HOW HEALTHY ARE THE GOVERNMENT'S MEDICARE FRAUD FIGHTERS?

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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HOW HEALTHY ARE THE GOVERNMENT'S MEDICARE FRAUD FIGHTERS?

WEDNESDAY, JULY 14, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Fred Upton (chairman) presiding.

Members present: Representatives Upton, Barton, Burr, Ganske, Bryant, Bliley (ex officio), Klink, Stupak, Green, Strickland, DeGette, and Dingell (ex officio).

Staff present: Chuck Clapton, majority counsel; Duncan Wood, majority professional staff member; and Christopher Knauer, minority investigator.

Mr. UPTON. Thank you, everyone, for coming this morning.

Today the subcommittee will hold a hearing on HCFA's oversight of Medicare contractors and their efforts to combat fraud and abuse in this program. We will hear the testimony of representatives from the HHS Office of Inspector General, along with the GAO and the Office of the Special Investigations, who have carefully analyzed HCFA's oversight efforts relating to contractors to date and found them to be woefully inadequate.

We will also hear from representatives from HCFA who will discuss what they are doing to try and remedy these problems. HCFA relies upon contractors to process fee for service claims for both Medicare Part A and Part B services. These contractors, which include both fiscal intermediaries and carriers, handle the approximately 900 million claims and were paid $1.6 billion in fiscal year 1998.

In addition to paying claims, HCFA also relies on the contractors to safeguard the Medicare programs from fraud and abuse by identifying inappropriate claims and payments.

As we will hear in today's testimony, several fiscal intermediaries have failed to perform the very basic tasks necessary to reduce the opportunities for fraud and abuse which has led to the loss of scarce Medicare program dollars. Several providers even went so far as to criminally conceal their inadequate performance by destroying claims, falsifying documents and reports to HCFA and altering or hiding files involving claims that had been improperly paid.

HCFA is certainly responsible for ensuring that fiscal intermediaries do their jobs accurately and efficiently, which includes

overseeing contractor performance. However, in three of the most egregious cases of contractor fraud which have been uncovered, HCFA failed to uncover the fraudulent acts.

Each of these cases were finally brought to the public's attention by qui tam suits, where whistleblowers identified the criminal practices of Blue Cross, Blue Shield of Illinois, California and Pennsylvania.

The resolution of these cases resulted in over $190 million in criminal fines and civil settlements along with a conviction of several employees of the fiscal intermediaries.

GAO has examined HCFA's contractor oversight efforts and identified several areas of systemic weakness that need to be addressed. These include the lack of review of performance data and contractor management controls, a lack of uniform performance standards to evaluate program safeguards against fraud and inconsistent reviews of similarly situated contractors due to inadequate coordination between HCFA's headquarters and their regional offices.

Dr. Marjorie Kanof, who is the Deputy Director for Medicare Contractor Management within HCFA's Center for Beneficiary Services, and Penny Thompson, who is the Director of HCFA's Program Integrity Group, will testify about HCFA's response to these allegations. Dr. Kanof and Ms. Thompson will tell us what new initiatives HCFA is pursuing to improve its oversight of Medicare contractors and hopefully what steps are being taken to address the serious problems that have been identified in the GAO, OSI and OIG reports.

Only 2 years ago Medicare had to be rescued from the threat of imminent bankruptcy by the changes that Congress made in the Balanced Budget Act of 1997. It is inexcusable to waste these valuable program dollars, which further limits our ability to better assist such valuable services such as home health care and skilled nursing facilities.

In light of these continuing needs, as well as the calls to further expand the scope of current Medicare benefits and services, it is unacceptable that HCFA is not doing a better job of protecting the Medicare program from fraud and abuse. I have yet to find someone that's for it.

However, by holding this hearing today, we can focus greater attention on the issue and encourage HCFA to implement substantive changes to ensure Medicare program integrity.

Finally, I would like to take this opportunity to welcome all of our witnesses and also to acknowledge the fine work on these issues which was done by the Senate Permanent Subcommittee on Investigation. While the Commerce Committee has been reviewing Medicare's anti-fraud efforts for several months in conjunction with the GAO, I would note that Senator Collins from Maine has also worked extensively with GAO on a variety of cost-cutting issues, and as an example of bicameral cooperation I am pleased that she has allowed GAO to release these reports at this hearing.

I look forward to further cooperation with all members, House and the Senate, as we continue our investigation of this critical area of Medicare, and I yield to the ranking member of this subcommittee, Mr. Klink.

Mr. KLINK. Thank you, Mr. Chairman, and we're pleased in the minority to join you in this hearing today. This is an important matter and one we've been looking forward to, as you mentioned, for well over a year. As you know, over many years, this subcommittee has spent considerable time and effort examining how HCFA's Medicare contractors oversee the Medicare program. In administering Medicare, HFCA currently uses the services the private sector insurance carriers, often called fiscal intermediaries, to process the claims, to conduct the audit, to provide medical reviews and to perform a host of other activities that are designed to prevent waste, fraud and abuse.

The government has essentially privatized many of the functions of safeguarding the program by allowing these intermediaries to process and pay out claims and conduct related audits. Ideally these intermediaries are supposed to conduct such functions by applying their own private sector expertise to the program; in theory the taxpayer should be getting state-of-the-art private sector techniques applied to the Medicare program. Nevertheless, as has been demonstrated over the years through a number of investigations, the effectiveness of some of the fiscal intermediaries in safeguarding this fund is open to very serious debate, in fact, serious doubt.

What we will learn today is in fact some of the very contractors the government hires to protect the program are the very entities that are ripping it off. As is revealed in GAO's report, no fewer than 1 in 4 contractors have been alleged generally by whistleblowers within the company to have integrity problems. In fact, GAO has identified at least 7 of HCFA's 58 current contractors as being actively investigated by HHS, OIG or by the Justice Department.

Mr. Chairman, more than a year ago, the ranking member of the full committee, Mr. Dingell, and I asked the GAO to examine a host of questions regarding the effectiveness of these fiscal intermediaries in safeguarding the Medicare program, and whether HCFA was doing an adequate job in overseeing their activities.

Specifically we asked GAO to look at the following: One, who were HCFA's fiscal intermediaries, and how were they being evaluated as to their ability to safeguard the Medicare program; what criteria or methodology was HCFA using to evaluate their activities and was it appropriate; two, did HCFA have reports, studies or lists ranking the caliber of safeguarding programs of the fiscal intermediaries then serving the program; three, were any of the fiscal intermediaries' safeguarding efforts substandard, and if so, why; for example, was it a reason of incompetence or was it a lack of resources? Was it a combination of many factors? We also asked what would ensure that any new contractors that were added to the program would not be exposed to the same problems. Fourth, and finally, we asked whether the addition or replacement of any fiscal intermediary would result in any efficiencies or any inefficiencies.

Soon after we sent this request to GAO, a fiscal intermediary known as Health Care Services Association, also known as Blue Cross-Blue Shield of Illinois, pleaded guilty to defrauding the Medicare program and other related charges. They agreed to pay nearly $4 million in criminal fines to the government and $140 million in

a civil settlement to resolve its liability under the Federal False Claims Act.

The activities of this Medicare contractor included in the submission of false claims the falsification of its own performance record and substandard claims and evaluations. In fact, the $144 million settlement against this fiscal intermediary was the largest ever issued against a Medicare contractor. Again, this case illustrates that the very entity designed to be protecting Medicare was undermining it.

This led us to expand our original request and to ask GAO to examine additional concerns; what were the facts surrounding the general performance and the illegal activities connected to Blue Cross-Blue Shield of Illinois; what regulatory measures did HCFA fail to have in place that may have prevented such an outcome? And finally in light of this case, what additional measures should HCFA immediately implement to gain better control over the Medicare contractors?

Mr. Chairman, I am happy to see the many excellent witnesses before us today that can provide answers to these questions and others. It's my understanding that many issues that were raised by Mr. Dingell and myself in earlier requests have been substantially addressed in that GAO report that you talked about that was released by Senator Collins in the Senate Permanent Subcommittee on Investigations.

I thank the members and the staff of that fine subcommittee for the excellent work that they have done. I also thank the IG's office and the GAO for their outstanding work.

While I hope that next time we can give the witnesses more than 3 days to prepare for the hearing, I, nonetheless, appreciate all of the hard work that you have done and finally, while many of our questions were addressed in the Senate's report, it's my understanding that the GAO still has ongoing work for this committee and will soon provide us with additional information. For example, part of Mr. Dingell's and my original request involved an open criminal matter that I believe may still be pending. Some of this work had to be put on hold and in fact at the request of the Department of Justice.

Much of the in-depth analysis that we asked GAO to perform on the Illinois Blue Cross-Blue Shield matter has been suspended until after all matters relating to the case are formally closed. Once that occurs, GAO will rejoin that effort, and I look forward to learning even more about what went wrong with that fiscal intermediary and HCFA's oversight of its operation. I also look forward to hearing what GAO has learned from the Department of Justice regarding when this work can be continued.

Mr. Chairman, I am attaching the original request addressing this subject with my opening remarks. And, again, I thank Chairman Upton for holding this hearing. This is a great subject, and it's of great importance to the people of this Nation. I look forward to hearing from the outstanding witnesses before us today. And, Mr. Chairman, I yield back my time.

Mr. UPTON. The gentleman from Tennessee Mr. Whitfield—excuse me.

Mr. BRYANT. Close.

Mr. UPTON. Right. Mr. Bryant.

Mr. BRYANT. Mr. Chairman, I would be happy to defer my time if you want to recognize the ranking member.

Mr. UPTON. Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you, but the gentleman has been most kind. I'm willing to wait and think it's appropriate he should go next.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Thank you, Mr. Chairman. Mr. Chairman, as you know, this Congress and the White House are currently locked in a debate regarding how best to use the projected budget surplus. Congressional Republicans, myself included, believe if the government has collected more money, it means the left over money ought to be returned to the taxpayer.

This administration has proposed using this extra money to create new or expand government programs. Of concern today to me—and I think extremely relevant to today's hearing—is the President's proposal to expand the Medicare program at the cost of approximately $20 billion. This is certainly not the forum for debating the details of this proposed prescription drug program, but I think it's important to point out that the President is proposing to dramatically increase both HCFA's responsibility in its budget at a time when both the IG and the GAO are releasing reports indicating that millions and potentially billions of dollars are being wasted by this very same agency.

Mr. Chairman, due mainly to the cold war in the 1980's, the Nation's and the Congress' focus was on the defense industry, and the media and the government watchdog groups correctly attacked the Department of Defense for wasting millions of dollars on $600 hammers and $800 toilet seats.

The 1990's will inarguably be recalled as the health care decade, and I wonder, Mr. Chairman, how long it will be before the headlines read $1200 Band-Aid, and $1500 tongue depressor. I'm constantly hearing from the doctors in my district who are frustrated by complicated and confusing forms, delayed reimbursements and unresponsive bureaucrats.

This combined with a type of waste and fraud described by the OIG and the GAO cannot be tolerated. They threaten both the solvency and credibility of this crucial program, and in my mind at least need to be addressed before even considering expanding HCFA's responsibilities.

I'm very anxious to hear from our distinguished witnesses, what steps need to be taken by both HCFA and this Congress to restore a sense of integrity to this program. And I thank the chair.

Mr. UPTON. Thank you. Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you. First of all, I commend you for this hearing. You deserve great credit and I appreciate the work that you're doing to see to it that the GAO report in this matter is gone into.

I've noted over the years, Mr. Chairman, that some of the most vociferous critics of waste, fraud and abuse in government programs seem to be blind to the role of private contractors in wasting tax dollars, defrauding the taxpayer and abusing the public trust. They also tend in many instances to be unconcerned about the

need to have a proper and adequate auditing effort within the Federal Government and massive cuts were made early in the administration of this Congress by the Republican members to GAO amounting to some 25 percent of that budget.

Now, I won't excuse the watchdogs at government agencies who slumber blissfully while the Treasury is raided; if anything, this subcommittee has a long history of exposing and criticizing the behavior of both the police and the thieves when we find improper expenditures of public moneys, and many of the matters referred to earlier in connection with defense, the hammers, the pliers, the toilet seats, and a large number of other things, were uncovered by the work of this committee.

The General Accounting Office report on Medicare contractors goes directly to the points I'm mentioning, and I think it should be quoted at this point. They said, "Medicare contractors are HCFA's first line of defense against provider fraud, abuse and erroneous Medicare payments. However, several of them have committed fraud against the government. Since 1990, nearly 1 in 4 claims administration contractors have been alleged, generally by whistleblowers within the company, to have integrity problems. GAO identified at least 7 of HCFA's 58 contractors as being actively investigated by HHS, OIG or Justice. Since 1993 HCFA has received criminal and civil settlement decrees totaling over $235 million from 6 contractors after investigation of allegations that the contractor employees deleted claims from the processing systems, manufactured documentation to allow processing of claims that otherwise would be rejected because the services were not medically necessary, and deactivated automatic checks that would have halted the processing of questionable claims.".

These are especially troubling facts when there are efforts to further privatize Medicare and also when we have seen cuts in the General Accounting Office and in the auditing effort of this government. The justification for hiring private fiscal intermediaries in the first place was to provide state-of-the-art private sector techniques to safeguard public funds.

The record suggests that we may have gotten state-of-the-art private sector efficiency in fleecing the taxpayer. Mr. Chairman, I hope we will go into these matters with all diligence and vigor.

I look forward to the testimony of our fine witnesses, and I commend you again for holding this hearing. Thank you.

Mr. UPTON. Thank you. Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman. I will be brief. Let me at the start commend the ranking member for his work on this in the past and the work of this committee, because certainly it has held people's feet to the fire. That's not enough. Clearly we asked GAO periodically to go out and tell us how bad it still is, not that it's gotten bad but it hasn't gotten any better.

Having the opportunity to look over the report, there are a lot of people to blame, there are intermediaries, there is HCFA, the one that is noticeably absent is Congress, because I think to some degree we deserve some of the blame. We legislate many of the mandates that go in. We require the system to be confusing and that confusion leads honest people to cut corners or to make decisions because of short payments, and that certainly is not an ex-

cuse that I'm trying to make for any of the third-party individuals. But clearly it has opened up a system to find ways to cut corners, to possibly reinterpret, to delay claims, not to make payments. It affects the quality of care, it affects the integrity of the system.

And I think what we're here today to do is how we bring integrity back into this system. It's not to blow up HCFA tomorrow. It's not to get rid of the third-party intermediaries. It's to find a system that works for once. I'm hopeful that this will be the last of the hearings where we come to hear how bad it is and possibly we can turn the work of GAO and the work of this committee over to the authorizing committee where they can work on solutions.

They can in fact look and see if we can make it simpler to understand this delivery system that we've designed, in fact, that HCFA can have an easier time at setting up a structure that checks claims of intermediaries and that intermediaries don't have an opportunity to interpret incorrectly what the policy is.

It's a confusing system that we've designed, and I think we have a responsibility to look at that system and fix it in all facets.

I thank the chairman for his time and his willingness to hold this hearing.

Mr. UPTON. Mr. Stupak.

Mr. STUPAK. Well, thank you, Mr. Chairman, and thank you for holding these hearings. As you know we've been on this committee for some time and I appreciate your leadership in this area, and I think it's particularly important that we have this hearing. When we're considering major overhaul of the Medicare program, it seems to be an especially important and pertinent issue at this point.

Two weeks ago the President released his proposal to strengthen and reform the Medicare program. I share in the goal to see that the Medicare trust fund is protected for future, while improving services for beneficiaries, including offering a prescription drug benefit for our seniors. However, we should not forget that one of the most obvious needs for reform in Medicare is fighting the fraud, waste and abuse as outlined in the GAO report.

As evidenced by that report, we can do better. We can do much more for Medicare beneficiaries across the country. Each year fraud, waste and abuse in the health care industry, both private and public, accounts for an estimated 10 percent of our yearly health expenditures as a nation. We can never eliminate every dollar of fraud, waste and abuse but we can do a lot better than what we're doing, and we must do everything possible to stop health care fraud.

The improper and fraudulent activities committed by contractors as described in the GAO report are shocking to many. Unfortunately these are the realities which Medicare beneficiaries have had to live through. Their realities have been having their Medicare claims being destroyed or deleted because the contractors couldn't process them or their phone calls going unanswered because customer service lines were cutoff or that fraudulent claims were processed because computer edits, these specifically designed to screen questionable claims, were turned off.

This has assuredly outraged Medicare beneficiaries and should outrage members of this committee. These contracted entities

should be held accountable to the beneficiaries for the mismanagement of scarce Medicare dollars. We are constantly stating the need for better management and performance of government agencies, which I think it's obvious that it is needed as we see in this GAO report.

There is also a need to have better management and oversight of the contracted entities who process these claims; however, if we're going to do that, we must give law enforcement and the law enforcement community the tools they need to enforce the fraud, waste and abuse provisions. When we take a look at, and Mr. Burr had mentioned that we share some responsibility, I remind our colleagues that back in 1997 during the balanced budget amendment, OIG, Department of Justice, GAO all wanted us to go after HPPA, and were looking for us to expand the jurisdiction of kickback provisions, they asked us to look at the dumping of patients, they asked us to expand the subpoena power and injunctive relief, and immediate repayment of overpayment by the government, some of these examples cited in this report. We offered the amendment. Unfortunately the amendment failed on party lines.

And I don't still—2 years later I still can't figure out when my friends on that side of the aisle would not give law enforcement the tools they asked for to crack down on some of this fraud and questionable practices going on.

So, Mr. Chairman, I certainly thank you for holding this hearing. I look forward to working with you. That amendment that I offered before during Balanced Budget Act on HPPA and others, we have dusted off and ready to run it again. And I look forward to working with you to make sure it becomes a reality to give law enforcement and GAO and Department of Justice, Office of Inspector General, the tools they need to crack down in this area as they have asked for repeatedly in the past.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. And I would echo the thanks for holding today's hearing. I'm glad to see that this committee is looking at action to stop private companies which are hired by the Federal Government to safeguard Medicare dollars from plundering the trust fund. And I think that we need to make sure that the HCFA administrators are adequately watching these private administrators.

In order to preserve the trust fund, it is essential that Medicare has an effective system to stop fraud and abuse. I think that, if anything, this GAO report clearly illustrates that our current system needs work. The fox is guarding the hen house when fiscal intermediaries hired by Medicare to ensure the validity of health care claims are the very entities who are committing fraud to hide their incompetencies. And as Mr. Stupak and others have articulated some of the these issues which are horrifying when you look at the GAO report; manufacturing documentation to justify payment of claims which should have been denied, and switching off of the consumer service lines when the staff can't answer incoming calls within the prescribed time limit I think has hit a chord with all of us.

While HCFA must take steps to improve the oversight of these claims of administration contractors, I'm troubled that the contractors paid to preserve the integrity of the Medicare program are defrauding the system. When the private companies hired to save billions of Medicare dollars turn off the computer programs HCFA requires them to use to catch questionable claims, there's only so much blame one can place on the agency itself.

Mr. Chairman, I hope that today's hearing will shed some light on the reasons why six companies were found guilty of defrauding the Medicare system and subjected to $263 million in criminal fines and civil settlements and why the IG's office believes there is more lawsuits to come. And I hope we can work in a bipartisan way to find ways to stem this in the future.

I will yield back the balance of my time. Thank you, Mr. Chairman.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

The Commerce Committee is deeply committed to keeping Medicare safe and sound for all our senior citizens and disabled Americans. That's why stamping out waste, fraud and abuse in Medicare is one of our highest priorities.

Nearly 40 million Americans rely on the health insurance provided by Medicare. Last year that translated into a $220 billion program responsible for processing nearly 1 billion Medicare claims.

Unfortunately, a lot of this money has gone astray. According to the HHS Inspector General at least $12.6 billion is misspent annually on unnecessary or improper benefit payments. The Inspector General and other experts believe that the real figure is probably far higher because little effort has been made by the Health Care Financing Administration in trying to measure the full scope of waste, fraud and abuse in the Medicare program.

For several months the Commerce Committee has been conducting a review of the anti-fraud activities of HCFA and its Medicare contractors. To that end we have issued requests for information in the form of written surveys to HCFA and to the leading fiscal intermediaries. In addition, the Committee has been working closely with GAO to examine HCFA's management structure and operational policies in order to determine the root causes of the HCFA management deficiencies that have been identified by GAO with regard to its oversight of fiscal intermediaries and carriers.

Today, the O&I Subcommittee will take a close look at HCFA's supervision of the Medicare contractors who are responsible for processing Medicare claims and who are supposed to constitute the front line in the battle against fraudulent and deceptive billing practices. We are asking two simple questions? How well is HCFA doing? And how well are the Medicare contractors doing?

The answers so far are deeply disturbing. In the past five years, criminal and civil actions have been brought against at least six major Medicare contractors because they have attempted to defraud Medicare. In each of the six cases, HCFA's own anti-fraud efforts failed to detect the deceptive contractor practices.

The contractors were able to dupe HCFA Contractor Performance evaluators because HCFA routinely gave them advance warning about the dates of any reviews and about the records the agency wanted to review. Furthermore, in one of the cases, it appears that HCFA actually gave the contractor a clean bill of health, even though it had received an anonymous complaint describing how the company had used false documents to pass its annual HCFA evaluation review.

Today's testimony from GAO and the HHS Inspector General will underline that the problems identified in these cases have not gone away and that HCFA is still failing to provide effective oversight of its contractors.

I commend Chairman Upton for holding this hearing and welcome all of the witnesses.

PREPARED STATEMENT OF HON. RON KLINK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Thank you Mr. Chairman and thank you for having this hearing. As you well know, over many years this Subcommittee has spent considerable time and effort examining how HCFA's Medicare contractors oversee the Medicare Program.

In administering Medicare, HCFA currently uses the services of private sector insurance carriers—called fiscal intermediaries—to process claims, conduct audits, provide medical reviews, and perform a host of other activities to prevent waste, fraud, and abuse. The government has essentially privatized many of the functions of safeguarding the program by allowing intermediaries to process and pay out claims, and conduct related audits. Ideally, these intermediaries are supposed to conduct such functions by applying their own private-sector expertise to the program. In theory, the tax payer should be getting "state-of-the-art" private sector techniques applied to the Medicare program.

Nevertheless, as has been demonstrated over the years through a number of investigations, the effectiveness of some fiscal intermediaries in safeguarding this fund is open to serious debate. What we will learn today, in fact, is that some of the very contractors the government hires to protect the program are the very entities ripping it off: As is revealed in GAO's report, no fewer than one in four contractors have been alleged—generally by whistle-blowers within the company—to have integrity problems. In fact GAO identified at least 7 of HCFA's 58 current contractors as being actively investigated by the HHS OIG or Justice.

Mr. Chairman, more than a year ago, the ranking member of the full committee—Mr. Dingell—and I asked GAO to examine a host of questions regarding the effectiveness of these fiscal intermediaries in safeguarding the Medicare program, and whether HCFA was doing an adequate job in overseeing their activities. Specifically we asked GAO to look at the following:

(1) Who were HCFA's fiscal intermediaries and how were they being evaluated as to their ability to safeguard the Medicare program? What criteria or methodology was HCFA using to evaluate their activities, and was it appropriate?
(2) Did HCFA have reports, studies, or lists ranking the caliber of safeguarding programs of the fiscal intermediaries then serving the program?
(3) Were any of the fiscal intermediaries' safeguarding efforts substandard, and if so why? For example, was it for reasons of competence or for lack of resources? Was it a combination of many factors? We also asked, what would insure that any new contractors added to the program would not be exposed to the same problem(s)?
(4) Finally, we asked whether the addition or replacement of any fiscal intermediaries would result in any *efficiencies* or any *inefficiencies*?

Soon after we sent this request to GAO, a fiscal intermediary known as Health Care Services Association (also known as Blue Cross-Blue Shield of Illinois) pleaded guilty to defrauding the Medicare program (and other related charges) and agreed to pay nearly $4 million in criminal fines to the government, and $140 million in a civil settlement to resolve its liability under the Federal False Claims Act. The activities of this Medicare contractor included the submission of false claims, the falsification of its own performance record, and substandard claims and evaluations.

In fact, the $144 million settlement against this fiscal intermediary was the largest ever issued against a Medicare contractor. Again, as this case illustrates, the very entity designed to protect Medicare, was undermining it.

This led us to expand our original request and ask GAO to examine additional concerns: What were the facts surrounding the general performance and illegal activities connected to Blue Cross-Blue Shield of Illinois? What regulatory measures did HCFA fail to have in place that may have prevented such an outcome? And finally, in light of this case, what additional measures should HCFA immediately implement to gain better control over their Medicare contractors?

Mr. Chairman, I am happy to see the many excellent witnesses before us today that can provide answers to these questions. It is my understanding that many issues raised by Mr. Dingell and me in these earlier requests have been substantially addressed in a GAO report being released today by the Senate's Permanent Subcommittee on Investigations. I thank the Members and the staff of that fine subcommittee for their excellent work. I also thank the IG's office and the GAO for their outstanding work. While I hope next time we can give you [the witnesses] more than three days to prepare for a hearing, I nonetheless appreciate all the hard work you've done.

Finally, while many of our questions were addressed in the Senate's report, it is my understanding that GAO still has ongoing work for this Committee, and will soon provide us with additional information. For example, because part of Mr. Din-

gell's and my original request involved an open criminal matter (that I believe may still be pending), some of this work had to be put on hold. In fact, *at the request of the Department of Justice,* much of the in-depth analysis we had asked GAO to perform on the Illinois Blue Cross-Blue Shield matter has been suspended *until after* all matters relating to the case are formally closed. Once that occurs, GAO will rejoin that effort. I look forward to learning even more about what went wrong with that fiscal intermediary and HCFA's oversight of its operations. I also look forward to hearing what GAO has learned from DOJ regarding when this work can continue. (Mr. Chairman, I am attaching the original requests addressing this subject to my opening remarks).

I again thank the Chairman for holding this hearing, and I look forward to hearing from the many outstanding witness before us today.

With that I yield back.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON COMMERCE
June 5, 1998

The Honorable JAMES F. HINCHMAN
Acting Comptroller General
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

DEAR MR. HINCHMAN: Recently, the Office of Inspector General for the Department of Health and Human Services (HHS OIG) conducted a major audit of the Health Care Financing Administration's (HCFA) Medicare operations and found a nearly 11 percent error rate in Medicare provider reimbursements. Projecting this error rate to the total Medicare program, the HHS OIG estimates that improper payments in fiscal year 1997 totaled about $20.3 billion nationwide. This waste of the taxpayer's money is clearly unacceptable.

In administering Medicare, HCFA currently uses the services of private-sector insurance carriers—called fiscal intermediaries—to process Medicare claims, conduct audits, provide medical reviews, and perform a host of other activities to fight waste, fraud, and abuse. The government has essentially "privatized" many of the functions of safeguarding the program by allowing intermediaries to process and pay out claims and conduct related audits. Ideally, these intermediaries are supposed to conduct such functions by applying their own private-sector expertise to the program. In theory, the taxpayer should be getting "state-of-the-art" private sector techniques applied to the Medicare program. Nevertheless, given the error rate estimated by the recent HHS OIG audit, and the resulting billions in losses this translates into, the effectiveness of these fiscal intermediaries in safeguarding these funds is open to serious question.

The Health Insurance Portability and Accountability Act (HIPAA) includes a provision that establishes the Medicare Integrity Program (MIP). This provision expands HCFA's contracting authority by allowing HCFA to enter into what is called a "Program Safeguard Contract" with new entities from the private sector to perform some or all of the activities now performed by existing fiscal intermediaries. Under the MIP contracting authority, HCFA is now planning to conduct a competitive bidding process to select new contractors from a pool broader than the one that exists today, to conduct the many safeguarding activities related to the program.

These "contract reform" initiatives, however, beg a fundamental question: What are the existing shortcomings of the fiscal intermediaries currently serving the program? For example, does HCFA really understand why the current error rate in the program is so high, and are the fiscal intermediaries largely responsible? If so, why? Does HCFA have a clear vision of *what* safeguard activities its fiscal intermediaries should now be performing and whether they are doing so? How are fiscal intermediaries evaluated for their performance in safeguarding Medicare funds? Does HCFA know which fiscal intermediaries are doing a good job, and can they be distinguished from those doing a poor job?

In light of the many questions concerning the role of fiscal intermediaries, the excessive error rate recently announced by the HHS IG report, and the reform proposals now being considered by HCFA, we request that GAO analyze the following:

(1) Who are HCFA's current fiscal intermediaries and how are they evaluated as to safeguarding activities? What criteria or methodology does HCFA use, and is it appropriate?

(2) Does HCFA have reports, studies or lists ranking the caliber of safeguarding programs of the fiscal intermediaries currently serving the program?

(3) Are any of the current fiscal intermediaries' safeguarding efforts substandard? If so, why? For example, is it for reasons of competency or for lack of resources? Is it a combination of many factors? What will ensure that the new contractors will not be exposed to the same problems?
(4) Will the addition or replacement of the current fiscal intermediaries result in any efficiencies or inefficiencies in safeguarding the program? What are the advantages and disadvantages of HCFA's anticipated bidding? Moreover, what factors will be used by HCFA to determine whether any new contractors can perform better than the current fiscal intermediaries?

If you have any questions on this matter, please have your staff contact Christopher Knauer or Kristen Ieyoub of the Committee staff at 226-3400. Your attention to this important matter is greatly appreciated.

Sincerely,

JOHN D. DINGELL,
Ranking Member, Committee on Commerce
RON KLINK,
Ranking Member, Subcommittee on Oversight and Investigations

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON COMMERCE
July 31, 1998

The Honorable JAMES F. HINCHMAN
Acting Comptroller General
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

DEAR MR. HINCHMAN: Last month we asked you to review the methods used by fiscal intermediaries to process Medicare claims, conduct audits, provide medical reviews, and perform a host of other activities to fight waste, fraud, and abuse. Some of these issues included the following:

(1) Who are the Health Care Financing Administration's (HCFA) current fiscal intermediaries and how are they evaluated as to safeguarding activities? What criteria or methodology does HCFA use, and are they appropriate?
(2) Does HCFA have reports, studies, or lists ranking the caliber of safeguarding programs of the fiscal intermediaries currently serving the program?
(3) Are any of the current fiscal intermediaries' safeguarding efforts substandard? If so, why? For example, is it for reasons of competency or for lack of resources? Is it a combination of many factors?

Recently, a fiscal intermediary known as Health Care Services Corporation (also known as Blue Cross-Blue Shield of Illinois) pleaded guilty to defrauding the Medicare program (and other related charges) and agreed to pay nearly $4 million in criminal fines to the government and $140 million in a civil settlement to resolve its liability under the Federal False Claims Act. The activities of this Medicare contractor included the submission of false claims, falsification of its own performance record, and substandard claims evaluations. The $144 million settlement against this fiscal intermediary is the largest settlement ever issued against a Medicare contractor.

As this case illustrates, the very entity designed to protect the Medicare program was itself undermining the program. This is alarming, to say the least, and leads us to again ask: who is ensuring that those charged with overseeing and protecting the Medicare program are adequately trained, competent, and effective?

As indicated, this case highlights many of our initial concerns with the general performance of some fiscal intermediaries and how they are managed by HCFA. In light of this recent development, we are expanding our initial June 5, 1998, request to also include the following:

(1) Please provide an analysis of the facts surrounding the general performance and illegal activities connected to the above Medicare contractor. Please also provide a review of the number of Medicare claims this contractor reviewed and describe what impact its actions have had on the Medicare program.
(2) Please describe the regulatory measures HCFA had in place to prevent such an outcome and address specifically why they failed. Please also conduct an analysis of any oversight HCFA provided over this contractor, including all audits, reports, and investigations. Please state whether GAO believes these were, or were not, adequate.

(3) Please describe, in light of this case, what additional measures HCFA must put in place to gain better control over their Medicare contractors.

If you have any questions on this matter, please have your staff contact Mr. Chris Knauer of the Commerce Committee Minority staff at 226-3400. Your attention to this additional development is greatly appreciated.

Sincerely,

JOHN D. DINGELL,
Ranking Member, Committee on Commerce
RON KLINK,
Ranking Member, Subcommittee on Oversight and Investigations

PREPARED STATEMENT OF STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you for scheduling this important hearing.

As a Member of the Health and Environment Subcommittee, I have attended several hearings on the issue of Medicare fraud over the past few years.

While HCFA has made significant improvements in reducing the amount of overpayments and mis-payments over this time period, I believe the new GAO report sheds new light on where we go from here.

The fact that there is no uniform way for HCFA to monitor the actions of its contractors is very troubling.

How can anyone, including HCFA and this Congress, expect to have accurate information for the country if every region compiles it differently and dedicate different levels of resources to reducing fraud by their contractors.

It seems from the GAO report that HCFA's solution is simply to increase competition. But how can you award contracts or expect intermediaries to crack down on fraud when there is no explicit expectation that they do so.

Before HCFA expands the number of contractors or changes which contractors serve each region, they need to develop an appropriate method of oversight.

Ultimately, it is our responsibility to make sure HCFA is taking every appropriate action to reduce fraud at every level of the Medicare program.

But for Congress to act on this issue, we have to have confidence that HCFA is doing all it can to meet it's responsibilities.

Unfortunately, this GAO report paints a very different and troubling picture of an agency that is essentially neglecting to properly oversee their contractors.

Mr. Chairman, I look forward to hearing from our witnesses and learning what steps Congress and HCFA can take together to address this issue.

It's hard enough to crack down on fraud and abuse when it is targeted—but it is impossible to stop it if we turn a blind eye.

Mr. UPTON. Thank you.

Now, we have a long tradition of testifying under oath. And do any of you have any objection to that? We also allow under House rules if you would like to have counsel with you, do any of you need counsel? Good. If you would stand and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. Thank you very much. We will start with Mr. Grob. We would like you to limit—we have your testimony, and we appreciate getting your testimony in advance by the way, and not everybody does that, we will give you 6 minutes instead of 5. But if you would like, as a bonus, if you would like to summarize that and obviously your statement is made a part of the record, and hopefully we won't be interrupted with votes too much this morning. Go ahead.

TESTIMONY OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTION, OFFICE OF INSPECTOR GENERAL, ACCOMPANIED BY JACK HARTWIG, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; LESLIE G. ARONOVITZ, MANAGER, CHICAGO FIELD OFFICE; ACCOMPANIED BY ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER GENERAL, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE; AND PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY GROUP, ACCOMPANIED BY MARJORIE KANOF, DEPUTY DIRECTOR FOR MEDICARE CONTRACTOR MANAGEMENT, CENTER FOR BENEFICIARY SERVICES, HEALTH CARE FINANCING ADMINISTRATION

Mr. GROB. Thank you, Mr. Chairman. And let me begin by introducing my colleague John Hartwig, who is the Deputy Inspector General for Investigations in our office, who is joining me here at the table today.

I would like to begin my testimony by recalling one of those moments that I remember very well, which was a group of us sitting around our offices, as we do periodically, trying to determine what the most serious vulnerabilities there are that are facing the Medicare program; and I remember very distinctly that meeting when one of the members of that group said we now have to conclude from what we know that one of the most serious vulnerabilities that we have are the contractors that administer the program.

And I remember it so well because I actually felt a little tremble of shock going through me, perhaps I should have felt a bigger one, about that because of the positions that the contractors hold as being right on the spot where the dollars ebb and flow and being the ones that we looked up to, being insurance companies, primarily with a competence and expertise to handle the flow of large sums of money, to realize we are having problems like that.

We of course intensified our reviews and efforts in this regard, and I would like to summarize them for you today, highlighting three facets of it. One of them would deal with their financial management abilities. Another one would deal with their capability to refer, to detect and refer cases of fraud. But perhaps the most disturbing one has to do with their own integrity.

I would like to deal with that one first. Between 1993 and 1999, we have completed nine cases in which we have found six contractors at fault for failing to administer the Medicare program properly. These were in Illinois, Pennsylvania, Massachusetts, California, Michigan and Florida. And this resulted in nine civil settlements and two criminal convictions yielding more than $260 million in settlements, a recent large one being for 140 million just last year, and $5.5 million in criminal fines.

The problems we uncovered in these investigations related to altering documents and manipulating data in order to improve scores and annual reviews which resulted in bonus payments and contract renewals. And this included such actions as covering up claims processing errors to increase evaluations scores, discarding documents that would have disclosed processing errors, and sub-

stituting backdated or altered documents for the original documents as theirs.

We also found improper processing of Medicare secondary payment claims and improper deletion of claims from the system, rigging of samples for HCFA audits, failure to recover overpayments, overriding payment safeguards to bypass electronic audits and edits when processing claims, performing inadequate cursory audits, and providers disregarding overpayments that were due.

The criminal convictions involved obstructing a Federal audit in making false statements to HFCA. I have provided each of you with a listing of the cases that we're talking about. It's hard to read the chart, but I believe that each of you has a sheet. I hope that you do. If not, I'm sure we can get it.

Mr. UPTON. We will find it.

Mr. GROB. We will get it to you right away.

Mr. UPTON. If you can maybe bring that a little closer. I'm getting lasix surgery but not until September.

Mr. GROB. It might be handy to make a reference to those from time to time here. Do you have the sheet? You should have it. kay. Now, a question with respect to this is how serious is the problem. Well, I think it is a pervasive problem, because right now we still have 21 active investigations of either former or current contractors in addition to these nine that were closed.

Another way to consider how pervasive the problem is with another chart that I will just show you just for a moment, which has to do with not the scope of the number of contractors covered but what's happening within the contractor. Here is a contract relating to one of the investigations that we conducted with—that's an organizational chart, and those positions that are marked in blue are cases where there is evidence of participation in the cover-ups and other activities that we found within that organization.

Now you have to understand that often when we detect fraud or abuse, we would have a case where one or two of those positions would have the blue, and you would solve that problem by conducting an audit and removing that individual or settling the problem occurring on that desk. But here we have a case that indicates a broader culture, I would say, of disregard for the rules that need to be implemented in a much more serious and pervasive problem.

Let me switch your attention now to the question of the fraudulence. We released a report just last fall on the fiscal intermediary fraud units and a couple of years before on the carrier fraud units, a report with similar conclusions, which is back at that time there were inadequacies in the way the fraud units were performing. We found a great deal of unevenness in their output and some cases inadequacies.

For example, in 1996, which is the year that we are using for that, some of these fraud units sent us only 3 complaints, others sent us 1800, some sent us 625 cases, some sent us zero. Only half of these units were actually undertaking proactive fraud detection that is required by the contractor.

There will be more discussion of the fraud units as time goes by. So with my time limited, I will defer to the written record that we have on that.

I would like to close then by mentioning the last of the problems, which is financial management, which is something that we would expect the contractors to be good at since they handle money for a living, and yet we have continued to find serious problems. For example, we actually discovered cases where the contractors handling our money were not using dual entry general ledger systems. This would be the equivalent of perhaps buying an interest in a baseball team and finding that they do not use bats. This is a very fundamental element of accounting.

We found that activity of payments and collections to be about $23 billion with residuals of about $3.6 billion, deficiencies included, lack of control of accounts receivable, lack of controls over cash, lack of ability to perform proper financial reconciliations, and weaknesses in electronic data processing.

Overall, to solve the problems that we've identified, we believe that a program which includes systematic scrutiny and vigilance, training, technical assistance and guidance and some new legislation to give HCFA additional flexibility in how it procures these services are all needed.

I want to say for the record, I think it's very important, on the investigations, HCFA has cooperated fully with us on these investigations, and in the other areas we have firm commitments and practical commitments from HCFA to address the problems that we've raised, and in some cases, we can demonstrate some substantial progress made in the areas that we've addressed.

Thank you.

[The prepared statement of George F. Grob follows:]

PREPARED STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL, FOR EVALUATION AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good morning, I am George F. Grob, Deputy Inspector General for Evaluation and Inspections, Office of Inspector General, Department of Health and Human Services. I am accompanied by John E. Hartwig, Deputy Inspector General for Investigations. We are pleased to be here today to discuss some serious problems with the contractors who carry out most of the day to day operations of the Medicare program. They are responsible for paying health care providers for the services provided under Medicare fee-for-service, providing a full accounting of funds, and conducting activities designed to safeguard the program and its funds. Unfortunately, we have found weaknesses and vulnerabilities in these operations. For some, we have even found problems with their own integrity, resulting in civil and criminal violations.

MEDICARE CONTRACTORS

The Medicare program provides health insurance for 39 million elderly and disabled Americans at an estimated cost of $217 billion for fiscal year 1999. The program is administered by the Health Care Financing Administration (HCFA) with the help of 64 contractors that handle claims processing and administration. There are two types of contractors, called fiscal intermediaries and carriers, depending on what type of claims they process. Intermediaries process claims filed under Part A of the Medicare program from institutions, such as hospitals and skilled nursing facilities. Carriers process claims under Part B of the program from other health care providers such as physicians and medical equipment suppliers. Hereafter, when I use the term contractors, I will be referring to both intermediaries and carriers. During this fiscal year, HCFA will pay its contractors an estimated $1.8 billion to carry out their responsibilities.

Contractor tasks for the Medicare program fall into 5 functional areas : 1) claims processing, 2) payment safeguards, 3) fiscal responsibility, 4) beneficiary services, and 5) administrative activities. Claims processing involves receiving claims, promptly paying those that are appropriate, taking necessary action to identify in-

appropriate or potentially fraudulent claims and either withholding payment or recovering overpayments. Payment safeguard activities require additional actions to further safeguard the integrity of the Medicare program and protect against fraudulent and abusive billing. Safeguard activities include medical review to determine the medical necessity of procedures and services, Medicare Secondary Payer (MSP) review [1], audits, and investigations by fraud units. Fiscal responsibilities by the contractors include all actions to ensure a full and accurate reporting of Medicare accounts receivable and financial reconciliations.

INTEGRITY PROBLEMS

Of all the problems we have observed, perhaps the most troubling has to do with contractors' own integrity—misusing government funds and actively trying to conceal their actions, altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. The examples I will describe are not isolated cases. At any given time, several contractors may be under investigation by our office. To date, our investigations have resulted in 9 civil settlements and 2 criminal convictions, and we currently have 21 former or current contractors actively under investigation.

Health Care Service Corporation

In July of last year, Health Care Service Corporation, the Medicare carrier for Illinois and Michigan, agreed to pay $140 million to resolve its civil liability under the Civil False Claims Act and the Civil Monetary Penalties Law. On an annual basis, HCFA evaluates the performance of its carriers, relying, in large part, on information, data and certifications provided by the carriers. Carriers that demonstrate poor performance on these annual reviews are subject to contract termination or other adverse action by HCFA. Between 1985 and 1997, Health Care Service Corporation altered documents and manipulated data in order to improve its score on these annual reviews. During our investigation, we found the following problems: improper processing of Medicare Secondary Payer claims, bypassing the system generated audits and edits during the processing of Part B claims, and improper deletion of claims from the system.

In addition to the civil settlement, the corporation pleaded guilty to obstructing a federal audit, conspiracy to obstruct a federal audit and six counts of making false statements to HCFA. Health Care Service Corporation paid a $4 million criminal fine in connection with these charges. Two of the corporation's managers pleaded guilty and five others have been indicted on various criminal charges related to this scheme.

HCFA terminated the Medicare contracts with Health Care Service Corporation as of September 30, 1998. This case resulted in the largest civil fraud settlement against a Medicare contractor to date.

XACT Medicare Services of Pennsylvania

In August of last year, a Medicare carrier located in Pennsylvania agreed to pay $38.5 million to resolve its liability for misconduct in its performance as a carrier. A joint investigation by the OIG and other Federal agencies found that during the years 1988 through 1996, the carrier engaged in the following misconduct: failing to properly process or take appropriate action to recover improper payments related to Medicare secondary payer claims; obstructing the carrier performance evaluation program by rigging samples for HCFA audits; failing to recover overpayments; failing to monitor End Stage Renal Disease laboratory claims; and overriding payment safeguards to by-pass electronic audits or edits when processing Part B claims. As part of the settlement, the carrier agreed to enter into an extensive corporate integrity program to ensure proper training for its employees and external reviews of its performance under its contract with Medicare.

Blue Shield of California

Blue Shield of California, the former Medicare carrier for northern California, agreed to pay $12 million to resolve its civil liability under the False Claims Act and the Civil Monetary Penalties Law. Between 1990 and 1996, the carrier was

[1] Medicare Secondary Payer activities identify other sources of payment, such as employer-sponsored insurance or other third-party payer that may cover health claims for Medicare beneficiaries. In overall responsibility, these payers are primary and Medicare is secondary.

found to have covered up claims processing errors in order to obtain a more favorable score under a HCFA program that evaluated and graded the carrier's claims processing capabilities. An OIG investigation determined that employees in several units in the carrier's Medicare division in Chico and Marysville, California, altered or discarded documents that would have disclosed claims processing errors; substituted backdated and altered documents for the original documents that contained errors; and rigged purportedly random samples of files in order to deceive HCFA auditors into believing that the carrier's performance was better than it actually was.

As part of the overall resolution of this matter, Blue Shield of California pleaded guilty in May 1996 to three felony counts of conspiracy and obstruction of a federal audit and was fined $1.5 million. The criminal conviction was the first of its kind against a Medicare contractor. As of September 1996, Blue Shield of California was no longer a Medicare carrier; however, it does continue to contract with Medicare as a provider of managed care. In order to continue doing business with Medicare, Blue Shield of California was required to enter into a comprehensive Corporate Integrity Agreement that will be monitored and enforced by the OIG until the year 2002. This case was brought under the *qui tam* [2] provisions of the False Claims Act by a former Blue Shield of California employee who will receive $2.16 million as his share of the $12 million settlement.

Blue Cross/Blue Shield of Michigan

On January 10, 1995, Blue Cross/Blue Shield of Michigan, a Medicare carrier, agreed to pay $27.6 million to settle a *qui tam* suit initiated by a former employee. At the time that the suit was filed, in June 1993, Blue Cross/Blue Shield of Michigan was also the fiscal intermediary for the Medicare Part A program in Michigan and was the carrier for the Medicare Part B program. As of September 30, 1994, HCFA terminated both contracts and Blue Cross/Blue Shield of Michigan no longer serves as intermediary or carrier. As the intermediary, Blue Cross/Blue Shield of Michigan was responsible for auditing participating hospitals' cost reports to ensure accuracy. An Office of Inspector General (OIG) investigation showed that they performed inadequate, cursory audits in which they disregarded significant overpayments. They later gave HCFA fraudulent work papers in an attempt to show that complete and accurate audits were performed. The precise amount of loss to the Government could not be determined because it would have required auditing more than 200 hospitals. As part of the settlement, the Blue Cross/Blue Shield of Michigan agreed to repay the entire amount HCFA had paid to perform audits over a 4 year time period, approximately $13 million.

Blue Cross/Blue Shield of Michigan also agreed to pay $24 million to settle charges of violating Medicare secondary payer laws. Under these laws, private insurers are required to act as the primary benefits payer under certain circumstances when an individual has medical insurance under both Medicare and an employer health plan. An OIG audit determined that in its capacity as the Medicare contractor in Michigan, Blue Cross/Blue Shield of Michigan paid thousands of dual coverage claims from Medicare trust funds rather than from its own funds in cases where there was overlapping coverage.

FRAUD UNIT PERFORMANCE

As part of their payment safeguard activities, Medicare contractors are required to have Fraud Units which are designed to detect and deal with problems of fraud and abuse within the provider community. The types of problems detected range from individual cases of suspected fraud, as well as patterns of fraud or questionable activity which may represent a broader program vulnerability.

As we work closely with these units, we in the OIG are keenly interested in their operations and effectiveness. In 1996 we reviewed the functions of the carrier fraud units, and in 1998 we reviewed the fiscal intermediary fraud units. Overall, we found that their effectiveness varies considerably and often their performance is not directly related to the size of the unit or the total number of resources allocated. Total case loads among the Fraud Units varied considerably, from zero to over 600 for the intermediaries. In reviewing carrier case files, we also found that some allegations of fraud were being lost during the overpayment adjustment process and were not properly developed as potential fraud cases.

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[2] A *qui tam* suit under the Federal False Claims Act (31 U.S.C. sec 3229-3733) permits a private individual, often on the basis of insider information, to file a civil false claims case on behalf of the Federal government, with the opportunity of collecting a portion of the recovered funds.

In addition to complaints received, Fraud Units are encouraged to proactively develop their own cases for potential referral to our office. Unfortunately, we found that less than one-half were actively engaged in developing their own cases. Similarly, less than one-half of the fraud units were active in identifying program vulnerabilities.

One key factor in success is a contractor management's commitment and attention to fraud matters overall. The most successful Fraud Units are those given significant prominence in the contractor's organizational structure, reporting to the highest levels of corporate management. Overall, however, effectiveness of the Fraud Units has been hampered by staff turnover, lack of proper background and training, and an overall lack of uniformity and understanding of key fraud terms and definitions.

Given the importance of this function, we are supportive of the new contracting authority granted to HCFA under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HCFA now has considerably more flexibility in contracting for program integrity functions and may enter into individual contracts or work orders for specific program safeguard functions, such as medical review and fraud detection, as well as cost report audits and Medicare Secondary Payer activities. We feel that, in addition to improved efficiency and effectiveness of program safeguard activities, HCFA may gain valuable insights that will be useful in considering and implementing other contractor reforms.

FINANCIAL MANAGEMENT PROBLEMS

For several years, we have reported problems in the Medicare contractors' financial management and accounting procedures and longstanding weaknesses in internal controls. In essence, their financial systems were not integrated with their claims processing systems and lacked basic accounting features, such as a dual-entry general ledger system, adequate source documentation, and proper cutoff procedures. Also, the contractors submitted periodic financial reports to HCFA based on subsidiary records maintained on ad hoc spreadsheets in lieu of entering amounts owed and tracking collections in a formal accounting structure. As a result, the amounts recorded, classified, and summarized were not always accurate. We noted millions of dollars in unsupported or unrecorded transactions over the years.

Most recently, our audit of HCFA's FY 1998 financial statements again highlighted the need for improving contractor controls over Medicare accounts receivable, cash, financial reconciliations, and electronic data processing, along with strengthening HCFA's oversight of the contractors' operations. We are unable to give an unqualified opinion on HCFA's financial statements, in large part because the contractors lacked sufficient documentation to support the receivable amounts reported.

Accounts Receivable

Medicare accounts receivable primarily represent funds that medical care providers owe to HCFA due to overpayments, as well as funds due from other entities in instances in which Medicare is the secondary payer of claims. The Medicare contractors are responsible for tracking, reporting, and collecting the majority of these receivables. For FY 1998, they reported over $22.9 billion of Medicare accounts receivable activity (overpayments added to the account during the year, plus collection of current and past year overpayments) with a net balance of $3.3 billion. This represents approximately 90 percent of the $3.6 billion total accounts receivable reported by HCFA at the year's end.

We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors reviewed. Some contractors were unable to provide documentation to support their beginning balances, others reported incorrect activity, including collections, and still others were unable to reconcile their reported ending balances to subsidiary records. For instance, two contractors had unreconciled differences in their reported ending balances of $44.7 million and $11.9 million, respectively. In addition, substantial amounts of receivables had been settled with insurance companies but were still presented as outstanding.

Although we had reported similar deficiencies since FY 1992, this area has not received sufficient attention. Contractor controls for identifying and accounting for billions of dollars of receivables are still ineffective, and the potential for materially misstating receivable balances remains.

Controls Over Cash

Since our first comprehensive audit of HCFA's financial statement in FY 1996, we have reported weaknesses in contractors' internal controls over cash. These controls are designed to protect assets against theft, loss, misuse, or unauthorized alter-

ation and to reduce the opportunities for occurrence and concealment of errors or irregularities. However, over the last 3 years, we found inadequate separation of duties; lack of general ledgers supporting cash balances; untimely bank reconciliations; and lack of documentation to support outstanding checks. For instance, one contractor reported $147 million in FY 1998 collections that were not supported by detailed records. Another contractor failed to properly secure Medicare blank checks.

Financial Reconciliations

The reconciliation of paid claims activity to "total funds expended," which contractors report monthly to HCFA, is an important control to ensure that all amounts reported are accurate, supported, complete, and properly classified. The HCFA uses the information from these reports to prepare its financial statements. Beginning in May 1998, HCFA mandated that all Medicare contractors prepare a monthly reconciliation of their prior months' reports to adjudicated claims processed and to other payments, recoveries, and adjustments as necessary. However, our review of the contractors' FY 1998 reconciliations identified internal control weaknesses similar to those reported in prior years.

For example: some contractors still were not reconciling their paid claims tape file to their monthly reports, whereas, other contractors took several months to produce payment tapes that reconciled with the reports. These reconciliations are similar to checkbook reconciliations to monthly bank statements. To prepare the monthly reports, most contractors had to obtain data from a number of sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates, yielding monthly reports more prone to errors. Several contractors did not independently verify the completeness and accuracy of amounts reported to HCFA.

Electronic Data Processing

For FY 1998, HCFA relied on extensive data processing operations at the contractors to process and account for $176 billion in Medicare fee-for-service expenditures. The contractors use one of several shared systems to process and pay claims. The shared systems interface with HCFA's Common Working File to coordinate Parts A and B benefits and to approve claims for payment.

Our FY 1998 review found electronic data processing control weaknesses at 11 of the 12 contractors sampled. Some of these weaknesses were also reported the previous year but were not corrected. For example, we were able to penetrate the security systems and obtain access to sensitive Medicare data. Contractors were able to deactivate or bypass edits, such as those used to detect duplicate claims, in two shared systems. We noted instances in which duplicate claims were paid on the same day without detection by these edits. Some paid claims bypassed processing by the Common Working File, and management review of the bypass process needed to be improved.

CONCLUSION

We in the Office of Inspector General, along with HCFA, will continue to identify and address problems within the Medicare contractor community. Through our investigations, financial audits, and evaluations of management practices, we hope to continue contributing to a system with greater integrity and effectiveness. The HCFA has fully cooperated with all of these investigative efforts and has underway a major effort to correct the accounts receivable problem with the contractors. We look forward to the changes in Medicare contracting that are taking place under the new Medicare Integrity Program, and we look forward to the upcoming discussions about broader contractor reforms.

Mr. UPTON. Thank you very much.

Mrs. Aronovitz, we will also give you 6 minutes.

STATEMENT OF LESLIE G. ARONOVITZ

Ms. ARONOVITZ. Okay. Mr. Chairman, and members of the subcommittee, first I would like to introduce my colleague, Bob Hast, who is head of our Office of Special Investigations. We're both pleased to be here today as you discuss HCFA's oversight of the Medicare fee-for-service claims administration contractors and demonstrate your interest in ensuring that HCFA's contractors are earnest stewards of the trust fund.

We also acknowledge the longstanding concerns expressed by the ranking minority member and Mr. Dingell, especially in the area of HCFA's selection and oversight of the fiscal intermediaries. We hope that our testimony today provides some information regarding the concerns you both expressed on this topic to us last year. We will be initiating additional related work when the needed data become available.

Today we are releasing two reports prepared for the chairman, Permanent Subcommittee on Investigations, Senate Governmental Affairs Committee, on weaknesses in HCFA's contractor oversight activities that could make Medicare more vulnerable to fraud, waste and improper payments. Our first report, which is the real thick one that's only in prepublication—we should have the blue-cover version next week—addresses systemic and programmatic issues which, if corrected, could make HCFA more effective in overseeing its fiscal intermediaries and carriers. In this report, we also considered whether any changes in HCFA's contracting authority might improve the agency's ability to manage its contractors.

Our second report provides more detail on Medicare contractor integrity cases in which there have been convictions, fines or civil settlements. The investigative report, which does have a blue cover and is issued in final today, identifies over $235 million that has been assessed in civil and criminal penalties against six current or former contractors since 1993.

I know you've alluded to some of these, but we would like to reiterate that, among the charges involved in these cases, are that contractor employees improperly screened, processed and paid claims, destroyed or deleted backlogged claims, manufactured documentation to support paying claims that otherwise would have been rejected as medically unnecessary, switched off customer service telephone lines when staff could not answer incoming calls within the prescribed time limit, arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review, and falsified documentation and reports to HCFA regarding the fiscal intermediaries' performance.

Currently, HCFA has no assurance that fiscal intermediaries and carriers are fulfilling their contractual obligations, including paying providers appropriately. We found that HCFA's regional reviewers did not often check the validity of contractors' self-reported financial and management data, nor look behind the contractors certifications of their internal controls. For years, HCFA left decisions about oversight priorities entirely in the hands of regional reviewers, which has resulted in regional offices not providing consistent and adequate oversight. For example, while some regions have imposed performance improvement plans on contractors when problems were identified, other regions rarely, if ever, required them. Central office has not formally evaluated its regional office performance nor has it regularly shared one region's best practices with the others.

HCFA officials believe that increased competition among contractors could enhance contractor performance, but that statute and current regulations limit its authority. HCFA is seeking new or explicit authority from the Congress that would allow it to do a few things: No. 1, choose its intermediaries rather than having pro-

viders nominate, and contract with nonhealth insurance companies; contract separately for specific functions, such as responding to beneficiary inquiries; and use payment methods that would allow contractors to earn profits on their Medicare business rather than reimbursing contractors only for their costs up to a preset target.

We endorse HCFA's efforts, as these changes may broaden the pool of contractors HCFA could choose from and would increase its flexibility in contracting for specific functions. However, past experience with other efforts to change the program has shown that HCFA will need several years to carefully plan, properly implement, and conduct a post-implementation review of any new contracting authorities.

HCFA has acknowledged to us that its oversight of contractors needs to be strengthened and has recently taken many, many steps to improve. For example, HCFA set oversight priorities when its regions performed fiscal year 1998 contractor evaluations, and this year it restructured headquarters offices that are responsible for oversight activities. We believe that HCFA's initiatives are indeed positive. But it is still way too early to tell whether HCFA's actions to date will address many of the fundamental problems it faces in ensuring quality performance from its contractors.

