

**RESULTS OF THE HEALTH CARE FINANCING AD-
MINISTRATION'S FISCAL YEAR 1999 FINANCIAL
STATEMENTS AUDIT**

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY

OF THE

**COMMITTEE ON
GOVERNMENT REFORM**

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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RESULTS OF THE HEALTH CARE FINANCING ADMINISTRATION'S FISCAL YEAR 1999 FI- NANCIAL STATEMENTS AUDIT

WEDNESDAY, MARCH 15, 2000

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

The subcommittee met, pursuant to notice, at 10:02 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

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

Staff present: J. Russell George, staff director and chief counsel; Bonnie Heald, director of communications; Bryan Sisk, clerk; Ryan McKee, staff assistant; Louise DiBenedetto, GAO Detailee; Trey Henderson, minority counsel; and Jean Gosa, minority clerk.

Mr. HORN. The Subcommittee on Government Management, Information, and Technology will come to order.

Today's hearing is the third in a series of hearings to examine the results of financial statement audits of selected Federal agencies. Today we'll focus on the Health Care Financing Administration. This agency, which administers the Medicare and Medicaid programs, helps pay the medical bills for millions of Americans, from the youngest and the sickest to the oldest and most vulnerable.

In 1999, the cost of these two programs exceeded \$300 billion. Last week, the Health Care Financing Administration released the results of its fiscal year 1999 financial audit. The Inspector General of the Department of Health and Human Services reported that, as of September 30, 1999, the Health Care Financing Administration's financial statements fairly presented the agency's financial position in all material respects. In accounting terms, that is often called a "clean audit opinion."

I commend the Health Care Financing Administration for achieving that goal; however, we need to sweep through some of the smoke and mirrors that cloud the agency's overall financial condition. Because of those longstanding financial problems, the reported financial information was technically reliable for only 1 day—Thursday, September 30, 1999.

The Medicare program continues to be vulnerable to fraud, waste, and abuse, partly because of the program's lack of oversight on a regular basis. For fiscal year 1999, the Health Care Financing

Administration reported an estimated \$13.5 billion in improper payments. Last Wednesday, the "Washington Post" reported that the Connecticut General Life Insurance Co., a contractor responsible for processing Medicare claims, agreed to pay about \$9 million to settle allegations it had overcharged Medicare for its expenses.

Yesterday, the "Washington Post" reported that the Department of Justice is seeking triple damages of \$1 billion from Vencor, one of the Nation's largest nursing home companies, saying it had defrauded the Federal Government's health insurance programs.

On another page of the same newspaper, reporter Steve Barr wrote, "The patients died, but the bills kept coming, and the Federal Government kept paying." In 1997, the Medicare program paid an estimated \$20.6 million for health care services to people who were dead.

In a renewed effort to reduce waste and fraud, the administrator of the Health Care Financing Administration said that she plans to increase the agency's oversight of the 56 insurance companies that process Medicare claims on behalf of the agency.

These recent examples of fraud demonstrated the great need for vigilant oversight. We must ensure the fiscal integrity of this program, and I welcome our witnesses, who will give us a very close examination of what they have done already in their role as the General Accounting Office, as the Inspector General of Health and Human Services, and as the agency itself.

We will start with panel one. If you will stand and raise your hands, we will swear you in.

[Witnesses sworn.]

Mr. HORN. We had five at the witness table and three at backups, the clerk will note.

We'll just simply begin as the witness list is. We'll start with the Honorable June Gibbs Brown, Inspector General, Department of Health and Human Services. She's accompanied by Mr. Joseph Vengrin, Assistant Inspector General for audit operations and financial statement activities.

Ms. Gloria L. Jarmon will be the next witness, and that's coming after Ms. Brown. We'll introduce her then, along with Mr. Hash, who will be accompanied by Ms. Snyder.

There's a statement from Mrs. Biggert.

Mrs. BIGGERT. Thank you, Mr. Chairman.

I think all of us here today understand what the Medicare and Medicaid programs mean to this country. For many Americans, particularly the elderly and the poor, these programs are the only thing that stand between them and disaster.

As Members of Congress, we have a fiduciary responsibility to ensure that these programs remain solid and dependable for this generation as well as the next.

As the agency with oversight over these programs, HCFA has an equally critical role to play; yet, as we'll hear today, I believe HCFA's management practices unnecessarily and sometimes unwittingly put these programs in jeopardy, and I don't think I'm the only one who thinks so.

For the last several years, the General Accounting Office has categorized programs run by HCFA as high risk for waste, fraud, and abuse.

Among other things, the GAO has been unable to estimate the national error rate for fee-for-service payments, which has resulted in billions lost annually in improper payments; has found that HCFA has been slow to deploy tools given to it by Congress to correct these problems; and GAO has found that HCFA has material weaknesses relating to the management of Medicare accounts receivables, financial reporting, and computer security.

I am aware of and commend the steps taken by HCFA to address its management problems. In fact, as we will hear, estimated improper Medicare payments for this past fiscal year were \$13.5 billion, down from about \$20 billion reported in fiscal year 1997, and \$23.2 billion for fiscal year 1996.

Despite this progress, \$13.5 billion of waste, fraud, and abuse is still too much, particularly given the poor financial condition the Medicare program finds itself in right now. This wasted money could have been better put to use shoring up the solvency of the program or as a down payment on a Medicare prescription drug benefit.

Today's hearing presents this subcommittee with an opportunity to review HCFA's financial management practices.

I trust that our expert panel of witnesses will help us work our way through the questions. Their expertise in the field of government management will be useful as we explore ways to rid our government of waste, fraud, and abuse. I look forward to hearing their thoughts on where HCFA is headed as an agency.

Again, Mr. Chairman, I thank you for calling this important oversight hearing.

Mr. HORN. Well, I thank the vice chair.

I would like to ask if the gentleman from Texas, the ranking member, would like to have an opening statement.

Mr. TURNER. Mr. Chairman, I think I will forego my opening statement and file it for the record so we can proceed with the hearing.

Mr. HORN. It will be put on the record between my opening statement and Mrs. Biggert's as if read.

Thank you.

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

Opening Statement of The Honorable Jim Turner
GMIT: "Results of the Health Care Financing Administration's Fiscal Year
1999 Financial Statements Audit"
March 15, 2000

This is the second in a series of oversight hearings on federal financial management. To date, we have reviewed the financial management practices of the Internal Revenue Service and today we will turn our attention to the Health Care Financing Administration (HCFA). Taxpayers deserve an accurate look at an agency's books and deserve to know how their tax dollars are being spent. Congress recognized, as early as 1990 with the passage of the Chief Financial Officers Act, that the federal government should maintain reliable financial information that can be audited. The Government Management Reform Act of 1994 required all 24 major agencies to conduct independent financial audits beginning in Fiscal Year 1996. Today, we have the opportunity to discuss some of the tangible results of this process with the fourth, consecutive audit of HCFA's financial statements.

In the first HCFA audit (for fiscal year 1996), the IG found that HCFA's financial information was so unreliable that the IG could not finish the audit nor draw any conclusions about the agency's financial statements. In the audits conducted over the last two years, HCFA received a "qualified" opinion, which means that while the financial statements were generally reliable, inadequate documentation existed for certain amounts. However, for Fiscal Year 1999, I am pleased to announce that for the first time, independent auditors have issued a clean opinion of the financial statements of the HCFA programs. This fourth

comprehensive audit showed the HCFA has made substantial progress in presenting reliable financial data on Medicare and the private insurance companies that, by law, process Medicare claims.

Over the past years, HCFA has also demonstrated a significant reduction in the total amount of estimated Medicare overpayments. In fact, HCFA has reduced the error rate by 50% and has been actively trying to reduce the amount of improper or inappropriate payments made by the Medicare program. The results of these efforts are beginning to show, and HCFA must continue to reduce these overpayments as aggressively as possible. Despite the improvements, auditors continue to raise several serious concerns, including a report that HCFA still has material internal control weaknesses which will hamper its ability to safeguard the fiscal integrity of the Medicare and Medicaid programs. The Subcommittee will explore what HCFA is doing to resolve its long-standing financial management problems, including its lack of adequate financial management problems, including its lack of adequate financial management over Medicare contractors.

Millions of Americans depend on HCFA administered programs to receive adequate medical care. Therefore, it is imperative that we ensure that these programs are running correctly and efficiently. In closing, I would like to commend HCFA for the significant progress it has made in the area of financial accountability. I commend the Chairman for his focus on this issue and welcome the witnesses here this morning. I am hopeful that the results of this audit will further improve HCFA's management and better protect the financial integrity of the Medicare program.

Mr. HORN. We will now proceed with Ms. Brown, the Inspector General.

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

Ms. BROWN. Thank you, Mr. Chairman.

I'm pleased to report to you, as you've all mentioned, that the Health Care Financing Administration [HCFA], has made great progress in reducing Medicare payment errors, and also in presenting reliable financial information.

I'd like to begin by acknowledging cooperation and support received from the Department, HCFA, and the General Accounting Office. HCFA's assistance in making available medical review staff at the Medicare contractors and peer review organizations was invaluable. Also, we worked closely with GAO in carrying out its responsibility for auditing the consolidated financial statements of the Federal Government.

My statement today will focus first on our review of Medicare payment errors, which we conducted at HCFA's request, and then on the fiscal year 1999 financial statement.

Our review included a statistical sample of 5,223 Medicare claims from the population of \$169.5 billion in fiscal year 1999 fee-for-service claim expenditures. Payments to providers for 1,034 of these claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that the fiscal year 1999 net payment errors totaled about \$13.5 billion nationwide, or about 9.97 percent of Medicare fee-for-service benefit payments.

This is the mid-point of the estimated range at the 95 percent confidence level. The range is \$9.1 billion to \$17.9 billion, or about 5.4 to 10.6 percent.

I mention those details because the sampling is not statistically significantly changed from what it was last year, because we work with these ranges.

As in past years, improper payments could range from inadvertent mistakes to outright fraud and abuse.

It should be noticed that medical personnel detected almost all of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

Mr. Chairman, our 4-year analysis substantiates HCFA's continued vigilance in monitoring and reducing payment errors. This year's \$13.5 billion estimate is, in fact, \$9.7 billion less than that for fiscal year 1996.

In addition, our audit results clearly show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and sufficiently supported.

For both fiscal years 1998 and 1999, we estimated that over 90 percent of the fee-for-service payments met Medicare reimbursement requirements; however, our analysis also demonstrates that unsupported and medically unnecessary services remained perva-

sive problems. These types of errors accounted for more than 70 percent of the total improper payments over the 4-years.

Our chart, which is also attached to the written testimony, demonstrates the trends in improper payments by the major types of errors we have found. The chart is on the board there. The red area indicates unsupported services where we saw a substantial increase. The blue indicates medically unnecessary services, a continuing problem. The green indicates incorrect coding. Finally, the yellow shows uncovered services and miscellaneous errors.

I'd like to talk a little bit about these error categories. Unsupported services represents the largest error category every year except in 1998, when they dropped dramatically. Although these errors increased by \$3.4 billion over last year's estimate, they remained below the levels found in fiscal years 1996 and 1997.

Unsupported services were largely attributed to three provider groups this year—home health agencies were \$1.7 billion; durable medical equipment, or DME suppliers, \$1.6 billion; and physicians, \$1.1 billion.

Medicare regulations specifically require providers to maintain records that contain sufficient support to justify the diagnosis, admissions, and other services.

As the second-largest error category this year, medically unnecessary services totaled \$4.4 billion. For these errors, medical reviewers found enough documentation in the medical records to make an informed decision that the services were not medically necessary. These types of errors in inpatient prospective payment system, or PPS hospital claims, were significant in all 4 years.

Incorrect coding was the third-largest coding category. Physician and inpatient PPS claims accounted for 90 percent of the coding errors over the 4-years.

For most of these errors, medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code.

Now, turning to our audit of the financial statements for fiscal year 1999, we are pleased to issue the first unqualified or clean audit opinion, both for HHS and for HCFA.

In achieving this important milestone, HCFA has successfully resolved billions of dollars in problems that affected our previous audit opinions. In particular, problems in Medicare accounts receivable, which are debts that the providers owe to HCFA, have been systemic and longstanding.

This year, HCFA embarked on an extensive effort to validate and document receivables, with the assistance of my office and two independent accounting firms. The validation effort, together with HCFA's aggressive action to require that contractors maintain support for this debt, enabled us to conclude that the receivables balance was fairly presented and sufficiently documented for the first time in 4 years.

