, training of contractor personnel and our own personnel as well, to ensure that we have in place enhanced procedures, passwords, validation systems, and transmission security through the lines that we lease to transmit electronic data.

So you are correct, we must be vigilant about this. Our intention is to continue working in this area of system security, particularly once we are past the Y2K window of the remaining part of this year, because we definitely feel like security must be at the highest, and our intention is to work with the IG as well as our own staff to make sure that any vulnerabilities are corrected.

Mrs. BIGGERT. But it sounds like you are saying once we have finished with the Y2K dilemma——

Mr. HASH. No, I think we have taken a series of specific steps in terms of new technology, training programs that we have undertaken that have greatly strengthened the security of our data systems, but we need to do more. We are on hold in terms of doing more until we pass the Y2K window.

Mrs. BIGGERT. Can you be a little more specific what these steps are?

Mr. HASH. I would be happy to supply for the record, if that is an acceptable statement, all of the steps that we are taking.

[The information referred to follows:]

Mr. HASH: Protecting sensitive information in our computer systems is essential, and we take this responsibility very seriously. We began a special "Security Initiative" in 1998 under the leadership of HCFA's Chief Information Officer to improve security policies and practices. We are especially committed to ensuring that data protected by the Privacy Act and Computer Security Act are safe from unauthorized access, damage or modification.

The Security Initiative includes several areas of concentration, such as:

- training and awareness;
- administration and management;
- risk assessment;
- security plan development;
- review, test and audit of security controls and safeguards;
- physical security;
- disaster recovery;
- security architecture; and more.

Mrs. BIGGERT. We appreciate that.

What other risks do the identified computer security weaknesses present?

Mr. VENGRIN. We also found problems with the shared system where they were able to maintain and have full access to the code. In many cases we found that they had the opportunity to shut off edits such as a duplicate payment. During one of the conference calls that I personally participated in, the person in the computer environment said yes, they had full capabilities to turn those edits off. So we advised Health Care Financing Administration that type of control should not be at the contractor level, and I believe they are in the process of trying to get that back.

Mrs. BIGGERT. So a contractor really could just change the amount?

Mr. VENGRIN. They could do that anyhow, but they should not be able to change mandated edits that the Health Care Financing Administration imposes on them. Right now they can.

Mrs. BIGGERT. What would those be?

Mr. VENGRIN. Duplicate payments. There is no reason that they should have the capability of turning that edit off.

Mrs. BIGGERT. Any other risks?

Mr. VENGRIN. We found a vulnerability, if a provider submitted a duplicate payment on the same day, they did not update their history file to capture that. Hence, we found a couple of duplicate payments that did occur on the same day, and I believe they moved aggressively to fix that particular vulnerability.

Mrs. BIGGERT. Why wouldn't the computer be able to catch that?

Mr. VENGRIN. Because it didn't update the history file for the activity of that particular day. It was a vulnerability in the process.

Mrs. BIGGERT. Is that an environment where an individual so inclined could make improper payments and cause unlimited damage if they have access?

Mr. VENGRIN. Yes, ma'am.

Mrs. BIGGERT. Do you have any suggestions or have you given suggestions to HCFA on how to correct this?

Mr. VENGRIN. We did. One of the recommendations that we made is that the contractor should not have total access to the code. They are agreeing in part with that, but again it has Y2K implications. As they do code renovations, they tell us if they don't have access to the code and there are problems in the renovations, they couldn't fix the claims processing and process claims. They are fixing things, but there are still problems is what they are saying.

Mrs. BIGGERT. It seems like this is such an issue, and I think probably on all of the committees that I serve on in this House that privacy and confidentiality is such an issue, and particularly even in subcommittees that I wouldn't expect, the medical records confidentiality comes up, in the Banking Committee and everything. It is such an issue and it is so important and it is something that has to be guaranteed to everybody. I hope that you will find a solution quickly.

Thank you, Mr. Chairman.

Mr. HORN. The gentleman from California, Mr. Ose.

Mr. OSE. Thank you, Mr. Chairman. I am aware that the gentlewoman from Illinois has additional questions, and while I have some, I would be willing to yield my time if she wishes to use it.

Mr. HORN. Do you want to finish up on a round of questions?

Mr. OSE. We are going to have another round, Mr. Chairman.

Mr. HORN. Go ahead.

Mr. OSE. When we do these audits, the providers have in some cases compliance systems and in some cases not. How many or how often did you find that the providers had compliance systems voluntarily imposed on their HCFA relationships?

Ms. BROWN. I don't have a percentage of the providers who have compliance systems. We have developed voluntary generic compliance plans for certain segments of the industry and we are doing others. For instance, we have done laboratories, we have done hospitals and so on. These are very comprehensive internal control plans, you might say.

The reason that we are making them voluntary is they have to accommodate the smallest institution and the largest. What I say in many speeches around the country is that we want them to have the flexibility to look at these internal controls that we suggest and pick and choose those that would apply to their institution. The carrot that we give them for putting in compliance plans is saying that should there be a problem in their organization, that both the Justice Department and my office make determinations on whether or not they should be allowed to continue in business because we have exclusion authority. The Department of Justice also has the decision whether or not to go forward with a criminal or a civil charge against them. In looking at the overall intent, their efforts to have compliance with the laws and regulations would be very influential in that. So, it could serve them well to have these compliance plans. We know that they are adopting them.

Mr. OSE. Have you found a correlation between the existence of a voluntary compliance plan and the accuracy on our audits?

Ms. BROWN. We don't actually audit the provider themselves, in other words, at least not in the financial system audit. We do other audits based on evidence of wrongdoing or high error rates or something like that.

Mr. OSE. When you do those audits, are they likely to have a compliance system or unlikely to have a compliance system?

Ms. BROWN. It is a growing thing. There were not many compliance systems 3 years ago or 6 years ago when I came to this job. But now a high percentage of them are, and I think the American Hospital Association just did a study that showed a very high percentage of hospitals either had them or planned to have them in the next year, and I will get you the percentage.

Mr. OSE. Do you have a copy of that study?

Ms. BROWN. Yes.

Mr. OSE. Mr. Chairman, I would be interested in reviewing that, and if we can add that to the record, I would appreciate that.

Mr. HORN. Without objection, it will be inserted into the record at this point.

[The information referred to follows:]

Overview

In September 1997, the AHA Board of Trustees encouraged all members to adopt a compliance plan for complying with Medicare's complex payment regulations and minimizing errors. Earlier this year, the Department of Health and Human Services Office of Inspector General (OIG) also issued compliance program guidance for hospitals. As AHA urges Congress to end the government's misuse of the False Claims Act in Medicare billing disputes, we need to demonstrate to the government and the public that hospitals are committed to preventing fraud and abuse.

In August 1998, AHA sent a short, confidential questionnaire to all members to assess the state of members' readiness related to compliance issues. AHA's survey of its membership is part of its ongoing emphasis on compliance. An analysis of the survey responses follows.

Objectives of the Survey

The survey was designed to assess:

- how many hospitals and health systems have adopted a formal compliance program or are planning to implement one within the next 12 months;
- what barriers exist to the adoption of a compliance plan among hospitals and health systems that do not have a program and do not plan to implement one; and
- to what extent compliance programs implemented and/or being implemented by hospitals and health systems have incorporated recommendations of the OIG's compliance program guidance for hospitals.

Overview of Research Methodology

A total of 4,300 surveys were distributed to AHA members. As of September 8, 1997, AHA received 1902 responses to the questionnaire, a response rate of approximately 44%. Respondents to the survey generally were reflective of the AHA membership.