Mr. Chairman, this concludes our formal statement, and we would certainly be happy to answer any questions you or other members of the subcommittee may have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, AND ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER GENERAL FOR SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you discuss the Health Care Financing Administration's (HCFA) oversight of its Medicare fee-for-service claims administration contractors. HCFA paid these contractors $1.6 billion in fiscal year 1998 to serve as Medicare's first line of defense against inappropriate and fraudulent claims made on Medicare funds. They pay out over $700 million each business day—making it a business whose size and nature require careful scrutiny. Revelations of inappropriate Medicare payments to providers totaling billions of dollars each year have heightened concerns about the program's management, as have cases in which contractors themselves have defrauded Medicare.

Mr. Chairman, by holding this hearing, we appreciate the interest you have shown in ensuring that HCFA's Medicare contractors are earnest stewards of the trust fund. We also acknowledge the long-standing concerns expressed by the Ranking Minority Member, especially in the area of HCFA's selection, oversight, and evaluation of the fiscal intermediaries. We hope that our testimony today provides some information regarding the concerns he expressed on this topic to us last year. We will be initiating additional related work when needed data become available.

Today we are releasing our report, prepared for the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, on the weaknesses in HCFA's contractor oversight activities that could make Medicare more vulnerable to fraud, waste, or abuse. We also considered whether any changes in HCFA's contracting authority might improve its ability to manage contractors.[1] We are also releasing a separate report today that provides more detail on Medicare contractor integrity cases in which there have been convictions, fines, or civil settlements.[2] That report

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[1] *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

[2] *Medicare: Improprieties by Contractors Compromised Medicare Program Integrity* (GAO/OSI-99-7, July 14, 1999).

- identifies recently completed cases of criminal conduct or False Claims Act violations committed by Medicare contractors,
- describes the deceptive contractor activities set forth in those cases or alleged by investigating agents and former contractor employees, and
- describes how these activities were carried out without detection by HCFA.

Our comments today are based upon both our report of HCFA's oversight and our investigative report. Although you are focusing primarily on the activities of the fiscal intermediaries, our reports cover both part A fiscal intermediaries and part B carriers.

In brief, although HCFA has taken recent steps to improve its oversight of claims administration contractors, HCFA's oversight process has weaknesses that leave the agency without assurance that contractors are fulfilling their contractual obligations, including paying providers appropriately. Since 1993, at least six contractors have settled civil and criminal charges following allegations that they were not checking claims to ensure proper payment, were allowing Medicare to pay claims that should have been paid by other insurers, or were committing other improprieties. For years HCFA left decisions about oversight priorities entirely in the hands of regional reviewers, did not evaluate regional oversight to achieve consistency, and set few performance standards for contractors to aid in holding them accountable. This has led to uneven review of key program safeguards designed to prevent payment errors. Our report contains several recommendations to correct identified weaknesses and improve HCFA's oversight of its claims administration contractors.

HCFA is also seeking new contracting authority that could help the agency increase competition and better ensure contractor performance. We believe the Congress may wish to consider amending the Social Security Act to allow the Secretary of the Department of Health and Human Services (HHS) explicit authority to more freely contract with appropriate types of companies for claims administration. Even if such legislation were enacted, however, HCFA would need several years to carefully plan and properly implement any new contracting initiatives to avoid the types of problems it encountered in the past when it tried to make changes to its contracting methods. We further believe that HCFA should be required to report to the Congress with an independent evaluation on the impact of any new authorities on the Medicare program.

WEAK CONTRACTOR OVERSIGHT INCREASES THE VULNERABILITY OF MEDICARE

Our work indicates that HCFA has had numerous cases in which questions about contractor integrity have surfaced, but HCFA has yet to incorporate the lessons from these cases into its oversight. Since 1990, nearly one in four claims administration contractors have been alleged, usually by whistle-blowers inside the company, to be conducting improper or fraudulent activities. We identified at least 17 contractors that have been either the target of qui tam suits [3] or the subject of HCFA integrity reviews. At the time of our review, at least 7 of the 58 current contractors were being actively investigated by the Department of Justice or by HHS' Office of Inspector General (OIG). Since 1993, over $235 million has been assessed in civil and criminal penalties against six current or former contractors. Among the charges involved in these cases are that contractor employees

- improperly screened, processed, and paid claims, resulting in additional costs to the Medicare program;
- destroyed or deleted backlogged claims;
- failed to recoup within the prescribed time moneys owed by providers, and failed to collect required interest payments;
- manufactured documentation to support paying claims that otherwise would have been rejected as medically unnecessary;
- switched off customer service telephone lines when staff could not answer incoming calls within the prescribed time limit;
- arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review;
- altered or hid files that involved claims that had been incorrectly processed or paid and altered contractor audits of Medicare providers before HCFA reviews; and
- falsified documentation and reports to HCFA regarding their performance.

Our investigative report focuses on three Medicare fee-for-service contractors with cited integrity problems. In these three cases, the contractors entered into civil set-

[3] *Qui tam* suits are filed under the False Claims Act, 31 U.S.C. sections 3729-3733. The act's qui tam provisions permit filers to share in financial recoveries resulting from their cases.

tlements totaling about $180 million. Also, in two of the cases, contractors pleaded guilty to multiple counts of criminal fraud.

The following illustrates the types of problems alleged at some contractors. A qui tam complaint filed in June 1993 alleged that from 1988 through 1993, Blue Cross and Blue Shield (BCBS) of Michigan (1) routinely altered its audit work papers in order to fix deficiencies and then forwarded the altered papers to HCFA for review, rather than forwarding the original work papers as required; (2) concealed its "clean up" efforts from HCFA and the participating hospitals; (3) lied to HCFA about the status of certain of its audits of providers to steer HCFA away from audits that were so poorly done that they could not be fixed before submission to HCFA; and (4) circumvented a requirement to collect overpayments within 30 days by using various evasive means to make it appear that payments were collected on time when, in fact, they were not.

In January 1995, this case was settled for $27.6 million. In the settlement agreement, the contractor denied the allegations contained in the qui tam complaint. Nevertheless, as a result of the allegations and resulting investigations, the Medicare fiscal intermediary and carrier contracts of BCBS of Michigan were not renewed. HCFA chose BCBS of Illinois as the replacement for both contracts. In 1998, BCBS of Illinois settled criminal and civil allegations of wrongdoing for $144 million and withdrew from the Medicare program.

Unfortunately, few contractor integrity problems have been detected through HCFA's oversight. Of the 17 contractors we identified as having had integrity problems, only 3 were first identified by HCFA. Despite this record of contractor problems, HCFA's oversight is not designed to detect deliberate contractor fraud. Information from whistle-blowers, federal investigators, former contractor employees, and HCFA officials familiar with integrity investigations suggests that the way HCFA conducted on-site verification of contractors' work allowed problems to go undetected. For example, for many years, HCFA notified contractor officials in advance of the review dates and the specific or probable records that would be reviewed. In addition, HCFA reviewers sometimes relied on contractor officials to pull claims or files for review, and sometimes reviewed copies of information made by the contractors rather than the original documents. HCFA's reviews were so predictable that companies were able to identify the areas in their audit operations that could be improperly altered to achieve favorable reviews. Based on our interviews with investigators and former contractor employees, we believe that HCFA may have placed too much trust in its contractors.

HCFA Oversight Is Uneven and Inconsistent

One of the key problems is that HCFA's current oversight process does not ensure that contractors are efficiently and effectively paying claims and protecting the integrity of the program. Poor management controls and falsified data have been common in the integrity cases, yet HCFA continues to rely on contractor self-certifications of management controls and contractor self-reported performance data it rarely validates. HCFA currently has few performance standards to measure contractors, has been uneven in setting priorities, and has given regional oversight staff broad discretion over what aspects of contractor performance to review and how to review them. Furthermore, HCFA does not check on the quality of regional oversight. Not surprisingly, important program safeguards have received little scrutiny at some contractors, and regions have been inconsistent in dealing with contractor performance problems.

HCFA Does Not Validate Contractors' Internal Management Controls or Workload Data—HCFA's first critical weakness is that it accepts Medicare contractors' self-certification of management controls without routinely checking that controls are working as intended. Medicare contractors are required to certify annually that they have established a system of internal management controls over all aspects of their operations. This helps ensure that they meet program objectives, comply with laws and regulations, and are able to provide HCFA with reliable financial and management information concerning their operations. In April 1998, the HHS OIG reported that the regional offices were not evaluating the accuracy and reliability of contractor internal control certifications. In response, HCFA headquarters sent guidance to the regional offices reminding them to validate contractors' self-reports within the 1998 evaluation review cycle. Our analysis of fiscal year 1998 reviews performed for seven contractors found no case in which a self-report of internal controls was validated. We believe systematic validations of contractor internal controls would significantly contribute to reducing the likelihood of contractor fraud.

An equally fundamental activity in overseeing contractor performance is obtaining reasonable assurance that performance and financial data self-reported by the contractor are accurate. We analyzed 170 contractor reviews for fiscal years 1995

through 1997 for the seven contracts we studied; only two of these reviews documented efforts to validate contractor-supplied performance data. For 1998, staff in one of the three regions we visited validated contractor data in five reviews. Staffs of the other two regions did not validate performance data over the 4-year period for the contractors we examined.

To address these weaknesses, we have recommended that the HCFA Administrator establish a contractor management policy that requires the verification that each contractor has the internal controls necessary to ensure the adequacy of its operations. We have also recommended that HCFA require the systematic validation of statistically significant samples of contractor-reported data. HCFA agreed on the importance of validating contractors' internal controls and reported workload data. In its response to our draft report, HCFA stated that it was hiring a firm to develop procedures and methodologies to evaluate contractor self-certifications of internal controls. HCFA also plans to contract for the development of a protocol to be used for data validation reviews that would begin in fiscal year 2001.

HCFA Sets Few Performance Standards for Contractors—Holding contractors accountable for meeting performance standards and measuring contractors on reaching these outcomes is one recognized way to improve performance quality. From 1980 to 1995, HCFA used an evaluation process for which performance standards were explicit but which focused on process rather than outcome. For example, it did not score contractors on the outcomes of their postpayment programs, such as whether their efforts resulted in recovering overpayments. Also, HCFA limited its review to standards published in the Federal Register at the beginning of each year, which, HCFA believed, caused contractors to mainly focus on those standards to ensure a high score. In response, in 1995, HCFA developed the Contractor Performance Evaluation (CPE) process to allow individual reviewers "greater flexibility in determining the appropriate types and levels of review for each contractor."[4] Under the CPE model, HCFA's reviewers have broad discretion to examine any aspect of contractor operations. Until fiscal year 1998, HCFA headquarters did not, however, issue guidance for reviewers to evaluate a minimum set of essential operations and did not require CPE reports to follow a standard format.

Except for standards mandated by legislation, regulation, or judicial decision, HCFA's current CPE process is more descriptive than outcome oriented. There are only a few mandated standards, such as processing certain types of claims within specific time periods. There are no standards required for HCFA reviewers to ensure that contractors adequately perform the most important program safeguards—such as medical review of claims. The lack of standards is worrisome because HCFA has made more effective medical review part of its plan to strengthen program integrity. In our opinion, the lack of clearly defined and measurable payment safeguard performance standards decreases the likelihood that HCFA will get maximum performance from contractors.

HCFA's mandated standards generally apply to contractors' claims processing—rather than program integrity—activities. We found, however, that HCFA has not ensured that regional reviewers check contractor performance on these standards. Reviewers are only required to evaluate whether contractors meet the mandated standards when the reviewers choose that specific area of contractor performance to review. Our analysis of CPE reports for three regional offices found that when HCFA reviewers did assess claims processing activities, they only checked about half of the applicable mandated standards. The three regions varied considerably in their reviews, with one region checking less than 15 percent of the standards, while another region checked over 80 percent.

To address these weaknesses, we have made a number of recommendations, including the development of a comprehensive set of clearly defined and measurable performance standards, the regular assessment of all contractors on core performance standards, and the development of performance reports that allow contractor comparisons on the core performance standards across regions. HCFA agreed with these recommendations and, in response to our draft report, outlined a number of steps it is taking to implement them including the development of a contractor-specific claim payment error rate as well as a contractor-specific fraud rate, which should facilitate contractor comparisons.

HCFA Regions Provide Uneven and Inconsistent Reviews and Remedies—With limited headquarters guidance and little follow-up to ensure that guidance is followed, contractor oversight is highly variable across regions. Without a set of common performance standards or measures, reviewers and contractors lack clear expectations. This has resulted in both uneven review of critical program safeguards

[4] HCFA, *Regional Office Manual,* Section 1100, "Contractor Performance Evaluation" (Washington, D.C.: HCFA).

and inconsistencies in HCFA reviewers' handling of contractor performance problems. Besides the inequity for contractors, such uneven review leaves HCFA without an ability to discriminate between contractors' performance when assigning new workload.

One such critical program safeguard for which oversight has been limited and uneven is that of Medicare Secondary Payer—so-called MSP—activities. Contractor MSP activities seek to identify insurers that should pay claims mistakenly billed to Medicare and to recover payments made by Medicare that should have been paid by others. This program safeguard has saved about $3 billion annually from 1994 through 1998. Our review of three regions' CPE reports shows that many of the key MSP activities most germane to spotting claims covered by MSP provisions were not reviewed at the seven contractors in our study. Also, the three regions varied considerably in how much review they gave to MSP, with one region rarely checking MSP activities at any of its contractors whose CPEs we reviewed.

This paucity of review is particularly disturbing because the potential for contractor fraud regarding MSP activities is significant as a result of an inherent conflict of interest. According to a former contractor employee, one contractor with a private line of business in health insurance in the same geographic area as its contract sometimes failed to send out letters to newly enrolled beneficiaries to determine whether Medicare payments should be secondary to those of another health insurer. HCFA has had to pursue several insurance companies—some with related corporations that serve as Medicare contractors—in federal civil court for refusing to pay before Medicare when Medicare should have been the secondary payer. In such a case filed by HCFA against BCBS of Michigan, the company paid $24 million in settlement of the MSP case, in addition to $27.6 million to settle fraud allegations lodged against it in another case. Since 1995, settlements in the civil cases filed by HCFA in which a company with related interests was also a Medicare carrier or intermediary have totaled almost $66 million. HCFA currently has an additional $98 million in claims filed against current and former contractors as a result of its MSP activities

HCFA's regions differ in their identification of problem contractors. For example, one company held two contracts for two states—each overseen by a different region. As part of its program safeguard activities, the company analyzed paid claims at one central location to identify possible fraudulent or abusive provider billing trends. While the company conducted identical types of analyses for both contracts, one region found that the contractor's data analysis activities were not fulfilling HCFA's expectations, while the other region found the contractor to be in compliance with HCFA's analytic expectations. Although these regions had signed a memorandum of understanding to seek consistency in how they directed the contractor and to coordinate oversight to avoid duplication of effort, they did not work together to resolve their differences and guide the contractor with one voice.

HCFA reviewers may not only disagree about whether a problem exists but also take dissimilar actions once a performance problem is identified. When it identifies a deficiency, HCFA's normal procedure is to require the contractor to develop a Performance Improvement Plan (PIP) to correct the problem, and then to monitor the plan. PIPs can be stringent corrective actions for contractors. Contractors operating under a PIP can be required to make complex changes in operations and to submit performance data and reports about their activities until HCFA decides that their performance has improved.

HCFA reviewers differ about whether they require PIPs, even in cases in which contractor performance is clearly not satisfactory. For example, one region required Contractor A to develop and follow PIPs for deficiencies in its performance in fraud and abuse prevention and detection. In contrast, another region, reviewing Contractor B, found many more serious weaknesses with its fraud and abuse prevention and detection activities. Contractor B was spending little or no time actively detecting fraud and abuse, failing to use data to detect possible fraud, not developing large and complex cases, and not referring cases to the HHS OIG. Furthermore, Contractor B was inadequately recovering overpayments, failing to focus on the highest-priority cases, preparing no fraud alerts, and not suspending payments to questionable providers. The reviewer concluded that Contractor B failed to meet HCFA's performance expectations, yet the region did not require the contractor to be put on a PIP.

To address this weakness, we have recommended that the HCFA Administrator designate one of the agency's organizational units to be responsible for

- evaluating the effectiveness of contractor oversight policy and procedural direction that headquarters staff provide to the regions,
- evaluating regional office performance in conducting contractor oversight activities, and

• enforcing minimum standards for the conduct of oversight activities.

Again, HCFA agreed with these recommendations, stating that it is exploring the use of an independent evaluation of its oversight policy and procedures and is laying the groundwork for evaluating regional office performance and establishing uniform requirements for CPE reports.

HCFA Has Started to Move to a More Structured Evaluation Process—HCFA has recognized that its oversight of contractors has been less than adequate and issued guidance in fiscal year 1998 to have regional reviewers follow a somewhat more structured evaluation process. However, these actions are only a first step in addressing problems with contractor oversight.

In May 1998, citing concerns raised by the HHS OIG and us regarding HCFA's level of contractor oversight, HCFA announced the "need to reengineer our current contractor monitoring and evaluation approach and develop a strategy demonstrating stronger commitment to this effort." As a result, HCFA issued a contractor performance evaluation plan specifying three evaluation priorities for fiscal year 1998: (1) year 2000 compliance activities, (2) activities focusing on a subset of financial management operations—accounts receivable and payable, and (3) activities focusing on a subset of medical review activities.

In 1998, HCFA also emphasized the need for regions to follow its structured CPE report format, including clearly stating whether or not the contractor complied with HCFA's performance requirements. Nonetheless, we found that some of the 1998 reviews continued to lack a structured format making it difficult to compare contractor performance. For example, HCFA's contractor evaluation plan for fiscal year 1998, issued 5 months before the close of the fiscal year, called for examining contractors' activities to review claims for medical necessity before they are paid (prepayment medical review). Our review of the three regions' fiscal year 1998 CPE reports shows that (1) two regions did not review contractors' determinations of medical necessity prior to payment at all contractors included in our study and (2) two regions did not consistently follow the structured report format, making it difficult for HCFA headquarters to evaluate or compare the results.

Despite HCFA's intent to provide more direction to the regions on contractor oversight activities, it continues to issue review guidance late in the year. Agency officials recently told us that its plan for CPE reviews for fiscal year 1999 will include more headquarters involvement in the assessment process, review teams from headquarters and the regions, and multiregional reviews. However, it was not until 8 months into the fiscal year that HCFA finally issued its fiscal year 1999 guidance.

HCFA Lacks a Structure That Ensures Accountability

HCFA's structure is not designed to ensure oversight accountability, with two aspects creating particular problems. First, HCFA reorganized its headquarters operations in 1997, dispersing responsibility for contractor activities from one headquarters component to seven. Second, HCFA's 10 regional offices—the front line for overseeing contractors—do not have a direct reporting relationship to other headquarters units responsible for contractor performance. Instead, they report to the HCFA Administrator through their respective regional administrators and consortia directors. We found that this structural relationship and the dispersion of responsibility for contractor activities to multiple headquarters components contribute to communications problems with contractors, exacerbates the weaknesses of HCFA's oversight process, and blurs accountability for (1) having regions adopt best practices; (2) routinely evaluating the regional offices' performance of its oversight; and (3) enforcing minimum standards for conducting oversight activities, including taking action when a particular region may not be performing well in overseeing contractors. In an effort to establish more consistency and improve the quality of contractor management and oversight, HCFA has recently modified its organizational structure once again by consolidating responsibility for contractor management within the agency and creating a high-level contractor oversight board. It is too early, however, to tell whether these changes will be sufficient.

HCFA WOULD NEED TIME AND CAREFUL IMPLEMENTATION TO REAP BENEFITS FROM NEW CONTRACTING AUTHORITY

To address perceived barriers to effective contracting for Medicare claims administration services and to help attract new companies to become contractors, HCFA has proposed legislative changes. The proposals include obtaining repeal of the nomination provision—which allows institutional providers to select their intermediary—and authority to (1) contract with other than health insurers, (2) contract for specific functions, and (3) award other-than-cost-based contracts.

When Medicare was enacted, the Congress authorized HCFA to use health payers—almost all health insurance companies—to be its contractors. Because pro-

viders were fearful that the new program would give the government too much control over medicine, institutional providers such as hospitals were allowed to designate an intermediary between themselves and the government. The American Hospital Association picked the national Blue Cross Association to serve as the intermediary for its members. Today, the Association is one of Medicare's five intermediaries and serves as prime contractor for 32 local member plan subcontractors that together process over 85 percent of all benefits paid by intermediaries. Under the prime contract, when one of the local Blue Cross plans declines to renew its Medicare contract, the Association, rather than HCFA, chooses the replacement. While this may have made sense to ensure that the fledgling program became successfully launched, today it leaves HCFA with less ability to choose and manage its contractors.

Similarly, HCFA's regulations limit its ability to contract for specific functions, rather than have each contractor perform the full range of Medicare functions. As a result, with one recent exception, HCFA has not experimented with having one or two contractors performing consolidated functions to achieve economies of scale. The one area where HCFA has begun to try functional contracting is for program safeguards, because in 1996, HCFA was given new authority to contract separately for these activities. However, HCFA's experience in implementing its new payment safeguard contract authority attests to the need for significant time to explore and resolve feasibility issues. Implementing these functional contracts will provide useful experience in the advantages and possible pitfalls of such functional contracts.

Apart from program safeguards, other functions might be better performed if consolidated at a few contractors. For example, in the fee-for-service Medicare program, each contractor conducts hearings on provider and beneficiary appeals of its own claims decisions, despite the possible conflict of interest and inefficiency. While choosing certain functions and consolidating them in a limited number of contractors could benefit Medicare, current Medicare contractors have expressed concern that contracting by function would be disruptive to their operations and the program. After 30 years of integration, contractors' functions may not be easy to separate, and having multiple companies doing different tasks could create coordination difficulties. Which functions would be best suited for separate functional contracts has not yet been determined, suggesting that some experimentation would be a necessary step for the success of such an initiative.

Contractor payment is a third area where HCFA is seeking change. Medicare law generally requires intermediary and carrier contracts to be paid on the basis of cost. Though generally not able to earn profits, contractors benefit when Medicare pays a share of corporate overhead. Nevertheless, the adequacy of current funding to attract and retain contractors is being questioned and may be contributing to contractors' withdrawing from the program. Existing constraints on earning a profit make participation in the Medicare program less attractive to companies that have been part of the program for years.

Under HCFA's proposal to repeal the cost-based contract restrictions, HCFA would be free to award contracts that would permit contractors to earn profits. However, HCFA's past experiments with using financial incentives generally have not been successful and raise concerns about the success of any immediate implementation of such authority. HCFA has experimented with competitive fixed-price-plus-incentive-fee contracts and with adding financial incentives to cost-based contracts. Between 1977 and 1986, eight competitive fixed-price contracts were established as an experiment. Our 1986 report noted that three of the contracts generated administrative savings, [5] but two resulted in over $130 million in benefit payment errors (both overpayments and underpayments) so that much of the administrative savings of the successful experiments was offset by program losses.

HCFA also had problems when, beginning in 1989, it was given limited authority to award other-than-cost contracts. HCFA provided financial incentives in several cost-based contracts, but some of the self-reported data contractors used to claim incentive payments were inaccurate. In one case, the incentives would not have been paid had a contractor with integrity problems not cheated by "correcting" errors in about a quarter of the 60 claims reviewed by HCFA.

The problems in previous experiments suggest that any change from cost-based contracting will need to be carefully designed and thoughtfully monitored to prevent loss to the Medicare program. Testing different methods of contracting could help HCFA ensure that implementation would improve, rather than weaken, program administration.

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[5] *Medicare: Existing Contract Authority Can Provide for Effective Program Administration* (GAO/HRD-86-48, Apr. 22, 1986).

CONCLUSIONS AND RECOMMENDATIONS TO HCFA

Medicare's fee-for-service program pays out the lion's share of program dollars expended by HCFA, making it a business that must be carefully monitored. However, we found that HCFA conducted limited scrutiny of contractor performance. Until HCFA starts regularly assessing the validity of contractor controls and data, it cannot be assured of a contractor's integrity, the accuracy of its payments to providers, or the contractor's fiscal responsibility in handling Medicare funds.

Contractor oversight could be strengthened if HCFA balanced an appropriate level of regional discretion with sufficient effort to establish measurable contractor performance standards, set programwide priorities for the assessment of all contractors, and developed a standardized report format facilitating contractor comparisons. HCFA needs to ensure that regions adopt best practices and incorporate lessons learned into its oversight—beginning with those learned from integrity cases. In addition, HCFA needs an organizational structure for contractor oversight that will ensure that there is evaluation of the quality of contractor oversight activities and of the effectiveness of contractor oversight policy and procedural direction.

Over the long term, HCFA could benefit from a strategic plan for managing claims administration contractors that could be used as a guide on the path from its current contracting mode to a new one. HCFA could design this plan to help it determine (1) the contractor activities that are most conducive to functional contracting, (2) the activities that could be performed by other than health insurance payers, (3) better cost information to facilitate the move to competitive contracting, (4) the functional contracts that might be conducive to other-than-cost payments, and (5) the feasibility of building financial incentives into the contracts.

In our oversight report, we make a number of specific recommendations to improve HCFA's oversight. Implementing these recommendations should help ensure that

- contractor internal controls are working;
- contractor-reported data are accurate and useful for management decision-making;
- contractor performance is evaluated against a comprehensive set of measurable standards;
- HCFA's treatment of contractors is more consistent; and
- HCFA has a strategic plan for implementing the legislative changes that it is seeking.

Mr. Chairman, this concludes my prepared statement. We would be happy to answer any questions you or other Members of the Subcommittee may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-4161 or Leslie G. Aronovitz at (312) 220-7767. Individuals who made key contributions to this testimony included Sheila Avruch, Mary Balberchak, Elizabeth Bradley, Stephen Iannucci, Bob Lappi, Don Walthall, and Don Wheeler.

Mr. UPTON. Thank you. Ms. Thompson.

STATEMENT OF PENNY THOMPSON

Ms. THOMPSON. Thank you. Mr. Chairman, Congressman Klink, distinguished subcommittee members. I am pleased to have this opportunity to discuss the Health Care Financing Administration's management of fiscal intermediaries and their efforts to combat fraud, waste and abuse in the Medicare program.

I would like to thank the HHS, OIG and the General Accounting Office for the invaluable assistance that they have provided us in improving and enhancing our oversight of contractors. We are committed to improving those activities. The results of the fiscal year 1998 chief financial officer's audit of HCFA by the IG are evidence of progress that we have made over the past few years.

This year's audits show that we have cut the Medicare payment error rate in half in 2 years from 14 percent to 7 percent. That 7 percent still represents $12.5 billion of taxpayer money and so

there's no sitting on our laurels or feeling that we've made all the progress that we need to make.

It is far too high still and we commit ourselves to sustaining and increasing the improvement that we have made thus far.

Let me talk a little bit about our benefit integrity units and the responses that we've made to the IG's report on contractor fraud units. Our benefit integrity units are an important component of our program integrity strategy. In fact, improving the effectiveness and efficiency of our benefit integrity and medical review activities is the first of 10 areas in our comprehensive plan for program integrity.

And I'm happy to report today on a number of activities that we have undertaken in that regard. Contractor fraud units received about $54 million this past year for their activities in combatting fraud. With those funds, those units are responsible for complaint processing and development, outreach and training, law enforcement support and fraud case development.

Let me mention briefly six activities that are underway or are completed which are designed to improve the performance of our contractor fraud units. First is with regard to improving our contractor performance evaluation. In order to enhance our ongoing contractor oversight and provide consistency in our review process, we have implemented a new national contractor performance evaluation strategy.

This new effort is a national multitiered approach and focuses our review on key high risk contractors and program benefit categories. National teams comprised of HCFA regional and central office staff are evaluating the fraud and abuse operations, as well as other functions of a number of fiscal intermediaries and carriers, including the five regional home health intermediaries and the four durable medical equipment regional carriers.

We have also strengthened review protocols for contractor benefit integrity performance to be incorporated in our contractor performance evaluation review protocols. These protocols provide consistent guidance to reviewers as to what areas of performance should be examined and what data should be collected and reviewed in order to inform the reviews.

The evaluations for benefit integrity center on the contractors' use of proactive and reactive techniques in detecting and developing fraud cases, use of corrective actions, such as payment suspensions, civil money penalties, overpayment assessments, prepayment reviews, edits and claims denials as well as referral to law enforcement and response to patterns indicative of fraud, proper development of fraud cases before the cases are referred to law enforcement entities so they can make appropriate judgments about whether to pursue those cases further, and improving the effectiveness of working relationships with internal and external partners, most particularly within the contractor in terms of its medical review activities externally with our law enforcement partners.

We are also developing new measurements for assessing contractor performance. One that I have high hopes for is in developing a contractor specific error rate methodology. Right now we have an overall program error rate methodology. We think it would be very useful to have that kind of error rate assessment done at a contrac-

tor specific level, so that we can determine whether there are specific problems either in the claims being submitted to contractors, or in the way that contractors are handling those claims in terms of contributing to the errors.

We also are improving contractor referral practices. We have recently sent out guidance to the contractors reminding them of their obligation to refer any cases of suspected fraud to the OIG, and to take administrative actions within their authority to respond to those cases as quickly as possible.

We have conducted a national contractor training with the assistance of the Office of Inspector General, the Department of Justice involving the Federal Bureau of Investigation, and Assistant U.S. Attorneys across the country in working with our contractors on referral of fraud cases.

We are developing a catalog of anti-fraud software and technology to assess both the tools currently being used by our contractors, who use a host of different tools, as well as the tools the private sector uses to identify patterns of fraud. We also will be pursuing a demonstration conference with the OIG and the Department of Justice in the next year to assess whether or not we want to require the use of some of that technology by our contractors.

We are also requiring this year that each of our contractors, in response to some of the issues identified by the OIG and GAO, develop a quality improvement program for their medical review and benefit integrity activities. And we are implementing our authorities under the Medicare integrity program to award new contracts for work to different kinds of entities other than the ones with which we were currently engaged. One of those task orders is a Benefit Integrity Support Center in New England, which is an idea that we've had, that if we can have a support center working very closely with law enforcement and with our current contractors to actively search out and respond to suspected fraud. We think that could be a successful model that could be implemented elsewhere.

These are all part and parcel of a larger set of activities designed to improve contractor performance, designed to improve our oversight, designed to improve our knowledge of contractor activities. Both good performance and the integrity of our contractors is essential to good functioning of the Medicare program.

Before I end, I do want to mention one of the most immediate steps of the Administrator, who recently launched a management initiative focused on our contractor oversight assessment and integrity, was to appoint Dr. Marjorie Kanof, who is with me on my right, as directly responsible for all contractor management activities within the agency. She is the Deputy Director, in the Center for Beneficiary Services, for Medicare Contractor Management.

Thank you.

[The prepared statement of Penny Thompson follows:]

PREPARED STATEMENT OF PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY GROUP, HEALTH CARE FINANCING ADMINISTRATION

Chairman Upton, Congressman Klink, distinguished Subcommittee members, I am pleased to have this opportunity to discuss the Health Care Financing Administration's (HCFA) management of fiscal intermediaries in their efforts to combat fraud, waste, and abuse in the Medicare program. I would like to thank the Department of Health and Human Services Office of Inspector General (IG) and the Gen-

eral Accounting Office (GAO) for the invaluable assistance they have provided HCFA in improving and enhancing our oversight of the contractors. We are committed to improving our management and oversight of contractor activities and are making solid progress in addressing the IG's findings in their November 1998 Report, *Fiscal Intermediary (FI) Fraud Units.*

The results of the Fiscal Year 1998 Chief Financial Officer's (CFO) audit of HCFA by the IG are evidence of the progress we have made over the last few years. This year's audit shows that we have cut the Medicare payment error rate in half in just two years, from 14 percent to 7 percent. That 7 percent represents 12.6 billion taxpayer dollars, which is a big step forward. But it is still too high and we must be diligent in sustaining and increasing the improvement we have made thus far.

Since the Clinton Administration took office, the Department of Health and Human Services has taken a number of steps to implement a "zero tolerance" policy for fraud, waste, and abuse. To do this, we must assure that Medicare pays 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, our contractors, providers, beneficiaries, and our many other partners, we have achieved record success in assuring proper payments. We also have made considerable progress in fighting fraud by increasing investigations, indictments, convictions, fines, penalties, and restitutions.

To this end, we developed a Comprehensive Plan for Program Integrity, which was released in March 1999. Its development began a year earlier when we sponsored an unprecedented national conference on waste, fraud, 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, including private insurers, consumer advocates, health care providers, state health officials, and law enforcement representatives, shared successful techniques and explored new ideas for ensuring program integrity. Their suggestions were synthesized and analyzed to determine the most effective strategies and practices already in place, and the new ideas that deserved further exploration. The result was our Comprehensive Plan for Program Integrity. One of the ten key areas included in this plan is related to improving the effectiveness of medical review and fraud detection within our contractors, including the fiscal intermediaries (FI) that process Medicare claims.

Improving Medicare Contractor Performance Evaluation. In order to enhance our ongoing contractor oversight and provide consistency in our review processes, HCFA implemented a new National Contractor Performance Evaluation Strategy in May. This new effort is a nationwide, multi-tiered approach and focuses our review on key, high risk contractors and program benefits categories. Our evaluation strategy for fiscal 1999 includes ten core evaluation areas such as millennium compliance, accounts receivable, audit quality, standards for timely processing of claims and customer service, as well as follow-up on performance improvement plans that we required contractors to submit based on program deficiencies identified during our fiscal 1998 reviews.

National teams comprised of HCFA regional and central office staff are evaluating the fraud and abuse operations, as well as other functions of a number of fiscal intermediaries and carriers, including the five Regional Home Health Intermediaries and the four Durable Medical Equipment Regional Carriers. In conducting their reviews, the teams will use a standardized fraud and abuse review protocol, and team members will participate in reviews at multiple contractors, thus helping to ensure the consistency of our evaluations across different contractors.

We also have established specific, objective standards for contractor benefit integrity performance that have been incorporated into our Contractor Performance Evaluation (CPE) review protocol. These standards provide consistent guidance to contractors as to what improvements are needed. The CPE system uses a standard data set to measure FI fraud units' performance in accomplishing established performance objectives.

Contractor evaluations center on the contractors':

- Use of proactive and reactive techniques in detecting and developing fraud cases;
- Use of corrective actions, such as payment suspensions, Civil Monetary Penalties, overpayment assessments, pre-payment or post-payment claims reviews, edits, and claims denials;
- Proper development of fraud cases before referral to law enforcement entities; and
- Effectiveness of working relationships with internal and external partners.

Improving Contractor Referral Practices. In December 1998, President Clinton announced that HCFA is now "requiring all Medicare contractors to notify the govern-

ment immediately when they learn of any evidence of fraud, so that we can detect patterns of fraud quickly and take swift action to stop them." To implement this, in December 1998 we issued a Program Memorandum to all contractors clarifying their obligation to protect the Medicare Trust Funds, and we are requiring contractors to take all necessary administrative action to prevent or recover inappropriate payments. This includes a reminder that contractors refer all cases of suspected fraud to the IG.

National Contractor Training. Beginning in May and continuing through July 1999, HCFA, the IG, and the Department of Justice (DOJ), conducted contractor training sessions for all Medicare contractor fraud units across the country to ensure timely and appropriate referral of fraud cases. We provided our contractors with expert guidance on how best to identify and develop cases of fraud for further investigation by law enforcement authorities. During the course of training, contractor program integrity personnel, HCFA central and regional office staff, as well as law enforcement personnel learned the proper procedures, documentation processes, and analytical methods necessary to ensure that the IG and law enforcement can take aggressive action and successfully prosecute all legitimate fraud cases.

Using Technology. We are always looking for ways to use technology to help us "pay it right." To ensure we are taking advantage of the latest in anti-fraud technology, we recently completed a comprehensive survey of software employed by our contractors to detect fraud and abuse. We are now expanding that survey to identify private sector tools. Our goal is to establish a system to routinely evaluate emerging technologies to ensure we possess the most effective tools for fighting Medicare fraud. We plan to undertake an analysis of these tools and their effectiveness in concert with our law enforcement partners.

Improving Qualifications of Contractor Program Integrity Staff. We will require both current and future contractors to ensure that their program integrity staff have the knowledge and skills critical for their jobs. Contractors will be required to demonstrate that they have appropriate staff to meet program integrity objectives. In particular, we are requiring contractor fraud units to implement training programs focused on fraud detection techniques, interviewing, and data analysis.

Quality Improvement Program. As recommended by the IG, we also are requiring each contractor to establish a Quality Improvement program that is tailored to best suit their particular operational procedures. The Quality Improvement program must be approved by the appropriate HCFA regional office. To assist the contractors in developing these programs, we will be sharing "best practice" findings gathered by our regional office staff, as well as providing technical assistance through our Fraud Unit Improvement Task Force.

Feedback from Performance Reviews. We also want to build on effective practices now employed in our fraud units and develop constructive solutions to common problems. At the end of the Fiscal Year 1999 contractor review cycle, we are holding a conference for our national and regional contractor review team members to provide an opportunity for all our reviewers to share their experiences, including contractor problems and best practice information, face-to-face.

Implementing the Medicare Integrity Program. In May, HCFA named 12 businesses with expertise in conducting audits, medical reviews, and other program integrity activities, to be the first-ever Medicare Integrity Program (MIP) contractors. MIP, as authorized under the Health Insurance Portability and Accountability Act, allows us to hire special contractors whose sole responsibility is ensuring Medicare program integrity. Until now, only the insurance companies who process Medicare claims have been able to conduct audits, medical reviews, and other program integrity activities. Under this new authority, we are contracting with these 12 firms to bring new energy and ideas to this essential task.

MIP allows us to issue Task Orders for any or all program integrity activities. And provides us a pool of contractors who are available to undertake work before we solicit proposals for specific contractors' workloads. We also will be able to turn to these contractors on-the-spot when various situations arise, such as the appearance of new fraud schemes or the departure of another contractor.

These 12 selected contractors are now eligible to compete for specific work assignments. Beginning with the six initial Task Orders also released in May, contractors will be selected for each of the following tasks:

- *Conducting cost-report audits for large health-care chains.* Through careful review of the way large health care chains allocate their home office costs, this task will ensure that Medicare pays providers appropriately.
- *Preventing possible Year 2000 threats to program integrity.* This task involves conducting national data analyses to detect and prevent potential risks of fraud and abuse during the critical months surrounding the millennium change.

- *Conducting on-site reviews of Community Mental Health Centers (CMHC).* These reviews will build on HCFA's ongoing CMHC initiative and require qualified mental health professionals to conduct unannounced visits to CMHCs to ensure they provide the services required by law and meet all other applicable federal and state requirements.
- *Identifying effective areas to target for national provider education.* Under this task the contractor will provide analysis of data and trends, surveys of healthcare providers, and other research to develop target areas for a national provider educational plan.
- *Performing data analysis and other activities to support the fraud units in New England.* This work will support the efforts of the relatively small fraud units at New England's Part A Medicare contractors, which will continue their current workload and staffing levels. The contractor will analyze regional data and develop fraud cases.
- *Ensuring providers comply with settlement agreements with the IG.* This work involves on-site reviews of providers who have established corporate integrity agreements to ensure the contractors meet the terms of the agreement as well as follow proper procedures.

OVERALL CONTRACTOR MANAGEMENT

The improvements discussed above are part of a larger initiative to improve our management of the contractors in all areas. I would like to take a few moments to highlight some aspects of this larger strategy. I also would like to express our appreciation to the GAO for the recommendations that they have provided us in this regard.

One of the first, and among the most important, steps we took was to restructure and consolidate HCFA's management of the contractors. In November 1998, we established the position of Deputy Director for Medicare Contractor Management as part of the Center for Beneficiary Services. Marjorie Kanof, M.D., is directly responsible for all contractor management activities within the Agency. Dr. Kanof previously served as a Medical Director of Blue Cross of Massachusetts and has firsthand knowledge of both contractor performance and HCFA's oversight.

In order to ensure the overall financial integrity of the Medicare program, we are taking action to ensure the accuracy of all of our contractors' internal financial controls and reported performance data. To this end, we are planning to contract with an Independent Public Accounting (IPA) firm to develop standard review procedures and methodologies for evaluating the documentation submitted by the contractors during the annual self-certification of their internal controls. In addition to preparing individual contractor review reports, the IPA will provide the contractors with information on best practices, as well as ways to improve management control certification processes and evaluation activities. Based on the results of these internal reviews, we are considering conducting additional audits to examine in detail the adequacy of the contractors' internal control policies, procedures, and documentation. And we anticipate issuing a contract to develop protocols for validating data reported to HCFA by the contractors.

We also are developing a new management reporting system, called Program Integrity Management Reporting (PIMR), to assist us in measuring contractor performance in the area of program integrity. This new procedure will use data derived directly from the contractors' claims processing systems, as opposed to the current system which relies on self-reported data, and will significantly increase the reliability and usefulness of the data.

We also are developing a business strategy for Medicare fee-for-service contractor operations, taking into account both our past experience and current environmental factors, including the changing business environment for Medicare contractors. One of our primary goals is to be more consistent in our management of fee-for-service contractor performance. The validation of several strategic management approaches, through limited pilot programs, will be critical to this effort. For example, our experience with the new MIP Program Safeguard Contractors will provide valuable information to us on how we can improve our contracting processes and oversight. Furthermore, we have established the Medicare Contractor Oversight Board, which provides executive leadership and establishes guiding principles for HCFA's oversight of the Medicare fee-for-service contractor network.

Finally, the Administration has proposed comprehensive contracting reform legislation numerous times since 1993. If enacted, this legislation would provide the Secretary with more contracting flexibility, bring Medicare contracting more in line with standard contracting procedures used throughout the Federal government, and

create an open marketplace so we do not have to rely on a steadily shrinking pool of contractors.

CONCLUSION

We are making substantial progress in fighting fraud, waste, and abuse in the Medicare program and ensuring that we pay right. We realize that more work needs to be done. And we are committed to continuing to build on the improvements we have made in our management and oversight of our contractors. We appreciate this Committee's leadership in this area, and the important work that our colleagues at the IG have done in highlighting areas that need improvement. I thank the Committee for holding this hearing and I am happy to answer any questions you may have.

Mr. UPTON. Thank you. Thank you all for your testimony. And we would just like to announce that we've had a number of members that have come in.

Mr. Strickland, did you want to give an opening statement?

Mr. STRICKLAND. No, thank you, Mr. Chairman.

Mr. UPTON. I would note—Mr. Green, would you like an opening statement?

Mr. GREEN. I will submit one for the record.

Mr. UPTON. And I know Mr. Bliley was here as well and Mr. Bilbray, so that offer remains and all members will be allowed by unanimous consent to put their opening statement in the record.

You know as I read these reports and listen to the testimony, it seems—and I hear the laundry list of abuse, particularly by Mr. Grob and Ms. Aronovitz, there's just a laundry list of problems that persist, and as careful as we might have tried to be in the Congress in trying to help the process and identify and correct areas of fraud and abuse in this massive program, it just seems like we haven't done a very good job.

We've identified abuses and they just persist and persist and persist. And as you all have looked at a number of specific cases outlined in your testimony and materials that were presented to us today, it's really—I sense that it's—you haven't examined all 50 States, right? You only looked at a handful of States. As I understand it, a majority of the States that you've looked at have enormous trouble. And so we probably don't still have a handle in terms of the fraud and abuse that's out there in this program. Am I correct?

Mr. GROB. We still have those 21 investigations underway.

Mr. UPTON. But how—if you're trying to extrapolate that for the whole country, we're still only scratching the surface.

Mr. GROB. We conduct our investigations when we have credible reason to believe that there's something to be investigated. So the fact that we have what approximately—I'm not sure it's one-third, but say one-fourth or so, is certainly an indication that they have reached the stage that we have to conduct investigations. Then that's certainly an indication there are serious problems.

I would like to state too that the problems of the accounting, the financial management that I mentioned, were found in all 12 of the contractors that we looked at, which were randomly drawn for the purpose of CFO review, so every one of those had that accounting problem.

Mr. UPTON. Ms. Aronovitz.

Ms. ARONOVITZ. We looked at cases that were a matter of public record that had already been closed and settled, so we do not know the extent of ongoing criminal behavior.

Mr. UPTON. Ms. Aronovitz, when you testified, you indicated that some regions of the country have done better than others, and yet a frustration that you were able to identify was that HCFA failed to share those results and sort of allow regions to compete with some strengths to correct the problems that were out there.

Ms. Thompson, I don't know if you have looked specifically at some of the results or some of those regions. But as you look to the future, is that something that HCFA plans to do?

Ms. KANOF. Well, in fact we have. We've begun to initiate some of those best practices. Specifically what we've begun for our fiscal year 1999 reviews, is to have national teams. Most of the large contractors are no longer just being reviewed by single staff from one regional office. Now, there are networks of regional office staff and central office staff going out to visit all the contractors that we've selected that are at high risk as well as the RHHIs and the durable medical equipment contractors. We are forming national teams so that we have consistency. We've learned from some of our best practices that we need coordination, consistency and centralization.

In addition, we are collecting information and we will be having a session at the end of this fiscal year specifically looking at what we've learned and addressing the best practices. So we have basically taken every one of the GAO recommendations and have either activity in progress addressing those recommendations, or plans to address each one of them.

Mr. UPTON. One of the things that Ms. Aronovitz mentioned was that with some of the changes that have been recommended that there was no assurance in fact that they may in the long term be able to correct some of the problems that were out there.

Are there some shortcomings that you see in HCFA not taking advantage of some of the things that you identified?

Ms. ARONOVITZ. No, we're actually very pleased that HCFA has responded so well and so quickly to some of the findings and concerns that we've had. As we started our work, we like to make an agency aware of what we're finding because we don't like to surprise them, we like to work with them, and along the way HCFA has made some fundamental changes.

The problem we have is that clearly these changes are either several weeks or months old or on the drawing board, and it would be probably unfair to the agency and to us to try to evaluate those until they're fully implemented. So we plan to continue to look at HCFA's actions, and we will be in the future able to comment on whether these actions will deal with a lot of the fundamental problems.

Mr. UPTON. We look forward to hearing your recommendations and thoughts in the future.

Mr. Klink.

Mr. KLINK. To start out, Mr. Grob, you know, to paraphrase, why would a baseball team not use bats? Did all 12 of these firms that you looked at not use the credible accounting system? I mean that sticks out like a sore thumb.

Mr. GROB. I think it's because it's not their money. I think what we have is the way that the system is constructed here we have cost-based contracting. We pay these contractors for their costs of doing this, which I believe is a very inadequate way to guarantee that you get a good product from government procurement as a general rule.

It basically motivates people to demonstrate that they have insured costs in order to get reimbursed. So I think it motivates people to do their accounting that way, but I think more fundamentally, it is not their money that is being managed so the incentives are not as strong.

Mr. KLINK. By not using the credible accounting methods does it also leave the ability to have all of those blue marks on the chart where people can be working toward ripping off the system and showing more of a financial advantage for their own companies?

Mr. GROB. It is a serious vulnerability to not have the normal expected accounting systems when tens of millions of dollars are passing through the office.

Mr. KLINK. I mean that to me is one of the most frightening things you have shown us thus far, and I assume that Medicare carrier X [referring to chart], this is an actual company.

Mr. GROB. Yes.

Mr. KLINK. This is not something that you just dreamt up and put an X on top, there is a company that this is their structure and every one that is blue there is evidence that they are participating in ripping off Medicare, the very people who are supposed to be protecting Medicare who we've hired to bring state-of-the-art private sector technology to show us how to manage Medicare to cover waste, fraud and abuse, to recover those dollars for the taxpayers and for the Medicare recipients, that many people are taking part for the private sector company in—at least there's the evidence that they are taking part in participating in ripping it off.

Mr. GROB. Yes.

Mr. KLINK. Ms. Aronovitz, I'm sure that you gathered from my opening remarks that we're still very much interested in having you revisit the work that Mr. Dingell and I requested last year on the Illinois Blue Cross-Blue Shield case.

What can you tell me about where the effort is now and any discussions you've had with the Department of Justice regarding when the job can be restarted?

Ms. ARONOVITZ. Yes. We've been in ongoing discussions with the Department of Justice. As you know, three management officials from that company have pled guilty. There are currently 5 criminal indictments that are pending; those trials are scheduled for September 13 of this year. The Department of Justice expects that those cases will take between 8 and 9 weeks.

They also state that there could be some actions after these trials are over in the form of appeals. But I should also say that the corporate plea agreement on the civil settlement for $140 some odd million is now final. The court has accepted that.

So we're in the process now of monitoring the status of the ongoing indictments and those trials, and we will work with you when those are finished to figure out what we can do to continue to look at that.

Mr. KLINK. You anticipate at this point that your Office of Special Investigations is going to be part of this continuing effort?

Ms. ARONOVITZ. I think a lot of it would depend on the specific issues that we agree need to be looked at further. And certainly our Office of Special Investigations and our division work very closely together and certainly we would provide you with any resources that are necessary to answer your questions.

Mr. KLINK. Thank you. We look forward to working with you on that.

Without a doubt, I got to tell you I'm very disturbed by the kind of activities that were being perpetrated by these various contractors that you identify in your report. Even though Mr. Dingell read this, I just want to read it again to you, and then I want to go over some of the points. This is from the report, "Medicare contractors are HCFA's front line of defense against provider fraud, abuse and erroneous Medicare payments. However, several of them have committed fraud against the government. Since 1990, nearly 1 in 4 claims administration contractors have been alleged generally by whistleblowers within the company to have integrity problems. One-fourth.

"GAO has identified at least 7 of HCFA's 58 contractors as being actively investigated by HHS, OIG or Justice. Since 1993, HCFA has received criminal and civil settlement decrees totaling over $235 million from 6 contractors after investigations of allegations that the contractors employees deleted claims from the processing system, manufactured documentation to allow processing of claims that otherwise would have been rejected because the services were not medically necessary and deactivated automatic checks that would have halted the processing of questionable claims."

We've had hearings in this very subcommittee talking about getting the latest software, make the software available so that—we should use Cox technology, we put money out for other technology, what in the hell are we supposed to do when they're turning it off? I mean is there not a check on the people that are supposed to be checking the system?

Ms. ARONOVITZ. We think there are a few fundamental actions that HCFA needs to take and they have now agreed to take in their strategic plan for overseeing contractors. One had to do with the fact that HCFA was not routinely validating the workload financial and management data that was being submitted to the regions in the process of overseeing the contractors.

You don't necessarily always want to rely on contractor-provided information; you want to go and verify that. Also, there's a requirement for contractors to certify that their internal controls are in place and are effective. And it's very important that HCFA reviewers go out and look behind those certifications to assure that in fact the company is conducting itself with integrity. Those are the kinds of things that HCFA was not able to do on a routine basis across the country.

It's those kind of actions that you would always want, no matter who is your contractor or processing your claims, you always want to have that arm's length oversight, and that oversight needs to be very vigilant, especially in the type of program that is so vulnerable to so many areas.

Mr. KLINK. Thank you very much for your work on this report and for your efforts. We look forward to working with you further on in this. Thank you, Mr. Chairman, I yield back.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

This is always a very popular subject in town meetings. And I know it's not the end-all to our health care problem, but it certainly is a big chunk of our money going out the door. In reading the materials, I find that in fiscal year 1998 there was $220 billion in outlays. Is that right, $220 billion in outlays? Does that mean money that was paid out to—supposedly paid out to providers?

Mr. GROB. Yes.

Mr. BRYANT. In other words, that was not administrative costs and salaries to HCFA?

Mr. GROB. That's right, billion.

Mr. BRYANT. $220 billion. And of that, as I understand the system, you've got Medicare and HCFA, and then you've got a layer of contractors——

Mr. GROB. Yes.

Mr. BRYANT. [continuing] that are in between HCFA and the providers?

Mr. GROB. Yes.

Mr. BRYANT. Now, there are two sources of fraud and waste; one is at the second layer, the contractors?

Mr. GROB. Yes.

Mr. BRYANT. And the other one is the provider level?

Mr. GROB. Yes.

Mr. BRYANT. Of the $220 billion how much of that do you estimate would be this fraud and waste?

Ms. ARONOVITZ. We can say that $220 billion was paid out in benefits on behalf of beneficiaries to providers and $1.6 billion was paid to the contractors in fiscal year 1998 to conduct their claims administration activities and their program integrity activities. I don't know if that helps in terms of the way that the money breaks down.

Mr. BRYANT. $221.6 billion total to those two groups? How much of that would be fraud, waste?

Mr. GROB. Let me try to answer. We really don't know how much is fraud, and we do know this and Mrs. Thompson already alluded to that, in 1998, we incorrectly paid about $12 billion of the $220 billion to providers, payments that should not have been made, most of them because the services weren't medically necessary or the people weren't eligible for it. In some cases because the documentation wasn't there.

This was a major improvement compared to a couple of years before that, and it truly is a matter of some celebration with the reservations that Ms. Thompson made that we still have to whittle this down. The reason we don't know how much of it is fraud, because by definition, fraud has not occurred until someone has been found guilty. So we really don't know if we have an investigation whether it's a mistake or whether it's just sloppiness, or whether it's an intention to see what you can get by with, whether it's something that is—you might want to classify as abuse instead of fraud—that is best recovered through a simple recovery of an over-

payment, we really don't know, and we don't want to say that it is all fraud.

There's probably also some fraud that's not detected in that audit. If someone is really good at it, we won't find it.

Mr. BRYANT. Let me ask again, I am just trying to get a handle on this. You're saying at the intermediary level $1.6 billion was paid to those folks, and from that $1.6 billion that's where they take their fraud and waste from?

Mr. GROB. No. I see what you're saying now. The total improper payments in the program would be the $12 billion. Now the problem we're finding here among the intermediaries, we found the settlements totaling $260 million out of the roughly billion and a half that they have for administering the program.

Mr. BRYANT. From the $1.6 billion that is paid to the intermediaries, that's the pool from which they steal?

Mr. GROB. Yes.

Mr. BRYANT. Okay. And you can call them to the tune of $260 million?

Mr. GROB. Yes. Over a number of years.

Mr. BRYANT. They can't steal from the $220 billion, can they?

Mr. GROB. One distinction if I can make for you, most of the money was defrauding how much we were supposed to pay them for doing their job, it's not as if they diverted money from the Medicare program to their own coffers. The only exception to that has to do with Medicare secondary payer provisions, that is whether or not they knowingly have Medicare pay for something that they themselves should have paid for because they were the primary payer of the beneficiary. But in general the point you're making is accurate.

What we're talking about here is fraudulently receiving money from us for not administering the program, not doing the job that we were paying them to do.

Mr. BRYANT. Now it seems to me that the intermediary problem would be easy to fix, and I may have overstated when I said steal, I know there's some of the things you alluded to, negligence and good faith and just simply mistakes, but I think there's more of that probably in the third tier, the provider area, where you've got $220 billion that's going out, I know that's caught through U.S. Attorneys and so forth. But how much can we improve this system in the provider area with the doctors and the hospitals and giving them better resources and better education and better training to avoid these mistakes, lack of bad faith, negligent situations where there's not an intentional fraud or abuse involved? Is it that we're not doing a good enough job in educating the provider level, doctors and hospitals?

And my time is up, so if one of you can answer briefly.

Ms. THOMPSON. I would be happy to answer that because I think we're not doing enough in terms of provider education. It's one of the reasons why we are instituting a new program that the Administrator has just accepted as a national program that was developed by one of our contractors in Florida. As part of this program, we will go out to physician groups and hospitals and so forth and do very intensive educational activities, use satellite technology, use computer-based training, so that people have access to informa-

tion about what they should be doing and how they should be doing it.

Of the set of the initial task orders that we're giving to our new Medicare Integrity Program contractors, I mentioned earlier that the Benefit Integrity Support Center in New England will try to gather all of the parties together and get all the skill sets in one place to really look at data and look and partnership and decide what to pursue.

Another one of the task orders is to develop a national integrity program provider education effort. I think a large portion of the reduction that we saw in the error rate in the last 2 years has been because providers have been paying better attention and we've been providing them information and they've been responding to that when they submit claims in the first place.

Mr. BRYANT. Thank you.

Mr. UPTON. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. Thank you for your kind mention, and I want to thank and commend the entire panel for your good work here.

I note that there have been a number of cutbacks at regional offices in the GAO, New York, Cincinnati, Philadelphia, Detroit. The number of people in these offices of special investigations continues to approximate about 38.

What is the practical effect on your efforts to address Medicare fraud, waste and abuse find in the closure of these three facilities? I note that you complained about the Michigan Blue Cross handling. I note New York is one of the major cities in the United States with an awful lot of government offices. I note the same is true about Philadelphia and Cincinnati.

What does the effect of those closures have on your efforts of addressing your problem of waste, fraud and abuse?

Ms. ARONOVITZ. I think we try very hard to use whatever resources Congress gives us as best as we can.

Mr. DINGELL. Closing those offices was not helpful, was it?

Ms. ARONOVITZ. Closing offices are never helpful to any type of resource.

Mr. DINGELL. What was the impact on your efforts to address waste, fraud and abuse?

Ms. ARONOVITZ. I think we have had to learn to work much smarter and to be much more efficient in terms of the way we use our audit resources.

Mr. DINGELL. But your efforts to address waste, fraud and abuse is done by communicating between your office and the folks in the regional offices and saying go out and audit these people, isn't that what you do?

Ms. ARONOVITZ. Right.

Mr. DINGELL. You aren't able to do that now with the closure of these offices in New York, Philadelphia , Detroit and Cincinnati, isn't that right?

Ms. ARONOVITZ. I actually hold two titles. I'm actually regional manager of our Chicago office, where we now are responsible for the work that is being done in Michigan.

Mr. DINGELL. Do you investigate waste, fraud and abuse in Detroit or in Cincinnati? You've got to send people there.