However, the underlying internal control environment and accounting systems at the Medicare contractors still need substantial improvement. Even such things as a basic double entry book-keeping system are needed, and adequate checks and balances to promptly detect errors and irregularities.

The control weaknesses impair HCFA's ability to reliably report activity related to Medicare debt and increase the risk that future debt may not be collected timely.

Our report also discusses our concern that HCFA has not yet established adequate financial controls, such as routine accounting analysis to detect accounting aberrations or sufficient controls over Medicare electronic data processing systems.

To briefly summarize, Mr. Chairman, we're encouraged by HCFA's sustained success in reducing Medicare payment errors and by the important progress made in resolving prior years' financial reporting problems.

We remain concerned, however, that inadequate internal controls or accounts receivable leave the Medicare program vulnerable to potential loss or misstatement.

As HCFA begins the lengthy process to integrate its accounting system with the Medicare contractor systems, internal controls must be strengthened to ensure that this debt is accurately recorded and an adequate debt collection process is in place.

With the year 2000 remediation challenge successfully completed, we urge HCFA to focus these critical internal controls, while continuing its effort to reduce payment errors and ensure provider integrity.

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

Mr. HORN. Thank you very much for your very full statement.
[The prepared statement of Ms. Brown follows:]



HCFA: FY 1999
Health Care Financing Administration
Financial Statement Audit

Testimony of
June Gibbs Brown
Inspector General
U.S. Department of Health and Human Services

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

March 15, 2000



Office of Inspector General
Department of Health and Human Services

**June Gibbs Brown
Inspector General**

Department of Health and Human Services

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities. I am pleased to report to you on the Health Care Financing Administration's (HCFA) progress in reducing Medicare payment errors and in presenting reliable financial information.

My statement today will focus first on our audit of Fiscal Year (FY) 1999 Medicare fee-for-service payments. This was our fourth annual estimate of the extent of fee-for-service payments that did not comply with laws and regulations. As part of our analysis, we profiled all 4 years' results and identified specific trends, where appropriate, by the major types of errors found and the types of health care providers whose claims were erroneous. Then I will briefly describe the significant findings of our audit of HCFA's FY 1999 financial statements, which is required by the Government Management Reform Act of 1994. The purpose of financial statements is to accurately portray agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the statements.

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

MEDICARE PAYMENT ERRORS

Overview

With expenditures of approximately \$316 billion, assets of \$212 billion, and liabilities of \$39 billion, HCFA is the largest component of the Department. The HCFA is also the largest single purchaser of health care in the world. In 1999, Medicare and Medicaid outlays represented 33.7 cents of every dollar of health care spent in the United States. In view of Medicare's 39.5 million beneficiaries, 870 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the program is inherently at high risk for payment errors.

Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, regulations specifically require providers to retain supporting documentation and to make it available upon request.

As part of our first audit of the HCFA financial statements for FY 1996, we began reviewing claim expenditures and supporting medical records. At HCFA's request, we have continued these reviews because of the high risk of Medicare payment errors and the huge dollar impact on the financial statements (\$169.5 billion in FY 1999 fee-for-service claims).

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

Sampling Methodology

To accomplish our objective, we used a multistage, stratified sample design. The first stage consisted of a selection of 12 contractor quarters for FY 1999. The selection of the contractor quarters was based on probabilities proportional to the FY 1998 fee-for-service benefit payments. The second stage consisted of a stratified, random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,223 claims valued at \$5.4 million for review.

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

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

Sample Results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,223 fee-for-service claims processed for payment during FY 1999, we found that 1,034 claims did not comply with Medicare laws and regulations. **By projecting these sample results, we estimated that FY 1999 net payment errors totaled about \$13.5 billion nationwide, or about 7.97 percent of total Medicare fee-for-service benefit payments.** This is the mid-point of the estimated range, at the 95 percent confidence level, of \$9.1 billion to \$17.9 billion, or 5.4 percent to

10.6 percent, respectively. As in past years, the payment errors could range from inadvertent mistakes to outright fraud and abuse, such as phony records or kickbacks. We cannot quantify what portion of the error rate is attributable to fraud.

Medical professionals detected 92 percent of the improper payments. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found.

Historical Analysis of Error Rates

Our analysis of payment errors from FY 1996 through FY 1999 demonstrates HCFA's continued vigilance in monitoring and reducing payment errors. This year's \$13.5 billion estimate is, in fact, \$9.7 billion less than the FY 1996 estimate. In addition, our audit results clearly show that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and sufficiently supported. For both FYs 1998 and 1999, we estimated that over 90 percent of fee-for-service payments contained no errors. This is a very positive reflection on the diligence of the health care provider community to comply with Medicare reimbursement requirements. However, our analysis shows that unsupported and medically unnecessary services continue to be pervasive problems. These two error categories accounted for more than 70 percent of the total improper payments over the 4 years.

The attached chart presents an historical analysis of improper payments by major error categories: (1) unsupported services, (2) medically unnecessary services, (3) incorrect coding, and (4) noncovered services and miscellaneous errors.

Unsupported Services

Unsupported services represented the largest error category every year except FY 1998, when they dropped dramatically. This year we saw a \$3.4 billion increase over last year's estimate; however, these errors remained below the levels found in FYs 1996 and 1997.

Medicare regulation, 42 CFR 482.24(c) specifically requires providers to maintain records that contain sufficient support to justify diagnoses, admissions, treatments performed, and continued care. When the records were insufficient or missing, medical reviewers could not determine whether services billed were actually provided to Medicare beneficiaries, the extent of the services, or their medical necessity. It should be noted that HCFA upheld 99 percent of the overpayments identified in the FY 1998 sample and recovered about 87 percent; the remaining 13 percent has not been collected due to an ongoing investigation.

This year's estimated \$5.5 billion in unsupported services consisted of \$4.5 billion in claims for which medical review staff found that the documentation was insufficient to support the billed services and \$1 billion in claims for which no documentation was provided. These errors were

largely attributable to three provider groups: home health agencies (\$1.7 billion), durable medical equipment (DME) suppliers (\$1.6 billion), and physicians (\$1.1 billion).

Some examples of unsupported services follow:

- A **home health agency** was paid \$84 for a psychiatric nurse visit to a patient. While documentation evidenced that the visit had been made, neither the patient's plan of care nor the doctor's orders authorized the home health agency to provide the psychiatric nursing care. As a result, medical reviewers denied the payment.
- A **DME supplier** was paid \$815 for an enteral feeding supply kit, a gastrostomy tube, and 380 units of enteral formula. Medical review staff concluded that the supplier's documentation was not sufficient to support the claim because the records did not include physician progress notes, laboratory values, radiological studies ordered, or weight charts. In addition, because the delivery ticket did not provide individual beneficiary information, medical reviewers were unable to determine what products were delivered and to whom. As a result, the total payment was denied.
- A **physician** was paid \$28 for a hospital visit. However, medical reviewers found a note in the medical records which stated, "Pt [patient] not in room." Because a patient encounter could not be verified and no other documentation substantiated the visit, the payment was denied.

Medically Unnecessary Services

Medically unnecessary services constituted a significant part of the historical error rate: 37 percent of the improper payments in both FYs 1996 and 1997, 56 percent in FY 1998, and 32 percent in FY 1999. For these errors, medical reviewers found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. **As in past years, Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the claims.

These types of errors in inpatient prospective payment system (PPS) claims were significant in all 4 years (FY 1996 - 39 percent of the total \$8.5 billion; FY 1997 - 31 percent of the total \$7.5 billion; FY 1998 - 40 percent of the total \$7 billion; and FY 1999 - 45 percent of the total \$4.4 billion). For example:

- A **PPS hospital** was paid \$3,883 to treat an inpatient with an episode of hypoglycemia. According to medical reviewers, the patient's condition and the treatment given did not require admission to the acute level of care, and the patient could have been safely evaluated and treated at a less acute level. Therefore, the entire payment was denied as medically unnecessary.

- Another **PPS hospital** was paid \$7,642 to treat an inpatient for dehydration. The beneficiary, who was initially treated in the emergency room, was eventually admitted to the hospital's acute care unit. The beneficiary received x-rays, blood tests, IV fluids, Tylenol, and a fever work-up but was discharged the same day. Medical reviewers concluded that the patient's condition did not require acute hospital inpatient care and that the services could have been rendered in an outpatient setting. Therefore, the entire payment was denied.

Incorrect Coding

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

Incorrect coding was the third highest error category this year, with \$2.1 billion in improper payments. Physician and inpatient PPS claims accounted for 90 percent of the coding errors over the 4 years reviewed.

Examples of incorrect coding follow:

- A **PPS hospital** was paid \$9,387 for an inpatient respiratory system surgical procedure. The medical records, however, supported a nonsurgical procedure. Medical reviewers' correction of the procedure code produced a lesser valued diagnosis-related group of \$2,481, resulting in denial of \$6,905 of the payment.
- A **physician** was paid \$50 for a psychotherapy session which requires medical evaluation and management. According to medical review staff, the physician's records evidenced neither the time spent nor the psychotherapy services performed. However, the records supported psychiatric medication management services in an office setting, for which a lower level of service would have been appropriate. Therefore, \$31 of the payment was denied.

Noncovered Services

Errors due to noncovered services consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. For example:

- A **physician** was paid \$30 for nail debridement. Medicare covers this procedure if there is evidence of diabetes in the beneficiary's medical history. However, there was no indication of diabetes in this beneficiary's history. Therefore, the service was considered routine foot care, which Medicare does not cover, and payment was denied.
- A **hospital** was paid \$21 for medications to an outpatient that medical reviewers determined could have been self-administered. Medications furnished in an outpatient setting are

covered only if they are of a type that cannot be self-administered. As a result, medical reviewers denied the payment.

FINANCIAL STATEMENT AUDIT

Audit Opinion

For FY 1999, we are very pleased to issue the first unqualified, or "clean," audit opinion on HCFA's financial statements. In achieving this important milestone in financial accountability, HCFA has successfully resolved billions of dollars in past problems that formed the basis of our audit opinion for 3 years. Deficiencies in reporting and supporting Medicare accounts receivable, in particular, have been systemic and longstanding.

Medicare accounts receivable are debts that providers and other entities owe to HCFA. More than 50 Medicare contractors are responsible for tracking and collecting most of this debt through their claim processing systems. However, as we previously reported, their claim processing systems lacked general ledger capabilities and traditional accounting system features, such as a dual-entry process. In addition, the contractors used ad hoc spreadsheet applications to tabulate, summarize, and report information to HCFA. This reporting process was labor intensive, requiring significant manual input and reconciliations between various systems and spreadsheets. Previous audits found millions of dollars in discrepancies as a result; that is, the Medicare contractors were unable to support beginning balances, reported incorrect activity, and could not reconcile ending balances with subsidiary records.

This year HCFA embarked on an extensive effort to validate and document receivables. The project, which was jointly conducted by HCFA, my office, and two independent accounting firms, covered accounts receivable at 15 Medicare contractors (accounting for over 80 percent of the contractor receivable balance) and at the HCFA central and regional offices. The validation team identified over \$2 billion in overstated and understated receivables:

- \$1.3 billion lacked supporting documentation,
- \$1 billion concerned cash advances to providers for which claims had already been submitted, and
- \$191 million in misstatements resulted from clerical errors, e.g., a contractor erroneously recorded a \$50 receivable as \$70 million.

This validation effort, together with HCFA's aggressive action to require that contractors maintain support for this debt, enabled us to conclude that the receivables balance was fairly presented and sufficiently documented for the first time in 4 years.

Internal Control Weaknesses

While the receivables balance was supported at the end of FY 1999, the underlying internal control environment and accounting systems still need substantial improvements, such as a basic double-entry bookkeeping system and adequate checks and balances to promptly detect errors and irregularities. These control weaknesses impair HCFA's ability to accumulate and analyze accounts receivable activity and to ensure that future receivables will be properly reflected in financial reports. These weaknesses also increase the risk that future debt may not be collected timely and that receivables may not be properly safeguarded. Compounding these problems, the HCFA central office does not routinely analyze receivable balances other than on a very aggregate level. Therefore, the FY 1999 report on internal controls again includes Medicare accounts receivable as a material weakness. Material weaknesses are defined as serious deficiencies in internal controls that can lead to material misstatements of amounts reported in subsequent financial statements unless corrective actions are taken. To ensure that future accounts receivable activity and balances are fairly stated, HCFA will need to continue a very aggressive validation effort.