Of the 1902 survey responses received (numbers in parenthesis indicate percent of AHA membership falling into the respective category):

- **Geographic Location**

  Urban: 42% (61%)
  Rural: 50% (39%)
  Not specified: 8%

- **Bed size**

  Under 50 beds: 20% (18.4%)
  50-100 beds: 19% (20.4%)
  100-200 beds: 21% (26.5%)
  200-500 beds: 27% (27.5%)
  Over 500 beds: 11% (7.1%)
  Not specified: 3%

- **Type of facility**

  Independent hospital: 45% (41.4%)
  Part of a multi-hospital system or network: 45% (58.6%)
  Not specified: 9%

- **Controlling organization**

  Non-government/not-for-profit: 62% (58.2%)
  Investor-owned/for profit: 10% (14.0%)
  State and local government: 18% (21.2%)
  Federal government: 1% (6.6%)
  Not specified: 9%

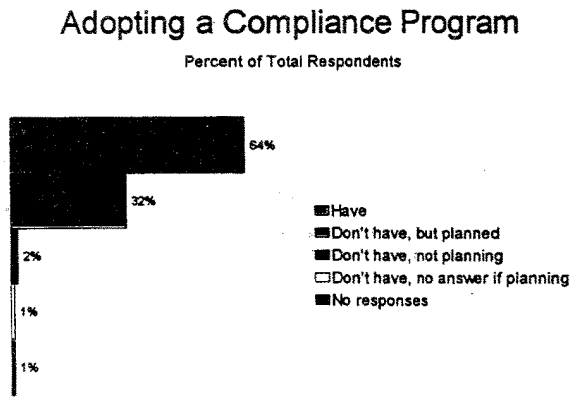
Summary of Survey Results

The OIG has endorsed voluntary compliance programs as a way to significantly reduce fraud and waste in publicly funded health care programs. Most hospitals and health systems have already started or refined efforts to build meaningful compliance programs for their institutions. *Ninety six (96) percent of hospitals and health systems indicate that they have a formal compliance program in place or plan to adopt one within the next year.* Of the 1902 respondents:

64% already have a formal corporate compliance program in place

32% do not have a formal corporate compliance program in place but plan to implement one within the next 12 months

Only two (2) percent of hospitals and health systems indicate that they do not have a formal compliance program in place and are not planning to adopt one within the next 12 months. Another one (1) percent indicated that they do not have a formal compliance program in place but did not indicate whether they are planning to adopt one immediately. Less than one (1) percent of respondents did not indicate whether they had adopted or were planning to adopt a compliance program.



Among the two (2) percent of hospitals and health systems that *do not* have and *do not* plan to implement a corporate compliance program within the next twelve months, the most frequently cited barriers to adoption of a compliance program were:

- restrictions on ability of federal government facilities to bill Medicare for payment (5 respondents from military facilities and 9 respondents from Veterans Administration facilities);
- cost (8 respondents); and
- lack of knowledge about the requirements of compliance (6 respondents).

Among the very few respondents suggesting that compliance was not a high priority for their facilities, barriers noted include: corporate reorganization, consolidation and/or merger; status as a charity facility that does not bill for any services; and the inapplicability of compliance requirements to a state-operated facility. Lack of appropriate personnel resources was not cited as a barrier to adoption of a compliance program.

The OIG compliance concept "builds on the ideas of checks and balances, ethics, common sense, trust and best practices." It contains the key elements of compliance standards and procedures, oversight responsibility, effective training and education, monitoring and auditing systems, effective lines of communication, enforcement and discipline, response and direction. The vast majority of the respondents with a formal compliance program in place have already incorporated these essential elements of the compliance process into their institutional activities. These facilities view compliance as an evolving process and indicated that they are planning to add components over time to achieve a more solid foundation for compliance efforts.

Of the 64 percent of hospitals and health systems (1224 respondents) that have a formal corporate compliance program in place, the following percentages of respondents indicated that these critical elements are in place currently or will be incorporated in their compliance programs in the future:

Compliance Program Element	Already Incorporated	Planning to Include
Compliance program is part of a larger initiative related to organizational ethics.	71%	6%
Designated specific individual within the facility has primary responsibility and authority for compliance oversight.	96%	less than 1%
Designated group of individuals to advise and assist in implementing compliance activities.	90%	2%
Provides senior corporate officers and board members with regular reports related to compliance.	86%	8%
Written policies identify specific areas of risk to the organization.	83%	11%
Written policies are disseminated throughout all levels of the organization.	84%	12%

Compliance Program Element	Already Incorporated	Planning to Include
Addresses special areas of increased risk such as upcoding, unbundling, teaching physician responsibilities, financial arrangements with physicians, self-referral, and patient dumping.	88%	7%
Compliance program applies to various state and federal laws and regulations in areas other than Medicare and Medicaid billing, such as tax exemption, labor, environmental, antitrust, occupational health and safety, etc..	79%	13%
Requires periodic training to keep individuals up-to-date on compliance requirements.	85%	11%
Considers adherence to compliance policies a factor in performance evaluations.	58%	29%
Specifies disciplinary action for those who fail to comply with compliance standards, policies and procedures, and federal and state laws.	76%	14%
Guarantees confidentiality and non-retaliation to those reporting compliance concerns.	93%	3%
Allows for prompt initiation of investigations of questionable conduct and appropriate corrective action.	93%	3%
Includes ongoing evaluation and monitoring of the effectiveness of the compliance process.	84%	12%

The responses from the 32 percent of hospitals and health systems (603 respondents) that do not have a formal corporate compliance program in place but are planning to implement one within the next 12 months suggest that these critical compliance program elements are already part of their emerging programs or will be considered as future additions to the programs after they are implemented:

Compliance Program Element	Already Incorporated	Planning to Include
Compliance program is part of a larger initiative related to organizational ethics.	37%	21%
Designated specific individual within the facility has primary responsibility and authority for compliance oversight.	73%	17%
Designated group of individuals to advise and assist in implementing compliance activities.	64%	21%
Provides senior corporate officers and board members with regular reports related to compliance.	51%	38%
Written policies identify specific areas of risk to the organization.	50%	40%
Written policies are disseminated throughout all levels of the organization.	48%	42%

Compliance Program Element	Already Incorporated	Planning to Include
Addresses special areas of increased risk such as upcoding, unbundling, teaching physician responsibilities, financial arrangements with physicians, self-referral, and patient dumping.	51%	39%
Compliance program applies to various state and federal laws and regulations in areas other than Medicare and Medicaid billing, such as tax exemption, labor, environmental, antitrust, occupational health and safety, etc..	42%	43%
Requires periodic training to keep individuals up-to-date on compliance requirements.	50%	40%
Considers adherence to compliance policies a factor in performance evaluations.	34%	48%
Specifies disciplinary action for those who fail to comply with compliance standards, policies and procedures, and federal and state laws.	44%	44%
Guarantees confidentiality and non-retaliation to those reporting compliance concerns.	57%	34%
Allows for prompt initiation of investigations of questionable conduct and appropriate corrective action.	56%	35%
Includes ongoing evaluation and monitoring of the effectiveness of the compliance process.	49%	42%

Detailed Survey Analysis

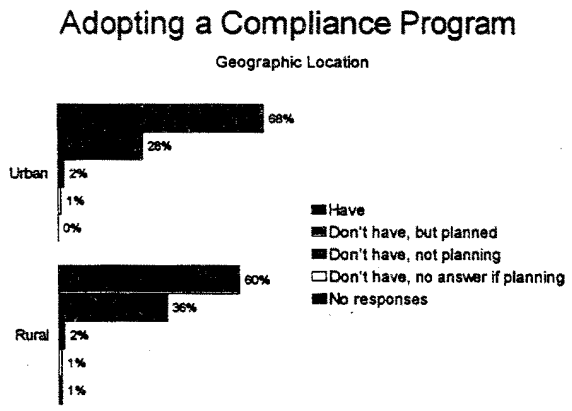
Regardless of the geographic location, bed size, status as an independent institution or part of a multi-hospital system or network, or controlling organization, all hospitals and health care systems need to have in place a coherent, well-planned and carefully implemented program for self-monitoring, or voluntary compliance. The more detailed analysis of the survey results indicate that:

- A majority of hospitals and health systems regardless of geographic location, bed size, and status as an independent institution or part of a multi-hospital system or network have implemented compliance programs or are planning to do so within the next year.
- A majority of non-government, not-for-profit and investor-owned facilities have a formal compliance program in place or are planning to implement one within 12 months.
- A majority of state and local government facilities have a formal compliance program in place or are planning to implement one within 12 months.

- A majority of federal government facilities, however, indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.