Ms. ARONOVITZ. We do travel extensively.

Mr. DINGELL. That means you have higher costs and time loss, doesn't it, and much less efficiency in the use of your personnel, isn't that right?

Ms. ARONOVITZ. We devote a lot of resources to travel. It's hard to say. I think we're working a lot smarter also but certainly it is a challenge for us.

Mr. DINGELL. But you're not able to function as well because you've closed these offices; isn't that true? Just talk to me. You're a friend. I'm not after you.

Ms. ARONOVITZ. To be very honest, I would like to give you a very honest answer. I think we have learned through this experience to try to figure out how to be more efficient.

Mr. DINGELL. I will accept that answer. I've got to say after 40 years of this I'm really kind of tired of it. And what I really want to hear, can you honestly tell me that you can't do your job as well because of the closures of these offices?

Ms. ARONOVITZ. With all due respect, I don't believe that that is necessarily true.

Mr. DINGELL. You don't think so? That's remarkable. Let's talk here about some other things. You tell us that they arbitrarily turned off computer audits that would have subjected questionable claims to more intensive review. This had a bad effect on the Medicare trust fund, did it not?

Ms. ARONOVITZ. Yes.

Mr. DINGELL. Okay. I'm going to ask you to submit what it did exactly for the record.

Ms. ARONOVITZ. Sure.

Mr. DINGELL. The next one, is that you said they falsified documentation and reports to HCFA regarding the contractor's performance. This had a bad impact upon the taxpayer budget, did it not?

Ms. ARONOVITZ. Yes.

Mr. DINGELL. I'm going to ask you to submit for the record precisely what that meant.

You said they destroyed or deleted backlog claims. Again this had a bad impact on both the taxpayer and the trust fund, did it not?

Ms. ARONOVITZ. Yes.

Mr. DINGELL. I'm going to ask you to submit for the record exactly what that did.

You say then that they improperly screened, processed and paid claims resulting in additional costs to Medicare program. Again, this had a bad impact upon the taxpayers, did it not?

Ms. ARONOVITZ. Yes.

Mr. DINGELL. I'm going to ask you to submit precisely what that did.

You said they failed to recoup within the prescribed time money owed by providers and failed to collect required interest payments. Again this had a bad impact on the taxpayer and the trust fund did it not?

Mr. HAST. It did.

Mr. DINGELL. I'm going to ask you to submit that for the record exactly what it did.

And you said some Medicare contractors altered or hidden files that involved claims that had been incorrectly processed or paid and, altered contractor audits of Medicare providers before HCFA reviews. Again this had a bad impact on the taxpayer, did it not?

Ms. ARONOVITZ. It did.

Mr. DINGELL. I'm going to ask you to submit exactly what that did.

Do any of the other witnesses or do you, Ms. Aronovitz, or you, Mr. Hast, desire to give us any comment about any other activities that might have adversely impacted the Medicare program and the business that we're discussing today?

Mr. HAST. I think that the litany that Leslie has gone through pretty much covers the things that we found. I think that one of the things that we found is that because of HCFA not being able to detect this, these types of activities could have taken place in any contractor. I mean we looked at several and these same type of——

Mr. DINGELL. But you got 25 percent of them that hadn't been looked at, isn't that right, or you only looked at 25 percent?

Mr. HAST. I think there are 25 percent that are under investigation.

Mr. DINGELL. How many haven't you looked at at all?

Mr. HAST. I would say that I would have to ask the Inspector General's office. But we have only looked at the ones that are actually in our report.

Mr. DINGELL. Okay. You have a lot of them that haven't been looked at. Is there any reason to assume these are a group of choir buys or angels who are preparing to sing in the heavenly choir about goodness of man?

Mr. HAST. I think they could have asked—any contractor could have done exactly what the ones we looked at did, if they were so inclined. We have no reason to think they did.

Mr. DINGELL. Why have these other folks not been audited?

Mr. GROB. I can address that if you wish. We do conduct the audit every year now, the so-called CFO audit, and part of that does include a representative sampling of the claims and the processing of them, and in the course of doing that, we picked randomly 12 contractors whose accounting systems and control systems we did review. And the financial management problems that I referred to, we did find those serious problems in all 12 of those that were randomly selected. So that would indicate that that those kinds of problems would be persuasive across the board because it was a random sample.

Mr. DINGELL. When are you going to get around to auditing so we can catch some other rascals?

Ms. KANOF. I think that is part of the HCFA program that began in 1999 and will continue in the future. Some of these referrals that the OIG has investigated, at least most recently, have been made by HCFA while they were doing a contract performance evaluation, and I think that's a significant forward step.

And I believe that as we provide rigorous oversight of our contractors and follow the recommendations of the GAO and the IG, that we will be doing more internal controls and more audits and,

as appropriate be making referrals to the OIG for additional investigations.

Mr. DINGELL. Mr. Chairman, I note my time is expired. I thank you for your courtesy.

Mr. BURR [presiding]. The gentleman's time has expired. The chair would recognize himself for 5 minutes.

Let me also take the opportunity to thank all of you and to commend you for your work as well as to commend HCFA, even though I think we agree that there's still work to do.

Let me just ask all of our panelists, is there anyone that would disagree that waste, fraud and abuse still exists today?

Everybody acknowledges it does.

In your professional opinion, has it always existed?

Everybody acknowledges it has.

Is there any solution that assures us that it won't exist in the future?

Ms. ARONOVITZ. I think you can never be sure and in fact there will always be some level of problems. It's really important to note that HCFA would not be expected to identify fraud in a company if there was an extraordinary effort to indulge in collusion or some activity where it would be impossible for an oversight organization to identify this. What we hope is that HCFA will try to do the things that are necessary to minimize the possibility of fraud being able to exist.

Mr. BURR. A solution would minimize the opportunity for it?

Ms. ARONOVITZ. Yes. That's really what we're talking about.

Mr. BURR. I think we would all agree. Mr. Grob, you talked earlier about some specific areas or deficiencies that you found. Dual entry accounting, I can't remember the litany of things. Let me ask you how difficult those were to identify.

Mr. GROB. Those were not difficult to identify at all, because it's a standard kind of review that's done.

Mr. BURR. In your assessment, do you believe that they adopted a single entry accounting system after they became a contractor?

Mr. GROB. It's really a mystery why those kinds of problems should be occurring.

Mr. BURR. I guess what I'm getting at, and to some degree this is a black eye to HCFA, if that existed when they applied to become a contractor, should they ever have been accepted with a single entry accounting system and the litany of other things that you identified?

Mr. GROB. I don't think that they should be contractors if they have those kinds of serious accounting problems. Those problems are also easily corrected and they should be corrected. You're asking a broader question, and if you would permit me to answer it in a broader way, I would like to, which is the way we got into the situation. In my opinion, is a cultural one that someone alluded to earlier and was something that everyone was kind of responsible for.

What happened here is that when the Medicare program was started, the real concern was to make sure that people could enroll in it and could get their benefits, and it was very logical at the time to look at the large insurance companies to be able to handle the funds that were going there, and I think people generally had

a lot of respect for the way that those insurance companies operated.

So the law has been set up in such a way that essentially requires that those kinds of companies be chosen for this. So it's been built into the law, kind of a conflict of interest, in a way, kind of a limitation of choice as to who can do this job, a limitation on how and what they should get paid for, a limitation on the kind of flexibility that HCFA ought to have in being able to manage this.

So there are built into this some very fundamental structures that make it a bit more difficult to correct easily. Now, that's not to say that legislative changes alone, you know, would solve it at all.

Mr. BURR. Let me ask you, given the elementary deficiencies that you found, I think we would all agree——

Mr. GROB. Yes.

Mr. BURR. [continuing] how much should that play a part of Congress' decision that at the request of HCFA to expand the pool of intermediaries?

Mr. GROB. I think that HCFA should definitely have the authority to expand the pool to be able to choose from others and to have much greater flexibility in deciding who to pick and to have much greater flexibility in the nature of the instrument that is used to pay them, the contractual instrument. I think choice, pool, flexibility, and perhaps even more importantly, how they organize the work. They can perhaps even separate the functions in different ways and organize it in different ways.

Mr. BURR. Ms. Aronovitz, let me turn to a book hopefully you're familiar with, High Risk Series, January edition, High Risk Program Management Areas, Reducing Inordinate Program Management Risk. I want to read you one part of it under the Medicare section. With an annual payment totaling $200 billion responsibility for financing health services delivered by hundreds of thousands of providers on behalf of tens of millions of beneficiaries, Medicare is inherently vulnerable to waste, fraud and abuse. For example, Department of HHS and the Health Care Financing Administration had not developed its own process for estimating the national error rate for fee for service payments for fiscal year 1997. The HHS inspector estimated that 11 percent of all Medicare fees for service payments for claims are about $20 billion, did not comply with Medicare laws and regulations, did not comply with laws and Medicare laws and regulations. Is that waste, fraud and abuse?

Ms. ARONOVITZ. Not necessarily fraud. What that means they were claims that should not have been paid. Now some of those claims on their face look perfectly acceptable and it was only after the auditors went behind the claims to look at the medical records and look at the local medical policy or the rules governing claims payment was it noted that they should not have been paid.

So some of that could in fact be fraud, if in fact it's proved; that also involves waste and just improper payments.

Mr. BURR. Let me go one paragraph further, while the Congress has given HHS new resources and authorities to improve oversight of Medicare, HCFA's deployment of these tools has lagged specifically. I will just mention one. HCFA has been slow to distribute

funding and implementation, implement new authority to help prevent fraud, abuse and mispayments in the Medicare program. HCFA has not yet implemented a specific specialty contract for claim reviews or other program safeguards, activities due to design issues. Furthermore, when implemented, the contract will likely have a more limited scope and provide fewer benefits than originally envisioned.

And the only reason that I mention that is to say in your January report, you basically said that the plan they've got in place, one, the resources we supplied have not been used as efficiently and effectively, they have dragged their feet and the plan that they have will not reach as far and will not be as beneficial as what they claim or what they sought.

Is that an accurate statement?

Ms. ARONOVITZ. Yes, we're referring to a specific set of authorities, and I would like to explain that if I could. At the time that HIPAA passed and developed a Medicare Integrity Program which created assured funding for Medicare and the contractors, it also authorized HCFA to engage in more of a demonstration or on a small scale the use of payment safeguard contractors, they would do one function, not process and pay claims, but just look at program safeguard activities.

The law did not require HCFA to do that right away, it authorized them to do that. In the process of doing that particular contract, HCFA was also responding to many, many requirements and program design in response to the Balanced Budget Act. So it was a very, very busy time for HCFA, but in fact, the program safeguard contractor initiative was slow to start and was on a much smaller scale.

It is now underway. They are being very careful and deliberate about how they're initiating that. The big problem we have right now with that particular effort is that it's not the right time to actually substitute a current program, claims administration contractor for one of these program safeguard contractors. Right now they're just supplementing what the contractors are currently doing.

Where we are really going to learn whether HCFA is able to do functional contracting is at the point where they're actually substituting their current contractors for the specialized contractors, and that's not going to happen at least until next year, after Y2K is complete.

I think HCFA legitimately is very concerned that if they do anything to distract the contractors right now that contractors could either leave the program or in fact not be ready for Y2K. So we are on—not exactly on hold, but we are slowing down in terms of some of the benefits that I think ultimately we will be able to show.

Mr. BURR. My time is expired. But I will allow you an opportunity to respond.

Ms. THOMPSON. Thanks. I have to actually disagree somewhat in terms of saying that we're moving more slowly than we would like. I think that we're doing the right thing in the right way. We have 12 contractors, many of whom we have not done business with or who have not done this work for us before, and I think that before we move a bunch of work from current contractors who have large-

ly been doing this work for many years and throw it over to a whole new group of people, I would like the new contractors to demonstrate that they can perform this work before we restructure the entire program to give it to them. I would like to see how they do, in very precise ways, demonstrating their capabilities and their performance.

Obviously Y2K has been an issue for us, and we have been very reluctant to do anything to disrupt our current contractors. But I think even under the best of circumstances, that the way we did it would have been the right way to proceed with that authority.

Ms. ARONOVITZ. I agree right now that is the way to proceed. What I'm concerned about more is that HIPAA was passed in 1996, and it is 1999, so it has taken you 3 years to get to this point and that is what we were a little bit concerned about in terms of getting underway.

Ms. THOMPSON. I think that's a fair point. There was a lot of work to be done in terms of developing a whole scope of work for an activity that we had never developed a scope of work for, and to develop our regulation. For example, how we would deal with conflicts of interests for entities that were coming in to bid for this work and so forth. So there was quite a bit a work, and obviously, as the GAO points out, at a time when we also had a substantial list of other activities to implement as part of the Balanced Budget Act.

Mr. BURR. The Chair is awfully tempted to ask about Y2K, but my time is expired.

I would recognize the gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Well, thank you, Mr. Chairman. I would like to pick up with Ms. Thompson on the comments made there, and I'm not looking to blame the victim and government taxpayers gets ripped off and the government sort of gets the blame. But in the HCFA—I mean excuse me, in the GAO report, they said that the closed relationship with HCFA representatives and the contractors had led to some of these abuses. It says—in fact I think it was the Michigan case where it's especially true the HCFA representatives has a long or exclusive relationship with the contractor, one interviewee noted that if the contractor looks bad, the HCFA representative who performs monitoring also looks bad.

Then it goes down here Blue Cross-Blue Shield, when you talk about experience, you need experience on these contractors, reassigned their most experienced employees to conduct claim reviews when they knew HCFA would be in there, slow down the process so these people would just do a couple and show 100 percent accuracy. It's too cozy of a relationship is what GAO is saying.

Ms. KANOF. We absolutely agree and, in fact, under one of our initiatives that also complements the GAO recommendations, we are looking at the relationship between the central office and regional office and believe these are national contractors. That's why this year the teams are not just having a regional office representative and in many cases it's not the regional office representative who is providing daily oversight to the contractor, but teams from several regions and the central office.

Mr. STUPAK. But what if we look at this whole thing. If you read the GAO report and you go all the way through this, you have out-

right fraud and deception going on here, and in these cases, I have to ask the question, is there really anything that HCFA can do that could implement that would prevent such activities from occurring? I mean isn't relying on the contractors also a trust program, and that is, if we trust private fiscal intermediaries to do their job correctly, then they have to do their job with integrity and honesty. No matter what you implement isn't going to work if you don't have honest and integrity amongst the contracts, right?

Ms. KANOF. That's correct, but you can create the playing field differently and we were giving the contractors significantly advanced notice before we came in.

Mr. STUPAK. Are you telling me there is a field that you can develop that will promote trust and integrity and honesty?

Ms. KANOF. I believe if we focus more on the contractors' internal controls and develop compliance plans that can be implemented then we would be able to do audits, interview the staff, and we will promote integrity—we cannot give you 100 percent assurance. And I don't think anyone here can. But there are many things we can do to shift the pendulum.

Mr. STUPAK. Ms. Aronovitz, do you want to respond?

Ms. ARONOVITZ. I think some of the things that Dr. Kanof is talking about, HCFA would at least be able to identify problems way sooner than they do right now. Right now, sometime it's really left to either qui tam suits or whistleblowers to identify what's going on internally. We think HCFA needs to do a lot more things where they are much more aggressively overseeing and understanding what's going on with the contractor.

Mr. STUPAK. Let me ask this question, and I guess it's what I'm driving at here. The entire system of relying on private companies to run the Medicare program is starting to remind me of the 7 years I've been here. Like the Department of Energy, the government originally contracts out work because Congress doesn't believe that the government can do it efficiently. But often it's more trouble than what it's worth, as many of my colleagues on this committee have seen, we've had huge problems with the Department of Energy contracts such as Lockheed, Pit Number 9, a contract in Idaho which involved hundreds of millions of dollars of cost overrun. We see the University of California contract with the DOE labs which have resulted in serious security breaches.

At what point does micromanaging a private sector contractor being so burdensome for the government that's easier to keep the entire job in-house as opposed to contract out, especially when you have to rely on things like honesty and integrity and trust which obviously we haven't been getting? Where do we reach that point?

Ms. ARONOVITZ. With all due respect to HCFA, I don't really think they were micromanaging the contractors. As a matter of fact, I think they were exercising more hands off than they probably should have. I think there's some core things that you would have to do whenever you have a relationship with a contractor, your overseer must provide an ongoing risk assessment of where you think there are problems in that organization.

In addition, you need to have core areas of review that, no matter what you're going to look at those and make sure those are re-

viewed. You need to validate the data that you're receiving and assure that internal controls are in place.

The other thing that HCFA needs to do is to spend a lot more time worried about looking at the way contractors are conducting their program safeguard activities, not just their claims administration or claims processing activities. It will not in any way change the climate in an organization, you're absolutely right.

If you have a contractor or a fiscal intermediary that wants to cheat or somehow has an incentive to do less than what they're being contracted to do, it's a very, very difficult thing. But there are aggressive actions that HCFA could and needs to take that would at least ameliorate some of these problems.

Mr. STUPAK. Mr. Chairman, if I may just follow up. But at what point, when do you say, look it, I mean every time I come to one of these hearings, it's always hundreds of millions of dollars wasted, fraud, blown off, can't find it, can't do this, we have serious security breaches with the nuclear weapon system? At what point do you stop contracting out and say wait a minute, any government isn't as inefficient as we look to portray it, and there's got to be a point in time when we've got to start looking at this differently and contracting out isn't always the answer.

Ms. ARONOVITZ. I agree with you, there are 22,000 people working at the contractors around the country both on the carrier side and on the fiscal intermediary side. If you wanted to ask 22,000 additional people to work for HCFA, that in itself is another consideration. It's a whole different discussion, and there are other challenges to try to manage that many people.

So, you know, I really don't have the answer. Although you wouldn't necessarily solve your problems by trying to bring it all in-house.

Mr. STUPAK. Thank you. Thank you, Mr. Chairman.

Mr. UPTON [presiding]. Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. John Dingell was chairman of this subcommittee I think for about 12 years, and he was also chairman of the full committee, and I became chairman for 4 years and now we have Congressman Upton. I remember the first hearing I did on Medicare waste, fraud and abuse. The people didn't even know how big the problem was, that they estimated it was around $20 billion a year.

And so the committee on a bipartisan basis insisted that some things be done and Nancy Anne DeParle promised that things would be done, and apparently a little has been done. We now have an estimate of about $12 billion, which is about 5 percent of the $220 billion.

But you read Mr. Grob's testimony, it says of all of the problems we have observed, perhaps the most troubling has to do with the contractor's own integrity, misusing government funds and actively trying to conceal their actions, offering documents and falsifying statements as specific work was performed.

And you go on to say there's 64 contractors, there have been 9 civil settlements, 2 criminal convictions and there are 21 former current contractors actively under investigation. Well, if you add 21 to 11, that's 33, that's half of the contractors. And then you go over later on in here, and it talks about these fraud units that have

been put in place to try—by the contractors, and according to Mr. Grob, it says that the caseloads among the fraud units varies considerably from zero to over 600.

We found that less than one-half are actively engaged in developing their own cases, and similarly less than one-half of the fraud units were active in identifying program vulnerabilities. You know, I'm just kind of at a loss. I have a little hospital in my own hometown, we have 15,000 people, it is a 32-bed hospital, there are about 8 people a day in the beds. The company that owns it told me 2 weeks ago they're going to close it in December because they lost $2 million.

We've got $12 billion in fraud. We've got the Balanced Budget Act of 1997. And according to the hospitals in Texas, that act, because of the way HCFA is implemented, it is ostensibly going to save $31 billion more over the next 5 years than it was intended to, which is about $6 billion a year, which is half of fraud. If we can cut the fraud down, we would have more money to keep my hospital open.

Now, which of you two from HCFA is the top dog? Is it Dr. Kanof or Ms. Thompson?

Ms. KANOF. We're a matrix management. I am responsible for the complete oversight of contractor management. If you wish to talk to the lead for the specific program integrity units within our contractors, that would be Ms. Thompson.

Mr. BARTON. Dr. Kanof, how can you put in place a system with the contractors for fraud and have half the fraud units not even actively engaged in developing cases? How can you look yourself in the mirror in the morning knowing that this program that was put in place at the insistence of the Congress, half the contractor units out there that are supposed to be checking for fraud aren't doing it?

Ms. KANOF. In fact, we do find that quite disturbing, and have set up new protocols to begin to evaluate the contractors more stringently and more consistently to evaluate what they're doing.

In addition, Ms. Thompson has given them new instructions that specifically direct their activities to begin to address your concerns.

Ms. THOMPSON. But I do want to point out that referrals to law enforcement are part of what we expect these units to do. That is not all of what we expect them to do. In fact, about half of the money that we give them they expend, with our support, in resolving beneficiary complaints of fraud.

That is when the Medicare beneficiaries call up and say, "I think somebody has done something really wrong here," and we want to have it investigated, and we want to be responsive to that beneficiary.

We also ask them to provide support to law enforcement so that as law enforcement begins a case or is undertaking a case both in terms of any agent from the Office of Inspector General or any agent from the Federal Bureau of Investigation or an assistant U.S. Attorney, oftentimes they need the contractor's support in looking at data with regard to a provider and so forth. So that is an important element of their responsibility as well.

Mr. BARTON. My time has just expired. Is there a sense of urgency, do you all understand——

Ms. THOMPSON. Yes.

Mr. BARTON. Congressman Bryant alluded to this earlier. When we do a town meeting every one of us, every Congressman, there is going to be somebody in that town meeting that stands up with a Medicare problem, a bill they don't understand, a horror story that they didn't get the treatment that they thought they were going to get, a doctor who is going to drop out of Medicare, a hospital that is going to close. Do you all go into the real world? Do you see the impact of sitting on your tail and really not taking this seriously how it affects the real world? This is not an academic exercise, it is a real problem.

Ms. THOMPSON. It is not taken as an academic exercise. You know our Administrator. She is committed to this effort.

Mr. BARTON. I think she is a fine woman. I think she personally wants to do the right thing.

Ms. THOMPSON. There is nobody here sitting on their tails not caring about this issue. There are people actively working in concert with provider groups, with law enforcement, with our contractors initiating a lot of activities to improve these outcomes. We recognize the amount of dollars that are at stake. We recognize the impact that it has on beneficiaries. We recognize the impact that it has on the Trust Fund. And we work at this very diligently every day.

Mr. BARTON. Well, I don't know what Chairman Upton intends to do, but I stayed on this subcommittee this year specifically to work on this kind of issue, because it's real dollars, it's big dollars, it impacts real people in the real world, and I expect you, Ms. Thompson, and you, Dr. Kanof, to take these recommendations seriously and not just shuffle the papers.

I mean if you're the two people in charge of this at HCFA, you've got billions of dollars that you ought to be out there trying to save so that the people that need the Medicare reimbursement, the hospitals, the doctors and the patients, they get it.

Ms. THOMPSON. We couldn't agree more.

Mr. BARTON. Okay.

Mr. UPTON. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. Well, you know, I'm sitting here listening to my friend and colleague from Texas, and I can't disagree. But it seems to me that part of the reason Congress privatized in this area was to eliminate some of these problems of fraud and abuse and everything we were identifying, and we were blaming HCFA for those problems.

Now we're blaming HCFA because the private companies are engaged in this process of fraud and abuse. It seems to me that the goal should be not to blame HCFA, but to figure out if this is really working, is this something we should do. I think we should look—if in fact we want to privatize, well, that's great, but then let's put the blame where it's due, and let's also make sure that HCFA has the tools so that it really can stop this from happening.

Let me ask a question related to that. Ms. Aronovitz said that there were some changes in the law that she thought would help HCFA to do a better job with these private contractors. One of them is giving HCFA broader discretion on contractors to choose, one of them is giving more detailed oversight.

I'm wondering, Ms. Thompson, what you think about those recommendations and if there are any other changes to the law that we could positively look at so that we can help HCFA better do its job in overseeing these private industries?

Ms. THOMPSON. Well, I will let Dr. Kanof answer part of this question, but certainly the administration has proposed contracting reform. That's something we've asked for consistently over the years, so that we do have alternatives, so that we can structure our contractor community in a different way, and perhaps Dr. Kanof would like to talk more about that.

Ms. KANOF. And really key to contracting reform is really the flexibility to be able to have contracts with other entities that we have currently. We are constrained by statute to our current pool of contractors, and we really believe that it is necessary to enter into a more competitive and broader market in which we can reach out beyond just insurers to do some of this processing.

In addition, if we had FAR authority, we would just gain additional ability to do different types of contracting than we currently have now. So those are really the two key issues that we believe would allow us to do what you've been talking about.

Ms. DEGETTE. Let me ask Mr. Grob and Ms. Aronovitz a question. You're talking about what these private businesses are doing with the Federal dollars, and I'm wondering if either of your agencies has ever looked at how these private firms run the private side of their businesses, and if you see some of these excesses in the private side of their businesses as well?

Mr. GROB. I'm not aware of studies we've done about that in particular, because we tend to audit within our authority that reaches for the Federal dollar. I can clarify though my earlier remarks about when the system was originally set up, that the requirements for these accounting systems and these control systems which we all regard as fairly elementary were not made an explicit part of the requirements when we contracted with these organizations.

I think we all assumed that, of course, they would conduct their business that way. Now, in recent years there's been a refinement of those requirements and the clarification of them, and I think that will lead to some of these improvements where we get beyond the troubles that we're in.

Ms. DEGETTE. Ms. Aronovitz.

Ms. ARONOVITZ. I would agree. We consistently and primarily focused on where the Federal dollars are and have not spent too much time looking at the private side of some of these businesses, except to the extent where the private side and the public side in fact have a relationship, and that would be in the Medicare secondary payer program and other initiatives where it's very important to look at the whole company.

Ms. DEGETTE. It just seems to me that especially if you're looking at intent, for example, being a defense lawyer myself, that it would be instructive for us who write these HCFA rules to know if these companies handling public money in a different and less responsible way than they're handling private money.

And I would certainly be one that would be in favor of looking at that. I don't know if it's possible or not.

Mr. GROB. I would comment on that, because I think we are seeing some signs of progress, some of which as a result of taking that viewpoint. First I would go back to what I said before, that really this is not their money and their financial stake isn't there, and it won't be. So what you've got to do is recognize that when there is a government program, different methods come into play. However one thing that was used in the private sector for many years was the financial statement, and there never was a requirement for those combined financial statements of the Medicare program in the past.

But in recent years, that requirement was put into place. It was true in the audit of financial statements that we were all finally able to get a handle on exactly how big the problem was, what institutions, and what parts of the program were problematic. It was that ability to see, through using those private sector type systems, that enables us, I think, to form the framework for the reduction in waste and fraud that occurred in the last few years, which has been significant.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Strickland.

Mr. STRICKLAND. Yes, sir. Thank you, Mr. Chairman. I would like to concur with my colleague, Ms. DeGette. I think that to blame HCFA for these problems that we've heard today is sort of like blaming the cop on the beat for the criminal who breaks into the convenience store. The fact is that the real culprits here are the dishonest people who set out to defraud the taxpayer.

Let me ask you, does the accusation or the charge or finding of fraud indicate purposeful intent?

Mr. HAST. Yes.

Mr. STRICKLAND. And is it true that HCFA has identified contractors who have engaged in purposeful fraud?

Mr. HAST. In some cases, but not all.

Mr. STRICKLAND. When that has happened, has HCFA terminated its relationship with that contractor?

Ms. ARONOVITZ. Most of the time.

Mr. STRICKLAND. Most of the time. Is it possible that we could have a contract with a contractor that it purposefully defrauded the government and we would continue a relationship with that contractor?

Ms. ARONOVITZ. When I say most of the time, it's all the time except for one specific case where the—there was not evidence of a corporate culture, there was evidence that there was some rogue employees and when that was brought to management's attention, they immediately reported it to HCFA and cooperated in the investigation.

Mr. STRICKLAND. Is this a real company?

Mr. GROB. Yes.

Mr. STRICKLAND. The vice president for Medicare operations apparently is in blue or she's in blue. Is it likely that that person would ever go to jail? Is that possible?

Mr. HAST. It's absolutely possible, but not very likely.

Mr. STRICKLAND. Why not likely?

Mr. HAST. Just in general, blue collar crime—or white collar crime——

Mr. STRICKLAND. Absolutely. I worked in a maximum security prison with poor people who were serving years in prison for breaking into a store to steal food. And I think if we had some of these folks facing jail time, if we treated them like they really are, criminals, criminals, we may have a different set of circumstances. But if we negotiate or plea bargain or cut deals or whatever and they are able to achieve hundreds of millions of dollars in fraudulent resources and settle for, you know, something that enables them to maintain their reputations and their status in life and their lifestyles, I mean there is such unfairness in this system.

And I would like to see those people in jail, and I think if they were in jail and if we took that kind of hard-nosed approach to this, Mr. Chairman, I am just sick and tired of the kind of injustice that we find throughout our system where blue collar, poor people who commit crimes, and I think they ought to be jail when they commit crimes, are treated differently than white collar executives that commit crimes and get off with their reputations or their lifestyles intact, and until we get serious about enforcing these kinds of laws I think this kind of abuse will continue.

I will tell you I believe that a corporate executive who thinks that they personally may be held responsible and may have to pay that kind of penalty would be much less likely to engage in purposeful fraud. I'm not talking about mistakes, but purposeful fraud, that's a serious thing. We're talking about billions of tax dollars.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you. I know a number of members have additional questions, so we're going to yield 5 minutes to members again for a second round for those of us who need it. I will take the first 5 minutes and yield 1½ minutes for someone who is running to a lunch, Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. I agree with Mr. Strickland, and certainly I think it's incumbent particularly on the Department of Justice at the Federal level to enforce the laws that are on the books that can catch these people. When I was a U.S. Attorney we had a health care task force and drastically pursued these types of cases.

Just quickly to follow-up on a comment Ms. Thompson made about asking for new contracting authority. I wanted to ask our GAO people about this, because every dollar, every delay that we have, every dollar that we lose is coming out of the Medicare trust fund. And, again, I'm with Mr. Barton on this, this is a real world situation.

I know that in the Balanced Budget Act of 1997, we gave a new limited authority to HCFA to let them contract for program integrity efforts, and I understand it's only recently been that HCFA has actually issued an RFP, request for proposal, for those so-called program safeguard contractors from GAO. I want to ask about HCFA's delay in implementing this new initiative and what concerns GAO would have about HCFA being given this sweeping new contract authority.

Ms. ARONOVITZ. I think Ms. Thompson said it very well. A lot of the things that have to go into contracting, according to FAR, where you have a statement of work and you have to describe the specific tasks that you want a contractor to do and you have to

have a cost estimate of what those would cost, that is not the expertise that HCFA has, traditionally, because the way they've contracted up to this point has not required that they have those types of—engage in those types of activities. So it has taken quite a while for HCFA to gain the experience, and we think they're just beginning to do that.

And we think that the program safeguard contractor is a very good lesson for HCFA to start learning how to develop the statements of work and how to do this on a much wider scale. So although we were very frustrated with HCFA, we could certainly understand some of the tasks it needed to learn before it could go full fledged into a different way of contracting.

Now, we again endorse HCFA having these new contracting authorities, however, we're very, very aware that in the past, when HCFA had some of these authorities on a very limited basis, that the experiments that they indulged in did not always work out. For instance, there were some incentive contracts that HCFA let where the incentives created perverse incentives for contractors and, therefore, the Medicare program instead of finding ways for contractors to do more efficient processing, in fact, lost more money for the trust fund.

So we think that HCFA should have these authorities, but they need to take a lot of time and a lot of care and they need to report to you on the evaluations they do in terms of their experience, developing the expertise to use these authorities correctly.

Mr. BRYANT. Thank you. Thank you, Mr. Chairman.

Mr. UPTON. Thank you. I have two questions. And I guess I would like both Ms. Thompson, Mr. Grob to respond.

First of all, are these penalties enough that you shared with us on your chart? Let me tell my two questions first and then comment on both. Are these penalties enough? I remember when we dealt with the Medicare reform bill in this committee a couple of years ago, and I had an amendment that passed that was later dropped in the conference, and it said that any individual, this sort of goes back to Mr. Strickland's comments, any individual that's convicted of fraud and abuse with Medicare would lose their own personal right to participate as a beneficiary in the Medicare program for life. Whatever your role is, pay your taxes, you're just not going to get Medicare period. I thought it was a good amendment, but the Senate didn't think so. So I would like to know what your thoughts are with penalties.

The other thing, I guess specifically with Mr. Grob, we wrote to the major contractors, as you know, asking them for their status on implementing recommendations in your report, and we forwarded those responses to you and I would be interested to know if you've had a chance to analyze their responses and it would be particularly important because we are looking for additional hearings on this topic and we're going to get some of the other folks involved that are not here today to come before we break in August. And we're working on getting a date that's good for both Mr. Klink and myself and the subcommittee to work on. So obviously these would be important. I would like if you could both comment on that, and then I will yield.

Mr. GROB. Can I take your second question first?

Mr. UPTON. Yes.

Mr. GROB. Yes, thank you very much. We were provided the answers that were received as a result of your inquiring from the 10 largest intermediaries what actions they had taken in the report. I did some additional sleuthing as well to see how things were going since our report was issued. People could probably use a dose of good news here in this hearing, so I will deliver a bit of that. Both from the reports that we received back from these responses as well as other things that we know about the Health Care Financing Administration is doing, and some results that we have seen in our investigative efforts, we can report some progress and positive developments for the fraud units.

First of all, with regard to the responses that we received—that you received rather, I see from these there was definitely an increase in the resources that were now being applied to these fraud units in terms of the peoples and the dollars. There was certainly an increase evident in the amount of training that they were receiving, and there was certainly an increase in the referrals that we were getting from them based on the responses.

Some places that probably still need a little bit more improvement is in the definitions, but we're not there yet. The definitions of case complaints are important because we need to be able to track how well they're doing, and that needs a little more refinement.

The goals that we thought should be established still need to be established. I think Dr. Kanof mentioned there was a plan to do so.

Ms. THOMPSON. Those actually have been established.

Mr. GROB. Good. And the tracking needs to be improved. I would like to give you another indication. Our data goes back to 1996. We looked at the percentage of cases that the Inspector General's Office was receiving that were attributable to the units, and several years ago about 25 percent of our cases came from the carriers and intermediaries. Today it's about 38 percent.

Now, that's really good, because the ultimate measure of referral is whether the material we get is good enough to use for a case, not just that it's a complaint. So the fact that that has increased and that it is of the quality that we can use to pursue an investigation is a very good sign.

And I do know that HCFA did sponsor some very important training over the last year for these units. We helped them do that and, I give them great credit for sponsoring that training and for being pretty systematic. Out of all of this we see some light shining here, and I'm very happy to be able to report that.

Now, I don't know if you want Ms. Thompson to comment on that before we take the general question.

Mr. UPTON. Yes, go ahead.

Ms. THOMPSON. Well, actually, I know that the inquiries had gone out to our contractors, but actually we don't have the responses. I would actually be interested in seeing what the contractors responded, that would be useful for us. And I am happy to hear what Mr. Grob has to report because I think it reflects the kind of effort and investment that we've made in this area.

I would also just as an aside say that in last year's budget round, there were 7 contractors that had not made any referrals to the Office of Inspector General for several years. And they had asked for more money, and we said, "No. Do a better job of using the money that we're giving you now, and then we will consider whether to supply you some additional funding." So I think that message was clear to the contractors that budget issues were going to be tied to performance measurement, and I think that's always a healthy message to send.

Mr. UPTON. What do you think about these penalties? Are they too much, too light?

Ms. THOMPSON. I will let Dr. Kanof talk about that. But those are the result of very significant negotiations and assessments by the U.S. Department of Justice, as well as by the Office of Inspector General about the financial resources and the damages to the government and so forth. I don't know if you want to make more comments about that. But, you know, sometimes you would like to have them be quite, quite large, but whether or not that is appropriate is another matter.

Ms. KANOF. I think the other factor that you need to add to that list are those contractors that are no longer doing business as Medicare fee-for-service contractors. The last contractor on the list, HCSC, had its contract nonrenewed and when they were going through an acquisition with Texas, we did not allow the Texas Blue Cross-Blue Shield Medicare work to be transferred over into that corporation.

So I think there are additional measures that you're not seeing on that sheet that have significant impact on businesses.

Mr. UPTON. Mr. Grob.

Mr. GROB. Overall I think they're reasonable. The justice system always results in something that when you're done, you have to say was reasonable because it always reflects by definition the best attempt to come up with a penalty that's consistent with the evidence that you have in the cases that are brought. But overall it does seem reasonable and, in fact, many of these contractors are not performing in the Medicare program.

There also have been some criminal fines levied to individuals and there's a sentencing or two that needs to occur here.

Mr. UPTON. Thank you. I have a copy of some responses I will personally put this in your hand here in a second.

Mr. Klink.

Mr. KLINK. Before I get started, Ms. Aronovitz, I enjoyed your discussion with Mr. Dingell about the closing of offices and how it's affected you, and I thought that was instructive. However, just on the side, we have had a lot of requests from our side of the aisle on this subcommittee that have been backlogged by GAO for quite some time. We would like to review those with you. If, in fact, resources are not a problem I would like to know why some of these things have taken in fact months. We're just getting around to an on-line securities investigation that we made probably at the beginning of this year.

Ms. ARONOVITZ. I would actually like to expand a little.

Mr. KLINK. Please do.

Ms. ARONOVITZ. What I would like to have said to Mr. Dingell if I could expand on my answer a little bit is that, clearly, more limited resources certainly don't make our life any easier and actually make it much more challenging for us. However, over the last few years in trying to be as responsive as possible, we have figured out much different ways to do our work. We have tried to use technology, and we've tried to use the resources within our organization to be able to respond much quicker and to work much harder.

So hopefully the lack of resources has been made up by the techniques and the efficiencies we've tried to encourage. I certainly don't want to imply that we don't need more resources. Of course, we always need more resources.

Mr. KLINK. As I say some of our investigations are impeded because it's taking us months to be able to get GAO, and we understand that you're pushed at any rate we would like to have that discussion.

I'm very much disturbed and I guess Ms. DeGette really touched on this briefly at the end of her questions. If there is a culture within these corporations, a reason that all of those blue blocks are up there, that many people there's evidence of participating in something that is in some instances perhaps criminal, in other cases it may or may not be criminal, we don't know, maybe careless, maybe inept, we don't know, what is the corporate culture on the other side—because we're talking about fiscal intermediary, they're insurance companies. On one side they sell private insurance, they make decisions, and it strikes me as very odd that the discussion in the other body, as they say—yesterday there was an amendment on whether or not with we allow the insurance companies to make a decision as to whether or not a woman can choose her OB/GYN to be her primary doctor or not. And it was decided that, by the majority that, yeah, we will let the insurance companies make that decision, not the woman.

Now we come here today, we're holding a hearing, and we're finding out that they're turning off software, they're losing claims, they're paying things that shouldn't be paid. They're doing all of these things which causes them since 1993 to have to pay $235 million in civil and criminal penalties. But we're going to trust them to run the insurance business for us to make medical decisions.

What evidence is there that these same insurance companies who are fiscal intermediaries are operating any differently on the private side of their insurance business making any better decisions not defrauding rate payers, not defrauding medical providers, than they are being found guilty of or being certainly suspected of when it deals with Medicare?

Ms. ARONOVITZ. I just want to say one thing about that in response. I believe that fundamentally on the private side, the fiscal intermediaries are pretty much spending their own money in their insurance business. In Medicare, they're representing the government in trying to be prudent payers, but the money that is coming out of the trust fund is the taxpayer's money, it's not the private companies' money; therefore the incentives are different. And I'm not sure that would account for the difference, but it's clearly a difference.

Mr. KLINK. If you just suspend. But the question is this, by denying claims, by denying the ability of a patient to see a doctor on the private side, by making it more difficult, by delaying the period of time at which you pay a medical provider, I'm asking if there is a culture, any evidence of a culture within these same questions on the private side where it would be to their fiscal incentive to operate differently, to make it more difficult for the rate payers to get the services that they in fact have purchased that insurance for. Is anyone looking at that?

Is there a simultaneous parallel investigation that if on one side as a fiscal intermediary you're doing something that is illegal, immoral, unethical, fattening, whatever you want to describe it as, are you on your profit side, is there a culture within your company, these same managers, these same supervisors or their counterparts that are doing something unethical, illegal, untold to deny the payment of benefits to increase corporate profits?

Mr. GROB. We don't have a study that addresses that, so we can only speculate about it in the same way that we all have been speculating about it simply using good principles of financial management and understanding human beings the way they are.

Mr. KLINK. Mr. Grob, what we know is that they've been found guilty of perpetuating fraud, they paid civil penalties, they paid criminal penalties. My question simply would be is there anyone within the Justice Department, within the GAO, within HHS, with anywhere else that can determine have they compartmentalized that fraud just in that portion of the insurance company which deals with Medicare, or is it prevalent within the entire corporation?

Because if we're going to trust these people to be making medical decisions, to be making life and death decisions, and that is the hot topic, it deals not only with the Medicare, the discussion going on in the other body right now is they're making all kinds of decisions. I'm also troubled by the fact, because I am from Pennsylvania, XACT Medicare Services of Pennsylvania, Mr. Grob, on page 3 of your testimony, you talk some rather—what appears to be some very serious things here, they were found guilty of failing to recover overpayments, failing to monitor end stage renal disease, laboratory claims, overriding payment safeguards to bypass electronic audits or edits when processing part B claims, they paid $38.5 million to resolve their liability.

And as part of the settlement, the carrier agreed to enter into an extensive corporate integrity program to ensure proper training for its employees and external reviews of its performance under its contract with Medicare, like they didn't know what they were doing was wrong.

Please tell me somebody was punished for this.

Mr. STRICKLAND. Yes, please.

Mr. KLINK. Tell me that somebody was punished for what they did. This can't be just an oversight. These are very serious things that were done.

Mr. HARTWIG. Pennsylvania Blue Shield, the XACT case differed slightly from the others, because we did charge individuals criminally with the activity. In the case of Pennsylvania Blue Shield, we did not believe that there was sufficient evidence to charge that it

was a corporate culture. In Pennsylvania Blue Shield, we were able to identify specific employees that had engaged in specific crimes, three of whom have already been convicted and that investigation and other individuals is continuing. So the case of XACT was just a little different in that we did not find all of those blue boxes necessarily at the XACT case.

Mr. KLINK. Thank you. I would just end, and I thank you for your patience, Mr. Chairman, page 10 of the GAO report, the draft report that we have here, page 10 it says, according to public records and statements, such activities, and we're talking about the illegal activities, allegedly spread as employees at various levels and units taught each other how to commit such improprieties. They're teaching each other how to rip off the public.

And my question is, is it only on the public side or is it happening on the private side of those same companies? I thank you, Mr. Chairman. And I thank you for holding these hearings.

Mr. BURR [presiding]. The gentleman's time is expired and the chair recognizes himself for 5 minutes, and also says that normally the ranking member and I agree on everything, but I think that the conclusions that he's trying to drive out of his questions as it relates to the results that we might find permeating the private side. In fact, if there were a study, I think it's a valid thing for us to look at.

It does not get us any further to a solution to the waste, fraud and abuse that exists in the Medicare system. And I would only point to the fact that I think that HCFA has prosecuted and found waste, fraud and abuse in physicians, am I correct, and in hospitals, am I correct?

Does that mean that all physicians and hospitals shouldn't be trusted for the delivery of care and that we should no longer empower them to make some of the medical decisions that we currently allow them to do and the answer I know is no, we shouldn't change the system.

Let me ask real pointedly, why do contractors cheat? What did you find? What's the reason?

Mr. GROB. Well, in these cases, there was a financial incentive for them to cheat, because they were receiving contracts from the Federal Government, and, furthermore, at the time of these activities, there was a system for scoring their performance. If they scored high, then they got bonus payments. So if they could manipulate the scores they would get more money.

Mr. BURR. So the system that we have in place to reward actually in some cases was the incentive to cheat?

Mr. GROB. The system that was in use for some of these is no longer in use. For that reason the scoring system as such is not in use any more, and this is probably one good reason for it. But, yes, that's what I believe, that if you get paid according to the scores, then you have an incentive to show that your scores are high.

Mr. BURR. Let me ask you, are there any intermediaries where their sole business is a contractor for HCFA for Medicare, or was Mr. Klink's conclusion correct that all of these companies have some private sector health insurance policy that they provide?

Mr. GROB. All of them do.

Mr. BURR. Is it safe to say to be found—to be accused of an impropriety would destroy the reputation of these companies as a health insurance provider in whatever markets they were in?

Mr. GROB. I don't think it's happened.

Mr. BURR. In any of the cases that we have found some question about the practices of the intermediary, I guess what I'm driving at, how many of the cases that have been settled do you think were settled because they didn't want to go through the litigation process because of the public black eye that they would have to their business?

Mr. HARTWIG. I think it's hard to determine why they settled the cases. I think they actually settled them because they had done what was charged, and it was just the easiest thing to do.

Mr. BURR. Do you agree with the fact that it would hurt the other side of their business?

Mr. HARTWIG. I certainly think going through a trial and losing hurts your public image.

Mr. BURR. Great. Let me go back to your request or suggestion that you be allowed to expand the pool of contractors. How many companies do you currently have who are asking HCFA we want to be—we want to contract with Medicare, we want to be an intermediary? How many additional companies are out there that are not part of the system today?

Ms. THOMPSON. Well, the best evidence of that is what happened when we went forward with the Scope of Work for Program Safeguard Contractors. One of the things people said about that was, "There is nobody out there that wants this business other than the people that HCFA is currently contracting with; you're going to go out there and throw a party, and nobody is going to come."

So we actually put together a solicitation conference for people who were interested in bidding on program safeguard work. And there were more than 400 people present at that conference, and actually we had a number of people who expressed interest in bidding.

When we structured the request for proposals for the program safeguard work we asked businesses to demonstrate that they could perform the whole range of program safeguard activities. That is, they needed to be able to demonstrate they could do auditing, they needed to be able to demonstrate they could do fraud case development, they needed to be able to demonstrate they could do medical review, and they needed to be able to demonstrate they could do provider education. I believe the number of actual, full proposals that we received was 24, of which we actually selected 12.

So I think, from that evidence, there's a great deal of interest, and there were a number of companies who also participated in that solicitation as subcontractors for a total of more than 50 companies participating in that bidding.

Mr. BURR. I would like to yield to Chairman Barton for one question.

Mr. BARTON. Thank you, Chairman Burr. I want to ask the HCFA people if they will send us either a monthly or quarterly report to this subcommittee on their monitoring efforts with their anti-fraud units and the contracts.

Ms. THOMPSON. I would be happy to do that. Can that be quarterly?

Mr. BARTON. I don't know how you all get the information. I would rather have it monthly, but if you can—if quarterly is what your normal system is, that's fine.

Ms. THOMPSON. That's right.

Mr. BARTON. I want to personally monitor what you all do, not that I don't trust you, but I think if you have us watching you, you're going to watch them a little more closely.

The second thing if you've got a problem in Texas, you let me know, and I will be your strongest ally. I may not clean up the whole country, but by God I bet I can help you clean up Texas. So I am willing to kick their butts, if you need a Congressman to get their attention.

Ms. THOMPSON. Thank you. We will come talk to you.

Mr. BARTON. Thank you.

Mr. BURR. I will attest to the fact that he can kick butt.

Let me just ask one question before I yield to Mr. Strickland. These requests to be part of the contractor world by these companies, was this after they understood what the reimbursement was for services?

Ms. THOMPSON. What we have basically pursued is that different contracts will be let with different kinds of reimbursements. For example, on the first 6 task orders that we developed, there's both fixed price contracts, where we feel like we can identify exactly how much we think that ought to cost us.

Mr. BURR. And do those companies who have shown interest know what that reimbursement is?

Ms. THOMPSON. They know there will be a fixed price, there will be cost plus, there will be time and materials, there will be different kinds of contracting, and they can decide of those 12 that are now eligible whether they want to or don't want to compete for any given task.

Mr. BURR. I can only speak for myself, but I'm sure that other members are experiencing the same thing when we look at the physician world with Medicare today; we don't see a lot of people applying to get in. We see a lot of people searching for a way not to handle Medicare patients, not to deal with the paperwork, but more importantly not to be reimbursed at a cost—at a price below their cost of delivering the services is the argument that we hear, and clearly my interest is more toward, is that the case for contractors as well. And certainly it's not based upon Mr. Grob's answer earlier, but you also said we've changed that. And I will be curious to monitor this as we go along.

Very quickly.

Mr. GROB. The change is only with regard to the fraud contractors, the contracts to do the mammoth work——

Mr. BURR. There's still performance based incentives for the other?

Ms. ARONOVITZ. That's cost-reimbursed contracts.

Mr. GROB. The main line is still cost reimbursement. The fraud units have the flexibility now to try out these new instruments, which I think is a very beneficial thing to do.

Mr. BURR. The Chair would recognize Mr. Strickland. And the Chair would also take this opportunity to announce that we do have a vote on. We will leave here with 5 minutes left in the vote or earlier, depending on Mr. Strickland.

I would ask our second panel, we will be back in 20 minutes, if you want to grab something real quick, but we would like to get the second panel called up and get this hearing underway.

Mr. Strickland.

Mr. STRICKLAND. I will be short. I want to thank you for the information you brought to us. And I want to say that I don't think that character or integrity can be compartmentalized. And if the individuals and the corporations and the companies that engage in this fraud using public dollars are willing to do that, that denotes a corporate and an individual character problem, and they don't suddenly become honest individuals when they start dealing with their own money, especially if their own money involves whether or not to provide medical care to their customers. The bottom line here is increasing profits, and you can do that by defrauding Medicare, using public dollars or you can do it by denying patients legitimate medical need in order to increase profits. I think we've got a serious problem here.

Now, the mentality that has prevailed in the House of Representatives over the last couple of weeks would say that maybe every contractor with Medicare should be required to post in their corporate offices a copy of the Ten Commandments, one of those commandments being thou shall not steal. Maybe they are just unaware that they ought not to be doing this.

Thank you.

Mr. BURR. I thank the gentleman from Ohio.

At this time the committee would recess until 12:35.

[Brief recess.]

Mr. BURR. The hearing will come back to order.

The Chair would like to call up Bill Mahon, Executive Director, National Health Care anti-fraud Association, and Mr. Dennis Jay, the Executive Director, Coalition Against Insurance Fraud.

Welcome to both of you. I'm sure that other members will find their way back here after the vote. I apologize. We had two votes instead of one, so it delayed us another 10 minutes.

At this time, Mr. Mahon, I would recognize you for your opening statement.

TESTIMONY OF WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI FRAUD ASSOCIATION; AND DENNIS JAY, EXECUTIVE DIRECTOR, COALITION AGAINST INSURANCE FRAUD

Mr. MAHON. Thank you, Mr. Chairman. Just for the sake of perspective, our organization is a private public organization that focuses on billing fraud typically by dishonest providers against third-party payers, either private or public, including Medicare, Medicaid, any tax funded program, and private health insurance plans, and that is the perspective from which I was asked to comment on some of the subject matter of today's hearing.

Fraud is a problem common to the private and public sectors. The estimates place the annual loss at between 3 percent to per-

haps as much of 10 percent of what we spend on health care every year, which this year will be a $30 to $100 billion estimated loss to fraud, if those estimates are correct.

In the context of today's hearing, it's important to emphasize that no one has yet cornered the market on how you address health care fraud successfully. There's no one out there who would claim to have found the right formula to get every bit of it and get all the money back and what have you. It's an insidious type of problem that, as one of the witnesses pointed out this morning, can't even be officially called fraud until and unless someone is convicted or pleads guilty to intentional efforts to defraud.

Having said that, I am familiar with the anti-provider fraud efforts of the private payers who are most active in this area, and as I noted in my remarks, there are three fundamental aspects of having a somewhat successful anti-fraud program. You have to allocate adequate resources to the task of detecting and investigating potential fraud, resources both in terms of people and technical capability that's required today in the electronic claims era.

You have to rest heavily on continuing education and training of the people who are charged with that responsibility. Because no one has the market cornered, one of the principal things that people do through our group is precisely that cooperatively teach other what it is they're finding, what is going on and how it can be addressed.

Finally, you need to have an organized effort to share investigative information with other private payers and with law enforcement, because typically the person who is defrauding one payer is doing it to many at a time so as to take it in smaller bites and reduce the risks of being detected.

In that context when you look at Mr. Grob's and his colleagues and his report on fiscal intermediaries, several things that jump to mind are the tremendous lack of consistency across those 41 fiscal intermediaries, at least as of 1996, in terms of these three key factors: The resources allocated to the task, the reliance on training as a principal means of case of development, and staying current with the state-of-the-art and also the referral patterns for matters that were referred to the Office of Inspector General.

There seem to be very few factors common to some of these inconsistencies. They vary according to size, to method of fraud detection and so forth, but one fundamental factor that I would like to note here is to say that at the bottom of the list of 41 FIs here is one intermediary that pays $110 million a year in Medicare claims, has a fraud unit budget of $15,400, and a fraud unit full-time equivalent staff of 1 quarter of 1 person. By no means under the sun does that constitute a fraud unit or an effective anti-fraud effort. You can't expect to do anything about fraud with a quarter FTE and 15,000 compared to a $110 million outlay. And of course the numbers go up from there.

So you have to make a respectable commitment at the front line to address the problem. One way in which the private sector is being required to address this more effectively is what the States have been doing in recent years. Now a total of 17 States say to private health insurers and other companies as a condition of insurance licensure in our State you can't just put your feet up and

say fraud happens, it's the cost of doing business; you have to demonstrate to the State as a condition of doing business that you have an anti-fraud plan, a special investigations unit that meets certain criteria that you have to refer specific cases to law enforcement. You have to provide specific types of training to anti-fraud people and so forth.

And granted in Medicare, the fiscal intermediaries are also constrained by the policies and procedures that the Health Care Financing Administration establishes for how you go about detecting and investigating fraud and what have you, and some of the policies sometimes can help, sometimes they might hinder those functions, but one general observation I would make based on comments this morning is that when HCFA contracts out for both the processing of Medicare business and the anti-fraud activities involved with that, I don't see why HCFA should have to bear the entire burden of brainstorming the fraud problem and saying to these private contractors, here is how we want you to go about going after the fraud and here's what needs to be done and what have you. Those entities on the outside should be coming to HCFA and saying we're the experts, here's what we're finding, we're on the front lines, here's what needs to be done from a regulatory legal standpoint to make this anti-fraud activity work better.

I think it's unfair and unrealistic to put all the burden on HCFA to write chapter and verse about what all of these entities are supposed to be doing.

I would suggest that HCFA, as a member of our organization, I would respectfully suggest that they look at what the States have done, and difficult as it seems to say, you know, simple HCFA solution in the same phrase, I think they really need to try to simplify. If HCFA is to be the anti-fraud arm, it represents a weapon that weighs 50,000 tons and has to be carried to the point of use by 100,000 people. HCFA cannot be the principal enforcement arm and detection arm. They have to exercise good oversight, but I think they also can lead by saying we're going to simplify and look at what the States have done and say if you want to be a contractor, these are the certain minimal standards you have to meet or exceed from the anti-fraud standpoint before we will even consider giving you a Medicare contract.You have to show that, you know, that you're up to the task of protecting us against the fraudulent aspect of the business.

Other things that they might pursue, there has been a start of sort toward tearing down the walls that have existed between the Medicare side of the house and the private side of many of these intermediaries. When it comes to the sharing of investigative information between the Medicare fraud people and the private insurance fraud people, there is no logical or legal reason that that sharing shouldn't take place because oftentimes these two segregated anti-fraud units are looking at the same suspect providers and conducting parallel investigations of the same people, unbeknownst to each other, and there has been a cultural, if not an actual legal barrier within HCFA for many years that prevents that sort of common sense discussion among these people.

HCFA started down the road last year of providing for that information sharing, but that has been stalled in part because it pro-

voked a reaction in Congress when some members mistakenly assumed that that meant sharing information about Medicare beneficiaries in this age of privacy concern. What it means is sharing information on active investigations and suspect providers and what have you within the proper legal constraints, but those are the kinds of things that sometimes stand in the way of a more effective effort being carried out at the front lines.

Other types of things that go to the way the system works; for example, HCFA has no claim-by-claim authority to suspend payment to a given health care provider, something analogous to a line item veto in the legislature. When they suspect fraud on the part of a provider or they think they have a given claim as fishy, the only option they have is either pay, deny or suspend all payments to that provider indefinitely.

There are little nuts and bolts things there that could make a big difference in the real world of going after some of these folks. Those are just some general and very hastily assembled observations that I would make. But I would be delighted to try to address any questions that you all might have as well.

But we thank you very much for the opportunity to come and offer our thoughts today.

[The prepared statement of William J. Mahon follows:]

PREPARED STATEMENT OF WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

Fraud has a substantial impact not only on Medicare and other tax-funded health care programs, but also on private health insurers. Across the board, fraudulent billings are estimated to account for between 3% to as much as 10% of the United States' $1 trillion annual health care expenditure—or between $30 billion to as much as $100 million each year.

Effective anti-fraud efforts rest on (1) allocation of adequate resources, both personnel and systems capability; (2) ongoing education and training of anti-fraud personnel; (3) structured, ongoing sharing of investigative information among payers' anti-fraud units.

The November, 1998 HHS-OIG Final Report on Fiscal Intermediary Fraud Units illustrates a significant lack of consistency in these key areas among the 41 F.I.s that were the subject of that report.

In the private health insurance sector, the states have taken the lead in requiring health and other insurers to establish and maintain a certain level of anti-fraud capability (see attached Guide to State Anti-Fraud Requirements).

Among Medicare F.I.s and carriers, the nature and ultimate effectiveness of anti-fraud activities also rests to some extent on the policies and procedures established by the Health Care Financing Administration, which in recent years has placed considerably greater emphasis on the issue.