The other material weaknesses noted last year also carried over:

- **Financial systems and reporting.** Controls over financial systems and reporting remain serious concerns. The HCFA did not perform adequate analyses of accounts receivable, revenues, and expenditures to understand why fluctuations took place and to ensure that balances were correct. For example:
 - ▶ The HCFA did not independently verify the Medicare Supplementary Medical Insurance (SMI) and Hospital Insurance (HI) trust fund balances, did not reconcile these accounts at a sufficiently detailed level, and used ineffective methodologies to calculate SMI and HI transfers. As a result, the SMI fund was underfunded by \$18 billion and HI was overfunded by \$14 billion. The SMI fund lost interest earnings of \$237 million and the HI fund realized excess interest earnings of \$154 million as a consequence. Although aggregate fund balances with Treasury and investment balances for the trust funds were properly stated in the FY 1999 financial statements, cash transfers related to the principal to make the individual trust funds whole did not occur until October 1999.
 - ▶ The HCFA did not periodically validate the National Claims History File to ensure the existence and completeness of the data. Due to a breakdown in internal quality controls, the file was missing 100 million Medicare claims amounting to over \$13 billion from June until December 1999. This file, which has since been corrected, is critical to accurately estimate Medicare benefits payable, to prepare the Medicare trustees report, to determine the SMI monthly premiums, to establish managed care rates, to update the diagnostic-related groups for inpatient hospitals, and to develop annual budget projections.

The HCFA had to make billions of dollars in manual adjustments to payables and receivables before producing final, auditable financial statements in late January 2000 — 4 months after the fiscal year ended. In addition, we noted that five of eight sampled Medicare contractors

did not formally reconcile paid claims activity to monthly expenditures reported to HCFA. Without these reconciliations, the risk of material misstatement in the financial statements increases.

- **Medicare electronic data processing (EDP).** Because HCFA's FY 1999 resources were largely devoted to Year 2000 readiness issues, not all prior-year EDP control problems were resolved. Weaknesses remained in access controls at the HCFA central office and in application change controls at a "shared" system used by certain Medicare contractors to process and pay claims. Internal controls over Medicare systems are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts.

Controls Over Cash Management

In a matter related to our financial statement audit, we recently reviewed certain controls over cash management. The HCFA and the Medicare contractors have agreements with several banks to maintain Medicare accounts to cover payments to providers. The HCFA expressed concerns about the way one bank handled Medicare funds related to eight fiscal intermediaries and one carrier. At HCFA's request, we reviewed the financial activities of the bank and the Medicare contractors. We noted that during an 11-day period, the bank withdrew funds from the Federal Reserve in excess of Medicare contractor expenditures. The excess ranged from \$104 million to over \$420 million per day and earned more than \$700,000 in interest.

In addition, since 1993, the bank has routinely withdrawn funds a day earlier than needed to cover Medicare expenses and has earned interest on those funds by investing them overnight. The bank estimated that the interest earned through these overnight investments totaled \$12.5 million. In 1999, HCFA advised the bank to stop this practice because it was contrary to the provisions of the agreement with HCFA and the Medicare contractors. Bank officials believed that withdrawing funds a day early was a "perk" of maintaining Medicare accounts and that bank charges alone were not sufficient to cover administrative expenses for the accounts.

Each of the Medicare contractors has a monthly limit on the total amount of Medicare funds that can be drawn down by the bank, and HCFA and its contractors have various reconciliation procedures to compare bank cash draws to expenditures and to Federal Reserve Bank reports. However, these controls were ineffective in preventing both types of improper withdrawals made by the bank.

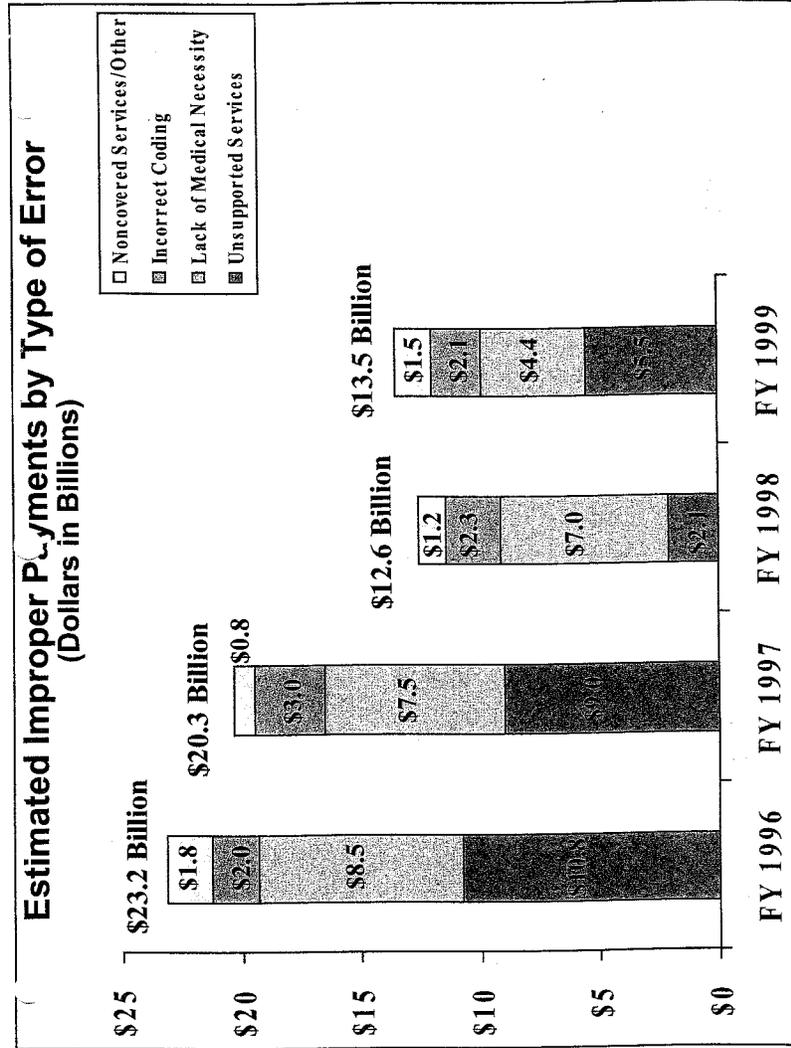
CONCLUSIONS AND RECOMMENDATIONS

We are encouraged by HCFA's sustained success in reducing Medicare payment errors and by the important progress made in resolving prior years' financial reporting problems. We remain concerned, however, that inadequate internal controls over accounts receivable leave the Medicare program vulnerable to potential loss or misstatement. As HCFA begins a lengthy process to integrate its accounting system with the Medicare contractor systems, internal controls must be strengthened to ensure that debt is accurately recorded, an adequate debt collection process is in place, and information is properly reflected on the financial statements.

We offered a number of recommendations which, if implemented, will strengthen controls over receivables and financial reporting. With the Year 2000 remediation challenge successfully completed, we urge HCFA to focus on these critical internal controls while continuing its efforts to reduce improper payments and ensure provider integrity. Specifically, we recommended that HCFA:

- Establish an integrated financial management system at the contractors to promote consistency and reliability in recording and reporting accounts receivable information.
- Establish a formal review process over accounts receivable to detect unusual fluctuations, anomalies, and unexpected variances.
- Ensure that contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of receivable amounts reported to HCFA.
- Develop an independent internal oversight group or internal audit function to monitor the contractors' compliance with HCFA reporting requirements for accounts receivable and verify the accuracy and completeness of information reported to the HCFA central office.
- Establish procedures for contractors to periodically reconcile accounts receivable balances to supporting documentation.
- Periodically review contractors' control procedures over the accounts receivable reconciliation process.
- Consider establishing a weekly limit on the total amount of Medicare funds that can be drawn by contractor banks.
- Require the HCFA regional offices to periodically test bank withdrawals to ensure there are no early withdrawals.

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



Mr. HORN. Next is the representative of the General Accounting Office, Mrs. Gloria Jarmon, Director of the Health, Education and Human Services Account and Financial Management Issues in the Accounting and Information Management Division, the part of the legislative branch which we are proud to have your fine staff working for us.

Please proceed, Mrs. Jarmon.

STATEMENT OF GLORIA L. JARMON, DIRECTOR OF HEALTH, EDUCATION AND HUMAN SERVICES ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, ACCOUNTING AND INFORMATION MANAGEMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mrs. JARMON. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss our review of HCFA's financial management activities for Medicare. Our report on these issues is being released today, and copies have been given to the subcommittee.

As Ms. Brown mentioned, over the past 4 years HCFA has worked hard to improve its auditor's opinion on its financial statements, from the auditors not being able to issue an opinion in fiscal year 1996 to the clean opinion in fiscal year 1999.

As you know, while getting a clean opinion is an important goal that HCFA should be commended for, it is not an end in and of itself. The ultimate goal is to keep improving internal controls and financial systems that support them and to generate reliable, timely, accurate, and useful information for decisionmaking on an ongoing basis.

Our report discusses some of the significant challenges that HCFA faces in meeting this goal. I will summarize these challenges into three areas.

First, Medicare contractor oversight—HCFA's over 50 contractors process about 3.5 million claims, worth an average of \$650 million each business day, yet HCFA's procedures for following up on audit findings and evaluating actions of these contractors to correct them were not up to par.

Audits of HCFA have repeatedly cited these contractors for internal control and financial reporting weaknesses, such as not safeguarding checks that providers give them for overpayments, and incorrectly reporting billions owed to the Medicare program for such overpayments.

Further, HCFA was not routinely analyzing the contractors' financial data to find irregularities and assess risks as part of daily monitoring, nor did it have up-to-date guidance for contractors on key financial matters.

The second challenge relates to financial reporting and related systems issues, which have been material internal control weaknesses in HCFA's auditors' reports for several years, since 1996.

HCFA relied on a manually intensive process to prepare annual financial statements. It had to make extensive adjustments, totaling billions of dollars. In short, HCFA obtained a clean audit opinion through a lot of hard work because its financial systems were not adequate.

The auditors reported that HCFA's systems did not fully meet the requirements of the Federal Financial Management Improvement Act. Basically, this means that HCFA's systems cannot reliably produce timely and useful financial information for day-to-day decisionmaking.

The auditors also cited weaknesses related to computer security, which is of high concern because of the sensitivity of the data in HCFA and its contractors' systems.

The third challenge relates to controls over Medicare accounts receivable. These receivables represent amounts due back to the Medicare program for things like overpayments to health care providers and other entities.

For fiscal year 1999, HCFA spent a lot of time and effort on this problem. It entered into an inter-agency agreement with the Department's Office of Inspector General, as mentioned by Ms. Brown, to help validate accounts receivable balances, and it wrote off billions of dollars of receivables that it considered invalid, uncollectible, and/or unsupported.

While these actions greatly improved HCFA's accounts receivable balance at year end, the basic control problems related to these accounts—namely, knowing what should be collected and from whom—remain. For this reason, the auditors still reported the Medicare accounts receivable issue as a material internal control weakness.

We know that HCFA's management recognizes that these problems are serious, and it has shown a commitment to making things better; however, with billions of dollars at risk, we cannot overstate the importance of safeguarding Medicare assets. The serious financial management weaknesses mentioned and described in more detail in our report stress the need for HCFA to have a very comprehensive strategy to direct its financial activities and assess its human capital needs related to these activities.

In responding to our report, HCFA's management outlined its ongoing and planned initiatives to address the problems highlighted in our report. Top management's continued support of these initiatives and sustained actions will be key to its success in resolving these problems. We plan to continue to monitor HCFA's progress in implementing its financial management improvement efforts.

Mr. Chairman, this concludes my statement. I'd be happy to answer any questions from you or other members of the subcommittee.

Mr. HORN. Thank you very much, Mrs. Jarmon.