By Geographic Location

- A majority of both urban (96%) and rural (96%) of hospitals and health systems have a formal compliance program in place or are planning to implement one within 12 months.
- A slightly greater percentage of urban hospitals and health systems (68%) have formal compliance programs than do rural hospitals and health systems (60%).
- An additional 28% of urban hospitals and health systems indicate that they will be implementing a compliance program within 12 months.
- An additional 36% of rural hospitals and health systems indicate that they will be implementing a compliance program within 12 months.
- Only 2% of both urban and rural hospitals and health systems indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.



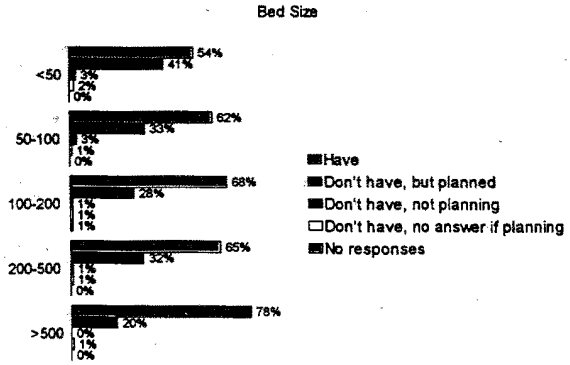
By Bed Size

- A majority of hospitals and health systems regardless of bed size have a formal compliance program in place or are planning to implement one within 12 months:

Less than 50 beds	95%
50 to 100 beds	95%
100 to 200 beds	96%
200 to 500 beds	97%
over 500 beds	98%

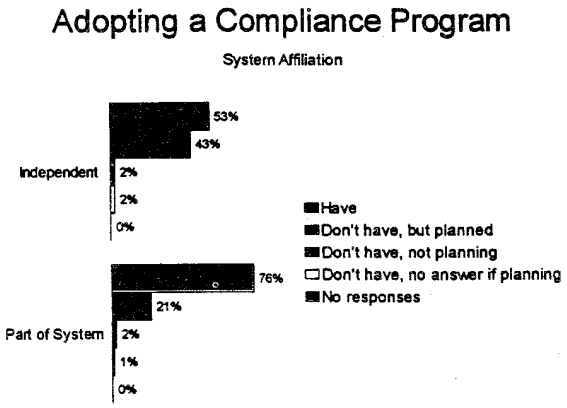
- Over 50% of hospitals and health systems with less than 50 beds have a formal compliance program in place but another 41% indicate that they will implement a compliance program within 12 months.
- For bed sizes ranging from 50-100 beds up to 200-500 beds, over 60% of hospitals and health systems in each category have a formal compliance program in place.
- Over 75% of hospitals and health systems with more than 500 beds have a formal compliance program in place.
- For bed sizes ranging from 50-100 beds up to 200-500 beds, more than 25% of hospitals and health systems in each category indicate that they will be implementing a compliance program within 12 months.
- An additional 20% of hospitals and health systems with more than 500 beds indicate that they will be implementing a formal compliance program within 12 months.
- Only 3% or less of hospitals and health systems in each of the bed size categories indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.

Adopting a Compliance Program



By System Affiliation

- A majority of facilities regardless of system affiliation status have a formal compliance program in place or are planning to implement one within 12 months (independent – 96%; part of system – 97%).
- A greater percentage of facilities that are part of multi-hospital systems or networks (76%) have a formal compliance program in place than do independent facilities (53%).
- Another 43% of independent facilities indicate that they will implement a compliance program within 12 months.
- Another 21% of facilities that are part of multi-hospital systems or networks indicate that they will implement a compliance program within 12 months.
- Only 2% of independent facilities and those that are part of multi-hospital systems or networks indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.

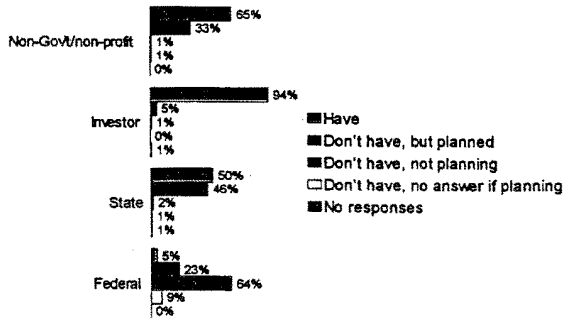


By Controlling Organization

- A majority of non-government/not-for-profit (98%), investor-owned (99%), and state and local government (96%) facilities have a formal compliance program in place or are planning to implement one within 12 months.
- 94% of investor-owned hospitals and health systems have a formal compliance program in place and another 5% indicate that they will be implementing one within 12 months.
- 65% of non-government, not-for-profit hospitals and health systems have a formal compliance program in place and another 33% indicate that they will be implementing one within 12 months.
- State and local government hospitals and health systems are about evenly divided between those that have a formal compliance program in place (50%) and those that will be implementing one within 12 months (46%).
- 2% or less of hospitals and health systems that are non-government/not-for-profit, investor-owned, and state and local government facilities indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.
- A majority of federal government facilities (64%) indicate that they do not have a formal compliance program in place and do not plan to implement one within 12 months.
- Only 5% of federal government facilities have a formal compliance program in place, but 23% indicate that they plan to implement one within 12 months.

Adopting a Compliance Program

Controlling Organization



Mr. OSE. The other question is with respect to the compliance systems that are in existence right now, how do they break out in terms of frequency of implementation relative to private, public, nonprofit, for-profit, nongovernmental, and governmental? It would seem to me very important, because if you find private providers without compliance systems with a high degree of errors, that is an "Over here, look here," kind of thing. So I want to make sure that we are ultimately using our resources in this manner effectively, rather than focusing them on areas where we already have a high degree of compliance and a relatively low level of errors.

Ms. BROWN. I would like to make a couple of points about them that I think you would find interesting. First of all, we started to develop these plans because there were many consultants in the business who were charging over $100,000 to help an institution put in a compliance plan, and it wasn't an effective one or one that we felt would do them any good or that we would consider as a good preventive measure. So we started to develop this as part of our prevention efforts, and the industry has adopted these. We are not far along enough that I can give you percentages of all of the nonprofit/profit and so on organizations who have adopted them, but there is a great deal of interest.

The other point that I want to make is when we have convicted somebody or an institution, we impose a nonvoluntary integrity plan. We have, as part of the settlement of that case, an integrity plan that is imposed on them and it is usually 5 years. They have to report back to us on the status of their business, the results of—how many complaints they have received, what they have done about them, and a variety of other things, and we monitor those plans. We are monitoring several hundred of them right now. We will continue to impose those integrity plans where we have found significant errors to have taken place.

Mr. OSE. My time has expired, Mr. Chairman.

Mr. HORN. Do you want to pursue that?

Mr. OSE. For the record, I will submit this in writing. How do you determine whether a voluntary compliance plan is satisfactory? You can respond subsequently.

Mr. HORN. Without objection, there will be space left here for your response and the Health Care Financing Administration's response.

[The information referred to follows:]

In determining whether a voluntarily established compliance program is effective, it is important to examine the comprehensiveness of the program, with a particular emphasis on an organization's policies and procedures to address the specific risk areas it faces; the system a provider has in place for evaluating whether it is in compliance with these procedures and applicable Federal health care program requirements, including oversight of the program; the adequacy of its training programs; and the establishment of a system to investigate and remediate identified problems.

Mr. HORN. I now yield 6 minutes to Mr. Turner of Texas.

Mr. TURNER. Mr. Hash, several months ago the President directed that all managed care providers under Medicare subscribe to certain patient protections. As you know, we are debating in the Congress patient protection legislation that would affect the private sector managed care companies. Has the President's order been implemented successfully by HCFA?

Mr. HASH. Yes, it has, Mr. Turner. We have put into place what we think are the toughest beneficiary or patient protection requirements in our standards for managed care plans of any managed care plan around the country. So the President issued an Executive order requiring that health care providers who do business with Federal programs, including our program, meet these patients' bill of rights protections as set forth from the President's commission on quality and patient protections.