In this context, HCFA might look toward establishing more specific standards for the funding, structure and workings of F.I.s' and carriers' anti-fraud operations; it also can continue to pursue practical implementation of its stated intention to establish effective information-sharing mechanisms between Medicare payers' and private health insurers' anti-fraud units—a function that is consistent with the universal acknowledgement on the part of private industry and law enforcement of the need for such information-sharing.

Mr. BURR. Thank you for your statement. Mr. Jay, you're recognized for an opening statement.

TESTIMONY OF DENNIS JAY

Mr. JAY. Thank you, Mr. Chairman. The Coalition Against Insurance Fraud for the record is a national alliance of consumer groups, government organizations and private insurance companies who are dedicated to fighting all forms of insurance fraud.

We seek to curb fraud through public advocacy, consumer education and research. And what I would like to do today is just very briefly talk about some of our experiences that we've had in looking at anti-fraud units of private insurance companies, and how there may be some lessons there for HCFA and their fiscal intermediaries and their own fraud units, and particularly talk about some of the property casualty insurance companies which we have more expertise in.

The property casualty industry has a great deal in common with health insurance in that a lot of the focus of anti-fraud activities are on medical providers who treat auto accident victims as well as people hurt in the workplace. In fact, it's some of the same medical providers who are defrauding property casualty companies, who are defrauding private health care companies, who are defrauding Medicare. They're truly equal opportunity crooks.

But what we have done over the last 6 years, we've had an opportunity to go into private insurance companies and take a look at some of the finest state-of-the-art anti-fraud programs out there that seem to be very successful and effective in not only detecting fraud but preventing it in the first place. And we've tried to isolate some key elements that we've seen in these programs, and perhaps HCFA would also like to take a look at whether the contractors that they're dealing with also have some of these same common elements.

I would like to quickly run down the list of things that we've seen common to excellent private programs out there. The first one is the recognition that there is a problem with fraud. And while this sounds like a very simple concept, because of the hidden nature of fraud, if you don't go looking for it, you're not going to find it. And frankly what we have found with private insurance companies, they tend to fall into three different categories when it comes to rooting out fraud, and those at the top recognize that there are problems, they dedicate resources to it, and they're doing an outstanding job of being leaders in going after it.

And in the middle, we have a whole bunch of private insurers that with a little bit of nudge basically through some of the State requirements that Mr. Mahon talked about, they have gotten into the ball game and they are investing some resources to go after fraud. And then we've got this bottom group of private insurers that basically don't have a clue. They don't recognize they're being defrauded and they don't recognize the importance of dedicating resources to going out and looking for fraud.

And frankly I hope that HCFA is looking at the top tier of contractors and not the middleman and bottom tier. But frankly our experience with private insurers is that health insurers more so than others tend to be in the middle and bottom tiers, and I don't know why that is, but in fact health insurers more than others have actually worked against our efforts in trying to build infrastructure in the States to try to set up anti-fraud programs.

But again there's excellent ones out there, and I think we should be isolating those and taking a look at them. These excellent anti-fraud programs on the part of private insurers take an integrated approach to fighting fraud. There is a dedication to rooting out

fraud from the CEO on down, it's not just a single unit going out to look for fraud.

There's a willingness to work in partnerships, whether that's with other insurers, whether that's with law enforcement, and they understand that in the best of circumstances fighting fraud is very difficult, trying to do it alone in isolation is nearly impossible. And we see some of the mature programs understand that there must be a partnership.

We see the good programs out there have informal communication networks set up, and I think it's one reason why property casualty may be a little bit more ahead of the game than life—than health insurers, and that's because they've been at it a little bit longer, their investigators are a little more seasoned and they've been allowed to set informal networks to be able to cover some of these scams a little bit earlier.

And frankly, one of the activities on the State level that has allowed for such communications has been the broad immunity from civil action that insurers enjoy and being able to share information back and forth. I'm not sure whether the FIs share or enjoy such immunity.

But with that said, we still see a great degree of a lack of communication out there. Within the insurance industry itself, we don't see property casualty insurers who are dealing with some of the same medical providers talking to the health insurers. We need to work on that. And we surely, as Mr. Mahon has pointed out, don't see the type of communication between the public and the private sectors in fighting fraud and, again, we're dealing with some of the same type of culprits out there, yet we tend to think that they may not be defrauding, and I think if we ever get to the point of information sharing the game will be half over.

The excellent programs out there are also very proactive, and I think we've heard a little bit about some of the shortcomings of the intermediaries in that they're not necessarily doing the things like data mining and initiating cases themselves. If you're just sitting there waiting for complaints to come in, the game will never be won.

And again the property casualty industry has done an excellent job of developing data bases. They have an all-claims data base now, and they're able to use these type of tools to detect patterns going on out there that health insurers and Medicare are starting to go in that direction but still have a long way to go.

And last, and again to reemphasize something that Mr. Mahon says, the States have been—some of them, excellent partners with the private insurers in setting up infrastructure to root out fraud, and I would also suggest that HCFA take a look at some of the experimentation that's going out there within State governments and the 44 fraud bureaus that have been set up.

We take a look at State activity on an annual basis. We have a study that's going to be coming out next month that shows that, for example, referrals that are going to some of these State agencies have gone from 61,000 to 92,000 in the last 3 years. The referrals that they're sending on for criminal prosecution has more than doubled in the last 2 years, and the conviction from those prosecutions have more than doubled.

So I think that there's a lot that is going on in anti-fraud activity in the State level that can be looked at as well.

In summing up, we found that overall it takes more than just an insurance company or the government to really have a successful program overall. We see a lot of different types of activities going on right now, but unless we can go together and look at where the money is draining out of the system, and still the big numbers tell us that medical providers are defrauding both public and private program at astronomical numbers, a coordinated approach to that is going to be the best approach to control this problem, we're not going to eliminate it, but to cut down drastically on some of those problems.

So I thank you for the opportunity today. I would be happy to answer any questions.

[The prepared statement of Dennis Jay follows:]

PREPARED STATEMENT OF DENNIS JAY, EXECUTIVE DIRECTOR, COALITION AGAINST INSURANCE FRAUD

Good morning and thank you for the opportunity to testify here today. My name is Dennis Jay and I'm the Executive Director of the Coalition Against Insurance Fraud. We are a Washington, D.C.-based national alliance of public interest groups, government organizations and private insurance companies who are dedicated to fighting all forms of insurance fraud. We seek to curb fraud through public advocacy, consumer education and research.

When it comes to the nuts and bolts of claims paying and fraud in the Medicare program, I will yield to the expertise of my colleagues on today's panels. However, because we seek to reduce all forms of fraud, we have a great interest in these issues and watch them closely. Today, I'd like to share our perspective and experiences of fraud-fighting by private insurers, and in particular that of the property/casualty insurance industry and what lessons might be applicable to the Medicare fiscal intermediary program.

The property/casualty industry has a great deal in common with health insurers and faces many of the same problems. Much of the focus of this anti-fraud activity deals with medical providers who treat injuries from automobile accidents and workplace accidents. What we see again and again is that providers who defraud tend to be equal opportunity crooks. They don't care whether an insurer is public or private, provides health insurance or property/casualty coverage. If there's a pool of money to be tapped into, they will find it and exploit it.

The property/casualty industry generally has been more involved than health insurers in fraud fighting efforts and has a longer history in combating fraud. While there is still a long way to go in controlling property/casualty fraud, these insurers have achieved some successes against the same kinds of medical fraud rings that plague health insurers and the Medicare program.

We have attempted to analyze successful anti-fraud programs to isolate key elements and shed light on why some programs seem to be effective while others are much less so. Many of these elements are common sense approaches to crime deterrence and detection, but important to note nonetheless.

The first element we found is that there must be recognition of a problem. This sounds simple, but with the hidden nature of fraud, unless you go looking for it, you may not recognize the existence or the severity of the problem. There are some insurers who have taken the lead on combating fraud and have very successful programs. Others have to be nudged into recognizing the problem and investing resources. And still others haven't a clue. Many states have enacted regulations requiring anti-fraud activities by insurers, and some private carriers come into the fraud fighting arena screaming and kicking. This seems to be especially so when it comes to health insurers.

It seems many fail to recognize they are being defrauded. They are not convinced that the severity of the problem warrants the invested capital it takes to sponsor an effective anti-fraud problem.

In the state of Washington, for example, health insurers got a law passed exempting themselves from modest regulations that most insurers supported. They claimed fraud was not a problem in health insurance in that state, and thus, the regulations were not necessary.

In Louisiana, they currently are trying to get themselves carved out of a proposed law that would fund a state law enforcement agency to fight fraud. Two years ago they were successful in doing exactly that in Virginia. While other insurance companies see these state agencies as good investments in combating fraud, some health insurers aren't convinced it is worth spending the money.

California passed a law several years ago that mandates that all insurers licensed in the state must maintain a special investigations unit to detect fraudulent claims. The only insurers fined so far for ignoring this law are health insurance companies.

And in Florida, where like many states, insurers are required to report all suspected cases of insurance fraud, the fraud bureau has reported that 75 health insurance companies have not referred one case in five years.

Some health insurers have excellent anti-fraud programs and should be commended for making the commitment to curb fraud. We wish more were in this camp.

Just recognizing the problem obviously is not sufficient. There must be a commitment to the anti-fraud effort from top managers on down and then it must become an integral part of the corporate culture. Half-hearted attempts rarely succeed.

Another common element we see in successful programs is the willingness to work in partnership with other entities. Fighting fraud in the best of circumstances is difficult, but nearly impossible if working in isolation. There should be a commitment by all parties affected that they will work together to reduce fraud. No one person, no one law enforcement unit, no one company, no one government organization can stop fraud. All of us together, including the general public, are affected by medical fraud, and we all must step up and do our part.

This means cultivating relationships internally and externally and communicating well. The best programs align the anti-fraud interests of consumers, insurers and law enforcement to fulfill of common goal of prevention and detection of fraud.

Along with partnership building is the need to communicate well. One reason property/casualty insurers may be more successful is because their investigators are more seasoned and have developed informal networks to share information about fraud cases. State laws that have provided insurers immunity from civil action in sharing information have been extremely helpful in getting a big picture on fraud. Each insurer may have a single piece to a fraud puzzle that together, they can solve, or at least provide sufficient documentation for law enforcement to take it to the next step. I question whether fiscal intermediaries feel that they can freely share such information among themselves. Perhaps their anti-fraud efforts could be enhanced with broader immunity protections as well.

With immunity and an increased willingness to share information, communications among fraud fighters has never been greater. Yet, while these informal networks are growing, there still is little communication outside of a small sphere of activity. While the property/casualty industry and health insurers are defrauded by the same people, there's little interaction between the two camps. The same can be said about communication between public and private insurance programs. Recent government information sharing programs are commendable, but the outreach needs to be much more aggressive and on-going to be effective.

On the state level, we have seen that once government starts to build an infrastructure to combat fraud, including laws, fraud units and outreach programs, private insurers seem much more willing to invest in their own anti-fraud programs and make long-term commitments to funding anti-fraud programs.

Once that commitment is made, the insurer's anti-fraud plan must be a part of an overall strategy. That plan must include detailed strategies for obvious things such as detection and investigation, education and training, technology and building public awareness.

Part of this strategy must be to adopt a pro-active stance in fighting fraud. Claims handlers and investigators who are properly trained and motivated can use 21st century techniques to discover schemes before claims are paid. The "pay and chase" method of fighting fraud is an expensive, time-consuming way to combat this crime, albeit currently a necessary one. More resources should be dedicated to the real savings in fraud—prevention. A pro-active strategy can work towards this end. Mature anti-fraud programs develop a long-term, holistic approach to the problem. They realize that this war won't be won by fighting fraud one claim at a time.

In the public awareness arena, property/casualty insurers have taken to lead to create effective and broad-based information and advertising campaigns designed to educate consumers about the costs of fraud—that it is in fact not a victimless crime, but that every consumer and taxpayer pays for fraud. We are not aware of similar efforts on the part of health insurers.

This is the critical issue, because unless we can change the American perception that fraud is not a serious crime deserving of our attention and resources, we will not be successful in the long run. For that reason, we applaud the creation of the

"Who Pays? You Pay!" outreach effort undertaken recently by HFCA in partnership with the AARP. Regardless of the protests from the medical profession, we believe this kind of effort is crucial to the anti-fraud fight because consumers are the first line of defense, as well as being the ones most affected by fraud.

Some states also recognize the value of public awareness programs. Pennsylvania's Insurance Fraud Prevention Authority created an anti-fraud campaign that many consider to be a model for raising awareness and changing attitudes. While the end results are not yet known, the initial positive signs have inspired neighboring states to take steps to put similar campaigns in place. For example, New York recently adopted a regulation requiring insurers to design and implement an anti-fraud awareness program as part of their overall anti-fraud plans. The Coalition Against Insurance Fraud, along with other groups, are developing broad-based outreach programs to consumers in that state.

However, no amount of legislation or regulation can force an attitude change in a corporation, be it a property/casualty company or a health insurer. But modest requirements can be a good start to building effective programs by some insurers. In our model legislation for the states [1], we require that all insurers create an anti-fraud plan to fight fraud. Several states have adopted this approach, and because of it, many insurers that otherwise have no plan of action are discovering the benefits to combating fraud.

We would encourage HFCA and this committee to consider some of the anti-fraud programs adopted in the states. There is a good deal of experimentation occurring that can further shed light on key elements for success in fighting fraud. Overall, the level of activity by state fraud bureaus is rising by almost every measure. In a study soon to be released by the Coalition Against Insurance Fraud, the number of referrals to these state agencies has climbed from 61,000 in 1995 to more than 92,000 in 1998 [2]. Cases presented for prosecution have more than doubled in that three-year period as have the number of convictions.

One area in which the government could be helpful is encouraging greater communications among private insurers. One way the property/casualty industry has been successful in uncovering sophisticated rings is through the use of claims databases. With access to a new all-claims database that includes bodily injury and workers compensation claims, an investigator can easily check a provider's claim record. In addition, sophisticated datamining tools exist that allow investigators to look deep into the data and uncover suspicious connections that are indicative of fraud activity much more quickly than humanly possible. Of course, that doesn't replace an investigator's gut instinct, which comes from long experience, but it does make the job easier. There is no equivalent database in the health care industry.

In summary, combating insurance fraud—whether in public programs or in the private sector is an extremely difficult task, especially when it is nearly impossible to quantity the level of fraud or place a quantifiable measure on fraud solutions. We shouldn't lose perspective that tremendous progress has been made in virtually every facet of fighting fraud during the last five years. But in some areas the progress has been slow. It's frustrating to know that the potential for greater gains is at hand if only we can every marshal the resources of both private and public sector

By taking a holistic approach involving partnerships among all interests, progress can be made. Government needs to hold industry accountable and vis versa in order to ensure that this partnership maintains needed balance for continued success.

Mr. BURR. Thank you for your testimony. What I will do is open it up for questions. I'm not going to keep a clock since Mr. Bryant and I are the only ones here. We will just sort of hit back and forth whenever we feel like it.

Let me right off the bat thank you for your willingness to come in and to share suggestions. I'm a little disheartened to hear that there are good models out there. You mentioned the State, you mentioned some excellent models to look at in the private sector. And we still hear GAO going through an evaluation of HCFA where they're saying they haven't found the right things to do yet,

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[1] Coalition Against Insurance Fraud. Model Insurance Fraud Act, drafted 1995, amended 1997.

[2] Coalition Against Insurance Fraud. A Statistical Study of State Insurance Fraud Bureaus, third edition, to be published August 1999.

yet you're telling me in the world of health care today there are people that have discovered what works.

And I think one of the challenges for this committee, even though, Mr. Mahon, you said that the responsibility shouldn't fall on HCFA. And I don't disagree with you. I would say that we assume a big responsibility as the ultimate facilitator of the programs as the gatekeeper of the finances. They have chosen the intermediaries, they have chosen the words of the contract, they have chosen to assess the capabilities of those intermediaries based upon some criteria that HCFA chose. So I think that some of the responsibility falls on them automatically. And when I hear the Inspector General say that the functions of some of the intermediaries would not pass his test for what they needed in place to be an intermediary, single accounting systems, and he had a litany of things. So I'm hopeful that that doesn't happen any more and that HCFA has gone back and repaired some of them.

But let me just go to a couple of specific things that you addressed. You said that HCFA needs to assure a minimum fraud standard for their contractors, some blueprint of here's the minimum we want you to do. How can we do that if in fact what the IG said is true, that we can't even assess whether their internal functions are great enough to be an intermediary? I mean should we have—I guess my question is, should we have a level of trust that is very high given that we've handed over a blueprint, but we have no idea and apparently we have no follow-through on did anybody fulfill the minimum requirements?

Mr. MAHON. Well, I think we're probably agreeing somewhere in there with respect to, you know, the responsibility that HCFA should bear ultimately for this anti-fraud function. My point I think is that there is no reason they should invent wheels that have already been invented and are being used elsewhere.

Mr. BURR. But they should pass them on, shouldn't they; if they see them out there, they should pass them on to these intermediaries?

Mr. MAHON. Absolutely, I think one of the phenomena at work in this whole thing is that HCFA and the Medicare program and other anti-fraud efforts in the private sector and even through law enforcement anti-fraud activities sometimes seem to fall into parallel universes, where a lot of reinvention is being done within the Medicare side by HCFA instead of a focus on being part of the mainstream of, you know, what the entire collective health care system is doing about fraud.

Mr. BURR. So how do you accomplish a dissemination of information from public to the private intermediary given this communication gap that both of you express exists, and I feel fairly confident that it does?

Mr. MAHON. There's a great deal of communication out there and the whole world has come to look at health care fraud in recent years, as you know, and there's a lot written about it, a lot said, a lot reported in the media. One of our main purposes in life as an organization is to provide ongoing training. We do 15, 16 real nuts and bolts training seminars a year for investigators, attorneys, what have you, and that's really the primary source of train-

ing and detection, investigation and prosecution that goes on in the country today.

I would like to see HCFA be much more involved in participation in that sort of training, rather than sit and say well, gee, we should conduct some training, how are we going to put together a training program, those wheels have already been invented, and they're being used by the rest of the universe, there's not necessarily a need to do a discrete program from scratch.

Mr. BURR. How much does the complicated Medicare structure contribute to the inability to identify fraud?

Mr. MAHON. Considerably. As one of the witnesses mentioned this morning, I think it was Ms. Aronovitz that payers pay, payers get kicked silly all the time for paying fraudulent claims, but the reality is that most fraudulent claims look perfectly good on the face of them. If you're a reasonably smart crook, you're not going to do something on their claim that gives it away as being fraudulent.

The system is very complex, the whole health care system pays about 4.5 billion claims and other transactions a year, you've got 1,500 payers out there, a million health care providers, and the typical MO in health care fraud as I said is to—you don't defraud just one payer, typically, if you're doing it to one, you're doing it to many, if you're doing it to Medicare, you're doing it to private insurers and vice versa, because that's how you stay below the radar screen with most of these folks for as long as you can.

So there's a very complex undertaking and all of this anti-fraud work happens in a system in which the pressure to pay claims rapidly is immense. The Medicare carriers are expected to pay claims rapidly and efficiently. State laws around the country sometimes require health insurers to pay claims within 15 days, you know, unless they're fraudulent. You're not going to have a clue that they're fraudulent in 15 days. You're going to pay the claim and then put yourself in the pay and chase situation when you find out it was a fraudulent claim.

So there's a great deal about the complexity of the Medicare system itself, the diversity of the players in it that makes it a very fertile environment in which to commit fraud. There's a lot of camouflage you can use.

Mr. BURR. Let me ask both of you, and then I would yield to my colleague, if either one of you would like to comment on the privacy hysteria, I will call it hysteria, it's a legitimate concern that is being raised in Congress and in the country. I think when we dwell on it to the degree that we are right now, hysteria is probably the right word. With that feeling that's out there, how will that affect our ability to detect fraud, waste and abuse, not only in Medicare, but in the health care delivery system, public or private, in the future?

Mr. MAHON. In looking at the bills that have been proposed most recently, they are somewhat more friendly to the need for an effective anti-fraud function than the bills that came out 3 or 4 years ago were. At that time there were tremendous obstacles that were being placed in the way of law enforcement and private insurers when it came to doing the essential work to investigate fraud and to prosecute it and what have you.

My sense of the bills that are up here today is that they present more of a potential problem for law enforcement, more hoops for law enforcement to jump through in the course of conducting an investigation, than they would for private payers. When it comes to investigating fraud, the main thing you are looking at 90 percent of the time is not the patient and the patient's medical information, you're looking at the actions of a health care provider who billed for things he didn't do, who billed for more expensive things than he did, who billed for things that weren't medically necessary, so only at a certain point in a given case do you get close to having to provide identifiable information about a patient, either as a part of an evidence package you turn over to law enforcement or as evidence you present in court, and even there in some court cases, the patient involved is known as, you know, patient A or patient B, what have you. Unless there's a compelling need to identify the subject of phoney claims, that generally is not done.

Mr. BURR. It is done incorrectly. Insurance company hires or creates a separate entity as their fraud arm, the legislation that addresses privacy is written in a way that forbids the insurance company from sharing the patient information or the claim with their anti-fraud arm. That would be a distinct problem for the system, wouldn't it?

Mr. MAHON. No question.

Mr. BURR. Does a relationship like that currently exist out in the private sector market? Let me go further into the public model. One might interpret that that if HCFA holds the information that the General Accounting Office would have to have the release of an individual to audit any specific set of claims, would that be a good interpretation?

Mr. JAY. Sure. There are many private insurers that subcontract for their anti-fraud activities, especially small or medium sized insurers, and that obviously would hamper their anti-fraud efforts.

But getting back to the law enforcement aspect of it, we're very concerned that not just the letter of the law may throw up a little bit of a roadblock, but just a cloud that potentially there could be problems with privacy, may deter law enforcement from taking some of these cases.

I mean these cases tend to be very complex, paper intensive cases for law enforcement to begin with. To give them any further disincentive to take a fraud case is going to hurt the effort.

And let me just also say that we're very concerned in some of the State legislation that we see in the privacy realm that would maybe not intentionally go after fraud investigators. They are always written for other purposes, but will have an impact of hurting fraud cases. Paparazzi legislation in California, for example, would have potentially hurt fraud investigators.

And it's an education effort with legislators. And I think what Bill talked about, as far as making legislators understand that most investigations do not entail patient information is one way that I think has really helped the whole debate and hopefully it will continue along that line.

Mr. BURR. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Mr. Mahon, you had mentioned, and I think the chairman has also alluded to this sub-

ject in his questioning, about how one of the ways you suggest that we can do better and HCFA can do better, and that was this communication between the various investigators, and your example would be Medicare and the private sector.

It seems to me that was an initiative that HCFA had suggested sometime back that they would do, and I gather from what I heard today they haven't done that at all.

What is your view of that in relation to HCFA, would you comment?

Mr. MAHON. Just about a year ago, last July, HCFA published in the Federal Register a notice of what they called three new routine uses for HCFA systems of records, which translated meant that they were establishing procedures through which HCFA could make disclosures of fraud related or fraud investigation related information to Medicare contractors, to law enforcement agencies and to any other entity that paid for health care services, meaning a private health insurer, and so long as the information was disclosed for the purpose of fighting fraud in a variety of ways.

We sort of hailed that as the end of an era of the prohibition against information sharing between the Medicare and the private side people and were anticipating its implementation, but as I say, it immediately provoked a response in the House here where one Member who is quite involved in health matters jumped all over HCFA, I believe, on the thesis that this meant HCFA was going to be trading beneficiary information with all kinds of private insurers and other entities and so forth, when as I say the reality is it is intended to allow fraud investigators to exchange information on providers who are the subject of their investigation.

Whatever took place after that, it is something that has not been implemented, and we have talked with the program integrity group at HCFA about some of the practical problems involved in how they proposed to do that initially, and we are looking at working with the Office of Inspector General to see if we can find a more practical alternative to the regulatory scheme in which that was proposed, but bottom line is nothing is happening yet to alter that cultural prohibition.

Mr. BRYANT. You feel it was someone in the House that perhaps stopped this initiative?

Mr. MAHON. I think so. It had the support of the Administrator, strong support I believe, and it had cleared all of the privacy offices and hurdles within HCFA itself, and I think they were quite pleased that they had reached the point of announcing this initiative, and so I say for whatever reasons, beginning with some congressional objections, I think it just became dead in the water after a while.

Mr. BRYANT. Now, you said your organization is primarily focused on what I referenced earlier today as the primary, the provider fraud, doctors and hospitals and clinics and labs and so forth.

Mr. MAHON. Yes.

Mr. BRYANT. What could HCFA do directly involving that tier to better find or ferret out this actual fraud because, you know, what I would do is divide it into the fraud that is the intentional, you know, a person goes out and says I am going to stick it to the government, and I am going to do something illegal and intentionally

versus as we talked about a little bit earlier today with the HCFA people where we might need more education and training, where it is just too complicated, when people put the wrong code in or they don't have qualified people doing the job or whatever. But focusing on the fraud part, what could HCFA do better at the provider level because I know at one point I used to hear about the explanation of benefits form, the EOB form. I think Medicare uses that now, don't they? Don't they send that to the patient?

Mr. MAHON. Thanks to HCFA in 1996, if I recall correctly, they required Medicare to provide an explanation of benefits for every Medicare service. Prior to that it was going south in that respect. The idea was we are going to cut administrative dollars by eliminating the benefit statement, and now it has come 180 degrees and there is a great emphasis on using the beneficiaries as a frontline set of eyes to say I wasn't in the doctor's office on that alleged date of service and to report that discrepancy. That is one thing that can and should be done, and ironically it is something that in the private sector often is not done. Eliminating an EOB is a valuable cost savings.

Mr. BRYANT. What other avenues could HCFA use?

Mr. MAHON. They should, I believe, look at the existing contractor, the carriers and the FIs and at these new payment safeguard contractors, the 12 firms to which Ms. Thompson alluded, and just say, look, in the statistics, at least from 1996, a very small proportion of the cases that were referred to the OIG were developed proactively, as they call it. In the private sector, when we surveyed our 90 member companies a couple of years ago, we found that about 58 percent of their cases are developed internally, about 10 percent come from hotlines, a small percentage come from health care providers who report other providers, but the main reliance these days because of the complexity of the system is on doing some heavy duty data analysis with tools that let you see the outliers and see other patterns that are indicative of potential fraud and then looking, doing the investigative work you have to do to follow up those leads.

There is a great disparity between what Mr. Grob and his colleagues found and how most active private payers develop their cases.

Mr. BRYANT. I was astounded with the statistics you provided in the beginning of your statement. I think you said one company that pays out something like $110 million a year has the equivalent of one-quarter of an employee that is in charge of investigating fraud and waste, and again, I just wonder how can that company deal in good faith with HCFA? I mean, would HCFA not know that and how could HCFA deal in good faith as a fiduciary to the taxpayers, both really the company, but with responsibility back to HCFA, how can that exist? Whose fault is that?

Mr. MAHON. Well, I think it is probably a cultural, institutional matter that hasn't been addressed, but you look at a State like New Jersey, for example, and I am not suggesting they get too specific but New Jersey requires health insurers to have a special investigation unit staffed with a ratio of 1 investigator for every 60,000 lives covered by the health policies, and this means if you cover 6 million lives you need 10 investigators, and so forth—I am

not a math major, but hundreds, and so, but they went so far as to say there must be a specific minimum number of investigators compared to covered lives. That is an extreme and some call it micromanagement, but it is a marker for saying, well, there should be some reasonable minimum number you would expect in any fraud unit that purports to be a fraud unit, and the formulas are many. You can say X investigators per dollar is paid out, X investigators per providers with whom you deal and were submitting the claims, but there should be some threshold one would think below which you don't meet the anti-fraud qualifications to be a participant here.

Mr. BRYANT. Mr. Chairman, I don't have any further questions. I would yield back the time.

Mr. UPTON. I would thank the gentleman. Let me make a few last comments. Let me first thank both of you for your willingness to stick around and your honesty with the committee.

I think that this member especially has tremendous confidence in our current HCFA Administrator, not only in her capabilities but I believe in her passion and determination to make changes. I don't expect all of those to be right, but I think her willingness to try things is certainly a light at the end of the tunnel.

My hope today is that this committee will actually turn up the heat, that we won't go away; that not only HCFA feel the heat, that the intermediaries feel the heat, that the private sector companies feel the heat; that people understand that there has to be change and there has to be enforcement, and for those who choose to continue to work outside of the framework of the contract or, as Mr. Klink referred to, the moral obligation that they have as part of the health care delivery chain or the ethical responsibilities that they have as part of the chain, that they are going to get caught and they are going to be prosecuted and they are going to pay.

I think that Mr. Dingell reminded me that it has been the experience of this committee that when we turn the heat up on defense contractors, I think it related to Department of Energy issues, when they became believers that they were going to get caught, they quit cheating. I think clearly we have got that same challenge before us as it relates to health care.

None of us can be naive enough to believe that you will ever eliminate 100 percent of the cheaters. There are going to be some bad apples everywhere, and one bad apple begins to spoil the rest of the bushel if in fact you are not successful at removing the bad one. I think it is clear we haven't been successful at removing many, that it has permeated a lot of areas for different reasons, and I think Mr. Bryant hit on a very important factor, that not all the claims that are before us are about the company. Some of them are about bad individuals at the company, and those companies have to police their own.

But clearly we have got our work cut out as it relates to the structural changes, to the simplification that we have talked about, to the communication that both of you have addressed. It demands that we open our eyes and look at the successful models that exist, whether they are in the private sector or the public sector, and I think that this committee will not stand for another year to go by where we follow up with a new GAO report that tells us the same

thing they told us this year, only for us to reconfirm that we have a waste, fraud and abuse problem where everybody speculates that the amount of money, nobody really knows what that money is, but there is one thing that you and every member up here will agree with.

Whatever money goes to waste, fraud and abuse does not go to patients. It is in fact a quality of care issue that we are here to address, and I think the quicker we can do it, the more resources we have, not only to assure there is no waste, fraud and abuse in the future, but we also can have a greater confidence in the Medicare system as far as a delivery of health that everybody appreciates.

I thank both of you for your willingness. This hearing is adjourned.

[Whereupon, at 1:30 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
OFFICE OF SPECIAL INVESTIGATIONS
July 22, 1999

The Honorable FRED UPTON
Chairman, Subcommittee on Oversight and Investigations
Committee on Commerce
House of Representatives

DEAR MR. CHAIRMAN: On July 14, 1999, representatives of GAO's Health, Education and Human Services Division and Office of Special Investigations (OSI) presented testimony, entitled *Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors,* before your Subcommittee. At that hearing, Representative John Dingell requested that OSI provide additional information to the Subcommittee. Specifically, he asked that we elaborate on the bulletted examples of contractor improprieties enumerated in the testimony and explain the effect of the improprieties on taxpayers. The enclosed document is submitted for the record in response to Representative Dingell's request.

Sincerely yours,

ROBERT H. HAST
Acting Assistant Comptroller General for Investigations

Enclosure
cc: Representative John D. Dingell

MEDICARE CONTRACTOR IMPROPRIETIES

1. Contractors improperly screened, processed, and paid claims, resulting in additional costs to the Medicare program. Contractors arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review

HCFA required contractors to properly screen and process claims to ensure that (1) claims submitted for payment were, in fact, eligible for payment under the Medicare program and (2) Medicare paid the appropriate amount on claims. Contractors' computer edits were designed to catch claims with errors or other problems, such as duplicate claims, claims with missing or inaccurate information, claims for services that were not medically necessary, or claims for services that exceeded the limit for such services. Claims that contained errors or that were incomplete were to be "developed" (reviewed and corrected) before payment to ensure that payments were correct.

In our review, however, we found that Medicare contractors had been accused of, or had admitted to, failing to abide by the above requirements. For example, it was alleged that:

- BCBS of Illinois sometimes failed to send out MSP [1] letters to beneficiaries, thus using Medicare funds to pay claims that were potentially the responsibility of

[1] In the early to mid-1980s, Congress passed legislation making Medicare the secondary payer on claims involving beneficiaries who are also covered by Black Lung, Veterans Health Administration, or private employee health plans, which are now treated as primary payers. HCFA requires carriers to send MSP letters to beneficiaries for completion when a Medicare claim is first

other insurers. In addition, in times of high claim inventory, BCBS of Illinois paid incomplete or improperly filed claims of less than $50 without developing them as required.

- In an effort to receive the maximum payment for the number of claims processed, Blue Shield of California rushed claims through the processing system, shutting off computer edits designed to catch problem claims. Blue Shield of California also paid claims without proper physician signatures or backup documentation. In other instances, it denied claims instead of developing them as required.

2. Contractors destroyed or deleted backlogged claims

Contractors admitted or were alleged to have unproperly destroyed or deleted claims before processing them so as to appear to meet HCFA's timeliness standards for claims processing.

For example, it was alleged that:

- BCBS of Illinois, using special computer coding, sometimes deleted (by pulling from the nominal processing line) claims that contained incomplete or incorrect information, which needed development, in order to eliminate backlogs of unprocessed claims. Once deleted, the claims were neither paid nor developed. Claimants were neither notified of the nonpayment of their claims nor informed of the items that needed development.
- When Blue Shield of California fell behind and was unable to process claims in accord with HCFA's timeliness standards, it sometimes deleted claims and then reentered them with new dates and control numbers. In doing this, the contractor gained additional time to process the claims while it appeared to meet HCFA's timeliness criteria.

3. Contractors failed to recoup within the prescribed time moneys owed by providers and failed to collect required interest payments

HCFA required that contractors recoup overpayments to providers within 30 days of the date an overpayment was determined. If overpayments were not secured within 30 days, contractors were required to assess interest on the overpayment amount and to withhold the total amount due from future weekly payments[2] to the providers. Despite this requirement, it was alleged that from 1988 through 1993, BCBS of Michigan had circumvented a requirement to collect provider overpayments within 30 days of the overpayment determination date and had used various evasive means to make it appear that payments were collected on time when, in fact, they were not. As a result, Medicare suffered not only from the untimely repayment of such overpayments but also from the lost interest that should have been assessed on overdue overpayments but was not.

Pennsylvania Blue Shield also allegedly failed to recover overpayments resulting from computer system errors.

4. Contractors switched off customer service telephone lines when staff could not answer incoming calls within the prescribed time limit

Individuals we interviewed told us that HCFA evaluated contractor response time to incoming customer telephone calls, which generally were considered "answered late" if they were not answered within 120 seconds. When BCBS of Illinois monitors showed that it was exceeding the 120-second time limit, supervisors, including the qui tam relator, were instructed to shut off some or all of its 1-800-telephone lines. This prevented the calls from showing up as "answered late" on computer reports, from which data was forwarded to HCFA.

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filed for their benefit. MSP letters establish whether beneficiaries are covered by other insurance plans, are used to determine the order in which Medicare will pay claims relative to other insurers, and affect the dollar amount Medicare will pay on claims.

[2] Some Part A providers receive weekly payments from HCFA under the Periodic Interim Payment program, based on their prior-year cost reports and current-year quarterly reports. Fiscal intermediaries are required to adjust weekly payments, if necessary, each time the provider files a quarterly report. The goal is for weekly payments to total at least 95 percent of the total actual provider costs for the year. At the end of the year, the fiscal intermediary must collect any overpayment from, or pay any underpayment to, a provider, as determined by the year-end cost report, within 30 days of the date of determination of an overpayment or underpayment, per HCFA criteria.

5. Contractors altered or hid files that involved claims that had been incorrectly processed or paid and altered contractor audits of Medicare providers before HCFA reviews. Contractors manufactured documentation to support paying claims which otherwise would have been rejected as medically unnecessary. Contractors falsified documentation and reports to HCFA regarding their performance

To circumvent HCFA's annual and periodic reviews of the contractors' actual performance, according to admissions and allegations, contractors, among other actions, improperly altered problem claim and audit files, hid problem files, or otherwise did not make problem files available to HCFA. For example, a former contractor employee told us that, for the weekly quality assurance reviews, Blue Shield of California improperly fixed claims that had been processed incorrectly and were to be reviewed by HCFA. It did so, for example, by (1) stamping "signature on file" on claims that had been paid without a doctor's signature; (2) detaching documents, such as another insurance company's Explanation of Benefits, from improperly denied MSP claims to give the appearance that the denials were correct; and (3) altering procedure codes to make it appear that claims had been paid properly when they had not.

HCFA's CPEP and CPE evaluations of contractor performance included, among other aspects, reviews of claims processing and payment safeguards. In support of these performance evaluations, Medicare contractors were required to file periodic reports with HCFA. These reports included information about claims processing errors, MSP errors, claims-processing timeliness, and contractor response time to incoming customer telephone calls. Both BCBS of Illinois and Blue Shield of California admitted in their plea agreements with the government that they had falsified reports to make their performance appear acceptable to HCFA.

EFFECT OF MEDICARE CONTRACTOR IMPROPRIETIES ON TAXPAYERS

When contractors improperly turn off edits, fail to properly develop, process, or audit claims, or improperly deny or delete claims, Medicare pays more or less than it should on claims. If Medicare pays more than it should, the result is additional costs to the Medicare program. If Medicare pays less than it should, Medicare beneficiaries do not receive the benefits to which they are entitled.

Customer service is also affected by improper contractor activities. Providers and beneficiaries are forced to resubmit claims that are improperly destroyed, deleted, or denied, causing delays in payment, unnecessary duplication of effort, and additional administrative costs to providers who must resubmit such claims. When claims are denied or deleted without the claimants being notified of any underlying problems with the claims, the claimants may me replacement claims containing the same mistakes. Further, shutting off customer service telephone lines results in customer calls not getting through to the contractor.

Providing HCFA with false work-processing samples relative to their performance under Medicare contracts resulted in contractors receiving false high scores and the false appearance of superior performance. This resulted in Medicare contractors retaining their contracts even when their performance was deficient. In the case of BCBS of Illinois, this also resulted in the receipt of over $1 million in incentive payments, for its supposedly superior performance, to which it was not entitled. Finally, it resulted in HCFA malting incorrect management decisions, such as when it awarded the intermediary and carrier responsibility for the state of Michigan to BCBS of Illinois after alleged contractor improprieties by BCBS of Illinois were brought to light. Later, BCBS of Illinois pled guilty to similar improprieties.

Medicare is a publicly funded program supported by taxpayer dollars. Taxpayers, including Medicare beneficiaries, may lose confidence in the Medicare program when it is the subject of fraud, waste, and abuse as the result of contractor improprieties.

HOW HEALTHY ARE THE GOVERNMENT'S MEDICARE FRAUD FIGHTERS?

THURSDAY, SEPTEMBER 9, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Fred Upton (chairman) presiding.

Members present: Representatives Upton, Barton, Cox, Bilbray, Ganske, Blunt, Bryant, Bliley (ex officio), Klink, Stupak, Green, McCarthy, and DeGette.

Staff present: Chuck Clapton, majority counsel; Amy Davidge, legislative clerk; and Chris Knauer, minority investigator.

Mr. UPTON. Good morning, everyone. Welcome back.

Today, the subcommittee holds another hearing examining the problem of fraud, abuse and mismanagement affecting the Medicare program. The focus of today's hearing will be on the Medicare contractors who are supposed to serve as Medicare's front line of defense in the war against health care fraud and abuse.

During the subcommittee's hearing last July we learned that at least some of these contractors have in fact been part of the fraud and abuse problem that they were supposed to be combatting. In too many cases, we found that the fox was guarding the hen house.

Medicare, which provides health benefits for the majority of America's seniors, faces a daunting problem relating to fraud and abuse, which costs the program billions of dollars every year. The Office of Inspector General at the Department of HHS has estimated that every year more than $12.6 billion worth of improper Medicare payments are made. Every time that a medical provider is paid for a fraudulent claim, a hospital is able to double bill for a service or a nursing home inflates the amount of care above which it actually provided, scarce Medicare funds are wasted. Every one of these dollars could otherwise be going to improve the quality of health care for America's seniors. It is imperative that we in the Congress do all that we can to combat this rampant abuse.

In several cases Medicare contractors were found to be committing acts of fraud which resulted in the waste of millions of Medicare dollars. During the July hearing before this subcommittee, the GAO released two reports which detailed several of the cases which had been brought against these contractors. These cases to date

have resulted in civil and criminal fines being leveled against these contractors in excess of $260 million.

We will hear from several witnesses who observed firsthand how these contractors cheated the system, either for their own gain or to hide their inadequate performance. These witnesses and other whistle-blowers like them are to be commended. But for them, many of these fraudulent schemes would never have been uncovered, and Medicare would in all likelihood still be continuing to waste untold sums of money on additional improper payments.

The activities these witnesses will describe are particularly disturbing: Contractors fabricating audits and other performance evaluation documents, failing to recoup moneys owed to the Medicare program, destroying Medicare claims, and improperly screening claims so that fraudulent or abusive claims went undetected. We will also hear about the ongoing nature of this problem with pending investigations of Medicare contractors continuing to relate to these types of allegations.

We will also hear from several Medicare contractors who have entered into civil and/or criminal settlements with the U.S. Government as a result of these allegations. Their testimony will hopefully shed light on how and why these abuses could have happened.

The subcommittee hopes to learn from this testimony what factors encouraged some contractors to break the law and why their activities went undetected for so long. In addition to reviewing the culpability of individual contractors, the subcommittee will also inquire into the role that HCFA's management of these contractors played in contributing to these activities.

During the previous hearing, GAO testified how HCFA's woeful lack of oversight of its contractors contributed to the problem. By assessing the reasons why this happened and possibly continues to happen, the members of this subcommittee will then be better prepared to consider appropriate reforms to combat this problem with the Medicare program.

Finally, the committee will hear from the National Association of Blue Cross and Blue Shield plans. Blue Cross Blue Shield plans represent the majority of Medicare contractors, under both Part A and B of the program. The Association will testify about some of the initiatives their plans are pursuing to ensure greater compliance with Medicare regulations, along with rigorous self-auditing and employee ethics training that will be used to detect and/or prevent future abuses. They will also make several recommendations regarding programmatic changes to reduce the opportunity for future abuses of the Medicare program.

I would like to thank the Association for agreeing to testify today and also for their assistance in setting up inspections by the committee staff of two of the better Medicare contractors over the past August recess. These inspections, which included meeting with senior management of the plans and examinations of their claims processing and anti-fraud units, shed valuable light upon what Medicare contractors are capable of when properly organized and operated. The standards of quality and commitment to program integrity maintained by these contractors should be commended and, more importantly, should be studied and emulated by all Medicare contractors.

This subcommittee is committed to working with all interested parties to ensure that the problem is resolved once and for all. Chairman Bliley, along with Mr. Barton and myself, recently wrote to Penny Thompson, Director of Program Integrity Efforts at HCFA, asking her to provide regular reports on the progress that has been made to remedy the numerous problems that have been identified with Medicare contractors in their processing of Medicare claims. Hopefully, by continuing to pursue such efforts and engaging in rigorous oversight of these issues, the subcommittee can effect some meaningful changes that will in fact reduce the incidence of fraud and abuse within the Medicare program. America's seniors and all who depend on Medicare for their health care should expect no less.

I welcome all of the witnesses who have come to testify today and at this time recognize my friend and ranking member of the subcommittee, Mr. Klink from Pennsylvania.

Mr. KLINK. I thank the distinguished chairman and welcome him back to Washington, DC. I trust everything was well in Michigan.

I thank the chairman for having this hearing. As you well know, over many years this subcommittee has spent considerable time and effort examining how HCFA's Medicare contractors oversee the Medicare program. In administering Medicare, HCFA currently uses the services of private sector insurance carriers called fiscal intermediaries. They process the claims, conduct the audits, provide medical reviews and perform a host of other activities designed to prevent waste and fraud and abuse.

The government has essentially privatized many of the functions of safeguarding the program by allowing these intermediaries to process and pay out claims and to conduct related audits. Ideally, these intermediaries are supposed to conduct such functions by applying their own private sector expertise to protecting Medicare dollars. In theory, the taxpayer should be getting state-of-the-art private sector techniques with the $1.6 billion that we pay Medicare contractors to run the programs. Nevertheless, as has been demonstrated over the years through a number of investigations, the effectiveness of some fiscal intermediaries in safeguarding this fund is open to serious debate.

What we will hear again today is that some of the very contractors the government hires to protect the program are in some cases the very entities that are abusing it. As was revealed in the GAO's July testimony, no fewer than one in four contractors have been alleged, generally by whistle-blowers within the company, to have integrity problems. In fact, GAO has identified at least seven of HCFA's 58 current contractors as being actively invested by the HHS OIG or Justice. That is a problem.

We need to figure out what is happening. We need to figure out its implications on safeguarding the Medicare program.

So I look forward to learning even more about what went wrong with the Colorado and the New Mexico fiscal intermediaries which both the HHS IG and the GAO will discuss in further detail today, and I look forward to hearing from some of the lawyers and the whistle-blowers related to certain Medicare contractors' integrity cases, including Blue Cross Blue Shield of Illinois and Blue Cross Blue Shield of Michigan.

Finally, I look forward to hearing from some of the Medicare contractors themselves, as well as their national associations, so that they might provide some insight or shed some light into what went wrong with each of their respective companies and what changes must be made to prevent such abuses from occurring again in the future.

Again, I thank the chairman for holding this hearing, and I look forward to hearing from many of the outstanding witnesses today. And with that I yield back my time.

Mr. UPTON. Thank you, Mr. Klink.

I yield to the chairman of the full committee, Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Fraud directed against the Medicare program is never acceptable. Whether it is committed by doctors, hospitals or pharmacies, such fraud impacts and diminishes the quality of healthcare which would otherwise be available for the 40 million American senior citizens and other beneficiaries who depend upon Medicare to help pay for their health care costs. In addition, these types of fraud cost the American taxpayers billions of dollars every year.

One of the most egregious form of Medicare fraud discovered by the committee has been those illegal activities perpetrated by the very contractors who are supposed to administer the Medicare program. These contractors are supposed to be protecting the program by leading the efforts to detect and prevent fraud and abuse. To the contrary, we have heard in previous hearings how some contractors have engaged in fraudulent conduct for their own enrichment or to hide their inadequate performance from the Health Care Financing Administration.

We learned at the last hearing on this topic how six Medicare contractors have either settled or been convicted of a variety of civil and criminal charges relating to their efforts to defraud Medicare. These settlements resulted in fines of over $260 million being assessed against these contractors. After the July 14 hearing, we then learned of a new Medicare contractor case which involves similar allegations of misconduct. This case involved the Medicare contractors in New Mexico and Colorado and resulted in guilty pleas on two serious felony charges as well as over $13 million in civil and criminal fines being paid to settle the government's claims.

It is unacceptable for contractors to be engaging in these types of behavior. Schemes such as the one I have detailed have caused Medicare to be deprived of untold millions of scarce program dollars. The organizations and persons responsible for this conduct should be vigorously investigated, prosecuted and, if found guilty, expelled from the Medicare program. In addition, they should be subject to the full range of penalties and punishments that the Department of Justice and the Office of Inspector General can impose upon them. There can be no excuse for cheating the Medicare program, and we must do everything possible to ensure that those that attempt to do so will fully understand that they will eventually be caught and punished accordingly.

While fully supporting the vigorous prosecution of all Medicare contractors who attempt to defraud the program, it is also important that we learn how and why these activities occurred. In our

last hearing we heard how HCFA's lax management of its own contractors, coupled with arbitrary performance standards, contradictory guidance for regional offices and complex and sometimes conflicting regulations all contributed to the contractor fraud problem.

I look forward to hearing from all of the witnesses, both whistleblowers and representatives from the contractors, on their views on how these factors contributed to the problem. We have an obligation to ensure that Medicare is doing the best job possible in fairly and accurately paying for the health care costs of America's seniors. The evidence developed by the committee to date suggests that the current program is failing to do so.

I would like to thank Chairman Upton for holding this hearing today, which will hopefully shed new light on how this program is being taken advantage of and how it should be improved to prevent further abuse.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you.

My friend from Michigan, Mr. Stupak.

Mr. STUPAK. Well, thank you, Mr. Chairman.

I don't have an opening statement.

I want to apologize to our witnesses. I have got a 10:30 I have to be at on youth violence. Then I will be back. So I will be in and out all day.

But this is an area I have worked on with all my years of experience in law enforcement. So I look forward to the hearing and thank you for holding it.

Mr. UPTON. Mr. Blunt.

Mr. BLUNT. Thank you, Mr. Chairman; and thank you for holding this hearing.

I'd like to associate myself with the remarks just made by the chairman of the full committee. I certainly agree in totality with his sense that this is a system where the Congress needs to be vigilant in ensuring that fraud doesn't occur.

I'd also like to add to that, though, that those agencies that work to eliminate fraud in this system have to be cautious that they don't do so in a way that stands in the way of legitimate health care. I think we have to be careful that we don't make the daily activities of health care providers subject to fraud where clearly mistakes can and will occur. I think that is the biggest thing we need to be aware of as we look at the answer to the fraud problem, that we deal with the problem of fraud and still create a system that allows health care providers to provide health care, not to constantly be subject to criminal penalty because of some paperwork mistake that can be made.

Now that is a difficult line to walk. I am not sure this committee can figure out how to walk it, but I am sure that we have an obligation to monitor the progress of fighting fraud and, at the same time, ensuring quality health care and that health care providers are provided health care, not filling out a single needless form but at the same time complying with all the things that have to be complied with to ensure that this system works the way it should work.

I look forward to the hearing and testimony, and I appreciate you having this hearing today, Mr. Chairman.

Mr. UPTON. Thank you, Mr. Blunt.

Mr. Green, do you have an opening statement?

Mr. GREEN. No, Mr. Chairman. I appreciate the opportunity.

Mr. UPTON. Well, we would note there are a number of subcommittees meeting this morning, all at the same time, and we will leave the record open for all members to make their opening statements as part of the record by unanimous consent.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

I thank the chairman for holding today's hearing. I would like to thank all of our panelists for being here this morning, and extend a special welcome to Michael Huotari from Blue Cross and Blue Shield of Colorado.

In our first hearing we heard that private companies, hired by the federal government to safeguard Medicare dollars, are plundering the Medicare Trust Fund through fraud and abuse. Nine companies had entered into civil settlements with the Federal Government as a result of fraud, and two had been convicted of criminal wrong doing. Today we will hear about three more guilty pleas. I hope we will use today's hearing to explore how we can prevent such activity. While HCFA and its entities have some of this responsibility, I am anxious to hear from the contractors themselves to learn what steps they have taken to prevent these abuses in the future.

In order to preserve the Trust Fund, it is essential that Medicare have an effective system to stop fraud and abuse. The GA0 report clearly illustrates that the current system needs significant work. It is inexcusable that the fiscal intermediaries hired by Medicare to ensure the validity of health care claims are the very entities who are committing fraud to hide their incompetencies. We must evaluate the current system that breeds these abuses and search for new ways to provide incentives for good performance as well as incentives for companies to report improper conduct should it occur.

The GAO reports of destroyed or deleted backlogged claims and revelations of manufactured documentation to mislead HCFA auditors certainly illustrate that there is plenty of blame to go around. It is shocking that seventeen of eighty Medicare contractors are currently under some sort of review for impropriety. The Federal Government pays billions to its Medicare contractors to police the Medicare program and ensure that taxpayer dollars are going toward necessary medical care. Now that we have learned that some of the cops on the beat have been skimming off the top, it is time to reassess. Let me make this clear, if Medicare contractors defraud the Federal Government knowingly and purposefully, they will be punished. But punishment after the fact will not solve the problem. If contractors are covering up mismanagement and failure to perform contractual obligations, perhaps HCFA should enlarge its oversight and improve its methods of measuring contractor performance. If contractors look the other way when improper conduct occurs for fear of retribution, perhaps these companies should improve their internal auditing practices and HCFA should develop guidelines to help companies come clean.

I hope today's hearing will shed some light on why six companies were found guilty of defrauding the Medicare system and subjected to $263 million in criminal fines and civil settlements. But, more importantly, I hope we will begin to hear how HCFA and its contractors can turn the tide against these abuses in order to safeguard the Medicare program and ensure that Medicare beneficiaries get the care they deserve.

Thank you Mr. Chairman, I yield back the balance of my time.

Mr. UPTON. At this point, I'd like to welcome the first panel: Ms. Leslie Aronovitz, a CPA from the Chicago field office of GAO, accompanied by Mr. Robert Hast, the Acting Assistant Comptroller General; Mr. George Grob, Deputy Inspector General for Evaluations and Inspection from the Office of Inspector General from the Department of HHS, accompanied by Mr. Jack Hartwig, who is the Deputy Inspector General for Investigations; Mr. Darcy Flynn; and Mr. Ronald Osman.

As you all may know, this subcommittee has a long tradition of taking testimony under oath. Do you have any objection to that?

We also, under committee rules, allow you to be represented by counsel, if you desire that; and seeing not, if you'd stand and raise your right hand.

[Witnesses sworn]

Mr. UPTON. You are now under oath, and I want to compliment you for turning in your testimony in advance. We were able to read it last night, and your testimony will be made part of the record in full. We would like you to limit your remarks, if you can, to 5 minutes or so.

We will start with Ms. Aronovitz. Thank you for coming.

TESTIMONY OF LESLIE G. ARONOVITZ, MANAGER, CHICAGO FIELD OFFICE, UNITED STATES GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT HAST, ACTING ASSISTANT COMPTROLLER GENERAL; GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTION, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JACK HARTWIG, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL; DARCY FLYNN; AND RONALD E. OSMAN, OSMAN & ASSOCIATES, LTD.

Ms. ARONOVITZ. Mr. Chairman and members of the subcommittee, first I would like to introduce my colleague, Bob Hast.

We are very pleased to be here today to discuss the activities of Medicare fee-for-service service claims administration contractors. These contractors, as Mr. Klink noted, received $1.6 billion in fiscal year 1998 to process more than $700 million in Medicare claims each business day on behalf of HCFA. Findings of inappropriate Medicare payments to providers, totaling billions of dollars each year, have heightened concerns about the program's management. Cases in which contractors themselves have engaged in improper activities and even defrauded Medicare dramatically compound these concerns.

Our testimony today expands onto that we provided to the subcommittee this past July. In it we focus on how deceptive activities became a way of doing business at some of HCFA's Medicare contractors, why HCFA did not detect these activities through its oversight, and weaknesses in HCFA's current monitoring process that could allow these types of activities to continue without detection.

Following allegations that they engaged in fraudulent or otherwise improper activities, at least six Medicare contractors have been convicted of criminal offenses, have been fined or have entered into civil settlements since 1993, and we heard in the IG's July testimony that several others are currently under investigation. This does not include additional contractors whose cases are the subject of Mr. Grob's testimony today.

As examples of the types of activities we are talking about, we found that some contractor employees engaged in improprieties and covered up poor performance to allow contractors to keep their Medicare business. Admitted or alleged improper activities included but were not limited to improperly screening, processing and paying Medicare claims, destroying claims and failing to prop-

erly collect money owed to Medicare by providers. In addition, contractors falsified their performance results and engaged in activities designed to deceive HCFA and circumvent its review of contractor performance. Also, because HCFA gave contractors too much advance notice of its oversight visits and the specific records that would be reviewed, it often failed to detect improper contractor activities.

The fraud alleged in integrity cases, such as those we have described today and will continue to describe, began when CPEP, which is the Contractor Performance Evaluation Program, was HCFA's primary means of assessing contractors from fiscal years 1980 through 1995. In some cases, the fraud continued under HCFA's current system, which is called the CPE oversight process.

The CPE process has a number of weaknesses that continue to make the program vulnerable to contractor fraud. For example, HCFA relied on contractors' self-certification of management controls and contractors' self-reported performance data, both of which it rarely checked. Further, HCFA currently has few standards to measure a contractor's performance. Until recently it had not set evaluation priorities for its regional review staff and still does not check on the quality of regional oversight to ensure that HCFA staff are held accountable for providing adequate oversight. Important program safeguards have received little scrutiny at some contractors, and regional staffs have been inconsistent in dealing with contractor performance problems.

In an effort to establish more consistency and to improve the quality of contractor management and oversight, HCFA has recently modified its organizational structure and is planning to take a number of other steps to improve its management and oversight of its claims administration contractors. We believe these actions have the potential to make the Medicare program less vulnerable to the types of abuses that have been described here today, but even the most sound oversight strategy is not foolproof.

Government contractors, especially those that play an important stewardship role in protecting the Medicare trust fund, must conduct themselves with the utmost integrity and honesty. We believe that there is no excuse for anything less.

Mr. Chairman, this concludes my formal statement. We will be happy to answer any questions you may have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, AND ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER GENERAL FOR SPECIAL INVESTIGATIONS, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss HCFA's efforts to monitor the activities of Medicare fee-for-service claims administration contractors. These contractors pay more than $700 million in Medicare claims each business day on behalf of the Health Care Financing Administration (HCFA)—the primary steward of Medicare funds. HCFA paid these contractors $1.6 billion in fiscal year 1998 to serve as Medicare's first line of defense against inappropriate and fraudulent claims. Findings of inappropriate Medicare payments to providers totaling billions of dollars each year have heightened concerns about the program's management. Cases in which contractors themselves have engaged in improper activities and even defrauded Medicare dramatically compound the concerns.

Our testimony today will expand on the testimony we provided to this Subcommittee this past July.[1] Specifically, we will discuss how deceptive activities became a way of doing business at some of HCFA's Medicare fee-for-service contractors; the details of Medicare contractor improprieties for which there have been criminal convictions, fines, or civil settlements; and the effect of these activities on the Medicare program.[2] We will also discuss why HCFA did not detect these activities through its oversight. Finally, based on the findings of our report on HCFA's oversight of its claims administration contractors, we will describe weaknesses in HCFA's current monitoring process that could allow these types of activities to recur without detection.[3]

In brief, following allegations that they engaged in fraudulent or otherwise improper activities, at least eight Medicare contractors have been convicted of criminal offenses, have been fined, or have entered into civil settlements since 1993. Over several years, some of these contractors' employees engaged in improprieties and covered up poor performance to allow contractors to keep their Medicare business. Admitted or alleged improper activities included, but were not limited to, improperly screening, processing, and paying Medicare claims; destroying claims; and failing to properly collect money owed to Medicare by providers. In addition, contractors falsified their performance results and engaged in activities designed to deceive HCFA and circumvent its review of contractor performance. These fraudulent and improper activities have adversely affected taxpayers, providers, and beneficiaries. Because HCFA gave contractors too much advance notice of its oversight visits and the records that would be reviewed, it often failed to detect improper contractor activities. HCFA's current oversight has other weaknesses that might allow the same types of improper contractor activities to continue undetected.