[The prepared statement of Mrs. Jarmon follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Government Management,
Information, and Technology
Committee on Government Reform
House of Representatives

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**MEDICARE
FINANCIAL
MANAGEMENT**

**Further Improvements
Needed to Establish
Adequate Financial Control
and Accountability**

Statement of Gloria Jarmon
Director, Health, Education, and Human Services
Accounting and Financial Management Issues
Accounting and Information Management Division



Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our review of the Health Care Financing Administration's (HCFA) financial management activities for Medicare. Our report¹ on these issues is being issued today and copies have been given to the Subcommittee. Medicare is the nation's largest health insurer, covering almost 40 million beneficiaries at a cost of over \$200 billion annually. Each business day, HCFA's contractors process about 3.5 million claims worth an average of more than \$650 million.

Addressing the financial management challenges associated with administering the Medicare program is a daunting task given the size and complexity of the program. As the Medicare program steward, HCFA is accountable for ensuring that funds are spent wisely and in accordance with applicable Medicare laws and that the Medicare program is well managed.

Over the past 4 years, HCFA has set and achieved goals of improving its audit opinion each year. For fiscal year 1999, HCFA received an unqualified, or "clean," opinion on its financial statements, and its audit reports were issued on time. Annual financial audits represent an important means to assure continued progress in improving financial management and to identify significant weaknesses in financial management that require management's attention. Audit results are also key indicators of the quality of the underlying agency financial data and related systems used to compile that information.

¹*Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (GAO/AIMD-00-66, March 15, 2000).

For HCFA, as well as other federal agencies, while obtaining an unqualified or "clean" audit opinion on its financial statements is an important objective, it is not an end in and of itself. The key for agencies is to take steps to continuously improve internal controls and underlying financial systems for programs such as Medicare. The ultimate goal is for agencies to be able to generate reliable, timely, accurate, and useful information for decision-making on an ongoing basis.

Since fiscal year 1996, audits of HCFA's financial statements have cited the agency for many financial management weaknesses that affect the agency's ability to establish adequate control and accountability. Many of the underlying internal control weaknesses in HCFA's operations continue. The Medicare program has also received increased attention as a result of investigations by the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) and the Department of Justice that cited Medicare claims contractors and providers, such as hospitals and physicians, for payment errors and fraudulent billing practices. For fiscal year 1999, the OIG estimated that claims contractors improperly paid \$13.5 billion in Medicare claims, mostly for medical services that were not covered by Medicare or were not reasonable, necessary, and appropriate.

At the same time, HCFA has been the subject of increased congressional interest since we designated the Medicare program a high-risk area in the early 1990s. Just recently, we testified before the Subcommittee on Labor, Health and Human Services, Education and Related

Agencies, Senate Committee on Appropriations, on Medicare program integrity issues, including the ongoing and emerging challenges HCFA faces in safeguarding Medicare payments.²

Today, I will discuss the results of our report that is being issued today on HCFA's financial management activities for Medicare. As our report highlights, HCFA has not yet established an adequate foundation for control and accountability over the Medicare program's financial operations. Let me begin by summarizing these weaknesses:

- Financial statement audits have repeatedly cited claims contractors for internal control and financial reporting weaknesses, including failure to safeguard checks received from providers for overpayments and incorrectly recording billions of dollars owed to the Medicare program for such overpayments. However, HCFA's procedures for following up on audit findings and evaluating corrective actions were insufficient.
- HCFA's monitoring of contractor financial activities was also insufficient. Until recently, HCFA's oversight focused mainly on contractor compliance with administrative budgets, which total about \$1.6 billion annually, instead of on the significant financial activities related to the approximately \$170 billion³ expended annually to pay Medicare health benefit claims. Further, HCFA did not routinely analyze contractor financial data to detect irregularities and assess risk as part of day-to-day monitoring activities, nor had it issued complete and up-to-date instructions to contractors on key financial matters.

²Medicare: HCFA Faces Challenges to Control Improper Payments (GAO/T-HEHS-00-74, March 9, 2000).

- Audit reports have also cited HCFA for inefficiencies in its internal financial reporting practices, including a lack of documented policies and procedures.

Overall, these shortcomings in HCFA's financial operations mean that it could not adequately ensure the reliability of data that the agency and the Congress used to track the cost of the Medicare program and to help make informed decisions about future funding.

HCFA's management has recognized the seriousness of these problems and has shown a commitment to improving financial management. To address these issues, HCFA has started several initiatives designed to establish better control and accountability, such as hiring outside consultants to evaluate contractor internal controls. These initiatives, if successfully implemented, will assist HCFA in correcting some of its longstanding financial management problems. At the same time, HCFA has not yet taken critical steps to address the challenges of implementing its planned improvement efforts.

- HCFA has not yet developed a comprehensive strategy to ensure successful implementation of the initiatives, direct financial management activities, and sustain improvements in the long term. In the absence of a comprehensive strategy, HCFA cannot effectively direct and monitor its many initiatives, potentially putting billions of dollars at risk for fraud and abuse and increasing the likelihood that financial management problems will continue.

³Of the more than \$200 billion in annual costs for Medicare, about \$37 billion was expended for managed care and about \$170 billion was expended to pay fee-for-service health benefit claims.

- HCFA has not yet completed ongoing assessments of financial management human capital needs. Without sufficient staff who possess the necessary skills to perform the oversight, analytical, and other tasks that are needed to manage the complex Medicare program, the prospects for improving HCFA's financial management remain dim.

Our report makes recommendations designed to help HCFA resolve these problems.

HCFA'S PROCESS FOR MANAGING MEDICARE FEE-FOR-SERVICE

In 1999, Medicare's traditional pay-per-visit or fee-for-service program covered almost 85 percent of Medicare beneficiaries. Physicians, hospitals, and other providers submit claims to Medicare to receive reimbursement. HCFA administers Medicare's fee-for-service program largely through an administrative structure of claims contractors. Since 1965, when the Medicare program was enacted, the law has called for insurance companies—such as Blue Cross and Blue Shield, Travelers, and Aetna—to process and pay claims because of their expertise in performing these functions. As Medicare claims contractors, these companies assume a large share of the responsibility for managing the federal funds of the Medicare program, although HCFA has ultimate responsibility.

Medicare claims contractors use federal funds to pay health care providers and are reimbursed for their administrative expenses incurred in performing the work. More specifically, contractors have financial management responsibilities that include (1) establishing agreements with

commercial banks to withdraw federal funds from the Medicare trust funds to pay Medicare claims, (2) submitting various financial reports to HCFA on the amount of funds withdrawn and expended, and (3) certifying that their internal controls are in place and operating effectively.

Over the years, HCFA has reduced the number of Medicare contractors from a peak of about 130 in 1966 to 56 in 1999. Generally, intermediaries are the contractors that handle Part A claims submitted by hospitals, skilled nursing facilities, and hospices. Carriers are those contractors handling Part B claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

HCFA is responsible for ensuring that contractors do their jobs accurately and efficiently, including managing Medicare funds in a fiscally responsible manner. HCFA is also responsible for establishing an internal control system to safeguard Medicare assets. At HCFA's central office, the Office of Financial Management (OFM) is responsible for monitoring of contractor financial data and activities in addition to facilitating the annual financial statement audit process, preparing financial statements, and executing daily internal accounting functions. HCFA's central office unit, the Center for Beneficiary Services (CBS) and the 10 regional offices share the responsibility for conducting annual oversight reviews of all aspects of contractor operations for the Medicare program as part of HCFA's Contractor Performance Evaluation (CPE) program. HCFA's OFM is expected to coordinate with CBS and assist the regional offices in assessing contractor financial activities.

**ESTABLISHING A SOLID FOUNDATION FOR
CONTROL AND ACCOUNTABILITY**

While HCFA officials had acknowledged its most serious and long-standing financial management problems, HCFA had not implemented processes to establish adequate control and accountability over the Medicare program. For example, HCFA procedures for evaluating audit findings and following up were not effective to ensure that corrective actions were implemented. In addition, HCFA had serious deficiencies in its oversight and monitoring of contractor financial activities. HCFA's guidance to contractors for executing financial activities was incomplete and in some cases outdated. Further, HCFA's internal accounting and financial reporting practices lacked documented procedures. These weaknesses in internal control and financial reporting processes pose a risk to the Medicare program because such weaknesses could result in losses to the government.

Significant Financial Management Weaknesses Persist

Over the past 4 years, HCFA has made progress in improving some of its financial management weaknesses. At the same time, many significant accounting and financial systems-related weaknesses cited by auditors in past reports on HCFA's financial statements still exist. For example:

- HCFA's systems do not fully comply with the federal financial system requirements of the Federal Financial Management Improvement Act (FFMIA).⁴ The federal financial system requirements prescribe the basic elements for integrated federal financial management systems and having financial systems that fully comply with these requirements is key to the goal of having reliable, timely, and useful information for day-to-day decision making.
- Contractor EDP controls over data processing systems do not provide adequate safeguards to reduce improper access to and manipulation of data.
- Medicare contractors are unable to accurately report some financial data due to insufficient accounting systems, inadequate independent verification of reported amounts, and lack of other financial controls.
- Medicare contractors' controls to properly account for cash balances and activity do not provide adequate safeguards to reduce the opportunities for theft and other irregularities in their cash procedures.
- HCFA's preparation of annual financial statements is manually intensive, requiring extensive adjustments due to lack of an accounting software package to automatically manipulate data for the development of financial statements. In short, HCFA obtained a "clean" audit opinion through a lot of hard work because its financial systems were not adequate.

⁴FFMIA requires that agencies' financial management systems comply with three requirements: (1) federal financial management systems requirements, (2) applicable federal accounting standards, and (3) the *U.S. Government Standard General Ledger* at the transaction level.

Most notably, HCFA has had long-standing problems in supporting the amount of accounts receivable due back to the Medicare program either for claims in which Medicare should be the secondary rather than primary payer (referred to as Medicare secondary payer) or for contractor overpayments to providers, beneficiaries, physicians, and suppliers.

For fiscal year 1999, HCFA devoted significant resources to address its accounts receivable problems by (1) entering into an interagency agreement with the HHS OIG to assist in validating the accuracy and completeness of accounts receivable balances at September 30, 1998, and March 31, 1999, as well as the activity for the first 6 months of fiscal year 1999 and (2) implementing procedures to write off almost \$3 billion of Medicare accounts receivable balances for fiscal year 1999. While these efforts were significant to improving HCFA's accounts receivable balance at September 30, 1999, and the auditors' opinion on the financial statements, the underlying financial systems problems still remain. The auditors still reported the Medicare accounts receivable issue as a material internal control weakness. They stated that many Medicare contractors are still using processes, such as ad-hoc spreadsheet applications and a wide variety of claims processing systems, for tracking receivables that often cannot be reconciled to control amounts. This means that misuse of government resources could occur and HCFA would not be able to detect it in a timely manner.

Audit Evaluation and Follow-upProcedures Were Ineffective

Evaluating the financial management problems identified from audits and implementing follow-up procedures is critical if HCFA is to resolve its financial management problems and establish financial accountability. We found that HCFA had limited procedures to promptly evaluate and resolve auditor findings. In the past, HCFA relied on auditors to ensure that Medicare contractors were implementing corrective actions to address weaknesses. Auditors had followed-up with contractors that were included in subsequent financial statement audits but had not followed-up with those that were not included. HCFA did not have back-up procedures that require its staff to follow-up at contractor sites to ensure that recommended corrective actions were implemented, nor did HCFA have adequate procedures to determine if problems found at contractors under audit were also occurring program-wide at other contractors. Weaknesses in HCFA's follow-up have hindered prompt resolution of financial management problems. In fact, during our visits to contractors included in previous audits, we found several instances where contractors had weaknesses in their internal controls over Medicare activities similar to weaknesses found in previous audits. For example, two contractors we visited did not have adequate controls to ensure the accuracy of their outstanding check amounts reported to HCFA. For the two contractors, outstanding check amounts totaled over \$100 million as of September 30, 1999.

Our review also found two contractors not included in previous audits that had problems with controls over cash and review of financial data, similar to findings reported on contractors in

prior audits. One contractor that receives cash from providers and other sources averaging about \$20 million a month did not physically secure checks while awaiting deposits, thus increasing the risk of lost checks and untimely deposits of Medicare funds. Another contractor with cash receipts of about \$1.5 million monthly did not record the amounts in a log when first received, thus creating opportunities for theft.

HCFA is just starting to document procedures for ensuring that its staff adequately evaluates audit findings and conducts follow-up with contractors to ensure prompt resolution. We believe that these new procedures are a good first step, but HCFA financial managers must coordinate with other HCFA units to ensure that adequate resources are available to support a comprehensive audit evaluation and resolution process.