Mr. TURNER. How long have those protections been in place?

Mr. HASH. We published a regulation in June of last year which implemented Medicare patient protections as a part of implementing something called the Medicare Plus Choice program, which is the Balanced Budget Act part dealing with managed care improvements, and the Medicaid improvements to patient protections are a part of a rule that we now have under consideration for Medicaid managed care. The proposed rule was issued at the end of September, and we expect later this spring to be publishing a final rule for the Medicaid managed care programs.

Mr. TURNER. So Medicare patient protections have been in effect since last June?

Mr. HASH. Yes, that is correct, Mr. Turner.

Mr. TURNER. One of the issues that comes up in patient protections is whether or not they are going to result in additional costs for health care. In the instance of patient protections in the area of Medicare, I think it would be interesting if you could comment on whether or not there has been a cost impact on the Federal Government as a result of implementation of the patient protections for Medicare?

Mr. HASH. We don't think so, Mr. Turner. Our experience and also in working with the associations which represent managed care plans, that many of them—many of the best plans—already had these protections in place for the most part. We believe that they have been endorsed by the associations representing managed care plans. So we think that there is a great deal of agreement on these protections that are now in place for Medicare Plus Choice.

Mr. TURNER. How are you able to determine whether or not a managed care company is making a reasonable profit with regard to the reimbursement rates that you provide?

Mr. HASH. Each year for a managed care company that wishes to contract with Medicare, we require them to file with us a statement in which they detail some of their financial information, including an estimate on their part of what it costs them to provide the Medicare benefit package to their Medicare enrollees. And that calculation is important because we compare what it costs them to what we pay them, and in those cases where their costs are lower than the Medicare payment rate, we require them to make up that

difference through either reducing cost-sharing for their enrollees or by increasing benefits.

So we actually have some window at least on the portion of their business that relates to the Medicare program. Overall, of course, almost all managed care plans have other lines of business besides Medicare, and we do not have access to their financial information across the board.

Mr. TURNER. Would it be important or appropriate that you have access to that information? Is there some overlap between their other activities that would be important to know about in assessing whether or not the Federal Government and the taxpayers are getting a fair deal from the managed care companies?

Mr. HASH. I think what we have concentrated on is this filing of their estimate of their costs to provide the benefits that are required under Medicare, that is the critical piece to ensure that what we pay is in relation to what their costs are, and if they are not, that the beneficiaries get the benefit of the difference between their costs and what we pay. We have recently completely revamped the system, the reporting system for those estimates from plans, and we think now it is a much stronger and more representative set of data about the costs of health plans to provide the Medicare benefit package.

Mr. TURNER. But what you base this on is the managed care companies' estimate of their costs?

Mr. HASH. That is true, but through our reporting system we are able to audit that more carefully because we have put into place more systematic requirements about how they go about doing that estimation. It is subject to requirements and standards that we put forth in a protocol that they must use to report to us their costs.

Mr. TURNER. Ms. Brown, do you have authority to audit the activities of these managed care companies?

Ms. BROWN. We can. We don't as a rule go into the private aspects of their business. However, there may be some occasions where we would be looking at the cost distribution, for instance, of their overhead, because they may be shifting costs so that it appears that it is all Medicare costs. Sometimes they are actually taking some of their private costs and putting it on the Medicare side.

Mr. HASH. Mr. Turner, in fact the General Accounting Office released a study within the last couple of years indicating that in their reporting to us of their costs, that there were some inappropriate allocations, particularly in the area of administrative overhead, where in fact the costs of the plans's overhead was being inappropriately allocated to the Medicare side, therefore affecting—raising inappropriately their costs.

And so this new reporting protocol that I referred to no longer allows plans to allocate their overhead in the same manner that some of them were doing in the past, and we believe now we have a much tighter system with respect to what it is they are reporting to us and whether or not it represents a fair allocation to the Medicare side from the business they are otherwise doing.

Mr. TURNER. How often are the rates readjusted for the managed care companies?

Mr. HASH. Once a year.

Mr. TURNER. Once a year, and does it occur at the same time for all of the companies?

Mr. HASH. January 1, the calendar year.

Mr. TURNER. Thank you, Mr. Chairman.

Mr. HORN. Let me pursue a couple of inserts that relate to policy matters, and we would appreciate the aspects of the Inspector General also on this.

I sent a letter to the Administrator with reference to a series of administrative law decisions on behalf of a particular surgeon that has had a brilliant record, and some of his things go against the pattern of other surgeons. The letter from the Administrator is dated February 8, 1999.

Thank you for your letter on behalf of your constituent, Robert A. Nagourney, M.D., regarding the distinction between the types of clinical resistance and sensitivity assay tests to determine the effective treatments for cancer patients. I regret the delay in response.

In the absence of a national coverage determination, coverage and reimbursement of all assay tests are left to the discretion of the local Medicare carriers. Dr. Nagourney is correct. The two recent cases by administrative law judges did permit the coverage of two cancer tests, extreme drug resistance assays and cell culture drug resistance assays, for individual patients. However, at this time the decisions of the administrative law judges are limited only to those individual cases and does not establish precedential coverage policy for the Health Care Financing Administration or our Medicare carriers.

I guess I would ask the question, if an administrative law judge rules a certain way and you have another case that rules another way, what does it take to get a policy changed?

Mr. HASH. Mr. Chairman, I think that is a very important set of questions because, as you may know, we were in the process of completely redesigning our coverage process at the national level. And what that means is we are putting into place a process that is much more open and transparent, that involves a federally qualified advisory committee to assist in making decisions about advancements in medical care that ought to be covered under the program.

You are correct in saying that when information—or at least I think you are implying, and I think it is a correct inference—that if we get information about a new test or a new procedure that holds some promise, and then we see that there are conflicts in the handling of that at the local contractor level, that it does behoove us to put that up into our system of review to first bring some consistency where we can to these kinds of issues.

I will say to you that one of the reasons that local medical review policies are in place is that over the years we have found that an effective way of dealing with new technology, because we need to have information about what kinds of patients benefit from a particular new procedure or new service, we need to know something about the costs in different settings, all of this information is initially gathered through local medical review policies which then feed into a decisionmaking policy for national coverage. But without that sort of opportunity to get experience with advancements in health care, it would be difficult to make appropriate national decisions.

But in this particular case, where there has been conflict, it should be something that we are reviewing through our coverage process, and I would be happy to get back to you with what might be the status of our look at that question.

[The information referred to follows:]

Mr. HASH: Where no national policy exists, our local contractors develop policy as they identify a need. This may in some cases provide access to new technologies before national policy is established. Our goal, however, is to provide more timely and consistent national policy to improve access to new technologies as quickly as is warranted by medical and scientific evidence for all beneficiaries regardless of where they live.

Mr. HORN. I would appreciate that. The Administrator goes on to say,

> We agree with Dr. Nagourney, there is a distinction between the types of in vitro chemosensitivity technologies. As Dr. Nagourney's letter indicates, these technologies are new, and despite the recent rulings by the administrative law judges, Medicare still considers these tests as investigative. I believe the type of research being performed by Dr. Nagourney is very important. Please be assured that when Dr. Nagourney's work reaches a stage where a national and/or local coverage decision is considered, we will carefully examine the scientific and methodological differences in the application of these cancer tests in the consideration of coverage and reimbursement policies, including the development of CPT codes.

Do you want to translate CPT codes for me?

Mr. HASH. Current procedural terminology. It is actually a manual of about 7,000 codes that describe various services and visits that physicians and others provide. It is compiled on an annual basis by the American Medical Association, and the Medicare program actually uses that coding system in its claims processing in order to communicate the type of services that have been provided.

What that letter actually did, as you read on, Mr. Chairman, is answer the status of this question in a way that I think—I would be getting back to you on. What happens here is we go through an evidence-based analysis of these kinds of new things. And when we cover something, it needs to have moved from the investigational phase to a point at which, in refereed journals and among practitioners of whom we consult, that it has been vetted and subjected to full scientific validation before we want to make a national coverage decision.