BACKGROUND

To illustrate the significance of the contractors' improprieties, I will first explain briefly what the insurance companies are required to do while processing claims and how HCFA determines whether the companies meet those requirements.

Under their contracts with HCFA, Medicare contractors are required to process claims in accordance with HCFA guidelines and report their performance accurately to HCFA. The contractors are required to, among other activities, (1) properly screen and process claims to ensure that the claims are eligible for Medicare payment and that Medicare pays the correct amount; (2) process claims in a timely manner; (3) answer beneficiary and provider telephone calls in a timely fashion; (4) provide samples of claims, provider audit files, and related workpapers to HCFA; and (5) accurately report claims processing and payment errors to HCFA.

During the 1980s and through fiscal year 1994, HCFA evaluated contractor performance through its Contractor Performance Evaluation Program (CPEP). During CPEP audits, HCFA examined sample files from various contractor units to score functions performed by each unit. HCFA used CPEP scores in several ways—for example, to determine whether contracts should be renewed, and sometimes to award incentive payments to contractors. HCFA terminated CPEP in 1994 because it found that contractors strove merely to maximize CPEP scores rather than improve their overall performance, and several contractors provided false information to HCFA to achieve higher CPEP scores. In fiscal year 1995, HCFA replaced CPEP with the Contractor Performance Evaluation, or CPE. The CPE process allows HCFA's reviewers discretion to evaluate any contractor activity, including claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities.

CONTRACTORS DECEIVED HCFA CONCERNING THEIR POOR PERFORMANCE

As we reported on July 14, 1999,[4] since 1993, criminal or civil actions have been taken against at least six Medicare contractors because of their performance. The criminal actions generally involved conspiracy, obstruction of federal audits, and

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[1] *Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors* (GAO/T-HEHS/OSI-99-167, July 14, 1999).

[2] *Medicare: Improprieties by Contractors Compromised Medicare Program Integrity* (GAO/OSI-99-7, July 14, 1999).

[3] *Medicare Contractors: Despite its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

[4] GAO/OSI-99-7, July 14, 1999.

false statements. The civil actions involved settlements related to *qui tam* [5] complaints filed by contractor employees in which the federal government intervened. Over $235 million in civil and criminal fines have been assessed against those six contractors.[6] On July 28, 1999, the Justice Department announced that two additional contractors [7] and a related company that the contractors jointly owned [8] have pleaded guilty to criminal felony counts related to their Medicare business. Similar to the cases we discussed in our July reports and testimony, the two Medicare contractors and the related company pleaded guilty to conspiracy to obstruct a federal audit after admitting they concealed evidence of poor performance from federal auditors. In addition, the two contractors pleaded guilty to attempting to obstruct a federal audit. The three companies agreed to pay a total of $1.5 million in criminal fines to the government. Also, the two Medicare contractors have entered into a civil settlement of nearly $12 million.

Our report on contractor improprieties focused primarily on three contractors—Blue Cross Blue Shield (BCBS) of Illinois, Blue Shield of California, and BCBS of Michigan. In all these cases, the contractors entered into civil settlements and, in two, contractors pleaded guilty to multiple counts of criminal fraud.

Employees at all levels of those contractors—including vice-presidents for Medicare operations, their directors of operations, managers, supervisors, and staff-level employees—had engaged, or were alleged to have engaged, in fraudulent and other improper activities for prolonged periods of time. These employees failed to properly conduct claims processing and safeguard activities and then covered up their poor performance by doctoring records that HCFA staff reviewed. The employees did so because they feared losing their Medicare contracts and their jobs if they did not meet HCFA's expectations. Investigators and former contractor employees told us that manipulating samples, covering up errors, and "fixing" HCFA-selected records before HCFA's review became a way of life at each of the three contractors. Indeed, the contractors allegedly designed the activities to deceive HCFA by creating the false appearance that they were meeting HCFA's criteria. According to three former contractor employees and investigators in two of the cases, such activities spread as employees at various levels and units taught each other how to commit improprieties.

Improper Contractor Activities Hid Poor Performance

Our report presents a number of examples of criminal and other improper activities that contractors allegedly or admittedly engaged in to deceive HCFA. In the three cases on which we focused, federal investigators documented many of the activities alleged by the *qui tam* whistleblowers. The five general categories of alleged improper activities illustrated by the following examples were related to us by federal investigators, *qui tam* whistleblowers and other former contractor employees, and one whistleblower's attorney, or were described in qui tam complaints, plea agreements, or other public documents:

- *Improperly screening, processing, and paying Medicare claims.* In an effort to receive the maximum payment by maximizing the number of claims processed, Blue Shield of California, according to the investigating agent, rushed claims through the processing system, shutting off computer edits designed to catch problem claims. Blue Shield of California, according to the qui tam whistleblower, also paid claims without proper physician signatures or backup documentation.
- *Improperly destroying or deleting claims.* In order to eliminate backlogs of unprocessed claims, BCBS of Illinois allegedly deleted some claims that contained incomplete or incorrect information by using special computer coding. Claimants were not notified that these claims would not be paid nor told what information was needed to correctly process their claims and then given an opportunity to provide it.
- *Failing to collect Medicare overpayments and interest, as required.* While not admitting to wrongdoing, BCBS of Michigan settled a civil suit for $27.6 million. Among the allegations in that suit was that, from 1988 through 1993, BCBS

[5] *Qui tam* suits are filed under the False Claims Act, 31 U.S.C. sections 3729-3733. The act's *qui tam* provisions permit filers, often referred to as "relators" or whistleblowers, to share in financial recoveries resulting from their cases.

[6] In addition to the $235 million recovered from these companies as civil settlements and criminal fines and penalties in civil and criminal fraud cases, at least three of these companies have also entered into settlements in civil liability cases brought by HCFA for recovery of about an additional $30 million owed to Medicare under the Medicare Secondary Payer program.

[7] Rocky Mountain Hospital and Medical Service (doing business as Blue Cross and Blue Shield of Colorado) and New Mexico Blue Cross and Blue Shield, Inc.

[8] Rocky Mountain Health Care Corporation.

of Michigan circumvented a requirement to collect provider overpayments within 30 days of the overpayment determination date by making it appear that payments were collected on time when, in fact, they were not. As a result, the contractor allegedly did not assess interest on the overpayments as required.

- *Falsifying documentation and reports to HCFA regarding performance.* BCBS of Illinois and Blue Shield of California admitted in their plea agreements with the government that they had falsified reports on which CPEP and CPE performance evaluations were based in order to make their performance appear acceptable to HCFA. These reports included information about claims processing errors, claims processing timeliness, and timely contractor response to incoming customer telephone calls.
- *Improperly altering or hiding files that involved incorrectly processed or paid claims and inadequately performed contractor audits of Medicare providers prior to HCFA's review of such files.* Blue Shield of California improperly fixed claims that had been processed incorrectly and were to be reviewed by HCFA. It did so, for example, by (1) stamping "signature on file" on claims that had been paid without a signature; (2) detaching documents, such as another insurance company's Explanation of Benefits, from improperly denied Medicare Secondary Payer claims[9] to give the appearance that the denials were correct; and (3) altering procedure codes to make it appear that claims had been paid properly when they had not. The whistleblower in the BCBS of Michigan case alleged that this contractor, prior to HCFA's review, redid original audit workpapers, improperly altered audit records, did required audit work that had not been completed, and obtained new information from providers that should have been collected in the original audit. In some cases, according to the whistleblower, the contractor steered HCFA away from problem audits by lying about their status if the audits could not be adequately "fixed" in time for HCFA's review.

Improprieties Harm the Medicare Program, Its Providers, and Beneficiaries

Medicare pays claims incorrectly when contractors improperly turn off edits; fail to properly develop, process, or audit claims; or improperly deny or delete claims. This can lead to additional costs to the Medicare program. When contractors use evasive means to make it appear that overpayments are collected on time, Medicare suffers not only from the untimely repayment of such overpayments but also from the lost interest that should have been assessed on overdue overpayments.

Customer service is also affected by improper contractor activities. Providers and beneficiaries are forced to resubmit claims that are improperly destroyed, deleted, or denied. This causes delays in payment, unnecessary duplication of effort, and additional administrative costs to Medicare claimants. When claims are denied or deleted without the claimants being notified of any underlying problems with the claims, the claimants may file replacement claims containing the same mistakes.

Providing HCFA with false work-processing samples relative to their performance under Medicare contracts resulted in contractors receiving scores that were too high, leading to the false appearance of superior performance. This allowed Medicare contractors to retain their contracts even when their performance was deficient. BCBS of Illinois received over $1 million in incentive payments as a result of its offenses.

In addition, providing false information led HCFA to make a poor management decision in reassigning claims administration workload. In 1994, HCFA awarded BCBS of Illinois the intermediary and carrier contracts for the state of Michigan, after alleged contractor improprieties by BCBS of Michigan were revealed. In a March 1994 announcement of this workload transfer, a former HCFA Administrator was quoted as saying, apparently based on HCFA evaluations tainted by the contractor's deceptive activities, that the Health Care Service Corporation (BCBS of Illinois) "has a record of outstanding performance in administering the Medicare program in Illinois." He was also quoted as saying that "the selection of Health Care Service Corporation as the replacement contractor was based on a record of integrity, cost-effective performance, claims-processing efficiency, ability to assume the workload, and experience." In 1998, BCBS of Illinois pleaded guilty to improprieties similar to those allegedly committed by BCBS of Michigan.

WHY HCFA DID NOT DETECT IMPROPRIETIES

HCFA did not detect fraudulent and improper activities in the three cases we reviewed in depth until former contractor employees brought them to light by filing qui tam complaints under the False Claims Act. The individuals we interviewed—

[9] Medicare is the secondary payer on claims involving beneficiaries who are also covered by Black Lung, Veterans Health Administration, or employer-sponsored group health plans.

including federal investigators, *qui tam* whistleblowers, and other former employees—gave the following reasons why HCFA did not detect contractor improprieties:

- HCFA notified contractors in advance concerning (1) the dates on which it would conduct CPEP reviews and (2) the specific or probable records that it would review. This gave contractors the time and opportunity to manipulate samples and hide problems. HCFA officials sometimes had contractors pull the records to be reviewed and relied on contractor-provided documents that consisted largely of copies, not originals. Document copies could be, and were, altered and recopied without detection.
- Contractors allegedly circumvented HCFA's review of their performance and deceived HCFA about their efficiency in customer service. For example, a former employee of BCBS of Illinois told us that he tracked HCFA's periodic, unannounced telephone calls, which HCFA had designed to check the contractor's response time. In doing so, he identified HCFA's calling pattern. The unit manager then used that pattern to circumvent HCFA's review by putting extra employees on the telephone lines during the anticipated times until they received HCFA's call.
- Contractors also allegedly deviated from their normal procedures to deceive HCFA. For example, according to former contractor employees, BCBS of Illinois reassigned its two most experienced employees to conduct claim reviews that occurred on the days that HCFA had scheduled for review. Contractor managers instructed these employees to slow down the review process and take their time to ensure that the reviews were done with 100-percent accuracy and included proper documentation.

PROBLEMS COULD BE CONTINUING UNDER HCFA'S CURRENT OVERSIGHT PROCESS

The fraud alleged in integrity cases such as those we have described today began when CPEP was HCFA's primary means of assessing contractors—from fiscal years 1980 to 1995. In some cases, the fraud continued under HCFA's current CPE oversight process. The CPE process has a number of weaknesses that continue to make the program vulnerable to contractor fraud. HCFA places too much trust in its contractors by relying on contractor self-certifications of management controls and contractors' self-reported performance data—both of which it rarely checks. Further, HCFA currently has few standards to measure contractors' performance. Until recently, it had not set evaluation priorities for its regional review staff and still does not check on the quality of regional oversight to ensure that HCFA staff are held accountable for providing adequate oversight. Important program safeguards have received little scrutiny at some contractors, and regional staffs have been inconsistent in dealing with contractor performance problems.

HCFA Seldom Validates Contractors' Internal Controls or Workload Data

Medicare contractors are required to certify annually that they have established a system of internal management controls over all aspects of their operations. This helps ensure that they meet program objectives, comply with laws and regulations, and are able to provide HCFA with reliable financial and management information concerning their operations. However, we found that HCFA accepts Medicare contractors' self-certification of management controls without routinely checking that the controls are working as intended. In April 1998, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported that the regional offices were not evaluating the accuracy and reliability of contractor internal control certifications. In response, HCFA headquarters sent guidance to the regional offices reminding them to validate contractors' self-reports during the 1998 evaluation review cycle. Our analysis of fiscal year 1998 reviews performed for seven contractors found no case in which a self-report was validated. We believe systematic validations of contractor internal controls would contribute significantly to reducing the likelihood of contractor fraud.

An equally fundamental activity in overseeing contractor performance is obtaining reasonable assurance that self-reported contractor performance data are accurate. HCFA, however, has largely relied on unvalidated contractor-submitted data to evaluate and monitor performance. We analyzed 170 reports related to contractor performance for fiscal years 1995 through 1997 for the seven contracts we studied; only two of these reports documented efforts to validate contractor-supplied performance data. For 1998, staff in one of the three regions we visited validated contractor data in five reports. Staffs of the other two regions did not validate any performance data over the 4-year period for the contractors we examined.

HCFA Sets Few Performance Standards for Contractors

Except for standards mandated by legislation, regulation, or judicial decision, HCFA's current CPE process is more descriptive than evaluative. There are only a few mandated standards, such as processing claims within specific time periods. No standards require HCFA reviewers to ensure that contractors adequately perform the most important program safeguards—such as medical review of claims. There are few performance standards to motivate contractors and no benchmarks for HCFA to use in holding contractors accountable.

Even where statute or regulation requires HCFA to follow clearly defined and measurable standards, we found that HCFA has not held its reviewers accountable for checking contractor performance for these standards. Reviewers have not always evaluated whether contractors met the mandated standards even when the reviewers were required to do so. Our analysis of CPE reports for three regional offices found that when HCFA reviewers assessed claims processing activities, for example, they only checked contractor compliance with about half of the applicable mandated standards. Furthermore, the three regions varied considerably in their performance of this requirement, with one region checking less than 15 percent of the standards, while another region checked over 80 percent.

HCFA Regions Provide Uneven and Inconsistent Reviews and Remedies

With limited headquarters guidance and little follow-up to ensure that what guidance there is is followed, contractor oversight is highly variable across regions. Without a set of common performance standards or measures, reviewers and contractors lack clear expectations. This has resulted in both uneven review of critical program safeguards—such as checking how effective contractors are at identifying insurers primary to Medicare—and inconsistencies in how HCFA reviewers handle contractor performance problems. Uneven review continues to leave HCFA unable to discriminate among contractors' performance when it needs to reassign workload.

One such critical program safeguard where oversight has been limited and uneven is that of Medicare Secondary Payer—so-called MSP activities. Contractor MSP activities seek to identify insurers that should pay claims mistakenly billed to Medicare and to recover payments made by Medicare that should have been paid by others. This program safeguard has saved about $3 billion annually from 1994 through 1998. Our review of three regions' CPE reports shows that many of the key MSP activities most germane to spotting claims covered by MSP provisions were not reviewed at the seven contractors in our study. Also, the three regions varied considerably in how often they reviewed MSP, with one region rarely checking MSP activities at any of its contractors whose CPEs we reviewed.

The low level of review is particularly disturbing because the potential for contractor fraud regarding MSP activities is significant as a result of an inherent conflict of interest: the private insurance business of the contractor can be the primary payer for some claims subject to the MSP provisions. HCFA has had to pursue several insurance companies—including some with related corporations that serve as Medicare contractors—in federal court for refusing to pay before Medicare when Medicare should have been the secondary payer. In such a case filed by HCFA against BCBS of Michigan, the company agreed to a $24 million settlement. Since 1995, almost $66 million in settlements have been made in cases filed by HCFA in which a health insurance company with private policies that were sometimes primary to Medicare was also a Medicare carrier or intermediary. HCFA currently has filed an additional $98 million in claims against companies affiliated with current and former contractors.

We also found that HCFA's regions differ in their identification of contractor problems and took dissimilar actions once a performance problem was identified. For example, one region required Contractor A to take steps to address deficiencies in its performance in fraud and abuse prevention and detection. In contrast, another region, reviewing Contractor B, found many more serious weaknesses with its fraud and abuse prevention and detection activities. Contractor B was spending little or no time actively detecting fraud and abuse, failed to use data to detect possible fraud, failed to adequately develop large and complex cases, and was not referring cases to the HHS OIG. Furthermore, Contractor B was performing poorly in recovering overpayments, had not focused on the highest-priority cases, prepared no fraud alerts, and was not suspending payments to questionable providers. The reviewer concluded that Contractor B failed to meet HCFA's performance expectations, yet the region did not even require the contractor to develop and follow improvement plans. Because HCFA reviewers are not held accountable for conducting adequate oversight, deficient contractor performance can continue.

HCFA Has Started to Develop a More Structured Evaluation Process

HCFA has recognized that its oversight of contractors has been inadequate and issued guidance in fiscal year 1998 to have regional reviewers follow a somewhat more structured evaluation process. In May 1998, citing concerns raised by the HHS OIG and us regarding HCFA's level of contractor oversight, HCFA announced the "need to reengineer our current contractor monitoring and evaluation approach and develop a strategy demonstrating stronger commitment to this effort." As a result, HCFA issued a contractor performance evaluation plan specifying three evaluation priorities for fiscal year 1998: year 2000 computer compliance activities, activities focusing on a subset of financial management operations (accounts receivable and payable), and activities focusing on a subset of medical review activities.

In 1998, HCFA also emphasized the need for regions to follow its structured CPE report format, including clearly stating whether the contractor complied with HCFA's performance requirements. In addition, the regions were supposed to review certain activities at all contractors. Nonetheless, we found that some of the 1998 reviews continued to lack a structured format, making it difficult to compare contractor performance. Although regions were supposed to review contractors' determinations of medical necessity prior to payment, we found that two of the regions we reviewed did not do so for all of the seven contractors included in our study. Plans for this year's CPE reviews include more central office involvement in the assessment process, joint review teams from headquarters and the regions, and multiregional team reviews.

HCFA Lacks A Structure That Assures Accountability

HCFA's organizational structure is not designed to ensure oversight accountability, with two aspects creating particular problems. First, HCFA reorganized its headquarters operations in 1997, dispersing responsibility for contractor activities from one headquarters component to seven. This functional dispersion was, in part, in response to concern that one office should not oversee all contractor activities. Second, HCFA's 10 regional offices—the front line for overseeing contractors—do not have a direct reporting relationship to headquarters units responsible for contractor performance. Instead, they report to the HCFA Administrator through their respective regional administrators and consortia directors.

In our July 1999 report, we found that these two aspects of reorganization—dispersion of responsibility for contractor activities to multiple headquarters components and regional office reporting relationships—contribute to communications problems with contractors, exacerbate the weaknesses of HCFA's oversight process, and blur accountability for (1) requiring regions to adopt best practices; (2) routinely evaluating the regional offices' performance of their oversight; and (3) enforcing minimum standards for conducting oversight activities, including taking action when a particular region may not be performing well in overseeing contractors. In an effort to establish more consistency and improve the quality of contractor management and oversight, HCFA has recently modified its organizational structure once again by consolidating responsibility for contractor management within the agency and creating a high-level contractor oversight board. It is too early, however, to tell how effective these changes will be in improving accountability for ensuring sufficient and consistent contractor oversight.

GAO'S PREVIOUS RECOMMENDATIONS TO THE ADMINISTRATOR

To improve HCFA's oversight of contractors, we made five recommendations to the Administrator in our July 14, 1999, report:

1. Establish a contractor management policy that requires (1) verification that all contractors have effective internal controls, and (2) systematic validation of statistically significant samples of essential contractor-reported data.
2. Improve annual contractor assessments by:
   —developing a comprehensive set of clearly defined and measurable performance standards, including measures for program safeguard activities;
   —assessing all contractors regularly on core performance standards and reviewing individual contractors on other activities identified by risk assessments; and
   —developing an annual report for each contractor that includes performance on the core standards and other HCFA-assessed standards, using a uniform format that permits comparisons among contractors and longitudinal assessments of individual contractors.
3. Designate a HCFA unit to be responsible for:
   —evaluating the effectiveness of contractor oversight policy and direction from headquarters to regional offices;

—evaluating regional office contractor oversight based on the headquarters' policy and direction; and
—enforcing minimum oversight standards.

4. Ensure that all relevant HCFA staff learns about contractor problems and best practices and that HCFA reviewers adopt best oversight practices.
5. Develop a strategic plan for managing Medicare's claims administration contractors.

In written comments to a draft of our report, HCFA agreed with each of our recommendations and described how it plans to implement them. Overall, we believe that HCFA is planning to take a number of steps in response to these recommendations that—if properly designed and implemented—should help improve its management and oversight of Medicare's claims administration contractors. While we do not believe that implementation of these recommendations will guarantee that contractors will no longer have integrity problems in their dealings with HCFA, we do believe that it will make the Medicare program less vulnerable to the types of abuses that have been described here today.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgment

For future contacts regarding this testimony, please contact Leslie G. Aronovitz at (312) 220-7600 or Robert Hast at (202) 512-7455. Individuals who made key contributions to this testimony included Sheila Avruch, Mary Balberchak, Elizabeth Bradley, Stephen Iannucci, Bob Lappi, Don Walthall, and Don Wheeler.

GAO RELATED PRODUCTS

Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors (GAO/T-HEHS/OSI-99-167, July 14, 1999)
Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999)
Medicare: Improprieties by Contractors Compromised Medicare Program Integrity (GAO/OSI-99-7, July 14, 1999).
HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century (GAO/T-HEHS-99-58, Feb. 11, 1999).
Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy (GAO/AIMD-98-284, Sept. 28, 1998).
Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS-98-160, June 1, 1998).
Medicare: Control Over Fraud and Abuse Remains Elusive (GAO/T-HEHS-97-165, June 26, 1997).
High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997)
Medicare: HCFA's Contracting Authority for Processing Medicare Claims (GAO/HEHS-94-171, Aug. 2, 1994).
Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).
Blue Cross And Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (GAO/HEHS-94-71, Apr. 13, 1994).
Medicare Secondary Payer Program: Identifying Beneficiaries with Other Insurance Coverage Is Difficult (GAO/T-HRD-93-13, Apr. 2, 1993)
Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992).
Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 22, 1986).

Mr. UPTON. Thank very much.

Mr. Grob, welcome back.

TESTIMONY OF GEORGE F. GROB

Mr. GROB. Thank you. And I would like to introduce as well John Hartwig, who is our Deputy Inspector General for Investigations.

The two of us were here on July 14, less than 2 months ago, and at that time we outlined three problems for your consideration: Material weaknesses in the financial management system used by the contractors, ineffective fraud units, and deliberate failure to carry out their contractual responsibilities and then fraudulently covering it up. Today, I'd like to give you an update.

Since we were last here, three companies have pled guilty to obstructing and conspiring to obstruct the Federal audit. You should

have—that was just provided to you—a paper version of that chart which is an update of the one I used in my last testimony by adding these three cases at the bottom of it.

New Mexico Blue Cross and Blue Shield, a Part A intermediary, had concealed billing errors. Blue Cross and Blue Shield of Colorado, a Part B carrier, had concealed, destroyed, and falsified documents related to HCFA's evaluation of its performance. And Rocky Mountain Health Care Corporation, which provided management services for the first two, was also implicated in the wrongdoings. All three companies had the same top executive officers from 1987 to 1995. The total settlement for all three entities amounts to $16 million, bringing our total so far up to about $277 million in settlements.

In addition to those three, two individuals were found guilty of fraud on cases unrelated to these.

The former Chief Operating Officer of Blue Shield of Western New York submitted false information to HCFA regarding his company's performance. In 1991, the company ranked in the bottom 20 percent of all carriers. As a result of its falsification, the company was ranked best in the Nation.

The former Chief Operating Officer with Blue Shield of Eastern New York, a subsidiary of the above company, generated false documentation indicating that private side employees were performing Medicare-related work. Those will be sentenced on October 21.

You had asked me to include in my testimony our recommendations to address the contractor performance issues. In response, I first want to note that the three general problem areas we have identified, weak financial management, ineffective fraud units, and deliberate failure to perform contractual duties, are interrelated and should be dealt with simultaneously.

Based on our knowledge gleaned from our investigations, audits and evaluations, we recommend strengthening HCFA's contractor performance evaluation protocol; integrating contractors' financial management systems with their claims processing systems and including in the systems such basic accounting features as a dual-entry general ledger system; strengthening internal controls over accounts receivable, cash, financial reconciliations and electronic data processing; routinely auditing contractors' internal control systems; giving HCFA broader legal authority in choosing what kind of entities may carry out contractor functions and more flexibility in organizing and assigning functions to them; and improving standards and training for contractor fraud control units, upgrading their proactive fraud detection and education efforts and evaluating their performance more rigorously.

We hope that the latest criminal pleadings and findings, which I have described here, will strengthen the resolve of all parties to make the necessary improvements in Medicare contractor operations and oversight. We in the Office of Inspector General will continue to work with HCFA and others to identify, address and, if necessary, investigate and prosecute problems in these areas.

Thank you.

[The prepared statement of George F. Grob follows:]

PREPARED STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Good Morning, I am George F. Grob, Deputy Inspector General for Evaluation and Inspections, Office of Inspector General, Department of Health and Human Services. Here with me today is John E. Hartwig, Deputy Inspector General for Investigations. Two months ago we came before this Committee to discuss some serious problems related to contractors hired by Medicare to process Medicare bills. These contractors are responsible for paying health care providers for the services provided under Medicare fee-for-service, providing a full accounting of funds, and conducting activities designed to safeguard the program and its funds. We specifically discussed three problems: 1) integrity—some contractors had failed to perform their contractual duties and had fraudulently covered up their poor performance by altering documents and falsifying statements that specific work was performed; 2) financial management—the accounting methods, reporting systems, and internal controls of many contractors are inadequate to keep track of Medicare funds entrusted to them; and 3) fraud control—the contractors' fraud units are often ineffective in preventing, detecting, and referring fraud in the Medicare program.

During my last testimony I described the results of 9 civil settlements and 2 criminal convictions which are also the subject of a General Accounting Office review. Today, I would like to provide you with an update of recent activity. In the past two months, three additional corporations have pleaded guilty and two individuals were found guilty of fraud and misconduct in connection with their responsibilities as Medicare contractors.

THREE MEDICARE CONTRACTORS

New Mexico Blue Cross and Blue Shield

New Mexico Blue Cross and Blue Shield was a fiscal intermediary responsible for administering the Medicare Part A program. It pleaded guilty to two felony counts that included obstruction of a Federal audit and conspiracy to obstruct a Federal audit. A joint investigation by the Office of Inspector General and the Federal Bureau of Investigation found that the company concealed billing errors during an annual field audit and impeded Federal auditors who were reviewing hospital billing. The nonprofit company agreed to pay $5.86 million to settle its False Claims Act liability. In addition, the company agreed to forgo $1.1 million in contract claims.

Blue Cross and Blue Shield of Colorado

Blue Cross and Blue Shield of Colorado was a contractor responsible for administering the Medicare Part B program. It pleaded guilty to two felony counts that included obstruction of a Federal audit and conspiracy to obstruct a Federal audit. The company admitted to concealing, destroying, and falsifying documents for the Health Care Financing Administration's (HCFA) Contractor Performance Evaluation Program. This is the system which HCFA used to evaluate the effectiveness of contractors in carrying out their responsibilities. Results of these reviews were considered in determining whether the contracts would be renewed and if financial bonuses would be given for superior performance. The company has paid $6.84 million to settle its False Claims Act liability. In addition, the company agreed to forgo $2 million in contract claims.

Rocky Mountain Health Care Corporation

Blue Cross and Blue Shield of Colorado and New Mexico Blue Cross and Blue Shield jointly own Rocky Mountain Health Care Corporation which provided management services for the companies in administering contracts to process Medicare claims. All the companies had the same top executive officers from 1987-1995. This company pleaded guilty to one count of conspiring to obstruct a Federal audit and was fined $500,000.

In summary, New Mexico Blue Cross Blue Shield is no longer a fiscal intermediary and Blue Cross and Blue Shield of Colorado is no longer a carrier. The total settlement for all three entities amounts to approximately $16 million.

TWO INDIVIDUALS

On June 24, 1999 a former Chief Operating Officer of Blue Shield of Western New York, the upstate New York Medicare carrier, was found guilty of fraud. The individual was found guilty of causing false information to be submitted to HCFA in 1992 concerning HCFA's Contractor Performance Evaluation Program. In 1991, the company ranked in the bottom twenty percent of all carriers, when compared

against its peers. In 1992, as a result of the falsification the company was ranked as the best carrier in the nation. The individual is to be sentenced on October 21, 1999.

Also on June 24, 1999, a former Chief Operating Officer with Blue Shield of North Eastern New York, a subsidiary of the former company, was found guilty of aiding and abetting the former Chief Operating Officer of Blue Shield of Western New York. This individual was found guilty because he generated false documentation indicating that in 1992 professional relations employees of the private side of the company were performing Medicare-related work. Evidence presented showed that the professional relations employees were not performing any Medicare work. The individual is scheduled to be sentenced on October 21, 1999.

CONCLUSION AND RECOMMENDATIONS

These cases are similar in character to the cases in Illinois, Michigan, Pennsylvania, and California which I highlighted in my testimony on July 14. Other investigations are underway.

Problems with Medicare contractors remain a serious concern. Dealing with them will require a two fold approach. First, we will continue to pursue thorough investigations and legal action with the appropriate remedies for contractors who have violated the law. Second, more systemic responses are needed to address the underlying causes of these problems.

At first blush, the three problem areas which I highlighted in my July appearance here—integrity, financial management, and fraud control—may seem to be discrete and unrelated. To some extent this is true, and it is possible and useful to construct remedies for each one by reforming the overall systems or general approaches for administering each function associated with these activities. However, there are important connections among them, and an overall approach dealing with all three problems simultaneously will be more effective than dealing with them in isolation of one another.

For example, the fraudulent activity of convicted contractors or their senior management officials is not generally due to their having stolen money from the Medicare trust funds. While this is the case with regard to the false claiming of costs for personnel not actually working on Medicare business and for deliberately paying for private side insurance claims using Medicare dollars (so-called "Medicare secondary payer" situations), most of the fraud is related to the contractors covering up their mismanagement and failure to perform their contractual duties. In some cases, this mismanagement included the turning off of computer edits which would have prevented improper payments of Medicare funds. This mismanagement increases the need for HCFA oversight and for effective methods to measure contractor performance. It is also worth noting that while fraudulent cover-up of mismanagement and dereliction of duty are far more prevalent than is acceptable, the inadequacies of contractor financial management systems and the shortcomings of their fraud units are more generally pervasive and may possibly be more damaging to the Medicare program.

Based on our knowledge of contractor operations and performance—gleaned from our investigations, audits, and evaluations—we believe that the following steps are needed to bring contractor operations up to a level compatible with their responsibilities for the Medicare program:

—Strengthen HCFA's contractor performance evaluation protocol;
—Integrate contractors' financial management systems with their claims processing systems and include in the systems such basic accounting features as a dual-entry general ledger system;
—Strengthen internal controls over accounts receivable, cash, financial reconciliations, and electronic data processing;
—Routinely audit contractors' internal control systems;
—Give HCFA broader legal authority in choosing what kind of entities may carry out contractor functions and more flexibility in organizing and assigning functions to them; and
—Improve standards and training for contractor fraud control units; upgrade their pro-active fraud detection and education efforts; and evaluate their performance more rigorously.

I hope the latest criminal pleadings and findings which I have described here will strengthen the resolve of all parties to make the necessary improvements in Medicare contractor operations and oversight. We in the Office of Inspector General will continue to work with HCFA and others to identify, address, and, if necessary, investigate and prosecute problems in this area.

Mr. UPTON. Thank you very much.
Mr. Flynn, welcome.

TESTIMONY OF DARCY FLYNN

Mr. FLYNN. Thank you, Chairman Upton and distinguished subcommittee members.

Mr. UPTON. Excuse me 1 second. If you could pull one of those mikes a little closer.

Mr. FLYNN. I have always held the position that I would discuss this otherwise private matter with an appropriate body that was concerned with policy and not the human interest side of it. I am, therefore, pleased to have this opportunity to testify before this subcommittee.

My testimony concerns three major points. First, from 1988 to 1993 the Medicare system in Michigan broke down. Obsessed with keeping its contract, Blue Cross Blue Shield of Michigan resorted to cheating in the CPEP process rather than producing quality audits. As part of the CPEP process, HCFA randomly selected five of the 50 Blue Cross audits for review annually to determine Blue Cross's CPEP score.

Faced with low CPEP scores prior to 1989 and the resultant threat of losing its Medicare contracts, Blue Cross needed to dramatically increase its scores. It hired two consultants to lead a CPEP team of auditors in efforts to fix the original audits prior to submission to HCFA by performing various audit steps that were never performed in the original audit. To conceal from HCFA the fact that the audit work papers were newly created, Blue Cross would back date the work papers. Sometimes employees back dated work papers to dates prior to their hire date. HCFA never caught this or any of the items I will address.

Blue Cross also mischarged its time of the CPEP team to special projects rather than to the specific provider it cleaned up. Part of the CPEP team's procedure was to have these consultants play the role of a CPEP reviewer and give the audit an initial score which often was around 50 percent. In the cleanup process—the cleanup process typically resulted in large recoupments of overpayments. Thus, where the money was really lost was in the 45 audits per year that were not selected by HCFA for review and were not cleaned up and hence probably would have gotten similar scores, around 50 percent, signaling huge overpayments to those hospitals each year.

Blue Cross also skirted its HCFA requirement to recoup overpayments from providers within 30 days by dividing large overpayments into small segments, then collecting from providers one small segment at a time. Another way around this requirement was to work out an arrangement with the provider whereby Blue Cross would set up a suspense account, withholding usually 20 percent of a provider's payment, letting that accumulate until they had enough to offset against the amount that the provider had been overpaid. This could take months to do and in the process cost the Medicare program millions of dollars just in this practice alone. Once the money was accumulated, it would then be offset against that overpayment.

The second point is that the network between Blue Cross and the providers was too close. Because Blue Cross in its capacity as a large private insurer had its own business relationships with the very providers it was charged with monitoring under the Medicare program, Blue Cross had little incentive to crack down on these providers in the Medicare audits. Providers had little incentive to object to Blue Cross's cheating because they benefited from Blue Cross's substandard audits by getting away with overbilling the Medicare program.

Third is the importance of the qui tam statute under which I filed my claim. It is clear that HCFA's oversight of the Medicare program failed. I am certain that had I reported this matter to HCFA little, if any, action would have resulted. In fact, just a few weeks after my complaint was filed in June 1993, a former Blue Cross employee sent a letter to HCFA describing the fraud in detail. However, months later, after the FBI was well into its investigation of my complaints, HCFA had taken no action on the former employee's letter, and even during my investigation, rather than contributing to it, HCFA seemed more of a hindrance.

I will leave it at that. Thank you .

[The prepared statement of Darcy Flynn follows:]

PREPARED STATEMENT OF DARCY FLYNN

Chairman Upton and distinguished Subcommittee members, I have refused several newspaper reporters' requests to discuss my Qui Tam case against Blue Cross Blue Shield of Michigan (BCBSM), because I thought their focus was more on human interest than on policy. I have held to the position that I would discuss this otherwise private matter, which until today very few of my acquaintances were aware of, with an appropriate body that was concerned with policy. I am therefore pleased to have this opportunity to testify before this Subcommittee.

My testimony concerns three major points. First, in Michigan, in the late 1980's and early 1990's, the Medicare system broke down. During that time period, HCFA monitored the performance of its fiscal intermediaries and carriers through the Contractor Performance Evaluation Program, known as "CPEP". Under CPEP, HCFA was supposed to randomly draw work performed by the intermediaries and carriers and evaluate the work to determine the overall performance of the contractor. In order to keep its Medicare contract, BCBSM's Provider Audit Department resorted to cheating in the CPEP process, rather than earning high CPEP scores by virtue of the underlying quality of the audits performed. That cheating cost the Medicare program tens, and possibly hundreds of millions of dollars.

Second, the network between BCBSM and the providers it was hired to audit was too close. Because BCBSM had its own contractual relationships with the providers, it had little incentive to crack down in its Medicare audits of the same providers. Providers had little incentive to object to BCBSM's cheating because they benefited from it. Most fired BCBSM managers slid easily into the private sector. A consultant who directed the clean-up scheme continues to profit from Medicare seminars.

My third point concerns the importance of the Qui Tam statute. It is clear that HCFA's oversight of the Medicare program has failed. I have reason to believe that had I reported the matter to HCFA, little, if any action would have resulted. The Qui Tam statute provides the efficiency, perseverance, and tenacity of a private Attorney General.

I. THE MEDICARE SYSTEM BROKE DOWN AND, OBSESSED WITH KEEPING ITS CONTRACT, BLUE CROSS BLUE SHIELD OF MICHIGAN RESORTED TO CHEATING IN THE CPEP PROCESS RATHER THAN PRODUCING QUALITY AUDITS

When performed correctly, a fiscal intermediary's Medicare audits often result in the recoupment by Medicare of millions of dollars. When performed poorly, as was the case at BCBSM for five years, the audits fail to recoup tens, and perhaps hundreds of millions of Medicare dollars.

Under its HCFA contract, BCBSM performed full audits on approximately 50 of Michigan's 200 hospitals annually. As part of the CPEP process, HCFA randomly

selected five of the 50 BCBSM audits for review annually, to determine BCBSM's CPEP score. Faced with low CPEP scores prior to 1989 and the resultant threat of losing its Medicare contract, Blue Cross Blue Shield of Michigan (BCBSM) needed to dramatically increase its CPEP scores. Because of the trusting relationship between BCBSM and HCFA, BCBSM was able to convince HCFA that because workpapers were often scattered around in different locations , BCBSM needed two weeks to gather its audit workpapers, when in fact the audit workpapers were invariably sitting on a shelf.

HCFA allowed BCBSM the two weeks to collect and submit its workpapers. However, rather than submitting its audit workpapers intact to HCFA, BCBSM hired two consultants to lead a CPEP Team of auditors in efforts to fix the original audits prior to submission to HCFA by performing various audit steps that were never performed in the first place. In order to conceal from HCFA the fact that the audit workpapers were newly created, BCBSM would back date the workpapers, either to the time of the original audit, or to the time of a fictitious "follow-up" audit that purportedly was done at BCBSM's own initiative well prior to the HCFA reviews, but in fact never existed.

In a further attempt to conceal the workings of the CPEP Team from HCFA, BCBSM mis-charged the time of the CPEP Team to "Special Projects", rather than charging the time to that specific provider. Blue Cross also attempted to conceal its clean-up efforts from providers, although many were aware of it.

Part of the CPEP Team's procedure was to have the consultants play the role of a HCFA CPEP reviewer and, at the outset of the two-week period, score the initial audit. Those scores often were around 50%. After the clean-up process, which typically resulted in large recoupments of overpayments, audits would often receive a perfect 100% from HCFA. Where the money was really lost was in the 45 audits per year that were not selected by HCFA for review, which would have received likely scores around 50%, signaling huge overpayments to the hospitals.

The consultants' scores on the initial mock-reviews of audits selected by HCFA were used by upper management in reviewing the performance of subordinates. Many employees acknowledged that were it not for BCBSM's cheating, HCFA would have hired another intermediary sooner. Employees also acknowledged that the cheating had a damaging effect on both the normal audit function and on morale.

In some cases, an original audit was done so poorly that it could not be salvaged in the two week period. In that case, Blue Cross successfully steered HCFA away from that audit by lying to HCFA about its status, falsely telling HCFA that the cost report had recently been reopened at the hospital's request, and therefore was not appropriate for review.

The Field Audit section of the Provider Audit Department was not alone in cheating in CPEP. The Administrative section also skirted its HCFA requirement to recoup overpayments from providers within 30 days by dividing large overpayments into small segments, then making demand for payments from providers one small segment at a time. BCBSM's other way around this requirement was to set up a "suspense account", in which BCBSM would put a partial (typically 20%) hold on a provider's payments, and accumulate the amount in a separate "suspense account". Once enough money had been saved, a revised overpayment settlement was processed, and the funds in suspense were applied against the overpayment, giving the false impression that BCBSM had recovered the overpayment in just one day. Providers did not object to using the suspense account to repay overpayments because they were able to avoid the 9% interest HCFA required on all overpayments taking longer than 30 days to recover. The Medicare program lost millions of dollars just in lost interest income as a result of the "suspense account" practice.

BCBSM claims that because no criminal charges were filed, its fraud was less egregious than that of other intermediaries. However, I believe it was prosecutorial discretion at the United States Attorney's Office in Michigan, and not BCBSM's lack of culpability, which allowed BCBSM to escape criminal charges. My belief is bolstered by the fact that the U.S. Attorney's office in Baltimore, where the complaint was originally filed, indicated a strong possibility that both BCBSM and several managers would face criminal fraud charges. To the extent I am familiar with the underlying facts of cases against other intermediaries, I believe the conduct of BCBSM to be every bit as egregious.

II. THE NETWORK BETWEEN BCBSM AND THE PROVIDERS WAS TOO CLOSE

Because BCBSM, in its capacity as a large private insurer, had its own business relationships with the very providers BCBSM was charged with monitoring under the Medicare program, BCBSM had little incentive to crack down in these providers in the Medicare audits. While the CPEP clean-up process was no secret among the

provider community, providers had little incentive to object to BCBSM's cheating because they benefited from BCBSM's sub-standard audits by getting away with overbilling the Medicare program. In fact, at a Healthcare reimbursement seminar in 1992, two certified public accountants from a prominent "Big 6" CPA firm, in an effort to attract clients in the audience, touted their practice of coaching providers on how to aggressively claim non-reimbursable costs and how to account for such claims by placing the money in a "cushion account", to be repaid to Medicare if, and only if, the provider were to get audited that year and if BCBSM detected the overcharge in its audit.

Most fired BCBSM managers slid easily into the private sector. At least one of the BCBSM consultants, who contemporaneously directed the CPEP team and advised certain hospitals on how to prepare cost reports and maximize reimbursement—an apparent conflict of interest—continues to profit by hosting various Medicare reimbursement seminars. III. THE IMPORTANCE OF THE QUI TAM STATUTE

It is clear that HCFA's oversight of the Medicare program has failed. In April, 1993, I described BCBSM's clean-up practice to a professor of criminal law, who not only assured me the activities were fraudulent, but urged me to report the matter to the appropriate authorities.

Having vowed to do just that, the only question was which avenue to take. In retrospect, I am certain that had I reported the matter to HCFA, little, if any action would have resulted. In fact, just a few weeks after my Qui Tam complaint was filed in June, 1993, a former BCBSM employee sent a letter to HCFA describing the fraud in detail. However, months later, after the FBI was well into its investigation of my complaint, HCFA had taken no action on the former employee's letter.

Rather than contributing to the investigation of my complaint, HCFA seemed more of a hindrance. The Department of Justice Trial Attorney assigned to my case, Sara Strauss, almost single handedly handled the case. The couple of experiences I had dealing with one seemingly incompetent HCFA investigator were very frustrating. The same investigator claimed to have built a "trusting relationship" with the very BCBSM managers who deceived him for five years.

Mr. UPTON. Mr. Osman.

TESTIMONY OF RONALD E. OSMAN

Mr. OSMAN. Thank you, Chairman Upton, distinguished members. It's really a pleasure for me to be here today. It's very seldom that a country lawyer that originally came from a town of 830 people gets an opportunity to participate in this democracy, and it is my pleasure to be here.

I have given you a written statement. It is a little short on detail for a reason. I represent Evelyn Knoob, who was the relator; and let me take this opportunity to ask the committee, as they go forward into the new millennium, the word "whistle-blower" has a bad connotation. I like to use the word "relator". Since we have been 5-year-olds we have been taught not to tattle on anybody, but yet we expect people to come forward and we have an Act that calls them whistle-blowers. I'm probably swimming upstream in a utopian world, but I prefer the term "relator" instead of "whistle-blowers" because of the bad connotation.

I represent Evelyn Knoob, who was the relator in the Blue Cross Blue Shield of Illinois case. As a result of Ms. Knoob's courage to stand up, it resulted in the largest civil money fine of any of the carriers of $140 million, a $4 million fine.

Blue Cross Blue Shield of Illinois, their corporate name, Health Care Service Corporation, pled guilty to eight felony counts, and there are eight individuals that have been indicted, four of whom have pled guilty, four of whom will be going on trial soon. That is the reason for my lack of detail in my statement in regards to these individuals, because they deserve a fair trial, and we do not want

to do anything that might in any way impinge upon the upcoming trial.

I believe from reading the testimony from the last hearing and also hearing the previous speakers that this committee has a flavor for the problem. We could see from the chart that the problem is obviously ongoing and has been long in the making.

I didn't come here today to denigrate Blue Cross Blue Shield, Health Care Service Corporation. I didn't come here today to talk about HCFA not doing their job, nor did I come here today to talk about the Department of Justice or anyone else. I think that there's enough blame to go around for everybody.

From my observation, it starts with Congress. Congress has established criteria for the processing of these claims that in my opinion are in many cases almost unattainable. They do so because of the pressure from the beneficiaries to get their claims paid quickly and correctly, but what they don't do is they do not take into account the problems that that causes for the carriers.

Federal Registers that I have here for 1994, list just one of several of the criteria, answer 98 percent of the phone calls within 120 seconds and have no more than 20 percent of your trunks busy at any one time. Think about that for a second. It's almost unattainable. The only way to pass that in many cases without getting their cost of claims extremely high was for them to cheat.

I believe that the first solution, the way to solve this problem, begins with Congress looking—sitting down with the intermediaries and carriers and getting realistic criteria of which to be graded by.

Now the second thing is we all wonder how this went on in the Blue Cross Blue Shield's case for 10 years without being caught. It's a simple answer. Nobody looked very hard. Nobody looked very hard at all.

To give you an example, in Marion, Illinois, where I now have my practice and live, there's a VA hospital. I have a client that did a subcontract on a project at the VA hospital. The total project was about $15 million, and during the time he did that project he had a resident engineer that looked at his work every day. They had an outside engineer that came in once a week. They even had a photographer that came in and took pictures once a month, three sets of photographs to see what the progress was, for a $15 million contract.

In 1996, Blue Cross Blue Shield of Illinois processed 22 million claims and paid out $1.4 billion and change of our money and nobody looked. They had a weekly report that was sent in that nobody checked the source data. They had several monthly reports that were sent in. Nobody checked the source data. They had one CPEP a year where two to three people came down at a preannounced time and looked at prearranged files, and we wonder why they didn't catch it. It was because they didn't have the resources.

Every year Congress cuts HCFA's budget for oversight. Every year Congress expects them to do more with less. It's a very simple problem, a very simple solution in my opinion. Put one person at each of the 60 intermediaries from HCFA every day, 40 hours a week, to be sure they comply with the contract. Develop a strike

force of about 20 auditors that have the right to go in at any time and randomly audit. Talk to the people actually doing the claims, don't talk to the managers. Go down on the floor, talk to the people doing the claims. Do the things that private industry does, do the things that we do in the military, do the things that anyone with just a little common sense would do, is make sure the contractors know maybe once every 3 years they're going to have a surprise inspection. They will then do the job correctly. They will give you a good product.

I do not agree that this is an area where the government should become more involved in paying the claims. I believe you have a good contractor community out there, but over the past 10 years, they have been allowed to become lax. They have been under pressure for profits from their shareholders, and they will do exactly what all of us will do if we're not watched fairly closely, they will stray. And, as I said earlier, I do not believe there's any bad people involved in any of these instances. It's good people with lax supervision, and I believe that supervision, if it comes from this subcommittee, could greatly benefit Medicare.

Thank you.

[The prepared statement of Ronald E. Osman follows:]

PREPARED STATEMENT OF RONALD E. OSMAN, ATTORNEY AT LAW, RONALD E. OSMAN & ASSOCIATES, LTD.

Chairman Upton, distinguished ladies and gentlemen of the Oversight & Investigations Subcommittee, and interested listeners, my name is Ronald E. Osman. I am an attorney whose practice is based in Marion, Illinois. I specialize in the investigation and prosecution of violations of the Federal False Claims Act, 31 U.S.C. §§ 3729-3733.

I have come here today to tell you a story. It is not a very pretty story. It is not a very nice story. Some aspects of this story sound like excerpts from a novel you might find advertised on the New York Times bestsellers list. I assure you, however, that this story is not fiction. This story is true. This is the story of one woman, Evelyn Knoob, and how that one woman had the courage to stand up and stop Health Care Service Corporation, the Medicare carrier for the State of Illinois, ("HCSC") from continuing to commit the Medicare fraud it had engaged in for over ten years.

On Friday, October 23, 1993, HCSC employees working under Evelyn's supervision found a box containing over 10,000 railroad retiree Medicare claims in the mailroom. Under its contract, HCSC was not required to process railroad retiree claims but was required to promptly forward all such claims it received to Travelers Insurance Company. From the receipt date stamped on the claims, Evelyn determined this particular batch of railroad retiree claims had been sitting in HCSC's mailroom for approximately three months. Evelyn reported the discovery to her manager and requested instruction on what should be done about these claims.

As all other employees were leaving for the night, Evelyn was instructed by her manager to bring the box of claims to his office. When Evelyn arrived, the manager pulled his curtains and locked the door. Evelyn was then forced by that manager to sit quietly on a couch and watch for three hours as he personally shredded all the railroad retiree Medicare claims which had been found that day. The manager then stuffed the shredded claims in twelve lawn-size garbage bags and discarded the remains in a trash dumpster in back of the HCSC building.

Evelyn adamantly protested the managers action while the shredding was occurring. Evelyn repeatedly requested upper level HCSC management be called to determine how the situation could be rectified. Evelyn's pleas, however, were responded to with threats of her being fired if she left the room. The Monday following the shredding, Evelyn again attempted to convince her manager that he should report the shredding of the claims to upper level HCSC management. In response, Evelyn was bluntly threatened that if she ever reported the shredding the blame would be put on her and the manager would personally insure she went to prison.

Despite these threats, Evelyn did report the shredding to upper level HCSC management. Management, however, refused to take any action concerning the shredding. The only step taken by HCSC management in response to Evelyn's report was

to embark on a two year campaign to brazenly harass Evelyn daily with threats of being sent to prison for the shredding of the claims.

A once exemplary employee, Evelyn abruptly began receiving negative reviews. Managers intentionally transferred Evelyn to work positions which were known to be the most stressful positions in the office. When Evelyn requested less stressful positions, she was singled out by supervisors as a "target" to be bullied. Evelyn's emotional balance quickly deteriorated from the never-ending harassment she endured from supervisors and managers. HCSC supervisory employees began placing derogatory memorandums into Evelyn's personnel file, with seven negative memos being drafted by the one supervisor on October 11, 1994 alone. On that same day, October 11, 1994, Evelyn was told by that same supervisor that she was being placed on involuntarily stress leave. On that same day, October 11, 1994, Evelyn attempted to take her own life.

I know this story brings several questions to your mind. Why did the manager destroy the claims? Why did the upper level management of HCSC allow this activity to go unreported? Why didn't HCSC just forward the claims to Travelers Insurance Company? Why would a large corporation like HCSC single out one employee in one of its numerous divisions and embark on an intentional campaign to destroy her both personally and professionally? The simple answer to all these questions is money.

By the time Evelyn witnessed the shredding of the claims on October 23, 1993, HCSC had transformed its Medicare contract into a substantial money making opportunity for HCSC and to a smaller extent to its upper level Medicare management. The Government was of the opinion that HCSC was one of the top Medicare Carriers in the nation. HCFA showed its appreciation for this "outstanding" carrier performance by awarding HCSC incentive payments, which were then partially passed on to HCSC's Medicare management, renewing the carrier contract, and expanding the carrier contract to include Michigan. Ironically, HCSC received the Michigan contract because Michigan was caught committing fraud. At the time HCSC took over the Michigan contract, its fraud, unknown to the Government, dwarfed the fraud committed by the Michigan carrier. Had HCSC reported the delay in sending the claims to Travelers Insurance, its performance rating in that area would have went down. A lowered score in this area would have affected HCSC's overall carrier performance rating and would have jeopardized the contract and the incentive payments HCSC was receiving from HCFA.

Evelyn was rendered totally unable to normally function by the mental harassment she endured at the hands of HCSC employees. Evelyn first came to my office seeking assistance with a workers compensation claim. Evelyn merely wanted to be compensated by HCSC for the wages she was losing as a result of their rendering her mentally incapable of working. When Evelyn arrived at my office, I had been involved in one False Claims Act action. Consequently, when I heard Evelyn's story, I recognized that several of the things she had been trained by HCSC to do in the course of her employment were actually flagrant violations of the False Claims Act. My firm performed a preliminary investigation into Evelyn's explanation of HCSC's Medicare operations. From our findings, it was obvious thatHCSC's status as an exceptional Medicare carrier for the people of Illinois was a carefully designed façade.

In March of 1995, my office filed, on Evelyn's and the Government's behalf, a Complaint against HCSC for violations of the Federal False Claims Act, 31 U.S.C. §§ 3729-3733, ("FCA"). An extensive investigation into HCSC's performance under its Medicare carrier contract was conducted by the Department of Justice, United States Attorneys Office for the Southern District of Illinois, the Federal Bureau of Investigation, the United States Postal Inspector, Department of Health and Human Services, Office of Inspector General and my office. The degree of fraudulent activities revealed by this investigation is nothing but incredible.

Under its Medicare contract, HCSC was charged with the responsibility to process Medicare claims correctly under Medicare rules and guidelines in the most effective and efficient way possible. HCSC, however, took the stance that its duty was to process Medicare claims at the lowest possible cost and bypassed several required procedures in processing claims. For example, rather than requesting information from new Medicare beneficiaries to determine whether or not Medicare was primarily responsible for payment of health costs, HCSC just paid the claims. Rather than determining whether or not claims under $50.00 that suspended during processing were actually charges covered by Medicare, HCSC just paid the claims. Rather than having to work extensive denials for claims for durable medical equipment, such as wheelchairs, in times of high claim inventory, HCSC just paid the claims.

Medicare claims processing software has in place several edits and audits which effectively stop claims which should not be paid from going through the system so that a determination regarding payment could be made. These edits and audits

were supposed to be HCFA's way of making sure carriers don't "just pay the claims." HCSC bypassed these check points in times of high inventory by simply turning them off. No claims would then be stopped by the computer system, and HCSC could pay all the claims in its systems with a touch of a single button. When the edits and audits were left on, claims did get caught in these check points because of incorrect information, no coverage, etc. On one million separate occasions when this happened, HCSC simply deleted the claims. Problem solved.

HCSC also was given the responsibility under its contract to provide telephone customer service to Medicare beneficiaries. Under this responsibility, beneficiaries could call the HCSC Medicare office and speak to a HCSC representative who could give them information over the phone regarding claims which had been submitted for processing. The telephone customer service was governed by guidelines covering such things as the timeliness of the calls being answered and questions being responded to. Due to the volume of beneficiaries it served, HCSC rarely met the service level required. Consequently, HCSC submitted phone records to HCFA wherein its service level and phone line down time were falsified. HCSC instructed its employees to place incorrect dates on telephone inquiries so its reporting documents appeared to be in compliance with timeliness processing requirements. HCSC even installed a shut-off switch on its beneficiary phone lines so, when call volume went up and HCSC was not meeting its timeliness requirement for answering calls, it could just turn the phones off. In addition to the above examples, HCSC engaged in several similar actions in either manipulating or falsifying dates to pass HCFA's annual inspection. The entire corporate culture at HCSC became one of doing whatever was necessary to pass the test instead of processing claims efficiently and effectively.

By now, many of you are asking, "How could HCSC be doing this? Weren't they required to make reports on their work to HCFA? Wouldn't these reports show they were not properly doing the work they had been contracted with to do?" HCFA did require HCSC to submit weekly and monthly reports to it so HCSC's work performance could be monitored. HCSC, however, simply submitted reports showing what it was supposed to be doing rather than reporting what it actually was doing. For example, HCSC was required to make weekly reports, through its Post Payment Quality Assurance Program, which provided HCFA an estimate of the incorrect payments made by HCSC. HCSC simply falsified these documents to make it appear it was conforming with its performance requirements and then manipulated supporting documentation to conform to the false information submitted. HCSC submitted false savings reports in which actual savings resulting from its Medicare Secondary Payor program were inflated. HCSC submitted false monthly timeliness reports to cover the true age of its unprocessed claims inventory and the true time it took for it to process claims.

HCFA performed a yearly on-site evaluation of HCSC's performance called a "CPEP". This evaluation determined whether or not HCSC's contract would be renewed. You might think, "Surely this evaluation would have uncovered the fraudulent information being sent to HCFA on a monthly basis." My response is that it might have—except HCSC was providing HCFA false information during its yearly evaluations as well and frankly HCFA was not looking very closely. In preparation for these evaluations, HCSC intentionally changed the manner in which it normally processed claims by allowing only its best claims examiners and reviewers to process claims to insure error free processing. If HCSC had a high inventory of unprocessed claims which it was unable to process prior to the on-site visit, the unprocessed claims would be hidden in employee vehicles or HCSC warehouses so the inspectors would not see the back log.