Oversight of Contractor Financial

Activities Was Limited in Scope

When daily financial operations of a program as complex as Medicare are delegated to outside entities, oversight mechanisms are important tools for maintaining financial control and accountability. HCFA's oversight of contractor financial activities for the Medicare program did not focus on ensuring that contractors had the necessary internal controls in place to account for and report on all financial activities related to the Medicare program. Until fiscal year 1998, HCFA's CPEs, the primary tool for evaluating contractor operations, focused largely on contractors' compliance with the annual budget HCFA establishes to pay contractors for administering the Medicare program—approximately \$1.6 billion a year. The financial responsibility reviews did not focus on some of the significant financial activities and data

related to the almost \$170 billion expended each year to pay providers' claims, such as Medicare accounts receivable, accounts payable, and funds withdrawal activities. In addition, regional oversight reviewers did not adequately examine contractor internal controls to gain assurance that contractors' reports on financial data were reliable.

Recognizing the shortcomings of the HCFA annual oversight process, in fiscal year 1998, the Chief Financial Officer (CFO) took steps to address weaknesses in oversight of financial activities. For example, HCFA's OFM developed procedures for the regions to use in checking and testing financial data related to accounts receivable and accounts payable for several of the large contractors. OFM also provided staff to assist regional reviewers in an attempt to develop and leverage the skills and expertise of staff conducting the reviews. The procedures, however, did not cover other key financial activities, such as contractor bank balances and funds withdrawal procedures.

Contractors and the commercial banks that act on behalf of contractors withdraw the almost \$170 billion required annually to pay Medicare benefit claims. Despite the magnitude of dollars that flow in and out of contractor bank accounts, HCFA has not developed detailed procedures to review contractor bank balances and the amount of funds withdrawn. We discussed with the CFO the need for expanded evaluation procedures to cover these areas. The CFO agreed and has begun discussions with officials in the HCFA headquarters unit responsible for contractor oversight about expanding financial management oversight.

In fiscal year 1999, HCFA solicited outside help to address some of its significant financial weaknesses. As discussed earlier, HCFA entered into a reimbursable interagency agreement with the OIG to assess and validate the accounts receivable activity and balances reported at September 30, 1998, and March 31, 1999. HCFA also contracted with outside consultants to validate internal controls at contractors in response to our July 1999 report that HCFA does not regularly check contractors' internal controls.⁵

While these two efforts demonstrate that HCFA is acting to address its long-standing problems, we are concerned that HCFA's financial managers have not yet comprehensively assessed how the agency will sustain strong oversight in these two areas in the future or address the recommendations that will likely result from these reviews. For example, HCFA has developed a work force planning project, but thus far this initiative has provided limited information about specific areas, such as financial management.

Day-to-Day Monitoring of Contractor

Financial Activities Is Insufficient

HCFA's day-to-day monitoring of contractor data is insufficient. HCFA did not routinely analyze key contractor financial data to detect irregularities in contractor financial activities and assess risk, despite the importance of such mechanisms in establishing sound internal control. For example, HCFA did not have adequate procedures to ensure that bank activity conducted on behalf of contractors was reasonable. In early 1999, HCFA was alerted to a problem in the

⁵*Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

banking activities done on behalf of the Medicare program. Examiners from the Federal Deposit Insurance Corporation discovered and reported to HCFA that a bank, which provides banking services for several contractors, had a practice of drawing funds from the U.S. Treasury on the day before the bank needed the money to pay Medicare claims. The bank was selling the amount to another bank overnight to earn interest and transferring it back to its accounts the next morning without HCFA's knowledge.

When HCFA was made aware of the situation, the CFO issued a letter to the bank president to (1) inform the bank that the practice was not in accordance with provisions of the Medicare program bank agreement and Treasury's regulations concerning collateral requirements for federal funds and (2) request that the bank immediately stop the practice. However, because HCFA has so little information on contractor bank activities and does so little analysis, it could not fully determine the extent of irregular activities by this bank. At the request of HCFA, the OIG investigated this bank to determine the amount of profit the bank made from this practice. HCFA officials said that they are awaiting the results of this report to determine what actions against the bank are needed, including disciplinary actions. In addition, HCFA officials said that they asked the OIG to conduct a separate review of bank procedures for a sample of banks participating in the Medicare program to determine if other banks are unfairly profiting from similar practices and to identify areas of potential vulnerability.

We also found that HCFA did limited analysis of quarterly reports submitted by contractors on bank charges, account balances, and collateral. OFM had one staff person who monitored the Medicare bank account balances for the approximately 20 commercial banks that maintain

Medicare accounts for the 56 contractors. The staff person said that because of other responsibilities, he only reviewed bank account reports for about 2 or 3 of the 56 Medicare contractors each quarter. When we asked to review his analysis, the staff person could not provide any support or written analysis procedures.

Contractors Lacked Sufficient Guidance To
Resolve Financial Management Deficiencies

HCFA's ability to address long-standing financial management weaknesses was also hampered because financial managers had not issued complete, up-to-date guidance to contractors for financial activities. According to contractors we visited, one specific area where instructions were needed was the allocation of cash receipts between the two Medicare trust funds.⁶ Because HCFA had not issued specific instructions in this area, contractors adopted different methodologies that in some cases led to inaccurate trust fund balances. One contractor adopted a procedure where all overpayments received were allocated to the Hospital Insurance (HI) trust fund. The contractor did not take any steps to determine if the overpayments were related to previous Supplementary Medical Insurance (SMI) or HI benefit payments. After adopting procedures to determine if receipts were related to HI or SMI, the contractor reviewed its allocation for a 9-month period in fiscal year 1999 and found that \$33 million which should have been allocated to the SMI trust fund had been incorrectly allocated to the HI trust fund. This

⁶Congress established two trust funds for Medicare. The Hospital Insurance (HI) trust fund is used to pay Medicare Part A claims and is funded primarily by employment taxes. The Supplementary Medical Insurance (SMI) trust fund is used to pay Part B claims and is primarily funded by Medicare premiums and a federal matching contribution.

error was significant because accurate data on Medicare trust fund balances is essential in managing and monitoring trust fund activities and funding needs.

HCFA's CFO acknowledged that more detailed instructions to contractors are needed because HCFA's contracting documents do not include enough specificity to contractors on their fiscal responsibilities. However, because HCFA lacks baseline data on its financial management instructions, it has hired a contractor to determine what financial guidance has been issued and to develop a manual of financial and internal control guidance. This effort has just begun and it is too soon to tell whether it will succeed in addressing these fundamental problems.

*HCFA Lacked Structure for
Internal Financial Reporting Practices*

HCFA had not taken steps to ensure that it had knowledgeable financial management staff and clearly documented procedures for executing accounting and financial reporting activities. We also found that HCFA did not have an updated accounting manual to direct accounting staff in performing routine accounting procedures for the Medicare program. A recent error in HCFA's financial reporting demonstrates the importance of written accounting procedures that are specific to HCFA operations. In October 1999, HCFA discovered misstatements in its reports to Treasury on amounts expended from the HI and SMI trust funds. Treasury relies on the amounts reported for expenditures because Medicare trust fund amounts not necessary to meet current expenditures are invested in interest-bearing securities of the U.S. government each month.

Senior OFM officials said that the staff person who prepared the report had assumed the responsibilities of a former employee but had not received adequate training. Because of HCFA's errors, the Medicare trust fund balances that Treasury invested for several months were incorrect, thus resulting in a loss of investment interest income of about \$80 million to the Medicare program.⁷ HCFA officials told us they have taken steps to enhance their procedures for reporting trust fund balances.

**RECENT INITIATIVES HOLD PROMISE
BUT SUSTAINED COMMITMENT IS CRITICAL**

Acknowledging the need to correct the significant financial management weaknesses in its operations, HCFA has several initiatives underway. These initiatives—ranging from new systems to help track amounts owed to HCFA, to contractor financial management guidance, to assessments of contractors' internal control—hold promise for improving financial management, establishing control, and making staff more accountable in achieving HCFA's mission. To be successful, HCFA will need to sustain these initiatives and institutionalize improvements. HCFA faces significant challenges in successfully implementing these initiatives. For example, HCFA lacked two key components of any successful financial management reform: developing a comprehensive strategy and assessing financial management human capital needs.

⁷Although incorrect balances in the Medicare trust funds resulted in a net loss of interest income to the Medicare program, other Treasury investments earned the interest lost by the Medicare program. As a result, these events did not result in a net loss to the U.S. government.

No Comprehensive Strategy or Plans for Implementing

Financial Management Improvement Initiatives

HCFA had not yet developed a comprehensive strategy to direct its financial management activities. HCFA lacked long- and short-range plans that provide a basis for prioritizing financial management initiatives, clearly defining goals and objectives, establishing time frames for completing initiatives, assigning responsibilities, and measuring performance. A comprehensive financial management strategy, along with plans for implementing the strategy, is important because of the recurring financial management weaknesses and the scope of current improvement initiatives.

HCFA's current financial management improvement initiatives include (1) developing an integrated accounting system that incorporates Medicare contractors' financial systems and HCFA's internal financial accounting systems, (2) developing new systems to improve oversight and financial reporting over Medicare receivables, (3) reviewing contractors' internal controls, and (4) developing a comprehensive contractor financial management manual. While these projects have the potential to provide major improvements in HCFA's financial management, the chances of success could be significantly improved if HCFA established and documented a specific strategy and implementation plan for sustaining the projects and institutionalizing improvements. HCFA officials provided us with broad conceptual ideas of how the initiatives would need to be implemented. As of January 2000, when we completed our fieldwork, HCFA was in the early stages of drafting more specific details for several of its financial management improvement initiatives.

Any delays in developing detailed plans could cause problems as the projects progress. Specifically, the integrated accounting system project, which HCFA describes as its most comprehensive financial systems development project, is critical and should be well planned. In the past, we have reported on the significant challenges that agencies face in ensuring that modern information technology management practices are consistently defined and properly implemented.

Another financial management improvement initiative that holds great promise for helping HCFA improve financial control is the current project to review contractors' internal control structures, identify poor internal controls, and suggest needed improvements. HCFA has contracted with several independent public accounting firms to perform these reviews. However, HCFA has not yet developed a comprehensive plan to ensure sustained oversight of contractor internal controls. HCFA officials envision that these contracted reviews will continue in future years, but HCFA has not determined what resources will be needed to do the reviews or respond to recommendations resulting from the reviews. Further, HCFA officials do not have alternative plans in the event that these reviews cannot be continued. Without alternative plans, this critical activity could be interrupted.

Assessing Human Capital Needs Is Essential

HCFA officials have stated that they lack sufficient staff with the specialized skills to perform key financial functions, including overseeing and monitoring contractor financial activities, analyzing financial data to detect irregularities, and developing and maintaining internal financial

reporting processes. Despite these resource challenges, HCFA has not completed assessments of its human capital needs.

In our recently issued exposure draft of an executive guide designed to help federal agencies achieve federal financial management objectives,⁸ we highlighted successful human capital efforts in leading organizations including three critical elements for developing first-rate staff teams. These elements include (1) determining required skills and competencies, (2) measuring the gap between what the organization needs and what it has, and (3) developing strategies and detailed plans to address current or expected future deficiencies.

In comments to our report, HCFA officials stated that they recently initiated an agencywide workforce planning project. This project consists of a four-phased model designed to incorporate critical elements similar to those mentioned in our guide. To date, the results of this project have provided HCFA with limited information, and more detailed assessments to analyze current and future work functions and competencies have not been completed. HCFA's current plans are to use results from its project to formalize hiring, staffing, and learning plans for fiscal year 2001. Having staff with appropriate skills is key to achieving financial management improvements. Therefore, emphasis on completing more detailed human capital planning within HCFA's proposed time frames is important.

⁸*Executive Guide: Creating Value Through World-Class Financial Management* (GAO/AIMD-99-45, August 1999, exposure draft).

Conclusions

With billions of dollars at risk in the Medicare program, the importance of ensuring that Medicare assets are properly accounted for and that adequate controls are in place to safeguard them cannot be overstated. In this respect, HCFA continues to face difficult challenges. Financial statement audits and other assessments and reviews have identified significant financial management problems at HCFA and its Medicare contractors year after year. Despite the seriousness of these repetitive problems, HCFA's follow-up on audit findings and recommendations, evaluation of contractors' corrective action plans, analysis of available financial data to detect inappropriate financial management activities, and financial guidance for HCFA and contractor staff has been limited. Further, it is difficult for HCFA to improve and expand oversight of contractor financial operations without first determining the required staff skills and competencies needed. In addition, HCFA's internal financial reporting processes render HCFA vulnerable to errors in critical data needed to administer the Medicare program.