But I think what often is the difficulty here is the speed, or in some cases the lack that may surround new developments, and people who think that they have an advancement that is benefiting people are understandably interested in making sure that all people who suffer from a condition that could be helped by it will be able to access this new advancement. And that is why we are committed to a much more time-sensitive, transparent, and evidence-based coverage process.

Mr. HORN. Well, let me finish with the last few words of the Administrator: "In that regard, our coverage and analysis group in the Health Care Financing Administration's Office of Clinical Standards and Quality would be most interested in Dr. Nagourney's research. Dr. Nagourney can send his materials directly to the attention of Dr. Grant Bagley," and the address, Baltimore, MD.

The reason that I am so wound up on this is I have known so many lives that he has saved. Chemotherapy often is just the wrong thing, and he has been able to match what actual therapy is needed in relation to that particular cancer. You see that proof and they are walking today, when others were dying, I want a little progress being made here. So that would help.

In another letter that I sent to the Administrator on September 25, 1998, I said: "This letter is in reference to the Health Care Financing Administration's policies on outpatient psychiatric services. Specifically, we are concerned with the lack of a national medical review policy for outpatient psychiatric services."

I noted that I am interested in reviewing Medicare's current national medical review policy for all medical treatments. I am also

interested in the number of claims which are processed by each carrier and with contracts with the Health Care Financing Administration. I would like to know the number of these claims that are accepted, the number rejected for each type of medical procedure.

I would also like to know at what level in the process, initial review, hearing, an administrative law judge hearing, each type of treatment that was accepted for payment. Further, I am interested in knowing which carriers are using the national model policy developed by the career medical directors for outpatient psychiatric services and which are not.

In the reply of the Administrator on February 26, 1999, this was turned over to Dr. Robert A. Berenson, director of health plans and providers, and the usual answer here: "The Administrator asked me to thank you for the Medicare policy for outpatient psychiatric services. I regret the delay" and so forth. "Staff members in our regional offices are often in the best position to be of assistance to the people in their area."

Well, we have written now with detailed requests for information to your San Francisco office, Health Care Financing Administration, Health Plans and Providers Branch, and I would like at this point in the record, without objection, to lay the correspondence down plus some of the future answers so we can get this one restored.

Just on the general point of Medicare policy for outpatient psychiatric services, what can you tell me, Mr. Hash, in relation to that, where are we?

Mr. HASH. The area that we have been concentrating on, and it actually came up in the audits by the Inspector General. It has to do with the coverage of the partial hospitalization benefit under Medicare which, as you may know, is being provided both by hospital outpatient mental health clinics as well as freestanding community mental health centers. The IG identified, as well as our own regional office staff, a significant number of providers who were enrolled as qualified to provide the partial hospitalization benefit, who upon site visit and further inspection did not meet our requirements, and furthermore that the kinds of claims they were submitting were not being properly documented and they were being submitted for services that were not covered, and so forth. In fact there is quite an extensive report about this.

What we have been doing is to first visit a large—not all, but a very large number of the outpatient mental health centers to ascertain whether or not they are in compliance. For those that are not in compliance, we have sent letters indicating they need to supply us additional information about that. With respect to medical review, we have enhanced the medical review of claims that are coming into our contractors for partial hospitalization programs.

Last, we have recommended to the Congress in the President's legislation for the year 2000 that there be a change in the law that makes it clear that partial hospitalization services cannot be provided in a patient's home or in a place that is not an appropriate clinical setting for such services, because we have found widespread abuse in this area, and that is where we have been concentrating our efforts on outpatient psychiatric services.

Mr. HORN. Is there a limit to the number of sessions that they can have with outpatient services?

Mr. HASH. There isn't.

Ms. BROWN. No, sir, but the requirement is that these services are something provided to somebody who would otherwise have to be a full-time patient in a psychiatric hospital.

I am sorry to say that this was the most appalling abuse area that I have seen in the 20 years that I have been serving as Inspector General in various agencies. Over 90 percent of the payments should not have been made that were being made in this program. Fortunately, it wasn't that large a program.

HCFA has taken aggressive action to make sure that the places providing the service are qualified and that the people are qualified and that there is something other than just baby-sitting type services that are being provided. Many of them were providing just simple crafts and things like that rather than true psychiatric services. This was one of those things caught at an early stage, and I think corrective actions are being taken.

Mr. HORN. Was there an actual certified psychiatrist behind this, and they simply were training people to do a few things that we would call what graduate students do when they try to help people?

Ms. BROWN. It was a range of services. Some of the services might have been helpful but they didn't qualify for this particular benefit. There may be other types of things that would cover services in the line of giving people care, but——

Mr. HORN. You gave me one example of somebody going astray. Can you give me a few more for the record on the outpatient psychiatric situation? What is another typical thing that happened that you had to do something about?

Ms. BROWN. The people may not have been qualified to receive the benefit. They may not have had a condition where they otherwise would have had to be an inpatient. They might have had some need for psychiatric sessions of some kind, but they would have to be covered under some different benefit, not the partial hospitalization. And of course there were many places who really weren't qualified to provide the service under the provisions of the legislation.

Some of them voluntarily withdrew, once challenged as to whether or not they met the qualifications. So it was one of those things where payments started to be made immediately, and people were sort of jumping in to collect without a careful screening of both the beneficiary's eligibility and the provider of services' eligibility.

Mr. VENGRIN. Some of the patients had no history of psychiatric illness whatsoever, and these services were of a recreational nature—dancing, social events, arts and crafts, as the Inspector General mentioned.

Mr. HASH. And in fact from a coverage point of view, Medicare does not cover adult day care. What some of these providers were running were adult day care centers.

Mr. HORN. Interesting. I yield to the gentlewoman from Illinois, Vice Chairman Biggert.

Mrs. BIGGERT. Thank you. In regards to Mr. Turner's comments, I think it is important to note that in counties surrounding my dis-

trict many managed care plans have elected not to participate in the Medicare Plus Choice program because their costs are not covered. I met with one recently who stated that although they are willing to break even under Medicare, they simply will not go into the red for Medicare. So as I think we discussed the relationship of managed care to Medicare, it is important to note that many Medicare beneficiaries are counting on HCFA and Congress to ensure that Medicare Plus Choice remains a beneficiary choice.

Second, as far as home health care, in one of my former lives I was on the board of directors of a home health care agency and I served as chairman of that group celebrating its 100 year anniversary, and so this was in existence long before all of us were here. And we went out of business because although we had a huge endowment, we were serving preservice, those patients who had no access to Medicaid, no access to Medicare, and also those that were the Medicare/Medicaid patients. We ended up subsidizing Medicare and Medicaid to the tune of $2 million a year, and we could have continued this for a number of years and then that huge endowment would have been gone.

We chose to become a foundation, to be able to help in the health care field rather than to continue that, because our nurses would not work when they were seeing acute care patients who were exiting the hospital earlier and earlier, and they were only able to provide that skilled nursing care for a very short period of time within the scope of the rules and regulations, and so it did end up as a subsidy.

And I just want to note that for the record that there are a lot of agencies that really are very committed, not-for-profit agencies and those for-profit which are very committed to providing that health care. I know that we are addressing the fraud and abuse today, but I think it is important to note that there are agencies that work very hard for us and are great providers.

Ms. BROWN. If I could just mention that one of the things that got us involved in this were complaints from long-term organizations who had been providing true health care services that were needed in the home, and they were saying they couldn't compete with these others who were providing cleaning services and other things to patients, who in many cases weren't qualified and were collecting the funding that was available. And those who were truly trying to provide services to patients were driven out of the business by the constraints necessitated by these other illegitimate services.

Mrs. BIGGERT. I have one other question. Ms. Brown, you stated in your testimony that the substantial year 2000 initiatives could negatively affect future error rates, and if the collection and processing of the electronic data poses challenges and risks, particularly in the year 2000, how does HCFA propose to collect the volumes of data that will be required in order to implement the risk adjuster it proposes? I guess that would be to Mr. Hash.