When HCSC first became a Medicare contractor, it was allowed to prepare its own sample of files to be evaluated. It was therefore easy for HCSC to have evaluated only those claims and reviews which were uncomplicated. When HCFA began selecting the sample of files to be evaluated from a range of control numbers, HCSC carefully reviewed the range selected and corrected all processing errors that had been made. In 1993 alone, HCSC changed 17 files out of a 60 file sample to cover its mistakes. HCFA's auditors did not discover the alterations.

Even errors which could not be corrected did not present a problem for HCSC. Employees were instructed to put a black dot on any file which could not be corrected. This black dot was a signal to every HCSC employee that this file was not to be shown to the HCFA representative. Such files were hidden away during the on-site inspection, and the HCFA representative was told the file could not be located.

HCFA also ran an annual computer systems test to evaluate the computer check points which were in place to catch claims which needed additional information for processing. HCSC manipulated its computer system so that HCFA's computer sys-

tems test would show that the check points were operating effectively during the time of the systems test.

The topic of discussion today is "How Healthy Are the Government's Medicare Fraud Fighters?" From my experiences with the HCSC case as well as the several other Medicare fraud claims my office is currently investigating, my answer to this question must be that the Government's strength over Medicare fraud is deteriorating. At this point, I believe that the battle is being lost because the Government is not providing the manpower needed to effectively fight Medicare fraud.

HCSC was evaluated on site by HCFA representatives once per year. HCSC was notified in advance of when HCFA would arrive and what HCFA wanted to look at while it was there. HCSC then had the opportunity to "cover its tracks" by correcting errors on the items requested and literally hiding thousands of documents from the inspectors. No surprise inspections were made of HCSC's various Medicare offices. No extensive checks were made into the information being provided to HCFA. HCSC got away with Medicare fraud because no one was really paying attention to what they were doing.

The Government needs to place more emphasis on the enforcement of the penalties for Medicare fraud. HCSC made the largest repayment ever made by a Medicare Carrier as a penalty for its Medicare fraud. The Department of Justice, however, had wanted to resolve the HCSC issue for a small fraction of this amount immediately after HCSC's fraud was brought to its attention. The Department of Justice seemed to merely want to say, "Okay, we caught you. Now go along and be a good carrier." The United States Attorneys Office for the Southern District of Illinois, however, is dedicated to fighting Medicare fraud. The United States Attorneys Office refused to agree to the settlement the Department of Justice proposed and pushed ahead with the investigation uncovering more fraudulent activity at every turn.

I believe it is impossible for the Government to fight fraud without public assistance. The public needs to be made aware of the items which constitute Medicare fraud and given the courage to speak up and stop the fraud. Persons who report Medicare fraud are currently referred to as whistleblowers. "Whistleblower" is synonymous with tattletale—something no one has wanted to be since they were five years old. The negative connotation given to those who report Medicare needs to be turned into something positive. The only entity that can make that change is the Government.

Evelyn, after all the mental stress and anguish she had been put through, found the strength to stand up to HCSC. I will confess to you that the duration of the investigation of HCSC was a long, hard road for Evelyn. At many points along with way, Evelyn almost gave up. HCSC tried to convince the Government Evelyn was a liar. HCSC tried to convince the government Evelyn had perpetrated the fraud. HCSC tried to convince the government Evelyn was out for revenge. The way Evelyn finally made it through the investigation is the way I hope each of you leave this hearing today. Evelyn got mad. Of course, Evelyn was mad at HCSC for what it did to her and her family. Evelyn was more angry, however, about what HCSC was doing to the elderly population of the United States by allowing money to be inappropriately paid from the Medicare fund. Evelyn became angry that her elderly friends, family, and former co-workers were having trouble making ends meet because of cuts in their Medicare benefits due to decreasing Medicare funds. Evelyn became angry that when her grandchildren reached the age of Medicare eligibility there would be no Medicare money left.

I hope you become mad that Medicare carriers and providers are providing false information to the Government so their management can receive large bonuses. I hope you become mad that the Medicare fund is shrinking rapidly as a result of Medicare carriers' and providers' fraudulent representations. I hope you become mad that when your grandchildren reach the age of Medicare eligibility it is very possible there will be no Medicare money left. I hope you become mad enough to provide HCFA the seed money to establish a simple and effective compliance program that I believe will return multiple thousands of dollars for each dollar spent.

It is common every day sense that unless there is constant monitoring of a contract there will be the tendency for Government contractors to begin to finesse the system. That attitude, if left unchecked, will result in cheating. I would propose that first the Congress, along with representatives from Intermediaries, establish realistic guidelines for processing claims. I understand the pressure placed on Congress by its constituents to process the claims quickly and respond immediately to beneficiary complaints; however, the claims processing guidelines must be realistic and obtainable. Second, each and every intermediary should be assigned an on-site HCFA representative whose sole job is to insure compliance with the contract and that claims are processed correctly. These on-site representatives should be rotated

on a regular basis to prevent familiarity with the contractor. In addition to the on-site HCFA representative and the annual review, HCFA should assemble a twenty (20) person audit team that would be broken down into five (5) four (4) person teams to do surprise inspections of the contractors on a random and unannounced basis. If the above was implemented, each contractor would know that it had reasonable criteria to be judged by and that someone was insuring that it was performing its contract appropriately.

This solution certainly seems simple. It will work because it is the same system that is being used in the private sector for banking, private insurance and other industries. In addition, it is basically the same system the Government uses when it enters into contracts for the construction of many of its Government projects. This is not a complicated problem, and the solution is simple. I urge you to consider some form of HCFA oversight similar to what I have described.

Thank you for allowing me to share our story. I commend the Oversight & Investigations sub-committee for taking an interest in the issue of Medicare fraud.

Mr. UPTON. Thank you all for your testimony.

We are going to proceed with questions from those of us on the subcommittee for 7 minutes each. The light will reflect such time.

First of all, Mr. Grob, I appreciated your testimony and insinuation that perhaps because of this subcommittee's work in July it was a little easier to come up with some convictions or some announcements of guilt in time, in the last 2 months.

And, Mr. Osman, I appreciated your testimony, too, and particularly in terms of the surprise audits.

As I sat here thinking about your testimony, yesterday was my daughter's first day at middle school, a big event. And as I quizzed her last night and she went through all of her courses, I believe it is the English teacher who is going to be having a quiz every week. You don't know what day it's going to be, but it's going to be there, and she is going to be ready for it.

And I think the idea of having a surprise audit with some regularity is a very good one and that all Medicare providers across the country ought to know at some point somebody's going to be knocking on that door wanting to look at the books and wanting to talk to some of the folks, in fact, that are preparing the forms.

But I guess the question that I have for all of you is, despite some success here in the last couple of months and really over the last couple of years in this subcommittee's efforts, not only under my chairmanship but others as well, trying to get after fraud and abuse, how widespread is it? The tools that we have been able to provide you all in the field I think have been good ones. I don't know that we have gone far enough, and I am curious to know what additional legislation you might recommend to us, whether it be an annual audit or maybe a quarterly audit, that type of thing.

I remember one of the provisions that I was able to get passed in the full committee was that anyone convicted of fraud in the Medicare program would lose their own right to participate in that program for their life. The Senate didn't agree with that, and it fell out of the conference bill, but at least it was another provision that was tacked on that anyone convicted would lose their personal right to participate in that program in their later years.

What types of efforts would you like to see us do here in this committee to have a stronger hand combatting fraud and abuse? Where can it be made easier?

Your comment, Mr. Osman, about not enough funds being appropriated by the Congress for enforcement, there was an actual increase in 1996. I don't know what's happened since then, but it's

something I think we should look at. But how can we make the job easier and how widespread do you think fraud and abuse is? What dollar value would you think is out there in terms of the efforts that we ought to undertake?

Maybe we will start with Ms. Aronovitz.

Ms. ARONOVITZ. First of all, I really do think that there's a lot that can be done by all parties; and I think an underlying foundation statement, though, is that we never would like a contractor to stay in a program or participate in any activity where they feel that there's no corporate reason for them to be in it. There's no excuse to be in an activity and have to cheat, no matter how complex or difficult the rules are.

On the other hand, there really are ways that HCFA could do a lot better.

I think the two areas that HCFA could be helped is, No. 1, in some contract reform. We had recommended in our prior report that HCFA have more flexibility in the type of entities that it contracts with and the type of contracts that it lets. Right now HCFA pays contractor costs—it cannot pay a contractor to make a profit or to have other incentives to do a good job. So we think that there's some room there. And, also, the nomination process on the Part A side might have outlived its usefulness and more of a direct relationship—a direct contracting relationship would help HCFA.

The other area that would help HCFA immensely would be to have a sufficient administrative budget to properly go out and do its oversight activities. We heard over and over again in the regional offices we visited that travel money and resources were very, very tight. Now, I think it's very important that HCFA show that it's doing the best it can with the resources it has. We don't always advocate that you need more and more money. That's not the panacea. Although we do think that HCFA does struggle very much with balancing a lot of oversight activities in different programs, and it could use that support.

Mr. UPTON. Do you know about how much more money it would need?

Ms. ARONOVITZ. We would have to look at that more closely, but we would certainly be happy to try to figure out at least from a regional standpoint what—what would help them.

In terms of the Medicare integrity program, the MIP money, that program has really helped HCFA assure that contractors have the money to do program safeguard activities; and we issued a report about a month ago that shows that, in fact, HCFA is doing a better job with its contractors on program integrity activities. They have assured funding. They get the funding at the beginning of the year, and we think that will help.

And the last thing I wanted to say is that HCFA has taken some of what you talked about in July and even before that very, very seriously, and they're making organizational changes and also taking other steps to do what our recommendations mentioned in our July report, where they will focus and have not a strike force but clearly have national teams that are focusing on core evaluation areas that have to be reviewed in the same format at all the contractors each year. So we are hoping that those types of initiatives

will make a difference, and it's just a little bit too early to know for sure.

Mr. UPTON. Mr. Grob, do you want to comment on that?

Mr. GROB. Yes.

First of all, let me address the first part of your question, which is how widespread is it. I think these cases where people have been convicted of fraud as a result of covering up their mismanagement are the most dramatic, and they are very troublesome. They do represent a minority of the contractors. That is, it's a substantial and worrisome minority, a quarter or so that are under investigation, and we are having these convictions.

But if you think about it, the weaknesses in the financial management and the fraud units are probably more serious because they are more pervasive. In other words, when we did the CFO audits, we found the weaknesses in the financial management to be pretty much across the board in the contractors, and since those are the systems to control the outflow of the money and to keep track of they money, in a way they may have a more profound effect on Medicare than the occasional fraud case that we uncover.

I did list my recommendations already in my testimony. They do cover the areas that have already been addressed by the other speakers so I will stand by those.

Mr. UPTON. Okay. Mr. Klink.

Mr. KLINK. Thank you very much.

First question for Ms. Aronovitz and Mr. Grob. We as a Federal Government originally hired these fiscal intermediaries to provide us with state-of-the-art private sector techniques. We wanted technology, we wanted the latest technology, we wanted some integrity. Is that not why we outsourced this work in the first place, so that the private sector would be able to add some efficiencies that we didn't think we would find in the government?

Let's start with Ms. Aronovitz and Mr. Grob.

Ms. ARONOVITZ. Yes, absolutely. We thought that the private sector companies had technology and creativity to be able to develop new initiatives and new approaches to doing these functions, and they had more experience.

Mr. GROB. I would say, too, a primary factor was there was a strong desire to get the Medicare program moving, and you had in place organizations that were able to do it, and at that time I think the financial institutions such as the large insurance companies in this country were looked up to as having the kind of expertise that you're talking about, and no one felt at that time there was any reason to question that.

Mr. KLINK. I am willing to whack the folks at HCFA for not having directed enough oversight to catch some of these things that were going on, and I think we need to look at their procedures, and some of that has been mentioned today, but ultimately the commission—I mean, HCFA's problem might be omission, of not having a system in place, it appears to me—but the commission of the fraudulent, purposeful act of ripping off these dollars appears to be done, by everything that we have heard today, by the contractor. They appear to be their transgressions. Am I missing something there?

Mr. GROB. No, you're right.

Mr. KLINK. Let me—we know that we pay and we mentioned the figure of $1.6 billion, that is a lot of money, every year. We ask them to take care of paying out $700 million each day. Again, that is almost incomprehensible. So I want to walk through some of the behaviors, Ms. Aronovitz, that you described in your July 14 testimony and some of the things that you have mentioned today regarding unscrupulous activities of some of these contractors—and for each of these things, I will read you what you said, and I want you to tell me if in your estimation it was because the HCFA rules were too complicated or for some other reason, like greed, that you think these things were done.

You said on July 14 that they arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review. Is that because the HCFA rules were too complex?

Ms. ARONOVITZ. No.

Mr. KLINK. You said today, and I like this—I will just read it directly—admitted or allegedly improper activities, included but not limited to improper screening, processing, paying Medicare claims, destroying claims, failing to properly collect money owed to Medicare by providers. In addition, contractors falsified their performance results and engaged in activities designed to deceive HCFA and circumvent its review of contractor's performance. Was that because HCFA's rules were too complex?

Ms. ARONOVITZ. I don't believe so.

Mr. KLINK. Mr. Grob, do you have an opinion on that?

Mr. GROB. I agree.

Mr. KLINK. I'm sorry, for the record, in the microphone, you agree as well?

Mr. GROB. Yes, I agree.

Mr. KLINK. That they falsified documents in reports to HCFA, they destroyed or deleted backlogged claims, that they altered or hid files that involved claims that had been incorrectly processed or paid and altered contractor audits of Medicare providers before HCFA's review. So, again, was it because the rules were too complicated?

Ms. ARONOVITZ. No.

Mr. GROB. I think they understood what they were doing.

Mr. KLINK. I want to get this clear, because we are going to have another panel after you, and I hope that you are familiar with the cases concerning the fiscal intermediaries on the next panel.

Each of the contracts with HCFA, as a fiscal intermediary, was terminated because of behaviors engaged in by at least some of the former employees of these FIs. Of the companies represented on that second panel, do you think that there are any that should not have had their Medicare contracts terminated? In other words, how serious do you think the issues were that were involved, and what was the potential or actual harm to the Medicare program?

Ms. ARONOVITZ. No, I don't believe so. But I would also like Mr. Hast, my colleague, to answer that. He has been involved in some of those—in reviewing some of those investigations.

Mr. KLINK. Thank you. That would be good.

Mr. Hast.

Mr. HAST. Yes, on the cases we reviewed, we do believe HCFA acted appropriately.

Mr. KLINK. Can you walk me through this a little bit, if it's possible, and tell me a little bit about some of these cases that—we understand it's three cases since we last met in July. Talk in a little more detail, if it's possible, or is there anybody here who might be able to talk about that, talk a little bit about these cases?

Mr. Hartwig, good. Thank you, sir.

Mr. HARTWIG. Actually, the three cases with the guilty pleas earlier in the summer were pretty much the same as the cases we described to you in July. Contractors had altered records or destroyed records to make their CPEP scores look better on the processing of claims and the timeliness of claims.

One of the contractors actually had altered their congressional inquiries. HCFA puts a time limit on the contractor to get congressional inquiries out on a timely basis. They were not making that standard, and so they had two files. One file they maintained where the congressional inquiries were moved out appropriately, and another file where they did not make the timeliness goal. They would show only HCFA that one copy. So they were well aware of the fact that they were not handling congressional inquiries on a timely basis and just didn't disclose that to HCFA.

We had another contractor that did a similar thing with their correspondence.

And one of the concerns that we have is that it is just not handling, but that they are not handling correspondence in a timely basis. The rights of beneficiaries to appeal their claims are based on a time limit that starts with the submission of the claims, and where contractors don't handle their inquiries appropriately they may be actually infringing on their right of due process.

Mr. KLINK. Just very quickly, Mr. Osman didn't go through his entire written testimony, but I just wanted to take a look at this Illinois case where the woman that he represents, Ms. Knoob, found a box containing over 10,000 railroad retiree Medicare claims in the mail room. Now, this intermediary didn't have to process it. They were supposed to forward this to Traveler's Insurance, and when she brought this to their attention, rather than admit that these things had been sitting for several months, they set in the office and shredded them, and then took them out in laundry bags and got rid of them. And when she persisted on telling other people about it, they made her life horrible, to the point that she attempted to take her own life. I am giving you a real brief Reader's Digest version.

But the thing that is also kind of unbelievable is that the same company is alleged then to have installed a shut-off switch on its beneficiary phone line so when the volume of calls went up they just shut down the system so that they appeared to be doing the job in an adequate manner. So I'm asking you, these are some extraordinary allegations. Are they that different than the kinds of practices that we have seen by fiscal intermediaries that have been thrown out of the Medicare system?

Mr. HARTWIG. I believe that the conduct in many of these cases of the contractors is similar: that is, the destruction of claims we see over and over again of backlogs of claims and the destruction of correspondence. The events that you described today have been similar in a number of contractors. The fact that employees have

notified senior management of contractors that these things are going on and nothing has been done is a common element of all the criminal cases and the civil settlements that we have testified about before you.

Mr. KLINK. Thank you very much. I yield back my time.

Mr. UPTON. Mr. Blunt.

Mr. BLUNT. Thank you, Mr. Chairman.

Mr. Flynn, in your testimony you said that the level of corruption at the Michigan plan appeared to include a large number of managers and senior staff. The Inspector General's corporate management chart indicate that the corruption was widespread. Can you tell us how high that corruption went and how you think that culture of corruption developed?

Mr. FLYNN. Sure. The levels, I am sure it went up to the vice president's level, as far as knowledge of the practice that I described, and I have—I have reason to believe it went to the senior vice president level, which was simply one level removed from the CEO of the company.

I have something that's not in—I went through—I kept records of conversations with everybody during this time period, and I came across one—I reviewed all of these last night, and in one that senior vice president actually came to our offices and put pressure on us to do all we could do to reverse our position of 5 years that a particular hospital was not entitled to $1.5 million of Medicare money, and in order to appease the CEO as well as the Wayne County executive to do all we could to give the provider that money.

I was asked as a new person in the department to write a letter saying that I've taken a fresh look—a letter to HCFA—I've taken a fresh look at this, and I think that the hospital should get the money.

That's just one example, and that's the only example I have.

Mr. BLUNT. Do you have any idea how that atmosphere developed in the plan?

Mr. FLYNN. My understanding is that prior to 1989 Michigan almost lost the contract. It took heavy lobbying by Senators Riegle and Levin to keep the contract because they were doing poorly on CPEP. Having retained the contract, they simply had to improve their scores, and I think they made a genuine effort to do it. They cleaned house. They brought in new auditors. I was one of these new auditors brought in, and I was excited to have the job, as were a lot of young new auditors.

They got rid of company cars and a lot of the perks that the previous auditors had had. But for some reason, in addition to really making a concerted effort to do better work, they brought in these consultants, and I think they thought maybe just in the meantime, for a temporary quick fix for the previous audits that we know were done poorly, we'll bring in the consultants to clean those up, and that's why it was originally started. Because previous audits, it was known that they done so poorly that they would never pass. They had to be fixed, and once they got into that system it simply never stopped.

Mr. BLUNT. I don't want to misphrase Mr. Osman's comment, and I will let him respond to this in a minute, but he said that he

thought in the other plan it was good people with bad supervision. Do you think that——

Mr. FLYNN. I said just as much. These are all decent people, I mean, accountants, good neighbors, and they—from my perspective, when you were first confronted with this, you thought, well, that seems kind of odd, I don't know if that should be allowed, but you were grateful to have the job. You wanted to do well. You wanted to please your supervisor, and you were surrounded by other people who were going along on with it. They expressed some concerns, and also the company effectively told us, you know, this is just a game we have to play with HCFA. They know we're doing it. There's this sort of a wink and a nod. They have these burdensome regulations so they kind of know we're doing it. They'd never admit it but they know, and so this is the dance that we do.

And we just figured, hey, if people three and four levels above me know what's going on, so if someone ever comes after me, I know they're going to come after the people four levels above me, too, and I think that was the general attitude.

Mr. BLUNT. Mr. Osman, you want to comment on that?

Mr. OSMAN. Yes, thank you. We found the same thing in Blue Cross Blue Shield of Illinois. In 1986 they were in serious jeopardy of losing their contract because of their poor postpayment quality assurance scores, and the new director that was brought in was brought in to fix that. His methodology of fixing it was to begin to cheat and finesse the system.

At that same time, HCFA, by the way, used to have a policy that they had an onsite representative at the carrier's place of business to ensure that they complied with the contract. In the latter part of 1986, the HCFA onsite representative for Blue Cross Blue Shield went to work for HCSC. He knew that the contract was about to be terminated, and then miraculously they went from number 47 in the Nation to number 3 in just a period of 2 or 3 years. Someone—a bell should have gone off someplace that there's a problem here. It didn't.

But getting back to what Mr. Flynn said, there was a corporate culture. I heard the same thing from witness after witness. HCFA's too stringent. This is a game we play. We're just getting ready for the test. They're too picky. We have to do this to keep our contract. In my case, they would have what they call town hall meetings and talk about—if you can imagine 350 people in one room talking about processing claims $50 and under and not reviewing them when they suspended because we have to do—we have to do the claims. So there was a corporate culture, and I think it was the same as Mr. Flynn talked about.

I really believe that Blue Cross Blue Shield of Illinois wanted to keep that contract. They got engaged in this system of finessing or cheating and couldn't get out of it because once you're a leader and you say to your subordinate it's okay to cheat on one item, what do you think they do the next day whenever they have to meet their data quota? They cheat on that also. And you as a leader are compromised. You cannot go back to that employee and chastise them for cheating or finessing because you have condoned it in the future.

So when they got into this corporate culture, there was no way out. They absolutely could not get out of it. They did seriously try, I think, to correct their problems, but they got into this problem. They couldn't get out of it. And unfortunately HCFA, by announcing when they were going to come in to do their CPEP, and by allowing them to pull their samples themselves, didn't provide effective oversight, and as I said earlier, you know, if that one man, a good person, would have been there the entire time, every bit of this could have been prevented.

Mr. BLUNT. Thank you, Mr. Osman. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I think from the panel we've heard not only from GAO, but also from the attorney that, one, there are no surprise inspections, and if there are, then they give you dates and what you're looking for. So maybe we need to look at that and see if HCFA can make some changes.

Mr. Osman, let me just ask one question from you. The opinion—what you're stating, is that something that was proven in court, testimony, or was that obtained through discovery, or was this just allegations or whatever? For example, the phones were turned off and things like that, was that actually proven by the Department of Justice?

Mr. OSMAN. Absolutely. There's absolutely no doubt that they had—and it was admitted to, and there was no doubt that there was a phone—whenever the volume of calls just got too great, they just turned off.

Mr. GREEN. I also appreciate in your testimony you talked about the local U.S. Attorney was making every effort to prosecute, yet the Department of Justice here in Washington were discouraging them from going forward?

Mr. OSMAN. Well, as you know, whenever there's a false claims action filed, you file the complaint under seal. You file it with the U.S. Attorney's Office, the local U.S. Attorneys and Department of Justice. The Department of Justice then circulates it, and they look at it from the Civil Division and also the Criminal Division. Early on I believed that there had been criminal activity and stated that. The Department of Justice in Washington did not believe so, and it would not institute nor start a criminal investigation.

After the first settlement conference, it became painfully aware to me that the case had not been investigated enough to be entering into settlement negotiations. I kind of reversed the procedure, went back to the U.S. Attorney Chuck Grace, and made a presentation to Mr. Grace. And much to his credit, he began a criminal investigation, and he is one of the—in my opinion, one of the heroes in this case and one of the reasons that the government received $140 million, because once the criminal investigation started, we had more assets in the form of OIG agents, FBI agents, postal inspectors to do a better job of investigating, and as we kept turning over rocks, we kept finding more fraud. And Mr. Grace and his civil assistant Laura Jones and Tom Daly deserve just an enormous amount of credit. Although I was pushing and was investigating and was developing formulas for the government, and in assistance with him, I certainly didn't have the wherewithal to

push that, and Mr. Grace is primarily responsible for the government receiving that $140 million.

Mr. GREEN. Mr. Flynn in his testimony and just under question from my colleague said that HCFA—this is a game they play. HCFA knows you have to comply, and I hope I'm quoting you correctly. Does HCFA know you turn off the phones when the volume gets too much or things like that? Was that ever shown in your investigation?

Mr. OSMAN. There was never any direct evidence. You keep in mind that there were only two people who would come down once a year, and I don't know what their schedule was. They may have had 15 other—it may have been overloaded. I think that's one thing that needs to be looked at. But it was the same person year after year after year. There was evidence that they took this HCFA official to dinner quite frequently, and there was evidence they would entertain him at their homes after there was an edict put out that you cannot accept payment of dinners. They became too familiar.

There was—one of the things that I didn't say in my statement is if you do this auditing, or if you put someone onsite, you have to rotate them because you cannot allow them to get so familiar with the people that they're overseeing that they begin to feel sorry for them. And so there was evidence of that. I mean, if you look at it, if you have limited resources, and you have a lot of work to do, you don't want to find mistakes in a lot of cases because what happens is if HCFA found this problem, then they had to go find another carrier. Then they would have to come back to a committee somewhere in Congress and explain to them why they had to replace this carrier. So in a lot of ways, it was not to HCFA's benefit to say, but it was much easier not to find the fraud than it was to find the fraud.

Mr. GREEN. Mr. Grob, Ms. Aronovitz, it appears we're starting to have more and more integrity problems. I see the list here, the last hearing from our financial intermediator. Is this area becoming more troublesome? Does it appear that way only because we're spending more time on resources investigating? Is it because you were looking more that we're finding these problems?

Mr. GROB. First of all, I do think it's been troublesome all along. We've had these investigations under way for a long time. Some of these investigations go back to acts that were committed in the early 1990's, for example, and continue through the years. We've had some investigations under way for some time. So I don't think it's because we're just discovering it now. I think we're discovering things that were there. But it is good to see the concerted attention now being paid at every level.

I think the system runs through all the layers of government, and I think by paying that attention, we're both coming up with solutions, but at the same time becoming more aware of the details of them.

Mr. GREEN. Ms. Aronovitz, you mentioned in your July testimony before the committee that falsified data reported to HCFA was a common theme for some financial or fiscal intermediators. My question regarding these fiscal intermediators, whether they also falsified the data they use on the private side of their business.

Also, what's the nature of the data they're faking, and what's their motivation for doing so, obviously outside of greed and incentives and what have you?

Ms. ARONOVITZ. We did not look at the private side. So, I really can't address the private side of their business, unfortunately.

Mr. GREEN. Some of the audits, though, were the same personnel used for the HCFA that were also used—for example, Blue Cross Blue Shield of Illinois, I'm sure they have other programs, the same personnel, or did they have a separate location for the HCFA?

Mr. GROB. Everything was supposed to have a good fire wall between the private side and the Medicare side.

Ms. ARONOVITZ. I'm sure the companies that will be speaking can elaborate on that, but I do believe there is quite a fire wall because you really do want to avoid a company working on the private side and also with Medicare, because there are some situations where a company—where Medicare would be a secondary payer, and you don't want a company to get confused in terms of what part of the business is going to be paying the claim.

Mr. KLINK. Would the gentleman yield for one quick moment?

Mr. GREEN. I will yield whatever time I have.

Mr. KLINK. I think we're also owing the chairman some time.

You did mention in July that they arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review. You just testified you don't have the authority to look into the private side. Who would be able to tell us whether or not that same practice were taking place in the private side or if, in fact, falsified documentation was taking place or destroyed or deleted claims or altered files, these kinds of things? How would we be able to find out if they're conducting business the same way on the private side as they are on the financial intermediary side? Getting thrown out of the Medicare program is pretty serious, and these dollar figures they've settled for is pretty serious, too. How would we find that out?

Mr. GROB. We'd have to start a study of that, and we'd have to—to see how we can reach that. What we have reached in our studies is that where that fire wall was breached—in the cases we have here—there were a couple of cases. One was a case in which the Medicare payer used Medicare funds to pay for insurance coverage which it knew it was responsible for on the private side. That was the Medicare secondary payer situation. And the other one was where they had charged to the Medicare program the expenses of employees who were definitely working the private side, and they knew they were working the private side and that they weren't working for Medicare, but they charged their time to the Medicare program. In fact, that was in one of the three recent cases where that happened. But in terms of reaching an analysis of their business practices on the private side, we certainly have not done that except where we have suspicions about its relationship to the Medicare program.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

Mr. Flynn, from your standpoint as an employee, I think you provide a great perspective on the problem with the inside information

that you've already testified to. You've indicated today that whistleblowers are sometimes motivated exclusively by desire of financial gratification, and that the proper course—you haven't testified to that, we have heard that—and that perhaps a better course would be for the employees to notify the proper authorities. In other words, the people on the other side are saying that this is all just about money, and what you should do is go up the chain of command and report what is going on. Based on what I'm hearing, that's almost ludicrous, but I will ask you that question. Would that be an effective means without the lawsuits that you simply go up and report it to your supervisors?

Mr. FLYNN. No, I don't think so at all. It's also my understanding that this is what Blue Cross is going to testify to this afternoon, the point you just made. And at least in my case, I have written documentary evidence going right back to before I even consulted my attorney that shows that I struggled with what should I do with this. I wrote, "Do I owe management an opportunity to somehow explain all this?" I talked to a law professor. I talked to a great trusted friend. I talked to two attorneys. I called Barbra Hoff at HCFA anonymously and asked her if there's a wink and a nod with this practice, and she said, you can take that straight to -OIG. That's fraud, flat out fraud. She didn't say you had to. Nobody suggested I report this internally. And then throughout this entire case, Federal investigators, including the Attorney General, unanimously told me I did the right thing by taking this externally.

So I grappled with it, and in deciding to pursue it externally, I know it was the right decision. And, in fact, in a meeting I had with Lisa DeMoss at Blue Cross near the time of our settlement, she acknowledged—well, let me back up. Ms. DeMoss challenged my admission to the New York bar. Blue Cross, I had to ask them to write a letter on my behalf when I applied for the New York bar, and Blue Cross' response was, it was wrong and immoral of him—me—to not pursue his grievances with his colleagues in the Office of the General Counsel or at other levels of management as required by the Corporate Code of Conduct. In this three-page letter I first assert that I complied completely with the code of conduct, which provided many alternative ways to report this type of behavior.

Mr. KLINK. Would the gentleman yield for a quick question?

Mr. BRYANT. Sure.

Mr. KLINK. Do you think, Mr. Flynn, at that point in time that the company had faith in their compliance program? Did they have any trust in the compliance program that was in place?

Mr. FLYNN. I think they did. I think they had—I'm not sure——

Mr. KLINK. Did the employees?

Mr. FLYNN. I don't know. I don't know if the other employees did. I sure didn't. To the extent I did, I had faith in them with the providers. I think they probably did a good job going out to the hospitals, recouping money from——

Mr. KLINK. Why didn't you have faith?

Mr. FLYNN. I didn't know of any internal investigations they did. When I called the number, it clearly—I did. I called this 800 number. This woman said, we pretty much just investigate hospitals. I said, do you ever do anything internally? No. She was oblivious.

Mr. KLINK. I thank the gentleman.

Mr. FLYNN. Ms. DeMoss told me there was a separate number I should have called. I never heard of it.

Mr. BRYANT. Let me say this. This is a difficult complaints area. I know there's blame to go around in many instances. HCFA regulations are complex. And I'm not just completely condemning your employer, Blue Cross Blue Shield, but I think there's some individual judgment you had to make at the time when you go up to your supervisors, or whether you felt it was so bad that perhaps there is a balance there that has to be achieved, and maybe just on a case-by-case basis how this is done. But I think I have concern, too, about how you were treated afterwards.

There's some indication—I know I've read a lot about this, retaliation, harassment, things like that, and of course that's one of the factors that you face if you go up the chain and you don't get results, and potentially somebody could really cause you some problems.

Mr. FLYNN. First of all, going up the chain I knew that my supervisor, manager, director and vice president were all taking part in it. The only person—and then I was pretty sure the senior vice president, based on what I said earlier, was not that concerned about with enforcing Medicare regulations. That left Dick Whitmer, the president and CEO of Blue Cross. I just wasn't going to go to him and——

Mr. BRYANT. Mr. Osman, as an attorney in these whistle-blower lawsuits, qui tam lawsuits, do we need a separate criminal statute on the books to protect employees from that type of harassment, or do you know if there's sufficient law on the books already, obstruction, intimidation of witnesses, things like that that would be helpful?

Mr. OSMAN. I don't believe you need a new criminal law. I think we have enough laws in the United States the way it is. The civil law, the whistle-blower statute as everyone calls it, has protections in there. It's subsection H which gives you protection in the event that you are retaliated against. Unfortunately nothing that you could write down is going to stop people from retaliating against you.

I agree 100 percent with Mr. Flynn. In my case, my client went all the way to the director of the Blue Cross Blue Shield at Marion, who was at that time the vice president. She went all the way to him, and it continued to be covered up. So without the qui tam statute and without the threat, without her coming into my office, which was the fifth attorney she'd come to, I'm convinced that Blue Cross Blue Shield of Illinois would still have their five Medicare contracts and would still be processing claims, and without that particular statute, she would not have been able to do it. In her case, she's completely disabled, so the retaliation—she didn't go back to work, so there was no further retaliation, but at one point her supervisor put seven negative evaluations in her file on the same day, seven. Now, they were backdated, but dated for months before, but she put seven negative evaluations in her file on the same day. So there was a concerted effort to discourage any of this type of activity.

Mr. BRYANT. Thank you.

I thank the Chair.

Mr. UPTON. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. When we had this hearing in July, I was impatient, and I feel impatient sitting here again today because frankly I think we should do things like encourage the HCFA auditors to be independent. We should find structural ways to make that happen. I think that we should simplify HCFA's rules and regulations so that people understand what they're doing.

But, you know, I practiced law for a number of years before I got demoted to this job, and you talk to thieves, for example, and they say, well, you know, the police coverage in this part of town is kind of low, so that's why we burglarize all the houses there, because we know the police patrol is not going to come by. Of course, they beefed up the police patrols when they had a series of burglaries, but nobody blamed the police.

I find some of this testimony shocking about how it's HCFA's fault because corporations are committing fraud, and I will also say—and this is not to accuse corporations or to excuse them, but I have found that where something is not clear, they will take that opening. Mr. Osman, I think you talked about that somewhat, too.

I guess my question short of stationing a HCFA employee or someone else next to the lady with the laundry bag and the paper shredder, next to everybody, how can we encourage legal behavior, and how can we beef up our enforcement or whatever we're going to do to stop illegal behavior? One of the questions I have is are there any incentives that we can give to folks, to FRIs, to take the legal route versus the shady perhaps and probably illegal route? I wonder if anyone can comment on that. Mr. Osman and then Ms. Aronovitz.

Mr. OSMAN. As I said when I started my testimony, I'm not here to bash HCFA, but I think—I think it's maybe a little Pollyanna, and I'm one also to believe that corporations are going to always do the right thing. Corporations are guided by principles that are a little different than individuals. They have stockholders to report to, or in the case of these companies, they have mutual reserve insurance companies that they have policyholders to report to to keep the cost as low as they can. I believe you have to assume, and you have to design a system that assumes, that someone is going to try to do something illegal, not design a system that assumes they're going to do everything right.

Ms. DEGETTE. That's not my question though. My question is are there incentives that we can give to people to do things right?

Mr. OSMAN. We had an incentive in the Blue Cross Blue Shield case. That incentive was if you process claims in a certain manner with a certain quality, you get extra money. What they did in that instance was they cheated on the CPEP, and they got an additional $1.2 million.

Ms. DEGETTE. Your answer is you don't think there are incentives that we can give.

Mr. OSMAN. I think there are incentives that you give, but you have to then temper it with and you have to make sure they're monitored.

Ms. DEGETTE. I agree. I'm not saying I disagree. You have to have both.

Mr. OSMAN. I don't think that what I have said is that you have to have one individual sitting at all 350 people's desks. You have to have one individual onsite whose primary job is to monitor that contract, and this—someone asked how much more money it would cost. I think for $10 million a year, you can do exactly what I've said you can do, and this problem will be solved. Now, it sounds simple, but it is simple. This is a simple problem, and there's a simple solution.

Ms. DEGETTE. I kind of disagree.

Ms. Aronovitz?

Ms. ARONOVITZ. For many years HCFA has proposed legislative reform, and some of these reforms do make a lot of sense, in our opinion. Right now HCFA does have a hard time competing contracts because the universe of potential contractors is very limited, and they would like to have more flexibility in being able to contract with any type of competent business or public entity. They're also interested in having reform where they would be able to contract for a particular function, like the appeals process or mailings and printing where you could take it out of a contractor and just separate a function. Now, I know that the current contractors are very, very concerned about that. They do think it would add tremendous cost because you are, in fact, having to interface with two contractors, and they're going to have to work together and all, but I think this is something that we would think HCFA should be able to experiment with.

But one other area is different payment methods for different types of contracting. Right now HCFA could only use cost-based reimbursement, and there are—there have been in the past certain experiments or demonstrations where HCFA has used incentive contractors that have not necessarily worked that well because of the perverse incentives involved. However, we do think it's time to experiment again and with very controlled demonstrations and with the right incentives to make companies have more of an incentive by being able to earn additional bonuses with the right oversight.

Ms. DEGETTE. What do you think of this idea to have one person in each site?

Ms. ARONOVITZ. When we went to the different regional offices, there was a lot of discussion and a lot of disagreement among the HCFA regions about whether an in-house or an onsite contract manager was appropriate. We heard a lot of pros and cons, and there's no final answer, I don't think. I think we're still studying this. On one hand Mr. Osman and Mr. Flynn had mentioned it's very easy to get too cozy, and you're having—if you have one HCFA person who is in a company, and they're by themselves, they eat their lunch by themselves or whatever, it's natural to interact and maybe even get too comfortable. That's why the rotation idea does make some sense. On the other hand, it is true that in our study we found that HCFA overseers really didn't make that many trips to the contractor. So there might be something in between in terms of having the resources to do better oversight, make surprise visits, do a lot more in that regard. But on the other hand, you also have

an issue of quality of life and to try to find a contractor who would be willing to travel extensively, you have to find that person.

Ms. DEGETTE. The problem you get is this coziness idea, but on the other hand, sometimes corporate policies, especially to midlevel or lower-level employees, seems so murky. Someone like Mr. Flynn, he would have someone he could go in to and say, I'm being told to do this, and I'm not so sure. I think that's the point.

Ms. ARONOVITZ. One thing that we found that really could work, and we found it in a few situations after an integrity problem was found and reported to HCFA, on occasion HCFA's central office went out and did what they called an integrity review. What that was was to privately meet with every single employee in the unit, or in the division or branch, and have a private conversation and say, what do you think about the operations of this company, how do you think things are working, do you have anything you want to discuss privately with us? Having the opportunity—giving an employee an opportunity to talk to someone at HCFA who they trust and know could take action—we think is very important, and we think if HCFA would just go out and do integrity audits occasionally, not only when problems are found, that that might go far to identify problems. Thank you.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Bilbray.

Mr. BILBRAY. Mr. Chairman, I just, I guess, would ask Mr. Grob, the availability of these records electronically to whoever is doing the auditing, there's a pretty well-developed electronic data base right now, isn't there? What percentage would you say of these records are available electronically?

Mr. GROB. I would say most of them are electronic.

Mr. BILBRAY. Historically that's not been the rule?

Mr. GROB. No, but it's where we're at and where we're going.

Mr. BILBRAY. Now we're moving.

Mr. GROB. Right.

Mr. BILBRAY. I only say this because I think we can find blame and say it's the private sector, it's the public sector, and we all take our historical positions there, but I think we need to take a look at the fact that everybody has to do their job, and everybody has got to be reminded that playing by the rules is not only nice, it's essential. It's got to be mandated.

My big question is with the advent of electronic data base, the private sector jumped into in the 1970's, I remember General Motors, because of all the fraud and abuse in their warranty process, set up a whole electronic data base that would not only allow access for audits, but would actually start automatic audits based on historical models. What's the ability for us to develop that technology, or are we developing that technology that the private sector has been looking at for 20 years to basically do what they would say in the IRS, throw the red flags up to start a ping based on certain patterns and certain data, so we don't have to literally go in and someone doesn't have to literally go into an office. This thing of telling someone we're going to come, we're going to look at this, those records should be available electronically at any time.

Mr. GROB. First of all, clearly, the broad use of electronics for processing the claims and for reviewing them is very much the

wave of the future, and there is a lot of progress being made. Most claims are paid electronically. They're submitted electronically, and they're paid electronically. The vast majority of them are. The sophistication of dealing with those electronic systems is also increasing on both sides of the equation, both the ability to game it and the ability to discover it. Don't forget, one of the things we found that these contractors were doing is turning off exactly those edits that would ping the bad claim coming in, turning them off.

So I would say on both sides it's sort of like the chess game has become more complicated, and the players are getting more sophisticated, and we're certainly all working to improve both sides of that equation.

Mr. BILBRAY. Some people in the administration will learn you don't necessarily erase e-mails and stuff on your personal computers. The fact is do you have the ability to track when those things have been turned off?

Mr. GROB. I can't answer that one.

Mr. OSMAN. I can tell you that that was one of the allegations that came out of the Blue Cross Blue Shield of Illinois, and in 1995, just a little bit background, when a claim comes through the system and there's something wrong with it, one of the edits and audit sets, it suspends. In 1994—these are round numbers—there was about 18 percent of the claims suspended. In 1995, it was 9.1 percent suspended. And in 1996, it went back up to 14 percent suspended.

I always suspected that the edits and audits were being turned off in 1995 because 1995 was the year that Blue Cross Blue Shield of Illinois, because of their great performance, was given the Michigan contract that Mr. Flynn talked about, and they were having problems administering both contracts, and I always suspected that they turned the edits and audits off. We were never able to get the data to prove that they'd been turned on and off because there's 1,004 edits and audits, and there was no—nothing in the system—we were told—whenever we requested this data, we were told there was no way in the system for us to run a report and see when a particular edit was set and when it was disabled. So we were not able to, in our case, do that.

Mr. BILBRAY. Now, in 1999——

Mr. OSMAN. I don't know.

Mr. HARTWIG. I think it's very difficult to show that edits were turned off. The way we have used it in some of the criminal cases is there have been actual memos saying, please turn the edits off for these dates. It makes it somewhat easier; but without that evidence, it's very difficult to show that edits were turned off.

We also have instances where claims were force-coded, where they were kicked out of the system, and then a code was entered to get them paid. That process is easier to show because you have a record.

Where we found it very difficult to go back and reconstruct exactly when computer edits have been turned off. We also found instances where computer data was recreated, and that is a difficult investigative process where you actually have computer files recreated to show something different. It's a much more tedious task, and you really rely on witness testimony on a lot of these instances

to go back to the beginning. So where you turn edits off, it's difficult. Where you force-code it, it may be a little bit easier.

Mr. BILBRAY. I would be very interested for us to seriously look at what major corporations have done to address their audit process and try to address these problems because I think we could learn a lot. My background is environmental health. One of the greatest breakthroughs we had in air emissions and water emissions was to the ability to constantly monitor electronically rather than go and do a test of what a smokestack was putting out. We actually had sensors that could tell you 24 hours a day what was going on so that on Sundays or midnight somebody didn't pump all the garbage out the stack; we'd detect it. It would be nice to be able to use that technology to make sure the process is working as it was designed.

I think we're looking at technology being used in a lot of ways to help double-check and check. We ought to be as innovative as the private sector has been. Maybe Microsoft has some ideas for us.

But thank you very much, Mr. Chairman. I know it didn't answer all the questions, but I think we raised enough questions where we can say there may be some opportunities out there. I yield back.

Mr. UPTON. Thank you.

Mr. Cox?

Mr. COX. Thank you, Mr. Chairman.

Mr. Flynn, your testimony and your responses to questions indicate, I think, your conclusion that there is a relationship between HCFA and, in your case, Blue Cross Blue Shield of Michigan that is perhaps too cozy to permit the kind of aggressive audits that should be performed; is that right?

Mr. FLYNN. Right.

Mr. COX. And likewise, Blue Cross Blue Shield had too cozy a relationship with the providers—who also had an incentive, that is, getting paid—to permit them to have the proper incentive to go in and do what's right. So between Blue Cross Blue Shield, the providers, now the government—and this even extended to the Department of Justice, although Justice in your case provided you a lawyer who is handling it by herself and doing a good job, it is my understanding—so that more of these parties, but for the qui tam procedure, was up to the task. Blue Cross Blue Shield wasn't up to the task. The providers were not up to the task; is that all right?

Mr. FLYNN. That's right.

Mr. COX. That leaves us then with the qui tam procedure. What's the status of your case?

Mr. FLYNN. It's settled.

Mr. COX. It is now finally settled?

Mr. FLYNN. Right.

Mr. COX. When did that occur?

Mr. FLYNN. January 1995.

Mr. COX. A long time ago. Okay. Pardon me. It was not clear from your testimony that that was the case. How much money was involved in the settlement?

Mr. FLYNN. $27 million.

Mr. COX. You had stated in your testimony that the cheating has cost the Medicare program tens, if not hundreds of millions of dol-

lars. And just to understand the workings of the qui tam statute in specific detail, that $27 million was the government's recovery?

Mr. FLYNN. Right.

Mr. COX. And then as the relator, you got a share which, by statute, since there was Justice Department intervention, should have been a minimum of 15 percent and a maximum of 25. What actually happened in your case?

Mr. FLYNN. Twenty percent.

Mr. COX. You got 20 percent. So roughly $5.4 million.

Mr. FLYNN. Yes.

Mr. COX. How many years was it from the time that you filed your qui tam action until the date of the settlement?

Mr. FLYNN. It was about 1½ years.

Mr. COX. And the Federal False Claims Act, unlike some statutes and unlike most civil litigation, provides that you also separately get to recover your attorney's fees, so that doesn't come out of a contingent fee percentage, right?

Mr. FLYNN. Right.

Mr. COX. Was there an additional payment on top of the 20 percent for attorney's fees, or in your case did the attorney's fees come out of the 20 percent?

Mr. FLYNN. I had an arrangement with my attorney that we shared the recovery, and so my 20 percent was before both taxes and attorney fees. But there are also—there are statutory attorney fees that the company has to pay above and beyond the settlement. They resisted, and the compromise that we struck was that they pay 50,000 some dollars to five charities that I selected in the Detroit area.

Mr. COX. So between your lawyer—how many private lawyers did you engage?

Mr. FLYNN. One.

Mr. COX. The two of you then split $5.4 million.

Mr. FLYNN. Right.

Mr. COX. And that works out to be something like a rate of about $3 million a year for 1½ years work. My question is whether, in the same way that taxpayers are paying too much because of Medicare fraud, we are also overpaying through the qui tam procedure to get these results. Because in the end the taxpayer is the same taxpayer, and whether we get cheated by Blue Cross Blue Shield or whether or not we pay $5.4 million for a two-person audit that lasts 1½ years, it's real taxpayer money. That $5.4 million is in the end going to come out of the Medicare system somehow.

Mr. FLYNN. That's right.

Mr. COX. What can we do to make the Federal False Claims Act more efficient so it doesn't cost us so much money? And also—this is an important part of the question—I don't mean to suggest by asking this question that this in any way has anything to do with your case or your bona fides, but also—how do we address the problem that we have already seen with HCFA having the wrong incentives, the government having the wrong incentives, and the provider having the wrong incentives, when we now have given somebody the opportunity to get 25 percent or even more of recoveries that can run into the hundreds of millions of dollars? They have an incentive to have fraudulent lawsuits because those are

big numbers. What can we do to make sure that the Federal False Claims Act is tightened up?

Mr. FLYNN. I guess a couple of thoughts. You can—first of all, I have no objection with the percentage being smaller. I'm sure plaintiffs' attorneys wouldn't want to hear that. I didn't even know what the percentages were when I pursued it. I'm sure a lot of relators would be still willing—to the extent they're motivated by money, they'd still be willing to do it for much lower percentages than I would have.

Mr. COX. Maybe $2 million a year.

Mr. FLYNN. I honestly——

Mr. COX. Seriously. You could still have big numbers if you reduce those percentages.

Mr. FLYNN. Absolutely. Absolutely. And I think you could lean on the companies to pay attorney fees above and beyond the settlement. You could separate it out. You could give the government's money back in the taxpayers' pockets and work out the compensation for the relater and their attorneys.

Mr. COX. That's enormously helpful, Mr. Flynn. I appreciate it. I see my time has expired.

Mr. UPTON. Mr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. We have votes so I'll be pretty brief. I appreciate this panel's testimony.

Mr. Osman, I find the story that you related to be pretty incredible but believable as a health care practitioner, physician, before coming to Congress. I can relate to some personal experiences where clearly it was very difficult to get the Medicare administrator to actually process claims or to get a determination that another carrier was responsible in the first place so that you didn't have to bill Medicare. I always thought that was very strange, and your testimony kind of threw some light on maybe why that would be. I mean, I thought to myself, look, why would they—why would Medicare want to pay for this when another company is responsible?

And I think that your testimony was also interesting to the effect that how important it is to have whistle-blower protections. In fact, I should point out to Mr. Cox and other members of this committee that we just had a big debate on the floor of Congress related to the Department of Defense inappropriately harassing and hassling a Department of Defense employee who blew the whistle, and it got rather—a lot of national attention, and I would be willing to bet that almost everybody in the Commerce Committee voted to protect that employee's right to blow the whistle.

I mean, I think this is crucial having this protection, this Federal protection, for Federal employees who blow the whistle. And I would point out that we have legislation pending before Congress that would provide the same whistle-blower protection to health care professionals who blow the whistle on HMO activities that could endanger the lives of their patients. They do not in our legislation have any qui tam reimbursement or things other than for simply protecting them from being harassed like your client was or possibly fired. And the provisions in the bill, H.R. 2723, the Bipartisan Managed Care Protection Act, are quite carefully crafted so that it would not interfere with an employer from appropriately re-

viewing an employee's performance and terminating an employee who is not doing their job properly. But there is a balance that you have to have in there, and I think it's in the public health insurance that we look at extending rights for those who blow the whistle on aberrant behavior that can affect people's health.

So I appreciate the testimony of this panel because it just simply, I think, identifies a problem that we need to extend in further Federal legislation as it relates to people not fearing for the loss of their jobs when they point out that behavior by an HMO, for instance, could be—is way past standard care and is actually—could result in the loss of life of a subscriber to that health plan.

So that's my comment. I look forward to hearing the next panel because we'll get the other side of this story, and, Mr. Chairman, I appreciate very much your having this hearing. The problem with identifying fraud and abuse is important. It is a balancing act. I've been a strong proponent of providing the Health Care Financing Administration with additional funding so that they can fulfill their job and so that we don't have so many stories like the ones we've heard today. Thank you, Mr. Chairman, and thank you to the panel.

Mr. UPTON. Thank you, Dr. Ganske. I would note we have about 4 minutes before the vote is completed. We are going to excuse you all, panel one. Thank you for your testimony. We look forward to your comments certainly in the future, and I would note that we will start promptly with panel two at 12:30. Thank you.

[Brief recess.]

Mr. UPTON. Welcome back. Our next panel, Panel II, includes Mr. Norman Becker, President and CEO of the New Mexico Blue Cross and Blue Shield; Mr. Michael Huotari—did I say that right?

Mr. HUOTARI. Yes.

Mr. UPTON. Thank you—executive vice president and general counsel of Blue Cross and Blue Shield of Colorado; Mr. Steven Hess, Senior Vice President and General Counsel of Blue Cross and Blue Shield of Michigan; and Mr. Fred Verinder, Vice President for Compliance Operations, Health Care Service Corporation in Chicago.

You heard our first panel. I think you were all here. We have a long history of taking testimony under oath. Do you have any problem with that?

Mr. HUOTARI. No, I don't.

Mr. UPTON. And under House rules you're allowed to have counsel, if you wish so. Do you wish to have counsel? You will be the first, if you did.

If you'd stand, raise your right hand.

[Witnesses sworn.]

Mr. UPTON. Thank you. You're now under oath.

I know members are coming back. There are a variety of different things that are going on. Again, if you could keep your comments to 5 minutes, that would be terrific. Your entire statement obviously will be made part of the record.

Mr. Becker, we will start with you. Thank you.

TESTIMONY OF NORMAN P. BECKER, PRESIDENT AND CEO, NEW MEXICO BLUE CROSS AND BLUE SHIELD; MICHAEL E. HUOTARI, EXECUTIVE VICE PRESIDENT AND GENERAL COUNSEL, BLUE CROSS AND BLUE SHIELD OF COLORADO; STEVEN C. HESS, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, BLUE CROSS AND BLUE SHIELD OF MICHIGAN; AND FRED B. VERINDER, VICE PRESIDENT FOR COMPLIANCE OPERATIONS, HEALTH CARE SERVICE CORPORATION

Mr. BECKER. Chairman Upton, distinguished subcommittee members, my name is Norm Becker. I am President, Chief Executive Officer of New Mexico Blue Cross and Blue Shield. I am pleased to have this opportunity to appear before you to share the lessons we have learned at our company over the past few years.

New Mexico Blue Cross has been a major health insurer in the State of New Mexico since 1940. At present, the company provides HMO, Point-of-Service, Preferred Provider and indemnity coverage to over 210,000 New Mexicans. In many States that would be considered a small health plan. In our State it is considered very much a large health plan based on our population. Blue Cross is one of the top three health care carriers in the State. In addition to providing health care coverage and other services, New Mexico Blue Cross employs about 600 New Mexicans, putting our company in the top 150 employers in the State.

I began work as President of New Mexico Blue Cross in 1996. When I came, we had recently lost our Medicare Part A contract, under which the company had furnished provider audits and other administrative services to HCFA. New Mexico Blue Cross was in the midst of an investigation involving allegations that the company's provider audit unit had performed certain hospital audits poorly and that management personnel had attempted to conceal that fact from HCFA.

It was apparent that we had significant problems that needed to be remedied if the company were to survive. The allegations involving the provider audit unit had to be investigated and appropriate resolution reached with the government. Employees involved in misconduct had to be separated from our company, and we had to implement policies and procedures to ensure that our employees understood the importance of absolute integrity in all of our dealings with the government, with providers, with the people we insured and with each other.

We have accomplished each of those goals. First, through a lengthy process marked by complete cooperation with our company, we achieved a fair resolution this year with all outstanding civil, criminal and administrative issues. The resolution compensates the government fairly. It punishes the company appropriately for the past misconduct. It puts in place a corporate integrity agreement that we frankly welcome and, most importantly, allows us to move forward.

Second, none of the employees connected with the problems involved in the provider audit unit remain with our company in any capacity. Indeed, the provider audit unit itself no longer exists.

Third, we hired Angela Vigil as Vice President for Compliance in 1997. Ms. Vigil has extensive experience as a former regulator with the New Mexico Department of Insurance. Under Ms. Vigil's guid-

ance, we have instituted a detailed Code of Business Conduct and a stringent Corporate Compliance Plan, both of which is instilled in employees through mandatory compliance training. The corporate integrity agreement that we entered into with HCFA this year further strengthens the Code and the Plan.

Although I am proud of the action we have taken in our company to remedy the past problems and to ensure they do not recur, none of the steps that I have outlined get to the heart of the matter. The core problem that we had was the corporate culture that permitted employees to sacrifice integrity in some cases for business advantage in an intensely competitive environment.

The key to solving that problem has been a fundamental change in our culture. No legislation, regulation or compliance plan will prevent fraud and abuse if a corporate culture implicitly condones such conduct—by, for example, stressing productivity over all other objectives. By the same token, the corporate culture that imbues employees with the conviction that absolute integrity is the highest value and implements that culture through an appropriate code of business conduct and compliance plan ensures that improper conduct will rarely occur and that when it does it will be detected, it will be reported and it will be corrected.

Through our management team, we have worked very hard to instill a corporate culture in our company that puts integrity first. In that effort, I have received the wholehearted support of our board of directors. My introduction is an example to the New Mexico Code of Business Conduct's—New Mexico Blue Cross and Blue Shield Code of Business Conduct which all employees receive, read and must sign, declares integrity and accountability are the core values of New Mexico Blue Cross and Blue Shield. In today's changing and highly competitive environments, the pressure to succeed seems is greater than ever. That pressure, however, does not absolve us of the responsibility to always do the right thing as we perform our jobs and operate our company.

That statement is more than a slogan for the management team. This is a credo that we attempt to manifest daily in every decision we make for our company, in every interaction we have with our regulators, with our providers of care, with patients, and in our dealings with each other. We are far from perfect, we are human, and we do make mistakes, but we firmly believe that we cannot do business—that if we cannot do business with honesty and integrity, then we should not be in business at all.

Thank you very much.

[The prepared statement of Norman P. Becker follows:]

PREPARED STATEMENT OF NORMAN P. BECKER, NEW MEXICO BLUE CROSS AND BLUE SHIELD

Chairman Upton, Congressman Klink, distinguished Subcommittee members, my name is Norman Becker, and I am the President and Chief Executive Officer of New Mexico Blue Cross Blue Shield ("NMBCBS"). I am pleased to have this opportunity to appear before you to share the lessons we have learned at NMBCBS over the past few years.

NMBCBS has been a major health care insurer in New Mexico since 1940. At present, the company provides HMO, Point-of-Service, Preferred Provider, and Indemnity coverage to over 210,000 New Mexicans. It is one of the top three health care insurers in New Mexico. In addition to providing health care coverage and

other services, NMBCBS employs almost 600 New Mexicans, putting the company in the top 150 employers in the state.

I began work as President of NMBCBS in 1996. When I came on duty, NMBCBS had recently lost its Medicare Part A contract, under which the company had furnished provider audit and other administrative services to HCFA. NMBCBS was in the midst of an investigation involving allegations that the company's Provider Audit Unit had performed certain hospital audits poorly and that management personnel had attempted to conceal that fact from HCFA.