The significance of the financial management issues facing HCFA emphasizes the need for a comprehensive strategy to direct its financial activities and assess its human capital needs. This strategy would help HCFA establish seamless systems and processes to improve financial management and accountability. HCFA has agreed with the recommendations in our report that we are releasing today. Management outlined its ongoing and planned initiatives to address the problems highlighted in our report. Top management's continued support of these initiatives and sustained actions, as outlined in HCFA's response to our report, will be key to its success in resolving these problems. We plan to continue to monitor HCFA's progress in implementing its financial management improvement efforts.

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

Contact and Acknowledgement

For information about this statement, please contact Gloria Jarmon at (202) 512-4476 or at *jarmon.g.aimd@gao.gov*. Individuals making key contributions to this statement included Kay Daly, Kim Brooks, and Meg Mills.

(916347)

Mr. HORN. We now move to the agency. Representing the Health Care Financing Administration this morning is the Deputy Administrator, Mr. Michael Hash, and he is accompanied by Ms. Michelle Snyder, the Chief Financial Officer of the Health Care Financing Administration.

Welcome.

STATEMENT OF MICHAEL M. HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MICHELLE SNYDER, CHIEF FINANCIAL OFFICER OF HEALTH CARE FINANCING ADMINISTRATION AND DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT

Mr. HASH. Thank you, Chairman Horn, Congressman Turner, Mrs. Biggert, and other members of the committee. I want to thank you for the opportunity to come here today to discuss our efforts to get Medicare's financial house in order and to fight and continue our fight against waste, fraud, and abuse.

With me, as you noted, Mr. Chairman, is Michelle Snyder, HCFA's Chief Financial Officer and the Director of our Office of Financial Management.

I would also like to acknowledge, in the effort that we have been talking about this morning, the invaluable assistance of our IG at the Department of Health and Human Services and the staff at the General Accounting Office for their highly constructive assistance in our efforts.

First, let me say that we are pleased that we were able to obtain a clean opinion this year. As you know, that represents a lot of hard work and confronting some very difficult issues.

We've worked with a number of CPA firms and with the IG's office to clean up our books, and so that we can delete bad debt and aggressively pursue the money that is owed to us. We are continuing a wide range of additional efforts to strengthen financial management and accounting systems and, importantly, we are developing an automated, integrated, and dual entry accounting system that we all agree is needed.

The audit also found examples of system weaknesses and human errors that need to be addressed. For example, funds that should have been credited to one of our trust funds were instead posted to another. And, while no taxpayer money was lost, we are working hard to fix what is broken and to make sure that these types of problems do not occur again.

We have also made progress in improving system security for the sensitive information that is included in our data bases, and we expect to make more progress on this front now that we have cleared the Y2K challenge.

Meanwhile, our payment error rate is holding steady. That's both good news and bad news, I think. The rate is a lot better than it was when it was first measured 4 years ago, and it is proof that last year's dramatic reduction was not a one-time phenomenon. It can and is being sustained.

It is noteworthy because this year's audit sample includes many more claims for known problem areas, including home health and durable medical equipment, but we all agree that the error rate

has to come down further, and we're working hard to make that happen.

We are focusing our immediate attention on the documentation problems that increased the error rate in this year's findings. To that end, we are contacting all physicians, home health agencies, and medical equipment providers to explain the seriousness of this issue and how to avoid common errors that they are making.

We also are testing new documentation guidelines for physician services that should be easier to use, and we are establishing toll-free lines where providers can get answers to billing questions.

While much remains to be done, we have made significant, I think, and sustained progress. With your support, we will continue to do so, Mr. Chairman.

I want to assure you that we are attacking our financial management challenges and problems with the same focus and energy that we brought to bear on our Y2K challenge, and we intend to be just as successful.

Thank you, again, for inviting me to be here. I would be happy to answer any questions that you or other members of the subcommittee may have.

[The prepared statement of Mr. Hash follows:]

**Testimony of
Michael Hash, Deputy Administrator
Health Care Financing Administration
on the
Fiscal 1999 Chief Financial Officers' Audit
before the
House Government Reform Subcommittee on
Government Management, Information & Technology
March 15, 2000**

Chairman Horn, Congressman Turner, distinguished Subcommittee members, thank you for inviting me to discuss our progress in getting Medicare's financial house in order. I would also like to thank the HHS Inspector General (IG) and General Accounting Office (GAO) for their valuable assistance to us in this effort.

The Clinton Administration has a zero tolerance policy for health care fraud, waste, and abuse. In 1995, we launched Operation Restore Trust, a ground-breaking anti-fraud project aimed at coordinating federal, state, local and private resources in targeted areas. The result is a record series of investigations and convictions, as well as new management tools to fight improper payments.

Since 1996, we have built on these efforts with findings from the Chief Financial Officer's audits through a series of aggressive actions to prevent improper payments and strengthen our financial integrity. The audit findings and GAO reviews serve as roadmaps directing us to needed improvements. We are attacking financial management problems with the same focus and energy that we used to meet our Year 2000 computer challenge, and we intend to be as successful in this as we were in Y2K.

We have seen tangible results from our efforts to address audit findings each year. This year, for the first time, the auditors are able to give us a clean opinion. And the claims payment error rate is holding steady at about half of what it was in 1996, even though this year's sample includes more claims for problem areas such as home health and medical equipment. These results show that our progress is not a one-time phenomenon but something sustainable on which we can build.

We are taking several new steps to further protect Medicare's financial integrity and bring the claims payment error rate down. Key among these are efforts to determine an error rate for every contractor that pays these claims. This will help us focus on specific problems in a far more targeted way than we can with the national error rate, which is extrapolated from claims for just 600 beneficiaries.

Another critical area includes efforts to help providers document and file claims correctly. We will test new documentation guidelines that should be easier for physicians to use. We will expand outreach and education programs to help providers file claims correctly. And we will contact all physicians, home health providers, and medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.

We also can expect to see more impact from the many program integrity efforts that we initiated this past year through our comprehensive program integrity plan and other steps.

- We hired special contractors to focus solely on preventing improper payments.
- We greatly strengthened contractor oversight through tighter performance evaluation standards, national evaluation teams, and mandatory corrective action plans.
- And we continue to seek contracting reform legislation so we can use the same contracting rules as other government agencies and expand the range of firms capable of serving Medicare and protecting taxpayer dollars.

We are aggressively addressing financial management issues identified by us, the IG, GAO, and accounting firms with which we have contracted. Most of these issues have their roots in the system established in the 1965 Medicare law, whereby Medicare must contract with private health insurance companies to process and pay claims. We have made significant progress already. We have an ambitious array of further actions planned or underway that are consistent with the GAO report's recommendations. And we are developing a comprehensive business plan to ensure successful implementation of these efforts. I am determined that Medicare and its contractors meet the same high standards of accounting required of major private sector corporations.

Background

Medicare pays more than \$200 billion to one million health care providers for services provided to nearly 40 million seniors and disabled Americans annually. The Government Management Reform Act has required annual audits each year since fiscal 1996, including review of a statistical sample of Medicare claims. That year a 14 percent claims payment error rate and several weaknesses in financial management were identified. We have been working diligently to address these issues ever since.

In response to the fiscal 1996 audit, we took several actions to address the most serious problems first. We contracted with Ernst & Young to help us clean up our accounts payable. We funded an audit to address concerns about the Social Security Administration process for withholding Supplemental Medical Insurance Premiums.

We also initiated several other actions to address the error rate that included:

- increasing the level of claims review and the number of physician medical directors who lead claims review activities for contractors;
- expanding the number and scope of computer “edits” that identify improper claims before they are paid;
- developing stricter enrollment safeguards to keep illegitimate providers from billing Medicare; and
- organizing a national fraud, waste, and abuse conference and using lessons learned to begin developing a comprehensive program integrity plan.

The fiscal 1997 audit verified our success in addressing issues with our accounts payable and the Social Security Administration. Also that year, the payment error rate dropped to 11 percent.

Following the fiscal 1997 audit, we took action to clarify our handling of cost reports and the Medicaid payables and receivables to the auditors’ satisfaction, and made progress in the remaining areas of concern raised by the auditors.

We also:

- made further increases in the level of claims reviews;
- began conducting site visits nationwide to ensure that durable medical equipment providers were in fact, legitimate businesses; and
- set stricter enrollment criteria to keep unscrupulous medical equipment providers and home health agencies out of the program.

Strengthening Contractor Oversight

Among the most important actions we took following the fiscal 1997 audit were steps to substantially strengthen oversight of the private insurance companies that, by law, process Medicare claims and thus carry out critical financial management functions. We consolidated responsibility for contractor management by establishing the new position of Deputy Director for Medicare Contractor Management. And we created a Medicare Contractor Oversight Board to set policy regarding contractor-related activities. These steps are proving to be critical as we move forward to address remaining issues.

The fiscal 1998 audit revealed more substantial results from our actions. The payment error rate was down to 7.1 percent, and only one area – accounts receivable – kept us from receiving a clean opinion.

In response to the fiscal 1998 audit, we hired independent Certified Public Accounting firms to assist us in an extensive analysis of accounts receivables that validated more than 80 percent of the outstanding debt. As a result, we identified \$2.6 billion in outstanding receivables, some as much as 10 years old, most of which should have been paid by other insurers.

As required by the Debt Collection Improvement Act, we will aggressively pursue this debt and, when appropriate, refer cases to the Treasury Department for further collection activity and litigation. In accordance with policy of the federal Chief Financial Officers' Council, we are removing these receivables from our financial statements so the statements reflect accurate economic value.

We also removed about \$300 million in debt that is as much as 10 years old with no potential for collection from our financial statements. Some of these debts exceed the statute of limitations for collection.

Our accountants also identified \$1.3 billion in adjustments from the books of our claims processing contractors, and these also were removed from our financial statements. We are requiring these contractors to implement corrective actions so they comply with generally accepted accounting principles and prevent these types of errors from recurring.

Also in the past year we:

- implemented our comprehensive program integrity plan, which details our overall strategy to reduce waste, fraud and abuse;
- hired independent Certified Public Accounting firms to analyze internal control systems at 25 of the largest and highest-risk Medicare contractors, representing 80 percent of Medicare fee-for-service payments;
- created standardized reporting and evaluation protocols and used national review teams to evaluate contractors' fraud and abuse efforts and other key functions;
- directed each contractor to implement corrective action plans to ensure that they can track funds more accurately;
- notified the contractors of our intent to amend our contracts with them to require details and time frames for correction of each deficiency identified;
- hired our first-ever national contractor to ensure Medicare does not pay claims that private insurance companies should pay;
- initiated steps to develop an integrated general ledger system to standardize the accounting systems used by all contractors; and
- created and filled a new high-level management position to coordinate the agency's business plans to further strengthen financial controls.

Fiscal 1999 Results

Our Government Performance and Results Act goal for 1999 was an error rate of 9 percent. The new fiscal 1999 payment error rate estimate is 7.9 percent, which is not a statistically significant change from the fiscal 1998 error rate. Due to the limited size and variance of the sample, the true error rate could range from 5.4 to 10.6 percent. We are committed to achieving our goal for 2002 of 5 percent.

The error rate plateau shows that our actions have achieved sustainable improvement. And it is noteworthy that the rate remained stable even though the fiscal 1999 sample included more home health and durable medical equipment claims -- areas where problems have been more common.

The clean audit opinion reflects our success in improving Medicare's financial systems to increase the efficiency and accuracy of our financial statements in accordance with standard accounting practices. This is an essential step in assuring that Medicare's financial status is accurately portrayed so that the most effective subsequent steps can be taken toward sounder day-to-day financial management. Several of these on-going reforms directly address contractor issues.

Contractor-specific Error Rates

While the national error rate has helped us focus our efforts on preventing improper payments, we need stronger tools to uncover the real problem areas. Key to this effort is our proposal to develop contractor-specific error rates. For each contractor, we will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health-care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance, but also the billing practices of the health-care providers in their region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

We will establish baselines and then track each contractor's rate of improvement. The results will guide contractor's plans to reduce errors much as the overall Medicare error

rate has guided our national improvement efforts. We will begin this summer by determining error rates for the companies that process nearly 50 million claims each year for medical equipment and supplies for beneficiaries nationally, and we plan to perform similar evaluations for all claims-processing contractors.