Mr. HASH. I think that is to me. We actually began collecting the data on hospital admissions with respect to managed care enrollees. It began on January 1, 1998. We have something in the neighborhood, I believe, of about a million discharges that have been reported to our data system. That formed the basis of the proposed

risk adjustment which we released at the beginning of March to the health plans who were contracting with us. We are in the process of putting together a plan to begin collecting outpatient data, physician services, and clinical encounter data to support a more comprehensive risk adjuster which is scheduled to come on-line in the year 2004.

Mrs. BIGGERT. I've heard that the systems have had difficulty processing the data where beneficiaries move from one county to another or one plan to another. How are you going to verify the accuracy?

Mr. HASH. We have been working with individual plans. We have about 300 health plans that contract with Medicare currently, and since we began collecting the data, we have been trying to work through any issues or questions about the validity or representativeness of the data, having the data coming from our contractors compared to what the health plans believe they sent in, and either finding where the discrepancies are, if there were, and correcting them and getting to a point where both us and the health plan are satisfied that the hospital admission data that they have submitted to us is in fact accurate, because we don't want to proceed on the basis of a risk adjustment that's based on faulty data.

Mrs. BIGGERT. And then you'll have a means to verify? What would be your accuracy level, do you think?

Mr. HASH. We've presented to each plan the information on the admissions that we have that have been reported to us, for them to in turn verify with their own internal records just to make sure that the data we have is consistent with what they think their records reflect in terms of hospital activity for their enrollees.

Mrs. BIGGERT. I've seen no detailed accounting of how money was spent, quite a good number of dollars to the beneficiary education program, and how effective your efforts have been in providing Medicare beneficiaries with the information they need to make the right decision for plans.

Mr. HASH. We have a full accounting which we'd be happy to share with you. We are very proud of the efforts we have undertaken. As Secretary Shalala is fond of saying, the Medicare education program is the largest peacetime program ever undertaken in this country.

We have set up a multifaceted approach which involves the submission of a handbook to each beneficiary, the creation of a 1–800 toll-free number, 1–800–Medicare, that actually connects individual beneficiaries with customer service representatives who are trained to answer commonly asked questions.

We also have an Internet site, Medicare.gov, which provides comparative information about the health plans in their areas as well as information about health plan performance, so-called HEDIS data, which is health employment survey data about the performance of plans and satisfaction data about the enrollees. All of this is being made available to beneficiaries.

And last, we've been working with a partnership group of private organizations who interface with our beneficiaries, such as State health insurance counselors and other organizations, unions, employers, to make sure that they can also provide counseling and one-on-one information to beneficiaries. This has been a very com-

prehensive undertaking. It is, as you alluded to, financed by an assessment that is made on the plans that participate in the Medicare program, which was how the Balanced Budget Act established the funding mechanism for these efforts.

Mrs. BIGGERT. I would appreciate the accounting.

Mr. HASH. I would be happy to supply that.

Mrs. BIGGERT. You have done an internal audit of that program?

Mr. HASH. We have. In fact, last year—you may have read about this—we decided not to provide the full array of our information services nationwide but to target five States. We did target five States, and in that process we went in advance of our efforts and did a baseline assessment of information needs, and then since the fall campaigns of November we have gone back and collected, after the fact, information so we could evaluate whether the materials were useful to people, whether they actually were intelligible to them, whether the toll-free number worked, and what sort of suggestions and recommendations that people had to strengthen the information program.

Mrs. BIGGERT. Did you share the results of that audit?

Mr. HASH. We're not completely through with the evaluation but as soon as we have it done, we would be happy to share it with you.

Mrs. BIGGERT. Thank you very much.

Thank you, Mr. Chairman.

Mr. HORN. Thank you.

The gentleman from California, Mr. Ose.

Mr. OSE. Thank you, Mr. Chairman.

Following up on the gentlelady's question, the five States that were targeted, Mr. Hash, which were they?

Mr. HASH. Which were they? They were Washington, Oregon, Florida, Ohio, and Arizona.

Mr. OSE. Let me jump ship for a little bit, back to my question on compliance itself. Asking a large multifacility system to engage in a compliance system is far different from asking a single facility rural clinic to engage in a compliance program. I'm curious if you have, on either side, any information about the impact on those two relative classes.

My district is largely rural, and we have a significant declination in the availability of Medicare in the rural areas, and I'm trying to figure out what it is that is causing that. Is it the reimbursement rates? Is it the cost of compliance? What is it? I'm wondering if you have any information about that, as to the impact of the compliance issue on a relative scale between large multifacility systems in urban areas and single site facilities in rural areas?

Ms. BROWN. I can tell you that we have a concern about this and, as I mentioned, we started putting out these generic compliance plans because we found that contractors were charging a huge amount of money and in some cases not adapting compliance plans to the needs of the organization. We have encouraged every organization to look at these generic compliance plans and look at everything, including is it cost-effective to implement a certain suggestion since it's made for the entire range of that type of provider. I always told them that they should then document why they made

their choices, including whether or not something would be cost-effective within the size organization we're talking about.

So, to have a tracking system of some kind, you know, a compliance manual might be much more effective for a small organization than a large one having a compliance officer; whether that individual is full-time or part-time; whether there's a whole team of people; or whether to have a hotline for reporting misdeeds should they occur. You know how elaborate that system would be. We have tried to consider the fact that there are a great many small providers where an elaborate system would be impractical and financially burdensome. They could adapt these compliance plans, a system of internal controls and procedures for making sure that top management gets the information and is aware of what's happening in their organization, that there's a reporting flow of information and so on, and that through plan ignorance they were not denied information about misdeeds that are going on within the entity itself. So, we have tried to consider that. I don't have statistics as to what the cost is per organization or anything like that.

Mr. OSE. Does HCFA have any information as to the declination and available care in rural areas as a result of the cost of compliance?

Mr. HASH. I don't have any information to quantify that, but what I would say is what we've been trying to do is invest in provider education initiatives, because we recognize that we have a responsibility to make sure that our rules and regulations are fully understood, that people have an opportunity to get clear answers to their questions. We have been working with educational programs through our contractors to in fact install around the country an effort to educate billing clerks of hospitals or of small physician practices so that they can get assistance in understanding how to complete an appropriate claim for the Medicare program.

We have targeted an educational effort at the beginning of physician's careers, that is to say, with over 6,000 residents who have participated in a training module for how to appropriately comply with and bill the Medicare program. And we have supported another Internet learning site that a very large number of physicians can sign onto, go through a training course, and not only physicians but their billing and business managers and other folk, in order to keep up with the changes in requirements and so forth, because again we recognize that we have an enormous responsibility to make sure people understand what our expectations are and what our requirements are.

Mr. OSE. I appreciate what you're telling me. The issue that comes up is, if there is no doctor there, it doesn't matter what the compliance requirement is. That just creates enormous problems in my district, because doctors are naturally aggregating or congregating in the urban areas and it's an enormous problem in my district.

Mr. HASH. One thing that has happened, I think, and it was a result again of the BBA, was the Medicare care program has been able to expand the types of practitioners who are eligible to actually participate and take care of patients and bill the program, most notably, advanced practice nurses, nurse practitioners, certified nurse anesthetists. These practitioners are not necessarily a substitute certainly for someone who needs a physician service, but

there is a great deal of work I think that can be done in reaching people who need primary care services through advanced prepared health professionals.

Mr. OSE. We have some facilities like that and I appreciate that flexibility. I do want to ask something, and I would appreciate visiting with you privately about, that is the definition of fair or adequate reimbursement for services within the system.

Again, going back to my district, if there's no medical service available, what is a fair reimbursement level? There's no doctor there. What's a fair reimbursement level? I don't know how to reconcile that. Rather than spending the time of the committee on that in discussion, I would rather visit with you privately, but it's an enormous problem. It doesn't matter what the reimbursement is if there's no doctor there.

Mr. HASH. I'd be happy to do that. There are some strategies that some communities have tried to put into place that would attract appropriate cadres of health professionals, but we should talk about this, because access for our beneficiaries who live not only in your district but in other medically underserved areas is something that we should be trying various strategies to get health care professionals an appropriate incentive to serve those individuals.

Mr. OSE. I saw nothing in the material. Maybe I missed it about initiatives addressing that particular issue, whether they're on an audit trail or audit basis for analysis purposes or initiatives that would follow on.