It was apparent that NMBCBS had significant problems that needed to be remedied if the company were to survive. The allegations involving the Provider Audit Unit had to be investigated and an appropriate resolution reached with the government. Employees involved in misconduct had to be separated from the company. And NMBCBS had to implement policies and procedures to ensure that employees understood the importance of absolute integrity in all of our dealings with the government, with providers, and with the persons we insure.

We have accomplished each of those goals. First, through a lengthy process marked by complete cooperation from NMBCBS, we achieved a fair resolution this year of all outstanding civil, criminal, and administrative issues. The resolution compensates the government fairly, punishes the company appropriately for its past misconduct, puts in place a corporate integrity agreement that we welcome, and allows NMBCBS to move forward. Second, none of the employees connected with the problems involving the Provider Audit Unit remains with NMBCBS in any capacity. Indeed, the Provider Audit Unit itself no longer exists. Third, NMBCBS hired Angela Vigil as Vice-President for Compliance in 1997. Ms. Vigil has extensive experience as a former regulator with the New Mexico Department of Insurance. Under Ms. Vigil's guidance, NMBCBS has instituted a detailed Code of Business Conduct and a stringent Corporate Compliance Plan, both of which are instilled in employees through mandatory compliance training. The corporate integrity agreement that NMBCBS entered into with HCFA this year further strengthens the Code and the Plan.

Although I am proud of the action we have taken at NMBCBS to remedy the past problems and to ensure that they do not recur, none of the steps that I have outlined gets to the heart of the matter. The core problem at NMBCBS when I arrived was a corporate culture that permitted employees to sacrifice integrity for business advantage in an intensely competitive environment. The key to solving that problem has been a fundamental change in culture. No legislation, regulation, or compliance plan will prevent fraud and abuse if the corporate culture implicitly condones such conduct—by, for example, stressing productivity over all other objectives. By the same token, a corporate culture that imbues employees with the conviction that absolute integrity is the highest value—and implements that culture through an appropriate code of business conduct and compliance plan—ensures that improper conduct will rarely occur and that, when it does happen, it will be detected, reported, and corrected.

Together with Ms. Vigil and the rest of the NMBCBS management team, I have worked hard to instill a corporate culture at NMBCBS that puts integrity first. In that effort, I have received the whole-hearted support of the NMBCBS board of directors. My introduction to the NMBCBS Code of Business Conduct, which all employees receive and read, declares: "Integrity and accountability are the core values of New Mexico Blue Cross and Blue Shield . . . In today's changing and highly competitive environment, the pressure to succeed seems greater than ever. That pressure, however, does not absolve us of the responsibility to always do the right thing as we perform our jobs and operate our company." This is more than a slogan for the new NMBCBS management; it is a credo that we attempt to manifest daily in every decision we make for the company, in every interaction we have with a regulator, provider, or patient, and in our dealings with each other and our employees. We are far from perfect; we are human, and we will make mistakes. But at the new NMBCBS, we firmly believe that if we cannot do business with honesty and integrity, then we should not do business at all.

I will be pleased to answer any questions you may have.

Mr. UPTON. Thank you.

Mr. Huotari.

TESTIMONY OF MICHAEL E. HUOTARI

Mr. HUOTARI. Good afternoon, Mr. Chairman and members of the committee. My name is Michael Huotari. Since 1996 I have been

Executive Vice President and General Counsel of Blue Cross and Blue Shield of Colorado.

Blue Cross Blue Shield of Colorado administered the Medicare B program in New Mexico and Colorado from 1966 to 1994. My testimony today is limited to matters related to the administration of that program.

In July 1999, the company entered into an agreement with the Department of Justice to settle the qui tam suit filed against the New Mexico Blue Cross and an affiliated management company, Rocky Mountain Health Care Corporation. You heard some of the details of that suit this morning. Specifically, it alleged, among other things, the manipulation of audit samples for HCFA CPEP scores.

What happened historically is that, in 1994, company management investigated an anonymous complaint regarding employee manipulation of CPEP results in connection with timely response to correspondence. The investigation revealed that employees in the communications unit had altered CPEP samples to improve response times for correspondence from beneficiaries and others. These actions were wrong and contrary to company policy. The employees responsible for wrongdoing were terminated or otherwise disciplined.

The company promptly reported the improper actions to HCFA. After HCFA completed its investigation—and this is all in the 1994 timeframe, Mr. Chairman—it was agreed that Blue Cross and Blue Shield of Colorado would relinquish its contract with the Federal Government. No further civil, criminal or administrative charges or claims were brought at that time.

There are several key facts the committee should consider regarding this matter.

First, it is important to note that the company notified the government of these wrongful acts. The wrongdoing was brought to management's attention as a result of a code of conduct program that existed or was instituted in 1994. We blew the whistle on ourselves by bringing these matters to HCFA's attention.

Also, none of the inappropriate actions by Colorado employees resulted in denial of benefits to any Medicare beneficiary. No correspondence was lost, destroyed or ignored. I'm not suggesting that samples were not altered, but no correspondence was lost, destroyed or ignored.

Finally, it's important to note that, while wrong, none of these actions directly affected claims processing or payment of claims by the government.

We settled the lawsuit and what had been a lengthy and expensive legal dispute. The company cooperated fully with the U.S. Attorney, OIG and HCFA investigations throughout the entire period from 1994 through the present. The U.S. Government asserted damages in excess of $70 million and criminal fines of $5,000 for each separate act of misconduct.

Make no mistake, we settled this lawsuit because our employees engaged in wrongdoing. The action that took place in 1992 and 1993 was wrong, and there's no question about that, no excuses for it. But we also settled it because we faced potentially catastrophic damages, penalties and fines.

The corporate culture of Blue Cross Blue Shield of Colorado has never tolerated and will never tolerate any inappropriate or illegal activities. We have established a corporate integrity and business unit to foster a culture based on ethics and compliance. By that I mean we strive for a culture that not only assures compliance with the law but also seeks to do what is right.

What could Congress do about this? What should be done? What can be addressed, addressing some of the questions that were asked this morning?

There should be some protection in the law for self-reporting, particularly when it's evident that there was no participation in or knowledge of wrongdoing on the part of management. Companies can often be deterred by disproportionate penalties from reporting wrongdoing. Some agencies of the Federal Government have developed corporate amnesty or self-disclosure programs that self-report wrongdoing. I understand that HCFA has initiated a prototype disclosure, but I know nothing further about it.

Blue Cross Blue Shield of Colorado is committed to being a good corporate citizen and to possessing a high degree of business honesty and integrity required to keep on track with the Federal Government.

Thank you for your attention.

[The prepared statement of Michael E. Huotari follows:]

PREPARED STATEMENT OF MICHAEL E. HUOTARI, EXECUTIVE VICE PRESIDENT AND GENERAL COUNSEL, BLUE CROSS AND BLUE SHIELD OF COLORADO

Mr. Chairman and members of the committee, my name is Michael Huotari. Since 1996, I have been the Executive Vice President and General Counsel for Rocky Mountain Health and Medical Service, doing business as Blue Cross Blue Shield of Colorado.

BACKGROUND

Blue Cross Blue Shield of Colorado is a Colorado non-profit corporation. New Mexico Blue Cross Blue Shield is an independent New Mexico non-profit corporation with its own board of directors, management, and employees. Rocky Mountain Health Care Corporation is 50 percent owned by Blue Cross Blue Shield of Colorado and New Mexico Blue Cross Blue Shield. It was organized to provide management services to both companies and their subsidiaries. It no longer provides services to any company.

During the relevant time periods, Blue Cross Blue Shield of Colorado administered the Medicare Part B program in New Mexico, Colorado, and North Dakota and New Mexico Blue Cross Blue Shield administered the Medicare Part A program in New Mexico and Colorado. Each company administered its respective program through its own employees.

On July 28, 1999, Blue Cross Blue Shield of Colorado entered into an agreement with the Department of Justice to settle a qui tam suit filed against it, New Mexico Blue Cross Blue Shield, and Rocky Mountain Health Care Corporation. The suit arose from an internal Rocky Mountain Health Care Corporation investigation that began in May, 1994, and a government investigation that began in June, 1994. Rocky Mountain Health Care Corporation reported internal allegations of improper actions regarding Medicare Part A administration to the Health Care Financing Administration (HCFA). The suit was filed in Albuquerque, New Mexico against all three companies in May, 1996, by two former employees of New Mexico Blue Cross Blue Shield. The United States determined to intervene and pursue the case.

The suit alleged, among other things, wrongdoing by certain employees of New Mexico Blue Cross Blue Shield in administration of the Medicare A contact and Blue Cross Blue Shield of Colorado employees in administration of the Medicare Part B contract. Specifically, with regard to Part B, the suit alleged improper reporting of HCFA performance measures contained in HCFA's Contractor Performance Evaluation Program, commonly known as CPEP.

My testimony is limited to matters involving the administration of the Medicare Part B program by Blue Cross Blue Shield of Colorado. Mr. Norm Becker, President and CEO of New Mexico Blue Cross Blue Shield will/has address(ed) issues arising in connection with the administration of Medicare Part A by New Mexico Blue Cross Blue Shield.

MEDICARE B

Blue Cross Blue Shield of Colorado began processing Medicare Part B claims in 1966. The Company's Part B contract was renewed by the federal government every year from 1966 to 1993.

In 1994, institution of a company-wide code of conduct program prompted an anonymous complaint regarding employee wrongdoing in connection with the Medicare B administration in 1993. A prompt investigation was undertaken by management of Blue Cross Blue Shield of Colorado. The internal investigation by the Company found that certain employees had altered reporting documents making it appear that the Company had responded to requests for information faster than it actually had, resulting in a higher CPEP score than was actually earned. It was also discovered that certain Colorado employees had attempted to improperly collect and group electronic claims submissions from providers during a specific time period so it would appear a higher percentage of providers were submitting their claims electronically than if the electronic submissions were not grouped together, again resulting in a higher CPEP score than was actually earned.

These actions by Blue Cross employees were wrong and in direct violation of Company policy. The employees responsible for manipulating HCFA CPEP performance records were terminated or disciplined. However, it is important to note that the wrongdoing did not involve claims processing.

The Company promptly reported allegations of improper correspondence procedures and misreporting of performance measures to HCFA. After HCFA completed its investigation, it was agreed that Blue Cross Blue Shield of Colorado would voluntarily relinquish its contract with the federal government to process Medicare Part B claims. No further civil, criminal, or administration charges or claims were brought at that time. There was no evidence that any Medicare Part B beneficiary had been denied benefits or needed care as a result of the improper actions by these few employees of Blue Cross Blue Shield of Colorado, and there was and is no evidence that actions taken by Colorado employees resulted in any financial loss to the government.

There are four key facts the Committee should consider regarding this matter.

First, it is important to note that Blue Cross Blue Shield of Colorado notified the government of these allegations. We "blew the whistle" on ourselves. We had internal policies and procedures to prevent and detect wrongdoing on the part of our employees. The inappropriate actions taken by certain Colorado employees were reported to management by their colleagues; management then launched an internal investigation and notified the government that these employees may have violated the law.

Second, there was no pattern of sustained wrongdoing. Rather, a limited number of misdirected employees took it upon themselves to engage in improper behavior. Senior management did not and could not have known about the alteration of records until an employee in the department brought it to their attention. Blue Cross Blue Shield of Colorado's internal policing and reporting policies reflected in its code of conduct worked and worked well.

Third, it is important to note that, while wrong, none of the inappropriate actions taken by certain Colorado employees resulted in any physical or financial harm to any Medicare Part B beneficiary. No inquiries were lost or ignored. All correspondence was answered and reviews were completed as required.

Finally, it is important to note that, while wrong, none of the inappropriate actions taken by certain Colorado employees resulted in any financial harm to the U.S. government. The government was not overcharged, nor did the government overpay as a result of these acts. The government received significant value for the services performed by Blue Cross Blue Shield of Colorado under the Medicare B contract. While Blue Cross Blue Shield of Colorado did receive a somewhat higher HCFA CPEP score than it earned as a result of employee wrongdoing, neither any individual employee nor the Company as a whole financially profited from that act. HCFA investigated the improper conduct and declined to impose any fines or penalties on the Company. After the improper conduct was discovered, reported, and corrected, HCFA, with full knowledge of these events, continued negotiating with Blue Cross Blue Shield of Colorado for continued service under the Medicare Part B contract. At the request of HCFA, Blue Cross Blue Shield of Colorado extended

the contract for two months to facilitate transfer of the contract to North Dakota Blue Cross Blue Shield. This transition was smooth and caused no disruption to the Medicare B program.

WHY WE SETTLED

Blue Cross Blue Shield of Colorado settled this suit to end what had been a lengthy and expensive legal dispute and avoid additional cost and time-consuming litigation in the face of potentially catastrophic damages and penalties. Because the False Claims Act is a strict liability statute, the fact that the Company had itself disclosed the improper reporting of performance evaluations to the government had little, if any, mitigating effect. Further, the fact that the government was never overcharged and did not overpay any party did not prevent the government from seeking damages from Colorado which, if proven, could have resulted in insolvency for the company. The U.S. Attorney argued he could impose joint and several liability against Colorado, New Mexico and Rocky Mountain Health Care for both the Medicare A and Medicare B contracts. The United States government argued that the False Claims Act entitled it to seek damages and penalties in excess of $70 million. Furthermore, the U.S. Attorney threatened to seek criminal fines and penalties of up to $5,000 for each separate act of misconduct. Make no mistake, the Company settled this suit because its employees engaged in wrongdoing, but Blue Cross Blue Shield of Colorado also settled because it faced potentially catastrophic damages, penalties, and fines that arguably did not reflect the culpability of the company as a whole or the proportionality of limited harm to the government or beneficiaries in this matter.

Blue Cross Blue Shield of Colorado determined the best course of action to protect the company and its subscribers was to settle this suit, avoid protracted litigation and possible financial disaster, and get back to work.

BLUE CROSS BLUE SHIELD OF COLORADO'S CORPORATE CULTURE

The corporate culture of Blue Cross Blue Shield of Colorado has never tolerated, and will not tolerate, any inappropriate activities that could harm subscribers, payors, or governmental entities. As part of its settlement with the government, Blue Cross Blue Shield of Colorado has entered into a Corporate Integrity Agreement that builds on the code of conduct program already in place to prevent, detect, and eliminate any wrongdoing on the part of Blue Cross Blue Shield employees, officers, or directors. We are committed to strict compliance with all laws and regulations and have procedures in place to prevent future problems. For example, all employees are given intensive training on the laws and regulations relevant to their areas of responsibility. Since 1994, we have had a code of conduct officer who trains employees on compliance issues and is the first line of defense for detecting and investigating potential problems. Each year, outside auditors evaluate the practices and procedures in place to make sure our procedures comply with the law and that our employees comply with our procedures. Every employee is trained to know where to report suspected wrongdoing, but in the event an employee is uncomfortable with the process, the Company has a toll-free hotline where individuals may report suspected wrongdoing anonymously.

Blue Cross Blue Shield of Colorado has also created a corporate unit to provide leadership and accountability for compliance and ethics activities. The Corporate Integrity and Business Practices unit is under the supervision of a company vice president who reports directly to the CEO and the Audit Committee of the Board of Directors. The unit serves as the center of accountability for activities that enhance compliance and acts as the catalyst to foster an ethical business environment. Blue Cross Blue Shield of Colorado will maintain a superior compliance program worthy of the trust of its subscribers and the federal government.

HOW CONGRESS CAN HELP

As I have said before, Blue Cross Blue Shield of Colorado felt compelled under the circumstances to settle the suit against it and return to our regular business. Our experience with the False Claims Act has, however, given us some insight into the law that may be of some use to Congress. There should be some protection in the law for self-reporting, particularly when it is evident that there was no participation in, or knowledge of, wrongdoing on the part of management. Companies are often in the best position to detect wrongdoing relating to government contracts, but they may be deterred from reporting suspected violations of the law. Contrary to sound public policy, our experience could be interpreted to encourage companies to look away from suspected bad acts rather than investigate, cure, and report possible problems to the government. While violations of the law should not be overlooked,

legitimate self-reporting of suspected violations should serve as a significant mitigating factor for any liability, damages, and/or penalties.

CONCLUSION

Blue Cross Blue Shield of Colorado is pleased to have this matter behind us and pleased that our employees brought this matter to the attention of management, enabling us to remedy the situation. In spite of the significant cost of settling this suit and the loss of the Medicare B contract, Blue Cross Blue Shield of Colorado does not regret reporting suspected violations of the law by certain employees to the government. We are committed to being a good corporate citizen and to possessing the high degree of business honesty and integrity required to contract with the federal government. We note we continue to be eligible to serve as a government contractor and are prepared to serve as such in the future if the need arises.

Thank you for your attention to my statement.

Mr. UPTON. Thank you.

Mr. Hess.

TESTIMONY OF STEVEN C. HESS

Mr. HESS. Thank you, Mr. Chairman.

Chairman Upton, members of the subcommittee, good afternoon. My name is Steven Hess. I am Senior Vice President and General Counsel of Blue Cross and Blue Shield of Michigan. As you know, Mr. Chairman, we are proud to be one of Michigan's largest businesses, employing more than 8,000 workers and serving over 4.5 million members.

The subject of today's hearing is an important one. On behalf of Blue Cross and Blue Shield of Michigan, I am pleased to assist the committee in its efforts by offering such insights as can be gained from a consideration of the integrity problems that were identified in our company in the late 1980's and the early 1990's. Although a more detailed discussion is contained in our written testimony, I would like to summarize those problems.

In October 1993, Blue Cross and Blue Shield of Michigan first became aware of a Federal Government inquiry into the operations of the company's Medicare provider audit department. This department audited hospitals and other institutional payers as part of Blue Cross and Blue Shield of Michigan's responsibilities as a fiscal intermediary for the Medicare Part A program in Michigan.

With the permission of the Federal authorities, Blue Cross and Blue Shield of Michigan was allowed to conduct an extensive internal investigation. In February 1994 the results were shared with government officials. It was determined that in order to achieve higher scores under HCFA's Contractor Performance Evaluation Program, CPEP, changes were made to audits after those audits were reported to HCFA as having been completed but before they were reviewed and scored by the regional office in Chicago.

Blue Cross and Blue Shield of Michigan also identified other improper efforts to maximize CPEP points, principally by manipulating the timing of the recognition and the recovery of overpayments.

Altogether, 21 people were separated from the company for participating in this activity. This conduct, which was clearly wrong and for which no excuse can be offered, was motivated by a desire to maximize the annual CPEP score which would, by that means, enable Blue Cross to retain the Part A contract. Blue Cross and

Blue Shield of Michigan did receive higher CPEP scores than performance warranted.

We cooperated fully with the Federal authorities, and the case was completely resolved by a civil settlement some 4½ years ago in January 1995. Significantly, in our situation, there were no criminal charges of any sort, either corporate or individual, that were ever filed or pursued or even seriously considered, as far as we know.

As you can appreciate, our integrity problems as a Medicare contractor in the early 1990's are extremely regrettable. We pride ourselves on being a highly ethical and reliable company, not only for government business but for all the people who choose our health insurance. These problems forced serious introspection by the corporation and an increased emphasis on the critical importance of ethical behavior and ethical decisionmaking and not just for government programs but for our private business as well.

The lessons that we learned from this experience have become an integral part of the employee education component of the Blue Cross and Blue Shield of Michigan compliance policy. Blue Cross and Blue Shield of Michigan remains a subcontractor for the FEP program, and through Blue Care Network, our subsidiary HMO, a contractor in the Medicare Plus Choice program. We take our responsibilities to the government very seriously. We have a compliance program that is strong and constantly improving. It is a compliance program that routinely uses our experience of the early 1990's as an object lesson to what can happen when a company or its employees lose sight of the ethical implications of its actions.

As you know, Blue Cross and Blue Shield of Michigan has not been a Medicare Part A and B contractor since 1994. Nevertheless, we are pleased to assist this committee in any way we can as it proceeds with this inquiry. I would be happy to respond to any questions you might have. Thank you.

[The prepared statement of Steven C. Hess follows:]

PREPARED STATEMENT OF STEVEN C. HESS, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, BLUE CROSS BLUE SHIELD OF MICHIGAN

Blue Cross Blue Shield of Michigan (BCBSM) is pleased to assist the subcommittee as it examines the issue of "How Healthy are the Government's Medicare Fraud Fighters." We hope that the insights which can be gained by an examination of the problems that were identified by our company in the late 1980's and early 1990's will prove constructive to the subcommittee.

In October of 1993, BCBSM first became aware of a federal government inquiry into the operations of the Company's Medicare Provider Audit Department. This department audited hospitals and other institutional payers as part of BCBSM's responsibilities as a fiscal intermediary for the Medicare Part A Program in Michigan.

In response to these concerns, with the permission of the federal authorities, and under the direction of its Board, BCBSM conducted an extensive internal investigation. In February of 1994, the results were shared with government officials. It was determined that, in order to achieve higher scores under HCFA's Contractor Performance Evaluation Program (CPEP), changes were made, largely cosmetic in nature, to audits after those audits were reported to HCFA as having been completed, but before they were reviewed and scored by the Regional HCFA Office in Chicago. In substance, the result was an attempt to take good quality audits and make them perfect. A perfect audit in this context meant absolute compliance with every HCFA standard and guideline with respect to audit form, format and substance.

It was conceded at the time that it was inappropriate to "clean-up" these audit reports after they had been reported as completed but before they were reviewed by HCFA. While in substance, the audits were of high quality and the accounting results largely unaffected by the clean-up activity, the "cleaned up" audits sub-

mitted to HCFA for review and scoring did not reflect typical audit work product, at least insofar as compliance with all of the very precise and exacting HCFA cost report audit standards.

BCBSM also identified other shortcuts and efforts to maximize CPEP points in certain categories of reporting and collection of hospital overpayments. Principally, these included some adjustments to the timing of the reconciliation of provider payments. Additionally, BCBSM took large overpayments identified through audit and broke them into two or more components for collection purposes. These smaller collections from the hospital enabled the facility to fully repay the overpayment within two, successive 30 day periods, thus scoring points on the CPEP standard relating to collection of overpayments within thirty days.

Unfortunately, the highly technical nature of this audit activity, involving adherence to thousands of pages of government rules, regulations and standards that are subject to routine modification and reinterpretation does not lend itself to the usual oversight controls deployed in other areas of corporate activity. Accordingly, this perverse obsession with CPEP scores went unrecognized outside this unit. Within the unit, BCBSM was guided, or perhaps misguided, in some of these activities by consultants who were subject matter experts and who were retained to develop and administer quality assurance programs applicable to the cost auditing functions of the HCFA contract.

Altogether, twenty-one people, including one vice-president, were separated from the Company for participating in this activity. None of these individuals or any other BCBSM employee profited from this conduct. The conduct was motivated exclusively by a desire to maximize the annual CPEP score which would enable BCBSM to retain the Part A contract. BCBSM did receive somewhat higher CPEP scores than performance perhaps warranted. There was no other benefit to BCBSM.

Notwithstanding a promise by BCBSM to make HCFA whole for any losses that could be shown to have been sustained as a result of these activities, and a pledge to do whatever was necessary to regain the trust of HCFA, the Contracting Officer elected not to renew the Parts A and B Contracts when they expired at fiscal year end 1994.

It has been over four years since the civil settlement was finalized and almost five years since the contracts expired. It has been nearly six years since BCBSM first became aware of allegations of improper activities, which activities occurred between six and ten years ago. BCBSM no longer contracts directly with HCFA. This is a regrettable chapter in the history of BCBSM which we have put long behind us. But, we have learned from the past.

The experience has provided valuable insight into necessary modifications to the BCBSM Corporate Compliance Program. The investigative findings have been used since 1994 as an object lesson in the educational component of the Program. This Program, which was reviewed by the Chief Assistant United States Attorney in Detroit prior to implementation in the early 1990s, is a good Program, which can always be made better. Clearly, its effectiveness is diminished if employees refuse to avail themselves of it. The employee who became the relator in the case against BCBSM chose not to contact the confidential hot line to initiate an internal review of his concerns. He also chose not to contact various individuals known to him within the Office of the General Counsel or the compliance officer at BCBSM. Instead of allowing BCBSM to investigate and timely address these issues, he chose a more aggressive and momentarily rewarding means of redress.

Today, BCBSM continues to serve the Federal government under a subcontract for the Federal Employee Program and through a wholly owned HMO subsidiary, as a direct contractor for the Medicare Plus Choice Program. These responsibilities are taken very seriously and continuous enhancements and improvements are made to the Corporate Compliance Programs of the parent and subsidiary. Included among these activities are efforts to modernize and expand upon employee education and to focus training on new employees with regard to expected behaviors. These include compliance with all laws, rules and regulations relative to the work that we do, as well as adherence to values based ethical decision making. Moreover, between 1994 and the present, BCBSM has conducted compliance reviews of the work performed for the government under these subcontracts. These have included both operational and legal reviews. Issues arising out of that process that required clarification or review by the federal government have been referred to their representatives and addressed to their satisfaction. This is consistent with the purpose and intent of corporate compliance activity.

In 1994, BCBSM responded quickly and appropriately to government allegations of inappropriate conduct relating to Provider Audit activity. No criminal charges were filed or pursued against BCBSM, in part due to BCBSM's full cooperation into the investigation and resolution of HCFA's concerns. The CPEP method for evalu-

ating contractor performance was apparently eliminated after 1994 and replaced with a system of contractor performance evaluations which measure performance in a much broader context.

On the same day, and because BCBSM and the Justice Department found it to be expedient and desirable, BCBSM settled an unrelated national test case, involving an interpretation of the Medicare Secondary Payor laws. BCBSM was one of three private payors sued in 1989 by the Justice Department and HCFA for alleged misinterpretation and application of the Medicare Secondary Payor laws which specify that the working aged with Medicare coverage could look to Medicare only on a secondary basis for health care coverage. BCBSM processed all of the subject claims in good faith reliance upon the information filed by the medical providers and indeed the Medicare beneficiaries themselves who claimed to be Medicare primary at the point of service. After extensive discovery undertaken in the test case, it was determined that a number of Michigan based Medicare beneficiaries' claims should have been paid as Medicare secondary, under the working aged coordination of benefits rules. BCBSM calculated a refund and settled the test case. BCBSM strongly disagrees with the inference that it intentionally used HCFA monies to pay for private health services incurred by working Medicare beneficiaries. This civil action was nothing more than a coordination of benefits dispute.

To the extent that these hearings are intended to focus on the performance of HCFA in fighting Medicare fraud, BCBSM advances the record and national reputation of its Corporate and Financial Investigations unit which reports to the Compliance Officer. This BCBSM department is a nationally recognized leader in fraud detection activities and works closely with federal law enforcement agencies in that regard.

BCBSM and its employees teamed a valuable lesson regarding the balancing of business efficiency with process and performance integrity. That lesson continues to be taught today in the employee educational component of the BCBSM Compliance Policy.

Because BCBSM has not been a Medicare contractor for almost six years and, has not had cause to maintain currency on contractor rules, regulations and oversight activities in the interim, we do not feel that we are in a position to offer much insight into proposed improvements or enhancements to the current relationship between HCFA and those contractors.

We appreciate this opportunity to discuss our experience with members of this Subcommittee.

Mr. UPTON. Thank you.

Mr. Verinder.

TESTIMONY OF FRED B. VERINDER

Mr. VERINDER. Good afternoon, Mr. Chairman and members of the subcommittee. I am pleased to be here today to assist this subcommittee in its evaluation of the Health Care Financing Administration's management of its Medicare contractor.

My name is Fred Verinder. I am currently the Vice President for Compliance Operations of Health Care Service Corporation. I have served in that position since December, 1997.

Before I came to work for Health Care Service Corporation, I spent 26 years in the Federal Bureau of Investigation, retiring in July, 1994, as the Deputy Assistant Director of the Criminal Investigative Division. The responsibilities in that position included the development of the FBI strategies in combating health care fraud.

After leaving the FBI, I served as Vice President of Compliance and Security at Laboratory Corporation of America, where I directed the company's compliance and ethics program.

I have also served as the Executive Vice President of the Counsel of Ethical Organizations. In that capacity I designed and implemented compliance programs, including development of hotlines, training programs and conducting internal investigations.

I am presently a member of the Ethics Officer Association and previously served on the board of directors and as chairman of the

membership. On May 20, 1999, I was elected as a Fellow of the Health Ethics Trust.

I joined Health Care Service Corporation in response to the government investigation of the submission of incorrect Contractor Performance Evaluation Program reports and the company's concern about compliance. My charge was to develop a state-of-the-art compliance program.

We are not here today to make any excuses for our misconduct, which was plainly wrong. We cooperated with the government's investigation and entered into a global settlement of all criminal, civil and administrative charges in order to fully accept responsibilities for our conduct.

We hope that our appearance today will help the committee ensure that other essentially good corporate citizens do not have to learn the lessons of Medicare contract compliance in the same costly and painful way that we did.

Our company provides health coverage for one out of every four Illinois residents. In 1998, we merged with Blue Cross Blue Shield of Texas and today have statutory reserves of more than $1.2 billion, insure more than 6 million individuals and employ more than 10,000 people in Illinois and Texas. We process approximately 65 million insurance claims per year and paid benefits to our insured members of approximately $6.5 billion per year.

Let us look at what happened, why it happened and what we have done to make sure it never happens again.

We first learned that there was a problem with our Medicare Part B operations in Marion, Illinois, in August, 1995, when we received a subpoena from the Office of the Inspector General. Upon receipt of that subpoena, senior management directed the company's full cooperation with the government inquiry. The company hired an outside law firm to conduct an internal investigation, who quickly discovered evidence of CPEP misreporting. This turned out to be the essence of the government's charges against us. We continued to cooperate with the government investigation for the next 2½ years.

How could this happen to a company like us? Given my experience in the FBI, I am inclined to consider two things, motive and opportunity. Here, both were present, which in my view led individuals to make choices that were plainly wrong.

First, CPEP provided the motive. For many reasons, getting a good CPEP score was seen by Marion, Illinois, employees as critical to keeping their jobs, a factor which cannot be overlooked in the economically depressed southern Illinois region.

Second, I believe the remote location of the Marion operations, along with the way in which oversight of the CPEP functions was handled by both the company and HCFA, provided the opportunity.

We have learned some important lessons and have used these lessons to help us develop a first-rate compliance program. A compliance program is not what industry experts refer to as a paper program. It isn't just teaching and preaching but, rather, includes training, in-depth auditing, monitoring functions, investigations and fixing problems that we find. Specifics of the program are outlined in my written statement.

I am looking forward to answering any questions you might have. Thank you.

[The prepared statement of Fred B. Verinder follows:]

PREPARED STATEMENT OF FRED B. VERINDER, VICE PRESIDENT FOR COMPLIANCE OPERATIONS, HEALTH CARE SERVICE CORPORATION

Good morning Mr. Chairman and Members of the Subcommittee. I am pleased to be here today to assist the Subcommittee in its evaluation of the Health Care Financing Administration's management of its Medicare contractors.

My name is Fred B. Verinder, and I am currently Vice President for Compliance Operations at Health Care Service Corporation ("HCSC"). I have served in that position since December 1997. Before I came to work for HCSC, I spent 26 years in the Federal Bureau of Investigation, retiring in July 1994 as Deputy Assistant Director of the Criminal Investigation Division. After leaving the FBI, I served as Vice President of Compliance and Security at Laboratory Corporation of America, where I directed the company's compliance and ethics programs.

I have also served as the Executive Vice President of the Council of Ethical Organizations. In that capacity, I designed and implemented compliance programs, including the development of hotlines and training programs, and conducted internal investigations. I am presently a Member of the Ethics Officer Association, and previously served on the Board of Directors and as Chairman of the Membership Committee. On May 20, 1999, I was elected as a Fellow of the Health Ethics Trust.

I was appointed to head HCSC's Compliance Operations in the wake of the government's investigation into the submission by certain HCSC employees of incorrect reports and data under the Contract Performance Evaluation Program ("CPEP"). HCSC does not make any excuses for the misconduct of those employees, which in so many respects was plainly wrong. Indeed, HCSC cooperated with the government's investigation and entered into a global settlement of all criminal, civil and administrative charges in order to fully accept responsibility for the conduct of its employees. We hope that our appearance today will help the Subcommittee ensure that other essentially good corporate citizens do not have to learn the lessons of Medicare contract compliance in the same costly and painful way that HCSC did.

I. HCSC IS A GOOD CORPORATE CITIZEN WITH A HISTORY OF POSITIVE INVOLVEMENT IN ITS COMMUNITY.

HCSC is the largest and most experienced health insurance company in the State of Illinois, providing affordable, high-quality health coverage for one out of every four Illinois residents. HCSC was incorporated in 1936 and enrolled its first member on Jan. 1, 1937. Since then, HCSC has grown to become one of the strongest health insurance companies in the country. In 1998, HCSC merged with Blue Cross and Blue Shield of Texas and today has statutory reserves of more than $1.2 billion, insures more than six million individuals, and employs more than 10,000 people in Illinois and Texas. HCSC processes 65 million insurance claims per year and pays benefits to its insured members of approximately $6.5 billion per year. In the highly competitive environment of the health care financing marketplace, we view these results as a vote of confidence in our ability to deliver a quality product.

HCSC has a long-standing, deep-rooted commitment to Chicago and the State of Illinois. That commitment is expressed through HCSC's corporate and personal involvement in community affairs and its active participation in government programs. In the early 1990s, rather than follow other companies to distant suburbs, HCSC chose to remain in downtown Chicago. Construction of the company's new corporate headquarters ended a five-year drought on building in downtown Chicago, reconfirmed HCSC's commitment to its largely Chicago-based employee force, and contributed to a renewed burst of economic vitality in its core community.

HCSC's involvement in community affairs includes its sponsorship of the "HCSC CareVans," two mobile immunization clinics that travel to the city's poorest neighborhoods helping in the battle against disease. Since this program began in 1990 on the heels of a deadly measles outbreak, CareVan nurses have administered hundreds of thousands of immunizations. In addition, a third HCSC CareVan serves the small communities and rural areas of downstate Illinois.

HCSC also sponsors Gallery 37, the City of Chicago's award-winning job training program in visual, literary and performing arts for young people. In 1996, HCSC was the driving force for creation of *The West Side Children's Garden,* a teaching site which has literally planted seeds of hope for students at two Chicago elementary schools.

HCSC is also a major supporter of numerous community events around the state of Illinois, including food drives and fund-raising efforts on behalf of local organizations. Statewide groups such as the Illinois Violence Prevention Authority ("IVPA"), the Mental Health Association of Illinois, and the Chicago Area Council of the Boy Scouts of America also receive support from HCSC.

Finally, as part of its commitment to the community, HCSC historically has been an enthusiastic, innovative participant in government programs. In addition to our 30-year history with the Medicare program, HCSC administers the Illinois Comprehensive Health Insurance Program, which provides access to health insurance coverage for individuals not otherwise able to obtain it. Moreover, as the only corporate member of IVPA, HCSC is one of the founding members in the "Safe Illinois" model program designed to prevent domestic-partner violence.

II. HCSC REACTED AS A GOOD CORPORATE CITIZEN IN RESPONSE TO THE DISCOVERY OF THE IMPROPRIETIES IN THE ADMINISTRATION OF ITS MEDICARE CONTRACT.

As you know, in July 1998, HCSC entered into a global settlement with the United States Departments of Justice and Health and Human Services and the Health Care Financing Administration ("HCFA") to resolve criminal, civil, and administrative liabilities arising out of a government investigation instituted in response to a *qui tam* complaint filed in 1995. The subject of the *qui tam* complaint was the processing of Medicare Part B claims by certain employees in HCSC's Marion, Illinois facility under HCSC's contract with HCFA. The *qui tam* complaint alleged that certain Marion employees submitted misleading performance data to HCFA and did not appropriately perform certain claims functions under the Medicare Part B contract. The complaint further alleged that the Marion employees falsified records to improve the evaluation they would receive in reviews by HCFA.

As soon as HCSC learned that it was under investigation by the government, senior management directed the company's full cooperation. HCSC hired an independent outside law firm to conduct an internal investigation and turned over the results of that investigation to the government. HCSC's full cooperation continued throughout the government's nearly three-year investigation, ultimately resulting in its entry of a guilty plea to eight felony counts and the payment of a $4 million criminal fine in addition to a $140 million damage settlement.

Both the government and the Federal district court with jurisdiction over this matter have explicitly recognized HCSC's full cooperation in the government investigation and its acceptance of responsibility for the actions of its employees. The government has publicly acknowledged that HCSC "fully cooperated in the investigation" and "clearly demonstrated recognition of affirmative acceptance of responsibility" for the actions of its employees. See Transcript of December 10, 1998 Sentencing Hearing (quoting Assistant United States Attorney Michael Quinley). As a result of this statement, United States District Court Judge J. Phil Gilbert ruled that HCSC was entitled to receive full credit under the Sentencing Guidelines for its cooperation with the government's investigation. *See id*

I believe it is very important to note that the company's senior management neither authorized nor had any knowledge of the activities of the Marion employees. Indeed, the government has publicly stated its view that the Marion employees concealed their improper activities from senior management at HCSC. *See, e.g., United States of America vs. Thomas F. Bartels, et al,* Crim. No. 98-40070-JPG (July 8, 1998) at ¶18 (indictment of five Marion employees which notes that as part of their conspiracy, the "co-conspirators would conceal their manipulation and falsification of samples and data submitted to HCFA from higher HCSC management."); Transcript of July 16, 1998 Plea Hearing at 19 (Assistant U.S. Attorney Michael Quinley noting that lower-level employees succeeded in "concealing their conduct from anyone in higher management at HCSC who might have stopped their activity."). In addition, during the Department of Justice's press conference to announce the settlement, the U.S. Attorney for the Southern District of Illinois, W. Charles Grace, whose office spearheaded the investigation, stated that "[t]here was no evidence whatsoever in this case that there was any fraudulent activity or any involvement by individuals outside of the Marion, Illinois, Part B facility." *See* Transcript of News Conference Announcing Settlement, Federal News Service (July 16, 1998).

III. HOW DID THIS HAPPEN?

I understand that you may have questions about how the events leading to the global settlement could have happened. In order to fully understand those events, I believe it is useful to consider some general observations about the Medicare program and HCSC's Marion office, where the Medicare Part B operations were headquartered. By making these observations, HCSC does not intend to absolve

itself of responsibility for the wrongful conduct of its employees. Thus, these observations are offered not as an excuse but rather to help the Subcommittee understand the context in which the conduct took place.

HCSC's involvement with Medicare began in 1966, when the program was first implemented, and continued without interruption until 1978, when it lost its Part B contract in a competitive procurement to the lowest fixed-price bidder. Five years later, HCSC won that contract back as the lowest fixed-price bidder in a second competitive procurement, and began its performance in 1984.

The start of HCSC's performance on the second phase of its relationship with the Medicare program coincided with a period of great volatility in the Medicare program. During this time, Congress enacted a number of statutes that significantly changed the Medicare program, including the Tax Equity and Fiscal Responsibility Act ("TEFRA"), the Deficit Reduction Act of 1984 ("DEFRA"), and the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). These legislative initiatives led to the implementation by HCFA of the Medicare Secondary Payer ("MSP") program, and changed the reimbursement mechanisms for numerous items and services, such as durable medical equipment ("DME") and hospital-based physicians. They also, however, greatly increased the volume of claims being received by all contractors, while at the same time increasing the complexity of the work being performed. Thus, between 1984 and 1987, changes mandated under TEFRA and DEFRA increased HCSC's claims volume by nearly 7.5 million claims. This represented a 37% increase over what both HCFA and HCSC believed would be HCSC's claim volume during that three-year period.

Also during this time, HCFA used the Contractor Performance Evaluation Program ("CPEP") to evaluate contractor performance. Under this program, HCFA audited contractor work to determine whether or not the contractor met a particular CPEP standard, and awarded points based upon that determination. HCFA then used contractors' CPEP scores to rank contractors, correct inadequate performance, and make determinations as to whether contracts should be renewed.

Unfortunately, as the GAO has concluded, the CPEP program had a number of problems. First, HCFA often did not announce CPEP standards until well into the review period, thus requiring contractors to operate without knowing what HCFA's priorities and performance expectations were. *See How Healthy Are the Government's Medicare Fraud Fighters?: Hearings Before the Subcomm. on Oversight and Investigations,* 106th Cong., 1st Sess. 11(1999) (prepared statement of Robert H. Hast, GAO). Second, as the GAO has noted, HCFA's evaluation process was focused more on process than outcome. Third, HCFA encouraged contractors to manage their activities in a way that would maximize their CPEP scores. *See Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 1999) at 27. Perhaps most fundamentally, however, the audit methodology that HCFA used was flawed. As the GAO has noted, HCFA's auditing methodology allowed problems to remain undetected because "HCFA reviewers notified contractors in advance concerning the dates of their on-site reviews and specific or probable records to examine, which allowed contractors to manipulate what HCFA reviewed." *Id*. at 23.

Now, let's turn to the situation in Marion. When HCSC was awarded the Medicare Part B contract, it consented to the request of various government officials that it locate its Part B operations in Marion, Illinois. Marion is approximately 330 miles south of HCSC's Chicago headquarters, and at that time was an area of high unemployment. In the economically disadvantaged Southern Illinois region, good jobs were scarce, so a job with HCSC was a highly valued commodity. Yet the office was relatively new, the volume of claims was exploding and the procedures for doing so were growing more complex by the day. Moreover, because the company had entered into a fixed-priced contract with the government for its services, the financial resources of the Medicare Part B operations were stretched to the limit. Accordingly, the employees of the Marion office were under tremendous pressure to perform. All of these factors created a culture where the Marion staff believed that the company was in constant danger of losing the Part B contract. Accordingly, a few of the Marion employees, in reaction to this pressure, crossed the line into clearly improper conduct.

HCSC's senior management in Chicago had no reason to suspect improper conduct in connection with its Part B contract. The Marion office was headed by an individual whom the company hired after a national search conducted by an outside recruiting office. This individual, along with other members of Marion's management team, actively withheld from HCSC's senior management the CPEP reporting problems in the Marion office.

Indeed, the information senior management did receive about its Medicare Part B operations showed that HCSC provided low-cost, often innovative, service. For

most of the period covered by the government's investigation, HCSC's unit cost per claim was among the very lowest in the country. In addition, HCSC's telephone review process and use of Provider and Beneficiary Advisory groups were cited by HCFA as models for the nation, and HCFA's own customer satisfaction surveys provided positive reports regarding the quality of HCSC's service. Moreover, HCSC's claim denial rates, as well as other claims history data, showed that HCSC's overall claims payment profile was in many respects in line or superior to that of comparable carriers.

IV. HCSC IS FULLY COMMITTED TO ENSURING THAT ITS BUSINESS IS CONDUCTED WITH THE HIGHEST DEGREE OF INTEGRITY AND HONESTY.

Looking to the future, HCSC is making every effort to ensure that the painful lessons teamed in Marion do not recur. In order to do this, HCSC undertook to develop a state-of-the-art compliance program, the elements of which are summarized below.

First, HCSC's Board of Directors has adopted a Corporate Integrity and Compliance Program ("Compliance Program") that incorporates the principles and guidelines which the Board believes are appropriate to ensure that HCSC always does business with the highest standards of integrity. HCSC's Compliance Program has the absolute support, direction and commitment of top management.

HCSC's Compliance Program is directed by a Corporate Compliance Committee whose membership includes an outside member of HCSC's Board of Directors and HCSC's President and Chief Executive Officer ("CEO"), Ray McCaskey, who is personally involved in the Committee's activities. HCSC also appointed a Corporate Compliance Officer who reports directly to the Board of Directors, HCSC's CEO (Mr. McCaskey), and HCSC's Senior Vice President for Law and Audit.

Second, HCSC codified its high expectations relating to ethics and conduct through development of its Corporate Code of Business Ethics and Conduct ("Code" or "Code of Conduct") which was approved by HCSC's Board of Directors on July 28, 1998. HCSC's Code, which has since been distributed to all employees, contains a letter from Mr. McCaskey to all HCSC employees stressing both Mr. McCaskey's and the company's strong commitment to compliance and ethics. The Code also describes HCSC's core values, and sets forth eleven "Integrity Standards" with which employees must comply, along with questions and answers to help clarify issues for the reader. On an annual basis, every employee must sign an acknowledgment that they have received, understand, and will comply with the Code.

HCSC's Code further states that all employees have an obligation to step forward and report any compliance or ethical issues of which they are or may become aware. The Code makes it clear that HCSC has an absolute policy against any retribution or retaliation for bringing forth a good faith concern regarding compliance. The Code provides instructions for addressing integrity concerns through HCSC's management structure, specific individuals within the company and/or the Company's Corporate Integrity Hotline.

The Code also states that supervisory personnel are responsible for the work-related acts of their employees, and have a special responsibility to create and sustain a work environment in which employees know that ethical and legal behavior is expected of them. To that end, beginning on March 1, 1999, advancing and adhering to HCSC's compliance initiative have been made a part of the performance standards for each HCSC officer, manager and supervisor.

Third, HCSC is committed to training its employees to ensure that they understand and are able to comply with HCSC's expectations concerning ethical business conduct. HCSC requires all employees to attend annual, mandatory Corporate Compliance Training. HCSC's upper management completed five hours of Compliance Training, which consisted of a detailed legal presentation, an explanation of the Corporate Integrity and Compliance Program, and a review of the Code of Conduct. Officers, managers and supervisors received a minimum of three and one half hours of training. Staff level employees received at least two hours of training, which included a general explanation of ethics and integrity, the presentation of a compliance training video, discussion of the most critical aspects of the Code of Conduct, and the presentation and discussion of selected case studies. The first of the training sessions began on August 20, 1998, and was completed, with the exception of limited make-up sessions, on June 4, 1999. Thus, more than 10,000 employees completed their mandatory compliance training in less than ten months' time.

Fourth, HCSC has provided a resource for employees and others to address ethical concerns and ensure that those concerns are addressed. The Compliance Department has developed specific and detailed procedures for documenting and tracking information concerning potential violations of the Code of Conduct. In addition, HCSC has created and now operates a Corporate Integrity Hotline in order to allow

HCSC employees to address integrity or ethical concerns, and to report any activities that they feel are questionable. The Hotline is staffed for nine hours each workday by employees who have been trained in Hotline operations. HCSC has widely publicized the existence and availability of the Hotline through its Code of Conduct, employee training, and posters that have been placed throughout HCSC's offices.

In order to help ensure that every employee has every opportunity to disclose any ethical concerns they may have, HCSC's Compliance Department also uses an exit interview process. Each departing employee is given the opportunity to complete a comprehensive Compliance Questionnaire. The Compliance Questionnaire provides employees with an opportunity to disclose any potential compliance issues of which they are aware, and to make suggestions concerning possible improvements to the Compliance Program.

Fifth, while HCSC's Compliance Program strongly emphasizes prevention, it also recognizes the importance of investigating issues brought to the company's attention. Trained investigators in the Compliance Department review each potential compliance matter brought to the Department's attention. If the matter requires further review, it will either be referred to the area with the most expertise relating to the issue (*e.g.,* HCSC's Human Resources Department) or investigated by the Compliance Department. Where warranted, the company takes corrective action to minimize the possibility of similar problems arising in the future, and if disciplinary action is appropriate, it is applied on a fair and consistent basis.

Sixth, HCSC has implemented a risk assessment program to evaluate its internal control structure and its ability to conduct business in accordance with all applicable laws and regulations. After performing a high level assessment of a particular function, department or contract, the Compliance Department works with management in charge of that area to address and correct any identified weaknesses and to strengthen existing control processes as needed.

Seventh, HCSC performs regular reviews to ensure that its procedures are being followed. The Compliance Department maintains audit staff in order to ensure proper implementation of HCSC's compliance controls. The Compliance Department's auditors work closely with (and complement the work of) HCSC's Internal Audit Department by reviewing compliance-related issues and procedures. Their duties will include tracking regulatory changes and where necessary, implementing policies and training designed to conform with those changes. They will also include monitoring the corporate business environment to keep abreast of current developments requiring changes in corporate policies and the Code, and auditing for compliance with the Corporate Compliance Policy.

IV. CONCLUSION

In HCSC's case, wrongful actions by a small number of employees resulted in serious repercussions for the corporation and its employees. Once HCSC became aware of these wrongful actions, it took every possible step to correct and atone for those actions on an ongoing basis. Also on an ongoing basis, HCSC has devoted a significant amount of resources to ensuring that such activity does not occur in the future. HCSC welcomes and is always in search of new ideas and suggestions to ensure that the corporation is a model for ethical behavior in the marketplace.

Mr. UPTON. Well, thank you very much. As you can tell with those buzzers, we have a vote on, and we are going to temporarily recess for about 15 minutes, and then we will come back. Thank you.

[Brief recess.]

Mr. UPTON. Okay. We are back. The votes, a lot of things got pushed back, a number of press conferences, that type of thing. So we will see what members' schedules are. Originally we thought this hearing would only go to about 12:30, so everyone's schedule got a little scrambled.

I have a couple of questions.

First of all, I appreciate all of you coming, and I appreciate getting your testimony in advance and being able to go through it last night, and I was also glad in listening to your statement, in reading it as well, that none of you took the Pete Rose strategy. Pete Rose, one of the greatest ballplayers of all time, banned from baseball forever, never agreed that he had a gambling problem, even

today; and you all have admitted that there were problems. You all have agreed that integrity ought to stand first and foremost, and I think all four, of all the problems that were undertaken in the past, in essence there is really nobody left in any of your shops that was guilty that is still there today. Is that correct?

Mr. BECKER. True.

Mr. HUOTARI. It is.

Mr. UPTON. And is it also correct that none of you were there then? You indicated that in your testimony, Mr. Becker. Mr. Huotari?

Mr. HUOTARI. That's my testimony as well.

Mr. HESS. I was there.

Mr. UPTON. I am not a lawyer. I called Mr. Hyde a little bit earlier his excellency, but that was just a joke. I was trying to get a bill passed. That's what you have got to do.

You know, as we listened to some of the testimony, you all were here for the first panel. The influence of whistle-blowers or the impact of whistle-blowers we all feel is very important to bring some of these charges public, and thank goodness we had some of those that testified today and others throughout the government as well. But in addition to the steps that you have taken—the guidebooks, the regulations, the training for your employees, the emphasis on integrity and honesty to do the right thing—I would sense that if we had your predecessors maybe once, twice or even three times removed here where these things happened on their watch, my guess is that they, at least publicly, would have thought that they had those things in place then. Is that not right?

Mr. BECKER. It would be.

Mr. UPTON. What can we do? I mean, what is it that we can try and do to make sure that this doesn't happen again?

Obviously, we start with a clean slate. You all are in a new responsibility from where you were when things went bad and new emphasis, for sure. The companies have had more than their fingers slammed in the drawer. I mean, pretty big, hefty penalties. But what is it that we have to do to try and make sure that this system works in the right way? What else can HCFA do to ensure that from day one we don't have this type of thing happen again? What comments would you have to offer? Do you think you can go beyond what you have done already?

Mr. BECKER. Mr. Chairman, what I think each one of us said, which I think is very important—and I will answer your question more directly—is that the culture has to be right so you are not punished for coming forward and saying I have detected a problem. What we have done in New Mexico Blue Cross and Blue Shield, for example, in addition to what you heard, there's a direct hot line to our vice president of compliance who reports to the president. Anybody can call and remain anonymous if they don't want to identify themselves.

Mr. UPTON. I am going to save that question for the next panel, the National Blue Cross Blue Shield, but do you know if that happens in other providers across the country? Is that same system in place in pretty much all of them, maybe some of them, do you know?

Mr. BECKER. I think—my guess is that several of them do have such a mechanism where you can call a compliance officer directly and even report your superior. I think that we have all learned our lessons through these types of arrangements.

As far as what can HCFA do, I look at how we are regulated by our department of insurance, every State is regulated by a department of insurance in our commercial business. They, too, audit us; and they conduct what is called a market conduct audit. And once every so often, it's a fairly regular—in our case it's every 3 years—they simply come into your building, and they open all your files.

Mr. UPTON. So sort of like the story with my daughter with her English teacher?

Mr. BECKER. Exactly.

Mr. UPTON. Pop quiz.

Mr. BECKER. Exactly. And you don't know exactly what they're going to be looking at. They'll follow trails, if it looks like there's something running down that trail that might be inappropriate.

Mr. UPTON. How often do they come?

Mr. BECKER. They have authority to come anytime they want to if they suspect something, but they come at least every 3 years. It's a triennial exam, and I think that, because if your culture is such that you have got fraud and abuse in your company and there's not ways to cure itself, there's not much you can do from a regulatory legislative standpoint that is going to cure that. There is always a way around it. And sticking a HCFA auditor, for example, inside my company I think in many ways compounds the problem for all of the reasons talked about earlier today, but, also, it makes us less and less efficient, which adds to the cost of the program. We all talked about the fact that this is underfunded already.

So that's my recommendation, Mr. Chairman.

Mr. UPTON. Mr. Huotari.

Mr. HUOTARI. Mr. Chairman, as you noted, I wasn't with the company back at that time, 1993, and the company hasn't had a contract since 1994, so I'm not in a very good position to talk about what HCFA does now or doesn't do with Medicare contractors.

I do see one pattern here that appears, at least to me, has been when these audit samples were taken, rather than taking the samples directly from the documents, they were allowing the company personnel to, in effect, pull samples. I think in my experience in the insurance industry and insurance department audits and other audits, outside auditors oftentimes go back to source documents and the like, and so that was clearly a flaw in the process.

I don't know what HCFA does today. I don't know whether that's been corrected, but that is one pattern I see. That certainly happened in our company where the samples were—were selected to improve the result.

Mr. UPTON. Mr. Hess.

Mr. HESS. We also are subject to triennial audits by our insurance commissioner. And I agree with Mr. Becker. Those are very intensive. They are every 3 years, but they last probably 6 to 8 to 10 to 12 months.

People do come into your offices. They have rooms in our facilities, and they really do have the ability to follow up on whatever they find, and I think that is very valuable. An audit is one thing.

An audit in-depth is something else again. I think that's an important, important feature.

I know, to be fair to HCFA, perhaps after our problems HCFA did change the CPEP scoring which was, we thought as we looked at it, primarily related to process issues, not so much to outcome. So they changed it to the contractor performance evaluation, which my understanding is—again, we are not in the program either, but my understanding is was more oriented toward outcome. I think that was probably a good first step.

I think that the challenge on compliance programs, and we saw when Mr. Flynn testified and I believe that he went through a difficult sort of agonizing appraisal, what to do with his information, but the challenge is to get the program out there and get the employees to really believe that the company means it, and it's difficult. It's an ongoing process. Because you need to convince the employees that if they do report something people will take it seriously and that they will investigate it, and I think there's a fair amount of cynicism and maybe that's been justified in the past, but that's something you have to get over.

Over and over again, you have to try to convince employees that no audit—no system of compliance is going to work without their assistance and without their help, without bringing these issues to the compliance officer or the compliance process and giving it a chance to work.

Mr. UPTON. And do you think that that mindset has now come about with the changes that you have done? Do you think that the Darcy Flynns of the world in fact have changed their mind in terms of the way things are working?

Mr. HESS. I can't say they have. I certainly hope they have.

Mr. UPTON. He is in the back, so I can ask him later.

Mr. HESS. I certainly hope they have.

I do know that since 1993 there has been an increased emphasis on compliance programs. We have spent a lot more time getting information out, giving speeches, incorporating it into various parts of our company process, doing much more training and, again, trying to get across the point to all of the employees that we are interested. We don't want them to lie or cheat or steal for us. The company doesn't want that. We want them to report it, and the company will try to investigate it.

That's something that's hard to get across, and I don't know if we have done a perfect job yet. No doubt we haven't, but it's a constant sort of effort. I think that most employees, if not all the employees, of Blue Cross and Blue Shield of Michigan would say the compliance is a much more important and much more pervasive program today than it was back in 1993, and I hope they would say that they would give it an opportunity.

Mr. UPTON. And does Michigan have a system similar as New Mexico does with a direct link to the compliance officer?

Mr. HESS. We have a number of links. I happen to be the compliance office of Blue Cross Blue Shield of Michigan. My name is listed along with the general auditor's name, along with the head of our corporate financial investigations unit, which is our fraud unit.

We also indicate they can call anybody they want. And there is also a hot line, which is a totally anonymous way of informing the

company of some concerns you might have regarding processes. All of these things do prompt some level of investigation. So, whatever the call, the calls are noted; and there is some level of investigation. Obviously, if we find something, we investigate it further, but all of them are investigated.

Mr. UPTON. Mr. Verinder.

Mr. VERINDER. Mr. Chairman, there must be an environment of trust and willingness to do the right thing, and it must be top-down driven, and it must be accepted across the board. In setting up compliance programs with different entities, I believe in training, training, training, followed by investigation, investigation, investigation. Be there for your employees, a policy of absolutely no retaliation, a trust. That broke down in our company. It's a culture. Our company's working hard. Bring that culture of trust so they wouldn't have the fear of bringing forth an issue. That is essential, and a compliance program is costly and has to be a commitment and is something I would insist on with companies.

The second part is, don't give the opportunity. Audit and audit for real. Don't call me up and give me the dates, the amounts, the files.

Mr. UPTON. Do you think that HCFA has the adequate resources to do the audits that they ought to be doing?

Mr. VERINDER. I have got a background in law enforcement, and people are refocusing on where they have to go, and that has to be an essential ingredient. You will have to ask that question of them and, if they don't, support them in their effort, if there is that need. But that has to be for real.

Mr. UPTON. Okay. I think that's fine.

Any of you want to add anything to your testimony?

Mr. BECKER. Mr. Chairman, I would like to say something that I think is important for you to hear because you have been kind of asking something that's fairly nebulous, and can it work, and we have talked about culture, and culture you absolutely can't get your hands around.