Additional efforts focused on contractors include:

- **Strengthening contractor oversight.** The President's Fiscal Year 2001 budget requests \$48 million for new positions at the contractors and HCFA to tighten financial controls and ensure a swift, coordinated response to waste, fraud, and abuse. The budget also includes a provision for HCFA to competitively contract with a qualified entity to audit and evaluate financial management systems.
- **Issuing contractor report cards.** We are working with the IG to create report cards on each contractor's performance against specific goals and criteria. Contractors that perform poorly and fail to improve risk losing their Medicare business.
- **Requiring corrective action plans.** We have already requested corrective action plans from contractors for problems identified in the fiscal 1999 audit. We have developed written procedures for requesting, tracing, and disseminating such corrective action plans, including time frames for evaluating them. Each contractor must include a detailed description of each problem, specify details of actions and time frames to resolve them, and submit quarterly reports on their progress. We plan to hire a Certified Public Accounting firm to evaluate how effective these corrective actions are. And, we will include review of corrective action plan effectiveness in our standardized Contractor Performance Evaluation process.
- **Strengthening Regional Office coordination.** We are consolidating responsibility for contractor management among our 10 regional offices by establishing four Consortium Contractor Management Officers. They will be accountable for management of specific contractors and oversee staff with primary responsibility for contractor management.
- **Seeking contracting reform.** We continue to seek contracting reform legislation to allow Medicare to use all firms capable of processing claims and protecting program integrity. Existing law requires Medicare to use only health insurance companies to

process claims, and allows some providers to choose their claims processor. This has hampered our program integrity efforts, as the commitment to these efforts has varied widely among these contractors. And some of these insurance companies themselves have been convicted of violating Medicare program integrity. The IG and GAO have agreed that we need to create an open marketplace so we do not have to rely on a steadily shrinking pool of insurance companies and can bring Medicare contracting in line with standard contracting procedures used throughout the Federal government.

Financial Management

We are also taking several steps to address financial management issues. These include:

- **Developing an integrated financial management system.** We continue to work towards an integrated financial management system to standardize the accounting systems used by all contractors. The project, which will make it easier to coordinate and reconcile data, is scheduled for completion by 2004, pending the results of the assessment phase currently underway. The President's Fiscal Year 2001 budget requests \$7 million to support this essential project.
- **Consolidating accounting functions.** We are consolidating all accounting and CFO Act reporting functions in one organization. And we are establishing a new division to concentrate on internal controls and risk adjustment, and ensure that procedure guidelines and accounting policies are written, designated, and implemented.
- **Assessing staff needs.** We are engaged in an agency-wide planning effort to assess staffing needs, including those for financial management. We also will consult with outside experts to help us develop staff skills in financial analysis and other pattern analysis techniques that can help identify potential problems. In the meantime, we have initiated a short-term project to organize regional office staff currently involved with contractor oversight in order to facilitate better national coordination of efforts. And we are assessing other resource needs for optimal contractor oversight.
- **Improving guidance to contractors.** We are developing a financial management internal control manual with standards for evaluating contractors' financial management performance. We are working with an outside consultant who plans to seek further input from contractors, and then create a database that we can post on the

Internet with all our financial management guidance and instructions for contractors. We expect this to be completed by September. In the meantime, we will clarify for contractors our instructions for allocating cash receipts between the two Medicare trust funds. We also will update our manual of instructions for contractors on a yearly basis to incorporate results from oversight and evaluation efforts by us, the IG, and GAO.

- **Developing comprehensive financial management plan.** We are developing a comprehensive financial management business plan to identify the strategies that will achieve our objectives. This is being led by our newly created position of Associate Director for CFO Audits and Internal Controls, and should be completed this summer.

Protecting Data

Protection of beneficiary data is one of our highest priorities. We have made some progress in addressing audit findings about systems security, and expect to make more substantial progress now that we have met our Year 2000 information systems requirements.

- We are moving aggressively to address all audit findings concerning security vulnerabilities and expect these problems to be resolved by October 1, 2000.
- We have established a Beneficiary Confidentiality Protection Board to develop and enforce a comprehensive privacy policy
- We are developing a robust security architecture that will provide a solid foundation for building security into all of our systems development and maintenance activities, both internally and at our contractors.
- We are assessing new technology for securing internet-based transactions.
- We are providing security awareness training for all employees and ensuring that there are security and contingency plans for all of major systems and applications.
- We are working closely with other HHS components to develop a department-wide strategy for implementing Presidential Decision-Directive 63, which requires federal agencies to take aggressive measures to protect critical information infrastructure from cyber-terrorism.

Error Rate Reduction

To bring the payment error rate down further, we are:

- **Ensuring proper payment.** We will continue to aggressively work to reduce the payment error rate to below 5 percent by fiscal 2002 through our comprehensive program integrity plan and other efforts. Although Medicare pays virtually all claims correctly based on the information submitted, improper payments occur for reasons such as insufficient documentation, lack of medical necessity, and improper coding by providers. The error rate does not measure fraud, but can include improper payments related to fraudulent conduct.
- **Focusing on inpatient care.** Medicare's physician-led Peer Review Organizations are working with hospitals to investigate, correct, and prevent claims that are improperly coded, insufficiently documented, or for unnecessary or uncovered services. Our new contracts with them include strong financial incentives for them to reduce improper payment rates for inpatient care.
- **Hiring special program integrity contractors.** Using specific contracting authority provided by HIPAA, we last year chose 13 companies, including financial management and technology companies, as our first-ever contractors devoted to protecting the Medicare Trust Fund. These contractors, who have health care expertise, will help us tackle key tasks, including audits, medical reviews, data analysis, site visits, and provider education.
- **Expanding the correct coding initiative.** We will continue to expand the correct coding initiative, which uses roughly 100,000 computer edits to identify improper claims before Medicare pays them. Begun in 1994, the initiative prevents more than \$250 million in improper payments each year.

Working with Providers

We also are continuing efforts to help providers file and document claims correctly. This is particularly important, as the current audit shows that the error rate plateaued largely due to a sharp increase in documentation problems since last year. Missing or

inadequate documentation accounted for 41 percent of errors in the current audit, which is more than double the rate of such problems found last year.

To help providers file claims properly, we are:

- **Testing new documentation guidelines.** We will this year begin testing new guidelines for physicians on how to document evaluation and management services, which constitute the majority of Medicare claims. The guidelines will help ensure Medicare pays claims correctly while minimizing the paperwork burden for doctors.
- **Expanding provider education.** We will expand efforts to help doctors, hospitals, and other providers learn how to properly file and document claims. This includes innovative computer courses on our web site on the proper filing and documentation of claims, as well as satellite broadcasts and other efforts.
- **Contacting key providers.** We will directly contact all physicians, home health providers, and durable medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.
- **Initiating Progressive Corrective Action.** We are undertaking a new initiative in which we will share more feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims. We believe this can have a substantial impact in reducing improper claims among the vast majority of providers who make only honest errors.

CONCLUSION

Protecting program integrity and strengthening financial management and contractor oversight are our top priorities now that we have met our Year 2000 obligation. The findings of this year's audit and the GAO report on financial management will once again serve as a roadmap guiding us to further improvements.

We look forward to working with Congress, our IG and GAO colleagues, and our contractor and provider partners to ensure that we meet our obligation to pay claims properly, fight fraud, waste, and abuse, and responsibly manage Medicare finances.

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Mr. HORN. Ms. Snyder, do you want to add anything at this point, or just respond to questions? What would you like?

Ms. SNYDER. I will be responding to questions.

Mr. HORN. OK. Because of the complexity of this situation and the money involved, we are going to have 10 minutes per member. I'll start, Mr. Turner will be next, and Mrs. Biggert will be next. Then, if we need more time, we'll go back and have another 10-minute round.

I read Mr. Barr's quote there on how they were still paying out the payments to the dead, and I guess my query is this, Mr. Hash: the Social Security Administration faces the same type of problem, that they might still be grinding out checks. Is there a coordination between the Medicare file and Social Security so that we wouldn't be paying checks to dead people?

Mr. HASH. Yes, there is, Mr. Chairman. There are two sources of information about deceased beneficiaries—one is the Social Security Administration and, one can be from our health plan, our Medicare-Plus-Choice plans.

In the instance that Mr. Barr referred to and that you are talking about, those systems did not work properly. We've taken steps to modify the reporting system on beneficiary death, and we believe that those errors will not reoccur, and we have recovered the funds that were paid inappropriately as a result of those system errors.

Mr. HORN. Yes. It came right to mind that Social Security does this, and, of course, we built the whole idea of Medicare on top of Social Security, so I hope those agencies are talking to each other in their computers.

Mr. HASH. They are, Mr. Chairman.

Mr. HORN. OK. Now, both the Inspector General and the General Accounting Office have reported various examples of instances resulting from inadequate controls and the oversight of the Medicare program. Now, we also have learned about a bank participating in the Medicare program, which was making a practice of withdrawing funds prematurely from the Federal Reserve System, which allowed the bank inappropriately to earn interest of \$13.2 million. So I guess I would ask the Inspector General, Ms. Brown, could you describe how this happened and how it was discovered? I think we have a chart here on that.

Ms. BROWN. Yes. Mr. Vengrin actually ran the audit which is still in progress, I might add—and I'd like him to give you the detail on that.

Mr. VENGRIN. Mr. Chairman, there are two instances where the bank did premature draw-downs during a 10-day period in February 1999. There were instances where the bank actually needed \$60 million. They drew down excessively between \$110 and \$450 million. We computed the interest on that at \$740,000.

This review was done at the request of Michelle Snyder, the CFO, who did learn about this. I believe this instance here was learned from the contractor. The other one I'm going to describe to you was learned by the FDIC auditors, who did notify HCFA.

We do believe that the bank has monthly limits. This particular bank services nine Medicare contractors. At their disposal, under the letter of credit system, they can draw down approximately \$3 billion. It is going to be our recommendation to Health Care Fi-

nancing that they consider periodic caps other than a monthly basis that would preclude banks from doing this.

The second instance was during a 7-year period, from fiscal year 1993. This bank withdrew funds 1 day to 2 days in advance of when they needed cash. For example, Mr. Chairman, if the contractor notified the bank that basically it was going to electronic transfer \$60 million and also it needed money to cover current cleared checks, if the bank actually needed this money on a Friday they would prematurely draw it down on Thursday. This practice, the bank estimated earned the bank approximately \$12.5 million in interest.

The bank, on its premature draw-down a day early, sent the money over and sold it to another bank, earning interest.

That is a clear violation, Mr. Chairman, of the agreement that HCFA has with this bank; namely, that these funds should not leave the Medicare account. In fact, they did.

Our review is still ongoing, sir, and we should have the final results in a couple weeks. We're trying to go back and secure the records for the prior period to compute the interest.

Mr. HORN. Just so we're clear on how this process works, the FDIC found it when they went through the bank records; is that correct?

Mr. VENGRIN. Again, there are two separate issues. The latter one, sir, I believe the facts are the FDIC auditors did note it when they were at the bank and they did notify HCFA.

Mr. HORN. Now, that bank would regularly draw down to pay the various bills of what? The intermediaries? Or was the bank the intermediary?

Mr. VENGRIN. As the contractors processed their check electronically, they would forward that information to their bank. The bank would consider both the electronic wire that they needed plus the cleared checks minus any deposits.

So on Thursday afternoon they would ascertain exactly how much cash they needed, and they would pull this down 1 day in advance from the Federal Reserve.

Mr. HORN. Now, you're telling me that the regulations of the Health Care Financing Administration are quite specific on this; that you only get from the Federal Reserve the funds you need to pay the bills? Is that it?

Mr. HORN. My understanding, Mr. Chairman, is that is in the contract that the banks have with us and with our intermediaries and carriers.

Mr. VENGRIN. I confirm that, Mr. Chairman. It is clear.

Mr. HORN. So you are saying every bank that is doing this, getting the money to go out to the intermediaries to pay the bills of the hospitals, the doctors, and so forth, that they all should know that, that anything else is a violation? In other words, you're saying they can take the money out of the Federal Reserve the night before, and then they're supposed to issue the checks?