Thank you, Mr. Chairman.

Mr. HORN. Well, I thank you. You've raised a significant issue. Mr. Turner and I have talked about it in his area and now you've mentioned it in your area, so I think what we'll do is hold a hearing in both districts. I know we're going to hold one in Sacramento on the Y2K bit, otherwise known as the year 2000 computer glitch, and we might well work in this if you'd like to do that.

Mr. OSE. Is this a double play?

Mr. HORN. This is a double play, yes. This gets the staff in one place at one time and we can do two or three things. So we welcome your thoughts on it.

Let me just ask a few closing questions, unless the gentlewoman from Illinois has some.

Mrs. BIGGERT. No.

Mr. HORN. Just for the record, we've talked about various reforms that the Health Care Financing Administration would like to have. Are those before the Committee on Ways and Means in the case of Medicare and before the Committee on Commerce in the case of Medicaid? Is that where they are?

Mr. HASH. You're referring to the contracting flexibility?

Mr. HORN. Yes, and different things which you've mentioned as reforms that you'd like to have.

Mr. HASH. Right. They would—the President's recommendations for the year 2000 legislation, I'm not sure whether the actual legislation has been transmitted to the Congress. It certainly is included in the budget in descriptive terms, but I'd be happy to let you know exactly whether it has been transmitted formally to the Congress.

[The information referred to follows:]

The statutory language for this year's fraud and abuse proposals has not yet been submitted to Congress. The Administration's contracting reform proposal will be submitted to Congress this year.

Mr. HORN. We did get into reorganization, but basically those are the authorizing committees.

Mr. HASH. That is correct.

Mr. HORN. They need to concur with the policy.

Mr. HASH. That's my understanding.

Mr. HORN. OK. I guess I would ask this question of the Inspector General, and it's probably outside of your jurisdiction, but do you ever have a chance to look at the revenue that flows into Medicare based on the withholding tax? Have we ever looked at how that's handled by the Internal Revenue Service?

Ms. BROWN. That was one of the areas, because we didn't have the jurisdiction to look at Social Security, we could not audit that as part of our financial statement review, and this year we have worked out arrangements.

Joe, did you want to go into that?

Mr. VENGRIN. Yes. Mr. Chairman, we are contracting on a task with the General Accounting Office, which contracts for the Social Security audit, to get that coverage, but that's on the Part B premium side. We could not go over to Treasury to audit the trust fund accounting, so in effect we are precluded from auditing that, Treasury as well as Social Security. I'd love to. My plate is kind of full, though, with Medicare.

Mr. HORN. Let me find out what's precluding you. Is it a law that's precluding you?

Mr. VENGRIN. We really could not go into another Federal agency.

Mr. HORN. Even though your revenue is based on how it's handled by that agency?

Ms. BROWN. That's true.

Mr. HORN. Well, we'll get at it some way. I have a memo I'm going to insert in the record, without objection, on how that revenue comes in for 14, 15 trust funds that are involved, one of which is related to Medicare, the area of which is related to Social Security, but there's a lot of others, the Aviation Trust Fund, the Interstate Highway, so forth.

And it's my understanding, having reviewed the financial status statement of the Internal Revenue Service, what you have here is an Office of Estimates that sort of estimates what the revenue is. I don't understand why we can't just, when the check is made out by the employer, employee—and Social Security, Medicare, where Medicare was modeled on Social Security, it works generally the same way—and I just can't understand why if the check is made out for that match in the fund of employee and employer, I can't understand why that isn't immediately segregated into that trust fund.

But what happens? It goes to one of the many banks that the Treasury anoints and that becomes the general revenue. So everybody is sort of a little murky about well, gee, did we lose 10 million? Did we lose $100 million in terms of the estimates? And we don't really have a good fix on that. Maybe the General Accounting Office does.

We'll be pursuing that with them, but it's something that does interest me and it interests—I turned a copy of the memo in to Chairman Archer last night, and he's going to take a look at it and see what happens also. But I am sort of amazed that we can't connect the revenue bit with the expenditure bit, and that the Inspectors General are precluded from maybe working as a team. And wherever those trust funds are involved, either GAO ought to do it as part of it or Treasury ought to do it as part of it, as to just are we accurate in terms of our revenue.

Ms. BROWN. I would appreciate that, sir.

Mr. HORN. OK. Let me close with a few detailed questions here that haven't been asked, to my knowledge.

Medicare contractors, as we saw, collected over $7.5 billion in 1998, and your report points out significant weaknesses in the area which we've been exploring. You reported that contractors do not maintain records to support cash collections. In addition, you reported that at some locations the same person that receives checks endorses the checks, prepares the deposit to the bank, performs the bank reconciliations. This situation puts this money at tremendous risk of being stolen.

You're absolutely right. The first thing you learn to do in any organization is "Look, we can't just let one person do it from end to end," as wonderful as Aunt Minnie might be, and you learned long ago when Aunt Minnie says, "Oh, I've got a lot of work to do, I don't want to take a vacation this summer," and Uncle Louie does the same thing in the next organization, you've got a real problem.

I'm a great believer in moving people around, making sure they take their vacations, especially when they're handling money, and let's see who sits at that desk and what they're going to do. And there have been great exposes, at least in the State of California we've had them, where somebody just took over for the summer, said, "Gee, I wonder where this," in this case 800 bales of hay went to the ranch of a vice chancellor of one of the systems in California and not to the ranch that was being run to educate students.

So I'm just curious what your recommendations are on that and if they're being followed, and can they be or is there some block to it with Medicare contractors, or can you just plain old mandate it?

Mr. VENGRIN. Again, Mr. Chairman, the Medicare contractors historically have done a great job on processing claims in an expeditious manner, but the financial controls are gradually catching on as a result of the CFO act. Believe it or not, in many cases they just didn't do bank reconciliations. We've made these recommendations and we have to see if they're following them. They're just not doing them currently.

Mr. HORN. I think we would all agree when you combine a poor recordkeeping of accounts receivable, the weaknesses in collecting cash, the computer security problem which you mentioned, that you end up with absolutely no control over the money. So you're saying how can we solve that one in the next audit.

Ms. BROWN. Well, I think as Mr. Hash mentioned, having a wider selection base for getting contractors so that there is a great deal of incentive for them to live up to the expectation of reasonable control systems would be very helpful.

Mr. HASH. If I might add a footnote, Mr. Chairman, we have incorporated into our system of evaluating contractors requirements with regard to financial reporting and documentation. And obviously now the job is, as the Inspector General has alluded to, that we are providing—that we need to make sure we're providing—sufficient oversight and evaluation of our contractors to make sure they're in compliance, because I think we have the standards now in place, the requirements for documentation and for financial reporting, and we are doing training sessions; in fact, this spring a whole series of training sessions on financial documentation and requirements. And as a result, we think we are beefing up through our regional offices the actual oversight of compliance with these requirements by our contractors, and that's certainly a responsibility that we have.

Mr. HORN. Inspector General, on page 9 of your statement before us, point 2, you note financial reporting remains a material weakness because Medicare contractors have not adequately reconciled expenditures reported to the Health Care Financing Administration. Also, the process for preparing financial statements is manually intensive. Now, what can we do on that? There must be computer programs here, and what do we mean here by "manually intensive?"

Mr. VENGRIN. Mr. Chairman, as a result of the preparation of the financial statements, they have to make hundreds of adjusting entries to ultimately produce the final statements. We've made recommendations that they pursue a software package to do this more expeditiously. They are exploring that. That way we can get the adjusting entries as part of this process.

Mr. HORN. Now, this is the contractors that are exploring it?

Mr. VENGRIN. No, this is HCFA central office.

Mr. HORN. Can they mandate that then along the line, whoever is inputting?

Mr. VENGRIN. Yes, they can do this work in central office. We're not talking about the contractors.

Mr. HORN. Is that going to be done, Mr. Hash?

Mr. HASH. I need to—I'm being instructed at the moment here.

I think what we have done, as I'm told, is that we have hired a contractor, an outside contractor to help us install those kinds of protections and procedures within our own activities, and it's a part of our overall effort to make sure that our own systems are adequately maintained and documented. We are acting on the Inspector General's recommendation.