A few years ago, we had another fiscal intermediary contract with the Federal Government that was not part of the Medicare contract, and a few years, not long after I arrived, one of our employees who realized that compliance was important—we had a compliance office code of conduct. She had signed it, had known for 2 years that there was a problem in this FI contract with one employee who was doing something wrong and covering it quite well. So she now came forward after 2 years of thinking she couldn't come forward.

She went up the line of command, which is very important, because we talked about that this morning, that some felt they couldn't go up the line of command or they weren't recognized. She went to her supervisor, who that day reported to her boss, who that day got ahold of me, and I was out of town. We immediately called a council. We immediately ordered an independent investigation of this particular process, and we immediately reported it to our client, told them what the problem was and what we were going to do to fix it and that they were made whole.

And what came out of that was not only did those things occur, the person who was performing the misdeed was immediately sus-

pended and later resigned, but we were not penalized. We did—in fact, we didn't lose the contract. We just renewed it for another 4½ years.

So I guess the theme of my story is that compliance plans very much do work if the culture is right and employees think that they don't have to file a qui tam lawsuit to make this happen.

Mr. UPTON. Thank you for that instance.

I have one other question that maybe would be worthwhile for me to ask. I know that—I guess for both New Mexico and Colorado the sentencing date is not until October; is that right? Wait—which—Illinois, I am sorry Illinois. And I don't know what sentence may be meted out, but I know in Michigan's case, and Mr. Hess, you indicate no criminal charges were filed. Do you think that it's—and I don't know the reason behind that—but do you think that as a means for the Federal Government to go after fraud and abuse that in fact we should hold individuals criminally responsible for their actions on this and maybe the Federal Government might have missed an opportunity if, in fact, there was grounds to do so?

Mr. HESS. You're speaking of the Michigan case?

Mr. UPTON. I am going to ask everybody the same.

Mr. HESS. I think that's an issue that has to be looked at on individual circumstances.

Mr. UPTON. The reason I ask that is because of my amendment, which passed in this committee before and passed on the House floor, which in fact did hold individuals criminally responsible for fraud and abuse. I thought that that would be an added layer of protection for the taxpayer if in fact it was known to be part of the equation, and for it not to be part of the equation I think makes our means to enforce the law less effective.

Mr. HESS. I can understand that possibility. I do think that there is certainly the possibility—I think everybody should recognize that that there is a possibility that this sort of conduct will lead to criminal sanctions. We've seen a number of situations where individuals as well as the corporations have been held criminally liable. I think it would have to be addressed, in my opinion, on a case-by-case basis to take a look at the situations that the individuals are in, the nature of the conduct and, to some extent, leave it to the prosecutor's discretion as whether to charge or not.

Mr. UPTON. Mr. Becker.

Mr. BECKER. I agree with what Mr. Hess said, except that I would just add one thing in our particular case. The people who actually performed the misdeeds were terminated by the company or left the company, and my assumption is—and I don't know where they are today—but my assumption is they are out working and living their life. They are not sitting here with us. So the 600 people left behind in Albuquerque are paying for it. I am not talking about the financial side of it, because we are not writing checks personally, but reputationally we were on the front page of the newspaper for something a few people did 6 years ago, and it infuriates me, quite frankly, and I happen to believe in our particular position that would be one that I think they ought to be criminally prosecuted.

Mr. UPTON. Mr. Huotari.

Mr. HUOTARI. It's my understanding, Mr. Chairman, that both individuals and corporations are criminally liable or potentially criminally liable for submission of false claims to the Federal Government, and so I think that penalty exists in potentially in every case. I think, as Mr. Hess said, it's a case-by-case determination of the circumstances. I also understand in each case there is a potential penalty for individual debarment from the Medicare or other government programs that exist. Again, I think that is a decision that's made under the circumstances of each case, and so it would vary from case to case.

Mr. UPTON. Mr. Verinder.

Mr. VERINDER. Mr. Chairman, the Federal Government must do a thorough and complete investigation and then a decision must be made on a case-by-case basis. So that's make us in agreement, with all four of us believing case-by-case basis here.

Mr. UPTON. Okay. Well, again, I appreciate your testimony. I might ask you that—I know that my colleague, Ms. DeGette, did want to come back, and she has got, I guess, the mayor of her community at a very important event relating to youth violence on the steps of the Capitol, but there may be some other members that may have some questions, and, if they do, we will ask that they may pose them in writing. If that happens, if you could report back in a timely fashion we would appreciate that.

You are excused. Thank you very much for your testimony as it helps us move on the right path. Thank you.

Our last panel includes Mr. Harry Cain, who is Executive Vice President of Blue Cross Blue Shield. Welcome to the subcommittee. It's a little lengthier hearing than many of us had anticipated when we brought the gavel down this morning. As you know our routine, we have asked all panelists to testify under oath. Do you have any objection to that?

Mr. CAIN. No, sir.

Mr. UPTON. And do you need to have counsel?

Mr. CAIN. No, sir.

I should introduce my colleague, Mr. Harvey Friedman, who is a Vice President of the Association, who has immediate responsibilities for the areas that we will be discussing today.

Mr. UPTON. Certainly.

If you both might stand and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. You are now under oath. And, again, your entire testimony will be made a part of the record. And try to limit your remarks to 5 minutes. That will be terrific.

TESTIMONY OF HARRY CAIN, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, ACCOMPANIED BY HARVEY FRIEDMAN, VICE PRESIDENT, MEDICARE, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. CAIN. I shall.

Mr. Chairman, I will just quickly try to summarize the essence of the remarks and along the way make a couple of comments on what I have heard here earlier today.

I want to talk first about the unethical and illegal behaviors that have been discussed here and the context in which they occurred.

Second, how has that context changed in the last few years? And, third, what about the future? What actions might the Congress consider to address these problems?

In terms of the behaviors themselves, we don't have any excuses. Neither the Association nor any of the Blue companies in which these behaviors transpired are going to try to excuse it.

The second, the context which may help put it in perspective. First, a broad observation that this program has been going on now for some 34 years; and, overall, the history is very impressive, very tough job done by lots of people, often under adverse circumstances. The whole picture is quite impressive. So I want to try to draw your attention to the fact that we're focusing here today on some broken pieces in a very large and handsome mosaic that goes back a long time. I'd hate to have the few broken pieces somehow impugn the entire history.

Third comment is, these unfortunate behaviors that have been discussed here earlier appear to have occurred in a particular period, beginning in around 1985 and going up until maybe 1994 or 1995. That's what everything that I have seen suggests is the case.

In that period, the contractors were in a particularly challenging situation, somewhat squeezed between three forces. One, the program itself was becoming significantly more complex, and the volume was growing greatly; two, HCFA had established a very high performance standard, performance requirements; and, three, the administrative funds made available to the contractors, even by HCFA's agreement at the time, were inadequate to support the kind of performance that was being required.

Now, contractors in that environment had essentially three choices. One was to get out of the program and terminate all of the affected staff, which over time a few of the contractors actually decided to do. The second choice was to get a lot more efficient and more productive, and all of the contractors that remained in the program had to in order to survive. And then of course the third choice was to cheat, and clearly some employees in some contractors took that third choice, and that choice remains inexcusable, but it is not incomprehensible as to how it happened.

Now, what has changed since those three forces formed the context of that kind of behavior? Well, one might argue that many of the same forces are still in place. A couple of changes. One, beginning in 1993, 1994, the Association and all the Blue plans have begun to put in place and greatly emphasize the kinds of codes of conduct that would prohibit or prevent such behaviors and effective compliance in programs. In today's world, we can no longer assume ethical behavior, unfortunately. We are now doing what we can to assure it and/or to assure that we can detect and respond to unethical behavior when it occurs. My full testimony gives more examples.

A second change in the context is that one of the most egregious features of the HCFA performance program has been dropped, which helps. If you want to get into that, I will be glad to.

And, third, in one area of Medicare administration, there is now more adequate funding, but in the other general administrative areas, the situation is very much the same today as it was in the 1980's.

The future, where do we go from here? Well, I am going to give you a short—two short answers. Given the current structure of Medicare, Congress I think can do two things to improve the situation. One is to allow, encourage, authorize and improve the contracting program, and our testimony, as well as suggestions from the GAO and the IG, have many specific examples. Mostly they rely on requiring HCFA to get more in concert with the Federal acquisition rules.

The second thing that Congress can do is to provide more adequate funding for administration. There is a very long history in this program now going back about 25 years of the Congress being somewhat penny wise and pound foolish regarding Medicare administration.

The other approach which you might do simultaneously is to reconsider the entire structure of the Medicare program. It is inherently an administrative morass. Better contracting and more adequate funding can improve it but fundamentally this program is exceedingly difficult to run. There are other alternative ways to go about it, even for a publicly funded entitlement program, but that is a fairly large subject for another time, perhaps some other set of hearings, and I thank you very much for the opportunity to be here, Mr. Chairman.

[The prepared statement of Harry Cain follows:]

PREPARED STATEMENT OF HARRY CAIN, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the Subcommittee, I am Harry Cain, Executive Vice President of the Blue Cross and Blue Shield Association. We represent 51 independent Blue Cross and Blue Shield Plans throughout the nation. I appreciate the opportunity to testify before the Subcommittee on various issues related to Medicare contractors, with particular emphasis on fraud and abuse.

Medicare is administered through a long-standing partnership between the private health insurance industry and the Health Care Financing Administration (HCFA). Since 1965, Blue Cross and Blue Shield Plans have played a leading role in administering the program. They have contracted with the federal government to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner. Nationally, Blue Cross and Blue Shield Plans process over 85 percent of Medicare Part A claims and about 57 percent of all Part B claims.

Medicare contractors have three major areas of responsibility on behalf of the federal government:

1. **Paying Claims:** Medicare contractors process all the bills for the traditional Medicare fee-for-service program. In FY 1999, it is estimated that contractors will process over 900 million claims, more than 3.5 million every working day.
2. **Providing Beneficiary and Provider Customer Services:** Contractors are the main points of routine contact with the Medicare program for both beneficiaries and providers. Contractors educate beneficiaries and providers about Medicare and respond to about 40 million inquiries annually.
3. **Special Initiatives to Fight Medicare Fraud, Waste, and Abuse:** All contractors have separate fraud and abuse departments dedicated to assuring that Medicare payments are made properly. According to the Department of Health and Human Services (HHS), these activities saved the government $9 billion in 1998.

Medicare contractors have been extremely efficient and cost effective for the federal government. In 1999, contractors' administrative costs represent less than 1 percent of total Medicare benefits. While workloads have soared over the last 25 years, operating costs—on a unit cost basis—have declined about two-thirds from 1975 to 1999. Few government expenditures produce the documented, tangible savings of taxpayers' dollars generated by Medicare anti-fraud and abuse activities. **For every $1 spent fighting fraud and abuse, Medicare contractors save the government $17.**

Medicare contractors proactively combat Medicare fraud, waste, and abuse through a multi-faceted program under HCFA's direction and review. Thanks to recent increases in funding, Medicare contractors are now able to expand their anti-fraud and abuse efforts, and we are seeing excellent results. We believe continued improvements are essential.

With this as background, I would like to focus on the following three areas in my testimony:

I. Contractor initiatives to combat fraud, waste, and abuse in the Medicare program;
II. BCBSA recommendations for contractor reform; and
III. BCBSA's response to the recent General Accounting Office (GAO) and 1998 HHS Office of Inspector General (OIG) reports.

I. COMBATTING MEDICARE FRAUD, WASTE, AND ABUSE

Contractors collectively employ over 22,000 workers across the country to process claims and prevent excessive, improper, or unnecessary spending in the Medicare program. Through their long-term relationship with Medicare, Blue Cross and Blue Shield Medicare contractors have acquired extensive experience and knowledge about this complex program. Our Plans have become experts in detecting ways in which some providers attempt to abuse or defraud Medicare. Blue Cross and Blue Shield companies also hire experienced investigators with diverse backgrounds to fight fraud, waste, and abuse. These professionals include law enforcement officials, physicians, nurses, attorneys, accountants, statisticians, and business managers.

Contractor Operations to Fight Fraud

The task of safeguarding Medicare funds is not limited to identifying instances where providers have intentionally sought overpayments. Instead, contractors rely on a multi-pronged approach. A successful program begins when a Medicare claim is submitted for payment. Once the claim enters a Medicare contractor's system, it is subjected to several layers of review to ensure its appropriateness. The following summarizes contractor anti-fraud and abuse activities:

Claims processing screens: Contractors' computer systems are programmed so that all Medicare claims are screened on the front-end. These initial computer checks seek to:

- identify duplicate bills;
- ensure the claim is from an enrolled provider;
- ensure the claim is for services rendered to an eligible beneficiary;
- determine the appropriate payment amount for a specific service;
- assure the bill is complete and consistent (for example, the screens would reject a bill for cataract surgery that listed the diagnosis as congestive heart failure); and
- screen out claims that appear suspicious and should be investigated before they are paid.

Provider registration screening: All providers must receive a Medicare registration number from a contractor before they can bill Medicare. Contractors review provider applications closely to prevent fraudulent providers from getting into the program by using false names or addresses.

Medical review: The purpose of medical review is to examine claims and supporting documentation to assure services are medically necessary and appropriate. Contractors' medical review staffs are assisted by physicians who obtain input from the local provider community in establishing each contractor's policies. Because of funding constraints, only a small percentage of Medicare claims and supporting documentation is actually reviewed. Recent increases in funding for anti-fraud and abuse activities have allowed contractors to review more claims; but the proportion of all claims reviewed by contractors remains limited.

Contractors conduct two types of medical reviews:

- **Prepayment review:** Contractors use a cost-effective, focused medical review process to determine which bills need to be reviewed further before payment is authorized. All contractors screen bills before payment to detect potential problems, such as unnecessarily intense or frequent care. Some screens are nationally set by HCFA, while others are developed locally to reflect regional problems. These screens are based on policies applicable to specific procedures, frequency of services, and provider-specific data accumulated from data analyses of previous services. Physicians are integral to the medical review process and lead reviews of complex cases.
- **Postpayment review:** After bills are paid, contractors monitor the Medicare claims experience of all providers and services in a region. Contractors typically focus on high-dollar and frequently performed services. Aggregated data are

analyzed to identify providers whose utilization patterns differ substantially from their peers. Contractors use different statistical software packages to track data and identify patterns or trends that may reveal inappropriate levels or types of treatments provided to beneficiaries. Examples of this type of profiling are identifying providers performing an unusually high number of services on beneficiaries, or ordering an excessive number of tests. These in-depth reviews can last several months and can involve patient surveys, review of medical records and discussions with providers. Actions taken based on these findings include: provider education; payment recovery where investigations reveal inappropriate or fraudulent billings; referrals to the OIG; and development of prepayment screens to identify future problems before bills are paid.

Cost report audits: The Medicare audit function represents the most all-inclusive opportunity for Medicare Part A contractors to impact Medicare dollars. The audit function is similar to the role of the Internal Revenue Service. Cost reports are the vehicle through which Medicare Part A providers make a final, comprehensive claim against the federal government for reimbursement at the end of the year for providing services to Medicare beneficiaries.

Professional accountants review the reports to ensure that all costs are appropriate and that they match previously submitted claims. Specifically, these accountants check for areas that indicate excessive claims for reimbursement, violations of program law or regulation, mathematical errors, or fraud and abuse. Contractors will send professional accountants to the provider site to perform a limited financial audit of a selected number of the provider's books and records, if judged necessary and cost-effective within constraints of available funding.

Medicare Secondary Payer (MSP): Contractors constantly check claims to determine instances where a beneficiary has private insurance coverage that should pay the bill instead of Medicare. The other payers whose coverage should pay before Medicare coverage begins include: employer group health plans covering working beneficiaries, workers' compensation, and auto, liability, and no-fault insurance. The primary functions of MSP include:

- reviewing claims for indications of other coverage;
- developing claims with indications of other coverage to determine if other coverage actually exists;
- ensuring that appropriate Medicare payment is made on claims for which Medicare is the secondary payer;
- tracking auto, liability, and workers' compensation cases to assure Medicare payments are either not made or are recovered from any settlement awards; and
- conducting outreach activities to educate beneficiaries, providers, attorneys, and insurers about MSP.

Provider and beneficiary education: Contractors educate both beneficiaries and providers on payment integrity and quality assurance issues. For example, contractors send providers newsletters, hold seminars, and host conferences to explain the latest billing techniques or new Medicare coverage rules. These educational efforts save the Medicare Trust Funds money by having the sentinel effect of preventing future fraud.

Contractors Work with Other Entities

Equally important as contractors' own anti-fraud activities is the interaction of contractors with other agencies. Contractors work with HCFA's central and regional offices to detect fraud and develop medical policies to prevent unnecessary spending of Trust Fund dollars. Contractors have also established relationships with other contractors, states, and local anti-fraud task forces to detect and fight Medicare fraud. One Blue Cross and Blue Shield Plan has worked with its local Operation Restore Trust office in a special fraud task force designed specifically to proactively identify the top fraudulent providers billing Medicare.

Contractors also work closely with law enforcement agencies. When contractors have identified and substantiated a case of potential fraud, they forward it to the HHS OIG for further investigation. HCFA's instructions direct contractors to give the highest priority to those cases that have the greatest impact on the Medicare program. These include multi-state fraud, patient abuse, high dollar amounts of potential overpayment, and likelihood for an increase in the amount of fraud or enlargement of a pattern. However, contractors do not refer potential cases to law enforcement solely on the magnitude of the case; each is evaluated and referred based on its own merit. Contractors develop various criteria based on guidance issued by HCFA in the Medicare Carrier and Intermediary Manuals. In general, contractors refer cases to the OIG once they have knowledge that the provider has intentionally engaged in improper billing, submitted improper claims with actual knowledge of

their falsity, or submitted claims with reckless disregard or deliberate ignorance of their inaccuracy.

Potential fraud cases can also be referred to the Department of Justice for prosecution. Contractors also hold training sessions for law enforcement agents to educate them on various aspects of the Medicare program, including proper billing procedures and how to read cost reports.

HCFA Review of Contractors

Medicare contractors operate under detailed instructions from HCFA. As government contractors, Medicare contractors must comply with numerous federal statutes, regulations, and Executive Orders. In addition, contractors must follow extensive HCFA issued program guidelines and manual instructions. To monitor compliance with these guidelines, contractors are visited annually by their local HCFA regional office staff for an assessment of their performance against HCFA's requirements. These reviews, termed Contractor Performance Evaluations, are conducted in various functional areas and culminate in a formal annual report called the Report of Contractor Performance. Also, several annual or special certifications are expected to be executed by contractors in support of the Chief Financial Officers Act, the Federal Managers Fiscal Integrity Act, the fiscal year budget proposal, and other areas of specific interest, such as Y2K readiness.

Challenges Facing Contractors

Medicare contractors face three key challenges to continued success in fighting fraud and abuse: (1) Inadequate funding levels; (2) Increased complexity of Medicare rules; and (3) Constant changes in direction. These challenges are described below:

Inadequate funding levels: Of utmost importance to attaining outstanding performance is an adequate budget.

However, Medicare contractors have been severely underfunded since the early 1990's and are facing poor prospects of receiving adequate funding next year. During the early to mid-1990's, reductions in funding relative to increases in workload seriously eroded contractors' ability to fight fraud and abuse. Between 1989 and 1996, the number of Medicare claims climbed almost 70 percent to over 800 million, while payment review resources grew less than 11 percent. As a result, the amount allocated to contractors to review claims shrank from 74 cents to 48 cents per claim. Because of the significant cost of reviewing claims, **this decline in funding resulted in HCFA's directions to contractors to reduce the percentage of claims that were scrutinized and investigated.** Similarly, the percentage of cost reports audited declined: between 1991 and 1996, the chances that any institutional provider's cost report would be reviewed in detail fell from about 1 in 6 to about 1 in 13.

Throughout this period, contractors identified to HCFA additional anti-fraud efforts they could undertake if awarded additional resources. BCBSA and Blue Plans urged both Congress and the Administration to allocate significantly more funds for critical anti-fraud and abuse efforts. Finally, in 1996, Congress created the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act. MIP provided a permanent, stable funding authority for the portion of the Medicare contractor budget that is explicitly designated as fraud and abuse detection activities. MIP funding was set at $500 million in 1998 and is authorized to rise to $720 million in 2002.

Thanks to this new funding mechanism, Medicare contractors have been able to improve their efforts to reduce the amount of fraud, waste, and abuse in the Medicare program. Earlier this year, the HHS OIG released its 1998 financial audit indicating that Medicare provider billing errors had fallen dramatically. Contractors' enhanced anti-fraud and abuse efforts due to MIP funding contributed to that significant decline in improper claims and documentation submission by providers. The OIG also found a greater number of providers submitting claims with proper documentation—a sign of contractors' enhanced education efforts to inform providers of proper documentation procedures. The Congressional Budget Office also has attributed the abrupt slowdown in Medicare spending between 1998-99, in part, to stepped-up policing of fraud and abuse, in which contractors have played a significant role.

But, the creation of MIP did not solve the budget problems for the remainder of the contractor budget. Even with increased MIP funding, total contractor funding (including MIP), on a per-claim basis was lower in 1998 than in every previous year back to 1989.

The largest portion of the contractor budget—program management —is subject to the annual appropriations process and continues to face severe funding pressures. Program management activities include claims processing activities, beneficiary and

provider communications, and hearings and appeals of claims initially denied. Under the appropriations process, contractors must compete for funding with high priority agencies such as the National Institutes of Health.

For example, between 1989 and 1998, funding for program management activities (adjusted for inflation) declined by 18 percent. During this period, the volume of Medicare claims increased by 84 percent; Medicare outlays (in real dollars), by 65 percent. Whenever possible, contractors responded to reduced funding by achieving significant efficiencies in claims processing, lowering program management costs per claim by 56 percent in real dollars over this period. But even these efficiencies have not been enough to keep pace with rising Medicare claims volume and diminishing funding levels: In 1998, for example, HCFA made up for funding short falls by instructing contractors to slow down payments to hospitals and doctors, make greater use of voice mail, and send fewer explanations of benefits notices to beneficiaries.

Inadequate budgets for program management also impacts Medicare's fight against fraud and abuse. While many think of program management activities as simply paying claims, these activities are Medicare's first line of defense and are critically linked to MIP anti-fraud and abuse activities. As an example, many of the front-end computer edits described earlier (e.g., preventing duplicate payments and detecting suspicious claims) are funded through program management. Inadequate funding impacts different functions at different times, but always disrupts the integration of all the functional components needed to "get things right the first time." It thus results in inefficiency and higher costs.

Moreover, increased anti-fraud initiatives have created increased workloads for program management activities. An expert study commissioned by BCBSA last year demonstrates that contractor program management funding will be significantly strained by the increased anti-fraud and abuse detection efforts under MIP. The report shows that every 10 percent increase in MIP funding will result in a $13 million increase in contractor costs due to increased appeals, inquiries, and hearings.

Increased complexity of Medicare rules: Another challenge faced by contractors is the significantly greater workload expected next year and in future years as the Medicare program grows more and more complex. The new payment mechanisms for outpatient departments, home health agencies, and skilled nursing facilities, to name a few, are very complicated and will require a great deal of resources to implement. Just as Members of Congress are hearing from these providers, so too are contractors who must answer their questions and concerns about new payment methodologies.

Furthermore, any Medicare reform legislation could have a profound impact on contractor activities. For example, the President's FY 2000 HCFA budget request included $60 million to implement various provisions of the 1997 Balanced Budget Act. Clearly, changes to Medicare coverage rules can have financial impacts on contractor budgets. Unfortunately, Congress does not generally provide the necessary administrative resources when enacting Medicare legislation. We urge Congress to assure that contractors are adequately funded when considering legislative changes.

Constant Changes in Direction: Medicare contractors are challenged by the very nature of the business. Medicare contractors must deal with hundreds of pages of instructions from HCFA. When last we counted (1993), the Medicare contractors had received, on average, a new instruction from HCFA every five hours of every day of every year. And the program has become even more complex since 1993. This constant state of change requires contractors to be extremely flexible—both in terms of its operations and its budget. It has not been uncommon in the past for contractors to be forced to abandon projects or reallocate staff midyear in order to adapt to HCFA's suddenly revised priorities or modified funding levels. HCFA and Congress seldom realize that these continuous changes in direction require time and money.

By law, Medicare contractors are not allowed any profit. Medicare contractors operate under cost contracts, and HCFA places budget caps, or limits, on the unit costs paid to contractors to process claims. Under these contracts, Medicare contractors essentially do whatever work HCFA requests, without "change orders." There is not a clear statement of work at the beginning of the year, and contractors generally must comply with constant change orders from HCFA without additional reimbursement. These demands make the Medicare contractor business extremely challenging.

II. BCBSA RECOMMENDATIONS TO IMPROVE THE MEDICARE CONTRACTOR PROGRAM

Consistent with the views of the GAO and the HHS OIG, BCBSA agrees that revisions to the Medicare contractor program are necessary to strengthen contractors' abilities to effectively and efficiently handle day-to-day administration of the Medi-

care program. Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance levels. We want to work with the Congress and HCFA to attain this objective. We recommend consideration of the following recommendations:

1. **Competitive Contracting:** We believe that Congress should explore revising Medicare contracts to allow qualified companies to compete based on the Federal Acquisition Rules (FAR)-the federal government's rules on competitive contracting. The FAR would instill at least two disciplines now missing in the program: a clear scope of work, and a professional contracting officer for each contract, through whom contract changes are made. Conducting such a competition under the FAR—which now governs all other government contracts—would ensure that contracts are awarded on the basis of fair competition, and it would give all contractors appropriate appeal rights and due process.

   The FAR would also ensure that HCFA pays termination costs to contractors that leave the program. I would note that HCFA's reform proposal would deviate from the FAR by eliminating this requirement. This would be unprecedented. No other type of government contract, including defense contracts, lacks the requirement that the government pay contractors reasonable termination costs.

   It is essential that any move to competitive bidding of these contracts be based on a strategic plan that lays out the timetable for this change to minimize disruption to Medicare beneficiaries and providers. Moving to a competitive bidding process will require careful planning, a sufficient transition, and additional HCFA staff to manage this major new contracting initiative. Congress may want to review a proposed strategic plan before granting HCFA this new authority.
2. **Alternatives to the current cost contracts:** Moving to the FAR would allow HCFA to contract with entities using other payment options, including fixed-price, cost-plus-fee, or cost-plus-incentive contracts. But before moving ahead too quickly, we urge that HCFA study the various contracting options available under the FAR to determine which method would be most appropriate. BCBSA would like to work with Congress and the Administration to develop the most promising proposals for improving the public-private partnership that administers the Medicare program.
3. **Voluntary Self-Disclosure Protocol:** Blue Cross and Blue Shield companies place the utmost importance on maintaining the highest possible levels of compliance and ethics—not only where Medicare is concerned, but in all aspects of their business. They are committed to assuring that there is a code of conduct, as well as effective compliance programs, within each Plan. However, it is critical that Medicare contractors have the appropriate incentives to report to the federal government when they detect probable wrongdoing in their own business. And most importantly, these incentives must be structured to allow these companies to take immediate corrective actions to remedy any identified problems. We believe HCFA should adopt a program similar to the Department of Defense's Voluntary Disclosure Program, which provides companies incentives to report problems and resolve them. Well-designed compliance programs should include the following seven elements considered necessary for a comprehensive program under the United States Sentencing Guidelines:
   - development of written policies and procedures;
   - designation of a compliance officer and/or other appropriate bodies;
   - development and implementation of effective training and education about compliance and ethics;
   - development and maintenance of effective lines of communication, including a hotline where employees can report concerns outside the normal chain of command;
   - enforcement of standards through well-publicized disciplinary guidelines;
   - use of audits and other methods to monitor compliance; and
   - development of procedures to respond to problems and to initiate corrective actions.
4. **Adequate and stable funding levels:** Congress should provide adequate funding levels to assure that contractors can perform the range of functions necessary to safeguard program funds. As highlighted earlier, funding has not kept pace with programmatic needs--important functions are not being funded. We urge Congress and the Administration to explore using a new methodology to develop Medicare contractor budgets. This method should assure that a set percentage of Medicare claims is reviewed annually and that each time a new Medicare law is passed, there are sufficient administrative resources to handle the new workload. While Blue Cross and Blue Shield Medicare contractors are

committed to continually achieving greater efficiencies, it is simply not realistic to expect contractors to attain outstanding performance levels with greater workloads and tighter budgets.

The prospects for adequate funding for program management activities, which are subject to the annual appropriations process, do not appear promising for FY 2000. The Administration is essentially proposing a **reduction in funding for the administration of the Medicare program of 7 percent.** This budget proposes $1,274 million, just $4 million above the FY 1999 level. However, the President's budget level is dependent on $93 million in new provider user fees, which Congress has consistently rejected in past years. Excluding these funds lowers the President's budget request to $1,181 million, 7 percent below FY 1999. Yet increased funding is critically needed next year to cover increased claims volume, implementation of provisions in BBA and HIPAA, and increased workload associated with expanded anti-fraud and abuse activities. It is imperative that Congress provide a stable and adequate funding stream for all contractor activities. As indicated earlier, underfunding program management activities can result in payment slowdowns to providers and beneficiaries, and deterioration in effective anti-fraud efforts given that program management and MIP functions are intertwined in the fight against fraud and abuse.

In the President's FY 2000 budget, HCFA indicated its interest in exploring alternative funding options for Medicare administrative activities. We support HCFA's efforts and would like to work with the Congress to move toward a stable and reliable funding source for the future.

5. **Coordinated Administration:** Finally, we recommend against awarding contracts in a way that would fragment and weaken Medicare administration, as proposed by HCFA in its contractor reform proposal. Competition does not have to mean fragmentation. Instead, competition should mean contractors compete on a level playing field to be the single manager of a contract, and be held responsible for subcontracting more specialized work to other entities, if appropriate. By breaking up contracting functions and spreading them among a large pool of new entities—many of whom would be inexperienced in Medicare—the claims payment process would be fragmented. This is likely to disrupt effective management of the program. Costs would invariably increase because claims processing, customer service, and fraud and abuse activities are interconnected; for example, claims processing and fraud control efforts would still require coordination and extensive data sharing after these responsibilities are divided. At the very least, a comprehensive plan to ensure efficient coordination among the functional contractors and an infrastructure to support the coordination must be developed and implemented prior to adopting HCFA's proposal.

Moreover, separating key functions to different contractors could hinder efforts to fight fraud and abuse for at least four reasons.

First, such fragmentation is likely to create competing, counterproductive incentives. BCBSA is very concerned with the unintended consequences of breaking up contractor functions. On the one hand, contractors are responsible for claims processing and paying claims based on a time schedule set by Congress. On the other hand, contractors are responsible for program safeguard activities—in essence, taking the time to review claims carefully to make sure they are paid properly. In a single organization, contractor management can balance these competing priorities to reach a productive synergy. However, were HCFA to separate these functions among competing organizations, neither organization would have the incentive to work together. This problem would be exacerbated if claims processing activities were further fragmented.

Second, the staffing resources required to implement and manage this type of new contracting authority are so immense that they would undermine HCFA's efforts to administer its other initiatives effectively. Potentially, HCFA would have to manage numerous additional new contracts for claims processing services and beneficiary/provider communications centers with entities unfamiliar with Medicare. Contractors currently work without a scope of work and without individual contract officers. This new legislation would require that each contractor have a unique contract with a specific scope of work and a separate contracting officer. Most significantly, HCFA would have to directly manage each of these separate functional contracts to assure the entire claims administration process runs smoothly. These requirements—in and of themselves—could not be met without HCFA adding more people with greater contracting experience than they currently employ. HCFA is already burdened by many other new responsibilities. With these other large workloads, we believe the agency does not have the resources, staff, or expertise to implement this type of new procurement activity.

Third, contracts could be awarded to entities that have no experience working with the Medicare program (a current program requirement), or even entities that have no familiarity with health claims processing. Allowing HCFA to contract with organizations unfamiliar with Medicare's intricate payment methodologies for critical claims payment or fraud detection activities could reduce payment accuracy, delay payments to providers, and reduce the quality of service providers and beneficiaries expect. An expert study commissioned by BCBSA found that awarding Medicare fraud detection functions to inexperienced contractors would be "highly questionable and risky."

Fourth, functional contracts are likely to increase, not decrease costs. Having multiple functional contractors replace single contractors is likely to increase costs to the government. There is likely to be significant duplication and overlap of efforts, including increased overhead costs, in addition to increased resource requirements for HCFA.

Above all else, fragmenting the claims payment process would destroy the current *single* point of accountability now available to HCFA, providers, and beneficiaries. I cannot emphasize enough the potential confusion and difficulty that may arise from managing a multitude of independent specialty contractors who share work but do not share accountability for the outcome (e.g., for a correctly and efficiently processed claim), and may even consider themselves competitors to each other. It is conceivable that under HCFA's proposal an individual claim could be handled by three or more individual contractors before it is finally processed. This fragmentation could increase claims payment timeframes, and such a proposal removes any accountability for processing a single claim properly —from beginning to end. GAO's previous statement to this Subcommittee sums up our concerns as well: "After 30 years of integration, contractor's functions may not be easy to separate, and having multiple companies doing different tasks could create coordination difficulties."

III. BCBSA RESPONSE TO GAO AND OIG REPORTS

In addition to recommending broad reform of the Medicare contractor program, GAO and the HHS OIG made several more specific recommendations to improve program management. We agree with many of these recommendations--some entirely, and some with certain qualifications.

1. **GAO recommended establishing an internal contractor management policy group to oversee contractor certifications.** We support this recommendation, but urge HCFA to ensure that the emphasis on certifications should be to look behind the existing contractor certifications and not to look for reasons to proliferate the number and type of required certifications.
2. **GAO recommended that HCFA establish annual core benchmarks for contractor performance and assess contractors based on those standards.** We support benchmarks for contractor performance that are well-defined, achievable, and in line with annual funding levels. These standards should measure the key components of expected contractor performance and not be based on measurement of micro-level, transaction-oriented activities, as in the past.
3. **GAO recommended designating an internal HCFA unit to evaluate effectiveness of oversight policy and direction by headquarters to regional offices, as well as regional office oversight of contractors.** We support any efforts to improve the consistency of information disseminated from regional and central offices.
4. **GAO recommended that a strategic plan be developed on how HCFA would implement contractor reform if HCFA were granted such authority.** We agree that HCFA should establish a strategic plan—including an independent study of its proposal—before proceeding with any reforms. This study should determine whether these administrative changes improve the efficiency and effectiveness of Medicare program operations. Because of its potential impact on the Medicare program, Medicare expenditures, and Medicare beneficiaries and providers, contractor reform must be carefully planned and its impacts fully understood before proceeding. This plan must also analyze the cost implications of functional contracting, which we believe may be substantial.

   HCFA has just awarded 12 new MIP contractors. Despite the fact that MIP allows HCFA to contract with new entities to perform program safeguards activities, HCFA has decided that these new contractors will *supplement, not replace,* program integrity functions performed by current contractors at this point in time. We approve of HCFA's actions, and recommend that HCFA's strategic plan for further contractor reforms include an analysis of this recent MIP procurement.

A strategic plan would also allow HCFA to understand the internal workload implications that contractor reform would impose on the agency. At a time when HCFA already has significant new responsibilities, including implementing the BBA and HIPAA, HCFA should have the resources necessary to properly and effectively carry out these new contractor changes before new authority is provided.

5. **GAO and OIG recommended improving contractor controls over Medicare accounts receivable, cash, financial reconciliations, and electronic data processing.** Contractors are continually working to improve their financial oversight functions. We would support moving to a dual entry accounting system once HCFA specifies the systems requirements and provides the funding to make the changes. Because of Y2K priorities, HCFA has indicated it will not allow any systems changes until 2001.
6. **OIG recommended establishing clear definitions of key words and terms (e.g. complaint, case, program vulnerability, and overpayment).** We would support having clear, consistent definitions and instructions regarding the operation of Medicare contractor fraud units.
7. **GAO recommended eliminating provider nomination**—the process by which providers can choose their intermediaries. Provider nomination was originally implemented to offer greater ease and simplicity of claims payment for institutional providers. This process is especially important for provider chains that are able to choose one contractor to handle claims from their providers on a nationwide basis. As Congress considers this recommendation, we urge you to obtain input from the provider community on the impact of such a change.

Response to Recent OIG Reports

Over the past year, OIG has issued two key reports related to Medicare contractor performance.

In November 1998, the OIG released a report that reviewed the effectiveness of Medicare contractors' fraud control units based on 1996 data. The OIG found that staff turnover, lack of proper training, and a lack of uniformity and understanding of key fraud terms and definitions have hampered the fraud units. In reviewing the results of this report, the Subcommittee must realize that effective anti-fraud and abuse efforts—especially the ability to retain trained staff—have been severely impeded by lack of adequate and, importantly, stable funding levels.

Unpredictable and insufficient funding patterns in the early and mid-1990's—when contractors were subjected to unpredictable cutbacks or additional funding late in the year—made it extremely difficult for contractors to recruit and retain well-trained staffs. This environment often made it necessary for contractors to reduce their fraud staffs (i.e., lay off experienced people), and later try to recruit new untrained staff as funding became available. It takes approximately one year to adequately train anti-fraud and abuse staff so that they become familiar with the complex Medicare rules. As mentioned earlier, the MIP funding which first became available in 1997 has eased this problem.

Congress should also be aware of another problem contractors faced in the early 1990's. Before 1997, contractors were often told by OIG to refer only "big dollar" cases to the agency, since it was ill-equipped to handle a large volume of smaller cases. OIG did not receive adequate anti-fraud and abuse funds to increase its own staff until 1997.

In February 1999, the OIG released its annual Chief Financial Officers report that demonstrated the new MIP funding had significantly reduced Medicare overpayments. While we are pleased that this study shows the outstanding job contractors performed in 1998 in reducing overpayments, this report indicated that additional efforts are needed. In assessing the performance of contractors, it is important to realize that the kind of errors identified by the OIG were associated with claims that, based on the information submitted, **were correctly processed by Medicare contractors.** However, the OIG in this audit had Medicare contractors look beyond the actual claim to the medical documentation (i.e., the patient's medical record in the physician's office) related to the service. By doing this, Medicare contractors found significant overpayments. However, Medicare contractors are not routinely instructed nor paid by HCFA to conduct this resource intensive type of review.

Medicare Contractor Compliance Efforts

Finally, allow me to address the serious compliance issues that were raised in the Subcommittee's July 14th hearing. The Blue Cross and Blue Shield Association deeply regrets any cloud over our Member Plans' role in the Medicare program due to actual or alleged misconduct of employees of certain Plans. For more than 30

years, the Blues have been committed to providing high-quality, cost-effective customer service to Medicare beneficiaries, providers, and our partners in the federal government. We are saddened that, in the eyes of some, the developments described in GAO's report may tarnish our long-standing track record as Medicare contractors.

Since the inception of Medicare, the Blues have been the undisputed leaders in private sector Medicare administration. Furthermore, Blue companies perform this public service at cost; they do not generate a profit on their Medicare claims processing work. Many health insurers believe that the legal risks and financial liabilities associated with being a Medicare fee-for-service contractor far outweigh the rewards or benefits. But many Blue companies remain committed to helping HCFA deliver timely, cost-effective services to beneficiaries who need them. Blue Plans also are committed to proactively rooting out provider fraud and abuse.

Medicare contractors collectively process more than 900 million claims involving more than $200 billion annually. The overwhelming majority of these transactions are handled without any adverse incident. In fact, HCFA has accepted and reimbursed more than 99 percent of the Medicare administrative costs submitted by Blue Plans over the life of the program.

With this said, all Blue Plans have, as part of the BCBSA licensing requirements, a code of conduct for all employees. In addition, all Blue Plans are committed to having a compliance plan and have taken significant actions to enhance their compliance plans and management controls to ensure that problems in the past do not occur in the future. Examples of Plan efforts include: appointing a compliance officer to oversee compliance efforts; routine training for employees on compliance; implementing an internal compliance committee; and implementing a 24-hour compliance hotline where employees can report concerns. Plans also use innovative ways to update compliance awareness in the organization. One Plan distributes a compliance question to all employees once a week. Employees must answer a certain number during the year. Answers are then announced and discussed. It keeps everyone thinking about compliance all the time. The same Plan requires managers to talk to their staff monthly about compliance and makes random phone calls to employees to see if managers are in fact discussing compliance issues with them.

In addition to the activities Blue Plans take to promote compliance and ethics within their own company operations, Blue Medicare contractors each year certify their compliance with Medicare rules and regulations using the Medicare Management and Operations Review Program (MMORP). The MMORP was created in 1995 by BCBSA and is a comprehensive audit program developed to verify the accuracy and completeness of Plan data. It is a national compendium of the 25,000 pages of laws, regulations, general instructions, and contract requirements that Medicare contractors must meet condensed into one manual, including step-by-step tests to help plans ensure the accuracy of their data. Blue Plans use the MMORP as a management tool to assist them with compliance with their Medicare contracts. Blue Plans provide BCBSA with suggestions about new enhancements to the MMORP; each year, we update and expand the manual to provide new, detailed information at the request of our member companies.

Along with using the MMORP, Blue Cross and Blue Shield Plans take part in numerous compliance training programs and examinations offered by BCBSA. BCBSA holds an annual conference for Plan compliance officers, legal staff, and other Plan staff that provides the most up-to-date information on compliance and ethics issues in health care and government programs. A forum is provided at the conference where Plans can share best practices of their own compliance and ethics programs. Following the successful completion of an examination, participants in each conference receive a certification of their compliance and ethics training.

BCBSA also provides different levels of compliance training programs to Plans. BCBSA supplies video presentations, case studies, and extensive discussion materials to Plans to inform them of compliance and ethics issues affecting their organization's operations. These training materials review such issues as conducting risk assessments, creating effective internal controls, and developing a conflict of interest avoidance plan. Plans can use these tools to conduct their own internal training or Plans can request that BCBSA staff run a training session for them. More advanced training is also available for Plan senior staff involved in compliance and ethics activities. BCBSA staff is also available to answer questions about compliance or help Plans with modifications to their compliance plans. Finally, BCBSA also makes compliance and ethics information available to Plans on the Association's Intranet.

CONCLUSION

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We believe more can and should be done to improve contrac-

tor's and HCFA's ability to safeguard the Medicare Trust Funds. Thus, we support exploring reform proposals that would allow contractors to compete on a level playing field, contract competitively as typical FAR-based government contractors, and contract on other than a pure cost reimbursement basis.

Success in Medicare claims administration requires that HCFA and the contractors work together toward their mutual goal of accurate and timely claims payment. Fragmenting contracts, as HCFA has proposed, would take us in the wrong direction. The true path to strengthening Medicare administration lies in raising performance standards, aggressively enforcing them, and terminating the contracts of underperformers. To get there, Medicare contractors will need (1) adequate and stable funding levels; (2) clear and consistent guidance; and (3) specific performance expectations.

We look forward to working with this Subcommittee and HCFA to make these needed improvements.

Mr. UPTON. We appreciate your testimony and again, like the others, appreciate your ability to get it up to us in advance in compliance with committee rules. I do have a couple of questions, and this has come out in a couple of the panels we've had now today, and that is the inadequate budget for enforcement. I realize, I guess in the plan they're supposed to do regular audits and I don't know if regular means once a year or once every 3 years. Someone earlier today testified that there had actually been cuts in HCFA's budget for administration. In earlier years I think though, from 1995 to 1996, it did go up but it's one of the things I know Dr. Ganske touched on, and I want to follow up with HCFA folks as well in terms of what has been the level of funding for the fraud and abuse arm of HCFA in their role and as we deal with their budget in the next couple of weeks. We want to work with the appropriators to make sure in fact their level of funding is adequate for fiscal year 2000. But are you—when you talk about codes of conduct and other very good practices that have been put into place by your subsidiaries across the country, you did mention that there was an egregious conduct of HCFA that was dropped. Tell me a little bit more about that. What was it that they did?

Mr. CAIN. Sure. First, a slight correction on some of what you just said. The association doesn't have subsidiaries. All the Blue plans are independent——

Mr. UPTON. Family members.

Mr. CAIN. [continuing] companies. Careful with it. What was the egregious action? Actually I believe it came out of a provision that was in a law that passed the Congress in about 1984 or 1985. It said that all the contractors would be annually ranked according to their CPEP scores. And the contractors whose scores were in the bottom 20 percent, no matter what their score was, if it was in the bottom 20 percent, the contractor was subject to immediate termination. Now, we had examples of contractors scoring 95 out of a hundred two consecutive years and being in the bottom 20 percent, which—I mean, this is an A student whose jobs are all at risk. It just didn't make any sense at all and I understand had only lasted for about 4 or 5 years. That is no longer in place. But I can tell you it scared the contractors to death.

Mr. UPTON. What else would you say we ought to do? We heard from the earlier panels about annual audits or full audits, certainly within 3 years. What else in addition to beefing up the fraud and abuse arm of HCFA with more administrative staff to try and walk

people through the right lanes? Do you have other suggestions in terms of what we might be able to do in terms of legislation?

Mr. CAIN. Well, again, it goes down two lines. If you keep the current structure of the whole program, then you really need to spend a lot more money on administration. Earlier today Mr. Klink a couple of times referred to the $1.6 billion spent on Medicare contractors, and he made it very clear that's a huge amount of money and it is. What is the total program? It's over $200 billion which means essentially something under 2 percent of the program is going to administration. Now, there isn't a private insurance program in the world which would be anywhere close to only spending 2 percent on trying to administer an effective program.

Mr. UPTON. In the earlier panel, four States indicated that none of the people involved in the malfeasance criminal acts were with the company anymore. Do you know where those—do you all track those people in terms of where they might have gone? Do you have some way to verify they didn't go from New Mexico to Arizona or Michigan or California? Do you have any idea?

Mr. CAIN. I haven't. I haven't a clue as to where they are. I can tell you——

Mr. UPTON. Can you tell us they don't work for Blue Cross/Blue Shield anywhere?

Mr. CAIN. No, I can't, but I would assume that's the case because the plan's hiring practices always requires investigating where did the person come from. So if nobody showed up at Blue Cross of Arizona having just departed from Colorado, Arizona is going to call up and find out what happened. So it's very improbable. It could happen, but it's improbable.

Mr. UPTON. Again, we appreciate your testimony and I would also like to put the same offer for all members of both the minority and majority to put their questions in writing if that is necessary and if you could respond in a timely manner, that would be appropriate. I ask unanimous consent—since nobody is here to object, it's not a problem—Pete Starks' testimony be made a part of the record as well. So without objection, it will be.

And you are excused. Thank you very much.

[Whereupon, at 2 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HON. FORTNEY PETE STARK, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Mr. Chairman: Thank you for holding this hearing today on the fight against Medicare fraud. It has been an uphill battle. But I believe there is substantial evidence that we have begun to make progress.

First, the Congressional Budget Office's July *Economic and Budget Outlook* concludes that Medicare outlays in 1999 are down by $1 billion from last year, due in large measure to stepped up efforts by the federal government to crack down on fraud and abuse. Like many other members, I hope and expect that the Medicare Integrity Program will scrutinize claims and billings by providers much more closely and carefully than Medicare's current contractors have done.

It is also good news for the government that many providers are showing signs of billing more cautiously. For example, the Health Care Financing Administration's chief actuary recently reported that for the first time ever, the hospital case-mix index went down by half a percentage point last year. There was a big shift away from DRGs with complications to those without complications. Similarly, there has been a big shift away from DRGs for respiratory conditions, to the much less expensive pneumonia DRGs. It is noteworthy that the Department of Justice investigated those two types of DRGs last year. This suggests that unlike the Inspector in *Casa-*

blanca, we should not be "shocked." When we have enough resources to monitor providers, the level of fraud, waste, and abuse declines. It is that simple.

Second, the HHS Inspector General's annual audit of the Health Care Financing Administration's payment error rate found that in 1998, improper payments were roughly half what they had been just two years before.

That's good news, but we must do better. By the IG's account, HCFA paid out almost $13 billion that it shouldn't have, and a substantial portion of those improper payments are likely due to fraud, waste and abuse.

If we are not vigilant, Medicare's recent record of success in combating fraud could easily be derailed. It was only last year that providers launched a full-frontal assault on the False Claims Act, the government's primary civil statute for fighting not only health care fraud, but defense fraud, and all other contractor fraud. Fortunately, with the help of Chairman Bliley, Congressman Barton, Sen. Grassley and others, those efforts were turned back.

If legislation gutting the False Claims Act had been enacted last year, the General Accounting Office's testimony on Medicare contractor fraud that was given at this subcommittee's oversight hearing on July 14 would have been far more troubling. Without the False Claims Act, there would have been no effective way to halt and penalize contractor fraud in New Mexico and Colorado, which resulted in guilty pleas on two felony counts this summer by two Blue Cross & Blue Shield companies. Criminal fines in the case are $1.5 million, and the civil settlement under the False Claims Act has been set at $12 million.

Reducing waste, fraud and abuse perpetrated by individual providers is just as critical to keeping Medicare whole. That's why efforts to gut the physician self-referral should be summarily rejected.

The law is designed to prevent doctors from ripping off fee-for-service Medicare by entering into referral-for-profit ownership and compensation schemes. We learned a long time ago that when physicians enter into compensation arrangements in which they receive free rent, discounts, large consulting fees, and other goodies in exchange for referring their patients to a particular facility, these doctors order many more services—at the taxpayer's and the patient's expense. Before the law was enacted, seniors were being steered to facilities in which their doctor had a financial interest, where they were given unnecessary services.

Critics of the self-referral law charge that it is too complex. In some respects, I would agree. That's why I have introduced the Medicare Physician Self-Referral Improvement Act of 1999. In contrast to a counterproposal that would wipe out the federal government's ability to set any parameters for physician compensation relationships, H.R. 2650 would make certain streamlining and clarifying changes. These changes would benefit honest doctors by adding flexibility to the law. I invite members of this committee to examine the bill I have introduced, a summary of which is attached, and to forward any comments you have to my staff or myself.

It is simply wrong and hypocritical for the American Medical Association and other provider groups to come up here and tell members that the self-referral law is not working. It is working so well, in fact, that Columbia-HCA, a hospital chain I have long criticized, today has in place a comprehensive system that scrubs all arrangements with physicians *before* any contract is signed.

One final point: The anti-kickback law is no substitute for the self-referral statute. As a criminal statute with an intent standard, it is applied retrospectively and is not effective at stopping the formation of sham arrangements in the first instance. Moreover, in some circuits, the anti-kickback law's intent standard requirement is impossible to meet.

Recently, a federal judge in Kansas City overturned a conviction of one hospital executive in a closely followed case, *U.S. v. Anderson,* on the grounds that the evidence for the jury's conviction did not hold up "on the element of intent."

Mr. Chairman, not only must we keep current laws intact and strong, we must take additional steps to pursue health care fraud. Following are several recommendations that I hope will be considered.

Medicare's accreditation process needs reform: A recent series of reports by the HHS Inspector General makes it clear that we must take steps to make the Joint Commission on Accreditation of Health Care Organizations more accountable. In brief, the IG found JCAHO's reviews have become far too "collegial," or soft. I believe JCAHO needs to be far tougher, and that the organization itself should be subject to federal review. As a start in that direction, I have introduced legislation, H.R. 2174, that would require a simple majority of the governing board of all accrediting organizations to be individuals who do not have a financial stake in the organization or any of the facilities it accredits. I will be proposing other reforms soon.

Far too many of our nation's long-term care facilities are delivering poor care. I commend the Commerce Committee for its fine work on the Nursing Home

Research Protection Amendments of 1999. And I commend Sen. Grassley and the Senate Aging Committee for conducting a series of hearings on the abysmal quality of care in some facilities, and on the lack of oversight generally of our nation's nursing homes. I was among the group of members in 1997 who commissioned GAO's report on California's nursing homes, which produced a long list of recommendations for various reforms.

Some of those are included in omnibus long-term care legislation (H.R. 2691) that I introduced last month with Rep. Ed Markey and Jim McGovern. The bill calls for nursing homes to **disclose the ratio of licensed and unlicensed staff to residents.** Another allows states to assess a fee on facilities that are substantially out of compliance to cover the costs of re-inspections. This way, facilities will have greater incentive to correct problems more quickly than they do today.

In addition, I hope the subcommittee will consider legislation I introduced this summer with Sen. Herb Kohl (H.R. 2627). It requires all long-term care facilities to conduct **criminal background checks on applicants.** And it establishes a national abuse registry that builds on existing state registries to screen out prospective workers who have a history of patient abuse.

Other reforms that could be considered are **beefing up Medicare survey and certification funding** for home health agencies and other providers. That will take money, and I strongly recommend that members of this subcommittee and others with jurisdiction over HCFA reject proposals to sharply cut the agency's funding. The true test of whether Congress is willing to continue to fight Medicare fraud and waste will be evident in how much we fund HCFA's administrative budget for FY 2000. I have testified before Chairman Porter's subcommittee on the urgent need to boost the agency's administrative funding from current levels, and I hope that you will join me in support of those efforts. I must ask, what good is an entitlement if no one is there to administer it?

I also urge this Congress to take steps to tighten parameters for providers to participate in Medicare's **partial hospitalization** program (H.R. 1543), which this subcommittee has held hearings on already. And while it is good news that voluntary compliance plans are slowly becoming more common among sectors in the health care industry, I believe that Congress should take steps to require that by date certain, all providers, large and small, have working compliance plans in place as a condition of participation in Medicare.

Finally, we are being lobbied by many to undo parts of the BBA which did so much to fight fraud:

—We must resist efforts to undo consolidated billing for skilled nursing facilities. If we give in and unbundle services, nursing home patients will again be flooded with supplies and equipment and SNFs will have less incentive to manage costs.

—We must also resist efforts to block competitive bidding for durable medical equipment and Medicare HMOs. We are being lobbied to block those programs because competitive bidding does result in savings to the taxpayer. The data out of Florida are exciting: equipment we have been told for years could not possibly be delivered for a penny less will be offered for as much as 31% less.

—We must continue HCFA's program of expanding the number of DRGs that are covered under the BBA's discharge and transfer rule (H.R. 1936). The data are clear that hospitals have been discharging patients quicker than average, usually to downstream facilities they own, where the patient stays longer and total costs to Medicare are often increased.

—We should resist the mis-statements of the managed care industry that they aren't being paid enough. The fact is that the HMO program costs Medicare and the 83% of seniors who are not in managed care more than if the enrollees had stayed in fee-for-service Medicare. Cries for a delay in risk adjustment are really statements that "we've enrolled healthier-than-average people, but please look the other way and keep paying us more than you should."

—We need to pass legislation such as H.R. 2559 of the 105th Congress, which bans the proliferation of hospitals now buying doctors' practices and calling them hospital outpatient departments. That is simply a way to increase charges on patients and Medicare.

—We should pass H.R. 2229, the President's package of anti-fraud initiatives. In particular, paying pharmaceuticals at 95% of the Average Wholesale Price is an insulting joke on the American taxpayer. The AWP system is basically an organized conspiracy to rip off taxpayers and patients. We should move to Actual Acquisition Cost plus an administrative fee.

We've come a long way in the last decade. But we still have a long way to go—and we should not retreat.

Congressman Pete Stark's Statement

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THE MEDICARE PHYSICIAN SELF-REFERRAL IMPROVEMENT ACT
Introduced by Rep. Pete Stark (D-CA)
July 29, 1999

BILL SUMMARY

The Medicare Physician Self-Referral Improvement Act of 1999 introduced by Rep. Stark refines the self-referral laws in a number of ways. Below is a summary of the bill that highlights major provisions in current law and major changes that this legislation makes to those provisions.

- Current law bans compensation between doctors and providers in certain designated health services areas. It is designed to provide a "bright line" in the law and to avoid requiring the government to investigate difficult "kickback" cases. The current law includes many complex exceptions to the total ban.

  The Medicare Physician Self-Referral Improvement Act of 1999 would replace most of the compensation exceptions with a single "Fair Market Value" test. It would maintain the exceptions to the ban for physician recruitment and de minimis gifts. Under the fair market value test, an agreement must be in writing, for a definite period of time, and not be dependent on the volume or value of referrals. The compensation in the contract must be a reasonable "fair market" rate.

- Current law requires "direct supervision" by referring physicians of those providing designated health services to qualify for the in-office ancillary service exception.

  The Medicare Physician Self-Referral Improvement Act of 1999 would require general supervision which is a less stringent standard than current law, but it would require that generally the physician be on the premises.

- Current law provides a general managed care exemption.

  The Medicare Physician Self-Referral Improvement Act of 1999 would clarify that the managed care exemption extends to Medicaid managed care plans and Medicare+Choice organizations.

- Current law provides an exception from the law in instances where no alternative provider is available.

  The Medicare Physician Self-Referral Improvement Act of 1999 would change that exception so that the Secretary of Health and Human Services would determine whether an area is underserved and therefore needed such an exception.

- Current law requires reporting of provider financial relationships and those of their immediate families, and institutes civil monetary penalties for failure to comply with such reporting requirements.

  The Medicare Physician Self-Referral Improvement Act of 1999 would repeal that reporting requirement and replace it with a requirement that physicians have records available for audit purposes. It would also abolish the civil monetary penalties that go along with the current financial relationship reporting requirement.

- Current law provides a list of designated health services that are covered by the self-referral ban.

  The Medicare Physician Self-Referral Improvement Act of 1999 would remove eyeglasses and lenses from the list and would clarify that the law does not cover ambulatory surgical centers or hospices.

- Current law requires HCFA to provide advisory opinions upon request, but has no deadline for their completion.

  The Medicare Physician Self-Referral Improvement Act of 1999 would require that advisory opinions be answered by HCFA within 60 days.

- Current law forbids providers from providing DME and parenteral and enteral nutrients as part of the in-office ancillary exception.

  The Medicare Physician Self-Referral Improvement Act of 1999 would eliminate the ban.