Mr. HORN. So the contractor will relate to the contractors?

Mr. HASH. Our outside contractor will relate to us as well as to the contractors.

Mr. HORN. All along the line on the accounting side, then, we're going to use software and not have to worry about manually intensive things being done?

Mr. HASH. I would say, as you can tell—what I'd like to say is that Mr. Vengrin is correct when you think about the history of what these contractors have been doing. This is not an excuse, but it's true that most of the emphasis has been on refining their claims processing systems and their audits and so forth as opposed to the area of financial documentation and reporting. And this is

an area in recent years that we've been paying increased attention to, and we should, and we expect that's going to show dividends in the next audit because we are committed to removing the qualification to our accounts receivable documentation for the next audit.

Mr. HORN. One last question relates to the year 2000 situation and are you using your need to get into conformity for that to solve some of your other problems within the agency, either in terms of new computers, new software, off-the-shelf, whatever?

Mr. HASH. One of the bright lights of the Y2K problem has been the opportunity that we've had to actually review something like 50 million lines of code in our claims processing systems and in other information systems that we maintain that are mission critical for the agency. And the result of that, I think, is at the end of the day we will not only have a Y2K compliant information system but we will have made improvements in that system that would otherwise probably have taken a longer time to get to. So I think one of the benefits of the intense scrutiny that has surrounded our efforts to become millennium compliant has been a very thorough renovation and testing of our information infrastructure and I think that will pay us and the taxpayers enormous dividends in the years ahead.

Mr. HORN. When did Medicare start in on the year 2000 conformity bit?

Mr. HASH. Well, I believe—I don't have a specific date but intensively over the last 18 months—and we obviously, as you are quite familiar with, set a goal for ourselves of December 31, 1998 to make sure that our internal mission-critical systems were renovated and certified. We made that deadline. We also set a similar deadline for our contractors. We did not fully make that deadline, as you know. We had 54 contractors who self-certified at the end of December of last year.

The governmentwide deadline is next week for compliance and self-certification. We are cautiously optimistic that we're going to be there with the contractor community. There are—there is one standard system which has gotten a late start in the testing phase, and for the seven contractors who depend on that standard system, they may be a little late in the final self-certification process, but otherwise we believe we're going to cross the finish line together with our 40 contractors and 78 mission-critical systems.

Mr. HORN. In 1989 both Medicare, Health Care Financing Administration and Social Security were in the same agency, namely Health and Human Services. Now, in 1989 the Social Security Administration realized they had to start moving on this, and the result is they've been given an A through our reporting process ever since, and they are the first agency to have year 2000 conformity and compliance.

Why didn't Medicare—and I know you just came in the last year. We're not going to pillory you, but perhaps the Inspector General has a long institutional memory. Why didn't Medicare do what Social Security was doing? Where was the Secretary? Asleep in 1989 or what?

Ms. BROWN. I came a little later than that as well, in 1993, but I think there's been several things. For one, in Medicare, worrying about all the contractors, there wasn't the funding to contract with

them to do some of this work. That was one of the problems. And having worked in both Social Security and on the rest of HHS, I had the privilege of signing the first clean financial statement for Social Security. We had done their financial statement audits for several years.

Although they're huge and it is a well-run agency, they don't have the number of systems, the number of different systems that we have in something like HCFA. So although the volume is tremendous and it's as large an organization as far as money being spent, it's a much less difficult one to both audit and to make changes in because they do have the uniform systems throughout the country. I think that's something that HCFA is striving for, and, in the future, will have.

Mr. HASH. I would just say, Mr. Chairman, I think the honest answer is we got a late start. There's no question about that. We did in fact consider making some transitions into a single operating system which failed to be realized. I think that was part of the reason why we got a late start, but I think we have really redoubled our efforts.

I think dealing with independent contractors has been a real challenge for us, but for the most part I think we would give them great credit for having cooperated with us, and the Congress great credit for having provided us significant additional resources with which to undertake the renovations and testing that are required to make sure we'll be in business on January 1, 2000. But it has been obviously a Herculean task, and a lot of credit is due not only to the work that HCFA has done but certainly the contractors themselves.

And as you know, we're now concentrating our attention on making sure the provider community is in fact taking the proper steps and devoting an adequate amount of resources to make sure that they're ready for the year 2000, because if we're ready and they can't submit to us a claim for services that's Y2K compliant, it will be very difficult to make sure that they get that claim processed. So we are now spending a lot of effort on outreach to the provider community to make sure that they have the assistance and the tools and the information to take the steps that are necessary to review all of their mission-critical systems, not only their information and billing systems but, as you know, their clinical systems that may have year or date problem sensitive issues, because the health care quality of the country is at stake if providers are not clear that their equipment has been properly reviewed and corrected and tested.

So I think there's lots of reasons for where we are, but we're quite proud of the accomplishments that we've made to date, and we think we're going to be ready at the end of the year.

Mr. HORN. The President has set a mark as March 31. Will Medicare make that?

Mr. HASH. As I said——

Mr. HORN. The Health Care Financing Administration, will you as an organization make that?

Mr. HASH. Yes, sir. We have actually at the end of December for our own internal mission-critical systems. They were renovated and

certified as of December 31. So we believe our own internal systems are ready and millennium compliant.

Mr. HORN. Unfortunately for you, they don't use the major groups within, they use the Cabinet department, so then you're in compliance but maybe a lot of parts of HHS are not compliant. And I guess I would ask the question, Congress removed Social Security from Health and Human Services; should we remove Medicare, Medicaid from Health and Human Services?

Mr. HASH. I'd like to——

Mr. HORN. Make you independent offices? Everybody would get a pay raise.

Mr. HASH. I would like to defer an answer on that to Secretary Shalala. Speaking on our behalf, I think we have benefited greatly by the efforts of the Department of Health and Human Services to support our efforts on Y2K, and that's no small part of the credit for the progress that we've made as well.

Mr. HORN. How about it, Inspector General? Looking at it from an independent view, would they be better off to be an independent agency?

Ms. BROWN. I do not believe so. I think the department adds a great deal of stability and assistance, and there's a great deal of overlap in the interests of the programs within the department, and that would only add another dimension of confusion.

Mr. HORN. You mean the confusion dimensions that are already there?

Ms. BROWN. That's true, sir.

Mr. HORN. OK. We'll let it go at that. Let me just mention in some closing remarks here, one, I thank all three of you for testifying. You're all very distinguished public servants.

Obviously progress has been made in reducing the amount of improper payments in Medicare. However, we've got some serious problems, as you all admit. The Health Care Financing Administration is responsible for managing two of the most important programs in the Federal Government, Medicare and Medicaid. There's no room, obviously—and we all agree on both sides of the table, both sides of the aisle—there's no room for waste, fraud, inefficiency in these programs which by 2009 will provide nearly $700 billion in health care for our Nation's elderly and poor.

Next Wednesday the consolidated financial report on the Federal Government as a whole will be issued. We will hold a hearing at 10 a.m., in this room to hear testimony from representatives of the Office of Management and Budget, the Department of the Treasury, and the General Accounting Office. These witnesses will speak to the many different financial problems found throughout the Federal executive branch. At the same time, we will issue our second report card grading the 24 largest Federal agencies on how they are handling more than $1 trillion a year in taxpayer money.

So my thanks are to you again. Sorry to prolong it so long. And let me now thank the staff who spent a lot of time putting this particular hearing together. J. Russell George is the staff director—and he's off working—as chief counsel for the Subcommittee on Government Management, Information, and Technology. Bonnie Heald is the director of communications, professional staff member. And to my left and your right is Larry Malenich, the General Ac-

counting Office detailee to this subcommittee, and his help is invaluable. Mason Alinger is the clerk for the subcommittee. Our able interns are Paul Wicker and Casey Baker, and I don't know if any of them are here. Faith Weiss is counsel for the minority, and we thank you. And Earley Green, staff assistant for the minority, and our two court reporters are Laurie Harris and Doreen Dotzler.

And with that, ladies and gentlemen, we thank you all for coming.

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]

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