Let's say they take it out Thursday night and they issue the checks on Friday, but they're not supposed to keep running interest game on the float.

Mr. HASH. Absolutely not. And not only is that a violation of our contract, but, as I understand it, Mr. Chairman, it is also a viola-

tion of banking laws and, in fact, when it came to the attention of the FDIC, it was because the bank, as I understand it, was having difficulty meeting its obligation to get the money to the Federal Reserve Bank each day. It was late in transferring the money. As the bank examiners looked more carefully, they determined that, in fact, the money had been deposited overnight in another account, in another interest-bearing account, and that interest was being kept by the bank and it was causing them to be late to make their deposits in the Federal Reserve system.

Mr. HORN. Without objection, I would like the language that is in the Medicare regulations put at this point in the record so it is very clear that those regulations exist.

And you're saying all banks have signed off on that?

Mr. HASH. It is in their contract language, Mr. Chairman.

Mr. HORN. And how often is that reviewed?

Mr. HASH. I beg your pardon?

Mr. HORN. How often is that reviewed, that contract?

Mr. HASH. I think the contracts have been pretty stable over the life of the Medicare program. In fact, this bank has been a depository bank for the program since 1978. We do look at those contracts on an annual basis, but I think the substance of those contracts has not significantly changed over the years.

Mr. HORN. OK. But in all the audits by either the Health Care Financing Administration—let's ask if GAO had ever done those audits, and if the Inspector General. This is the first time it has come up, I take it?

Mr. HASH. Yes, sir.

Mr. HORN. But the tip-off was the FDIC auditors.

Mr. VENGRIN. Right.

Mr. HORN. So they had never discovered it either; is that correct?

Mr. VENGRIN. That's correct, sir.

Mr. HORN. Yes. And have they looked at other banks in the country now?

Mr. VENGRIN. I don't know whether they are, sir, but we are expanding our review and we've got pilots in three additional banks, and we're in there right now. Plus, after the results of this survey, we will reassess and expand it even further to make sure other banks are not doing this.

Mr. HASH. If I may, Mr. Chairman, when this matter came to our attention from the FDIC, we brought it immediately to the attention of the Inspector General's office and we did ask them to expand their review of these practices at other contracting banks, and we also sent letters reminding all of our banking contractors of these particular requirements. So we have tried to followup aggressively on this once it was uncovered.

In the first instance, it took place, as Mr. Vengrin described. Actually, what brought it to our attention was the providers who were served by a particular intermediary were not getting paid in a timely basis, and when they inquired about not being paid it turned out that that was a result of the banks not properly processing the electronic funds transfer in a timely manner, and that's how that happened to come to our attention.

Mr. HORN. Because of letting another bank use the money overnight and thus gaining the interest for bank one, does that mean that they were slow in getting the needed money to the providers?

Mr. HASH. I'll let Mr. Vengrin speak to this, because he knows more of the details than I, but I believe that the instance that I was talking about, which was the 10-day period of drawing down too much money, was a systems failure of the bank.

Mr. VENGRIN. That is correct. In the instance that you just described, Mr. Chairman, what happened, as Mr. Hash was alluding to, was they encountered trouble with the banking institute, because when they made electronic transfer, actually they were short of funds because bank B delayed getting the money back. So this set off the whistles and bells with the Federal Reserve System that money should have been there but was not, because of this delay getting the money back overnight from bank B.

Mr. HORN. Now, do we know if the Federal Reserve System is depending strictly on the FDIC auditors, or do they have their own auditors?

Mr. VENGRIN. I believe it is depending on the FDIC.

Mr. HORN. So where are we with the FDIC? Have they looked at all of these banks just to check them, or is that the Inspector General doing it?

Ms. BROWN. Well, I'm afraid I can't speak for what the FDIC is doing, but we have let everyone know that is concerned in this that we are expanding our review to see whether this is an anomaly, which I think it is, but it is possible that that has happened in other banks, and we want to make sure that that hasn't become a practice.

Mr. HORN. Well, can the Inspector General reveal what bank it is, or are they under review by the U.S. Attorney?

Ms. BROWN. They are not at this point. It is Highland Bank in Chicago.

Mr. HORN. And they have been a long-time bank for depositories—

Ms. BROWN. Yes, they have.

Mr. HORN [continuing]. To pay the bills. And do you know how far back that practice goes?

Ms. BROWN. We're going back to 1993, and it appears to have gone back that far, at least.

Mr. HORN. And when did they start? Are they considered an intermediary or simply the funding of the intermediaries?

Ms. BROWN. Strictly the people who arrange for the funds. The money is transferred to them, and then they are supposed to electronically, that same day, distribute the money that is needed as a result of the contractors work. Contractors let them know the exact amount that they are going to have to disburse, and they are supposed to take that exact amount out of the Federal Reserve and have it available for payment.

Mr. HORN. Do we know whether or not, when the money goes from the Federal Reserve to the bank in Chicago, and then goes to a variety—maybe a dozen or more—intermediaries that are paying the bills under either part A or part B of Medicare, how do we know they aren't keeping the money and not paying the hospitals or the doctors and making a little money off of it?

Ms. BROWN. The money never goes to the contractor. The money is available. The contractor makes it known how much is to be transferred, and the bank electronically transfers that amount for payment.

Now, there is another account where there are a few paid by check, but relatively few. Most of the money is electronically transferred.

So the bank is the only one who really has possession of the money, other than the Federal Reserve, and, of course, the recipient.

Mr. VENGRIN. Mr. Chairman, if I could embellish Ms. Brown's statement—

Mr. HORN. Yes.

Mr. VENGRIN [continuing]. HCFA does monitor the Federal Reserve draw-down on a monthly basis and compares monthly expenditures on a report called a 1522/21, so they do monitor that. There is a tie-in to the draws, as well as the expenditures paid.

Mr. HORN. Yes, Mr. Hash?

Mr. HASH. I want to say, since we've named the particular institution, Mr. Chairman, that that institution is withdrawing from participation as one of our contracting banks.

Mr. HORN. And has that already happened, or what?

Mr. HASH. It has happened. They served eight of our contractors, and I believe they have ceased serving seven of them. The remaining one they are serving is only to, I think, next month, and it happens to be a contractor that is otherwise leaving participation in the Medicare program.

Mr. HORN. OK. Any other comment, Ms. Snyder?

Ms. SNYDER. No, sir.

Mr. HORN. OK. I now yield to the ranking member, Mr. Turner, for 13 minutes. That's what we took here.

Mr. TURNER. Thank you, Mr. Chairman.

Mr. Hash, I'm interested in the use of sampling. I understand that the contractors are utilizing sampling. In many cases, I'm told by some of the providers that sampling methodology, when applied to an individual provider, can be very burdensome, and oftentimes of questionable validity.

Who sets up the standards for sampling techniques used on an individual provider?

Mr. HASH. Mr. Turner, what you are referring to is some of our program integrity activities, where we may be doing enhanced medical reviews of a particular provider because of a pattern we've discerned in their billing, and we go in and actually audit the claims or a sample of the claims to determine whether they can be supported by the medical record.

That process is governed by a statistically valid sampling methodology, which we would be happy to supply for the record. It has been reviewed independently by statisticians, and it is found to be an appropriate tool from which we can extrapolate to the universe of claims that a particular provider has filed with us.

Mr. TURNER. So you just go in and take one sample, and, based on that sample, the provider would be advised that they owe back X number of dollars? That's basically the way it works, as I understand it.

Mr. HASH. I believe that's correct, Mr. Turner.

Mr. TURNER. It just seems to me, from some of the discussions I have had with providers, that you could do a sampling process twice and come up with entirely different numbers; that there's not any way of really verifying that the sampling technique is all that accurate.

Mr. HASH. My understanding of how this process works is that when the sampling is done and the extrapolation is computed, that a provider has the option of having all of their claims more intensively reviewed or to accept the results of the sample. Most providers have accepted the results of the sample, but they're not bound to accept that result. They have the option for a more-thorough review of all their claims.

Mr. TURNER. But if they exercise that option, which is quite a lengthy process, and during that interim they're still charged back for the amount that the sample reveals they owe the Government. Isn't that the way it works? And so it is very difficult for an individual provider to want to exercise that option of having all their claims reviewed.

Mr. HASH. I'm not totally certain of the detail of that, Mr. Turner, but I would be happy to get you a more-definitive answer.

I believe that they have the option to have a more-intensive review. During the pendency of that review, what I'm uncertain about is whether the extrapolated amount is beginning to be offset from the future claims that they may be submitting. I don't know.

I would like to get a more-complete answer for the record, if I may, Mr. Turner.

Mr. TURNER. For example, I would be interested in knowing what the policy is if the sample is taken and the provider immediately shows that certain individual payments that you put in the sample were simple errors—somebody forgot to make an entry, or something that didn't represent any fraud or really any actual over-payment, but just a clerical oversight—whether those can be corrected and that sample adjusted and the extrapolated number changed in short order.

Mr. HASH. The answer to that I'm more confident is yes. And, clearly, this process is not designed to make a judgment that, in fact, the ones that are in error are in error because of intentional fraud. They just happen to be erroneous for various reasons, some of which you have just suggested. But it is not a judgment that, in fact, the errors are the result necessarily of intent or wilful defrauding.

Ms. SNYDER. If I could add, Mr. Turner, this statistical sampling methodology was well discussed and well reviewed, both by the provider community as we went through this process, and the statisticians who worked with us in figuring out how to select and assess those samples.

Mr. HORN. Ms. Snyder, you're going to need to put that microphone within 2 inches of your mouth. That's the only way we can hear you.

Ms. SNYDER. The statistical sampling methodology, as I was saying, was well reviewed by the provider community. This statistical sampling methodology was presented to the provider community as we started to move to that type of sampling technique. We worked

through it with them. We had a number of meetings with different groups. There were a number of independent statisticians who looked at this to say it was a sound methodology.

If I might, it's the same type of methodology that is used by the Office of the Inspector General in doing the statistical error rate.

So we've tested this in a number of ways in a number of sort of formats, and so we are pretty confident that it is a good way of projecting those overpayments as a way of also saving resources, and working through it pretty quickly.

There are also, within the process, itself, opportunities to correct the kind of errors that you mentioned. If we get into that and we find out it was simply the document was missing, they can submit that. If, for some reason, a plan or something that needed to be there as a process matter isn't there, we accept that. That does modify the amount of the overpayment.

It is not perfect, but, we think, in light of resources and the dollar volume that is involved, it is a good way to estimate the overpayments.

Mr. TURNER. When there is an overpayment determination made after the provider has exercised whatever options they have to appeal, what is the options for how to handle the repayment of the overpayment? I know there are many providers who complain about the fact that once they have been assessed an overpayment they really, in some cases, can't even figure out financially how to handle it. So are there options that you have for the providers there?

Ms. SNYDER. Yes, sir, there are. From the agency perspective, though, I must say our preferred option is that we have a continuing business relationship with them to net that overpayment out of the next month's payments that are due to them, and we do collect a lot of our debt through offsetting collection and have been pretty successful.

But when we have folks that are having financial difficulties, we do work with them to do what we call "extended repayment" plans, where we look at their financial ability to repay, and I think an example of that where we've used it quite a bit is with our home health agencies, where, as many of you probably know, there were difficulties there because of changes in payment methodology.

So we do work with people to try to do extended repayment plans. If we have to have an extended repayment plan, we like to do it within 12 months. We have gone up to 3 months, and in some cases even longer than that, so we do try to work with the provider and consider their financial viability.

Mr. HASH. If I may, on the home health I think what Ms. Snyder meant to say was up to 3 years, because in the case of home health agencies who had overpayments as a result of the interim payment system, I'm sure you may be aware that we have provided many of them with up to a 3-year and some longer than 3-year opportunity, the first year of which has been interest free.

Mr. TURNER. How many home health agencies do we have in this country today, as compared to, say, 3 years ago, before the changes were implemented?

Mr. HASH. I think we were, 3 years ago—and these are round figures. I would be happy to get more specific for the record; 3 years ago we had 10,500 agencies, and now we have about 7,500.

Mr. TURNER. You have an initiative that I understand will begin this summer with four companies that will take a look at the durable medical equipment providers. Why were those providers selected, as opposed to any others, for this particular emphasis?

Mr. HASH. I think, in part, the Inspector General may want to respond to this, as well, but this is an area where we have uncovered significant problems in billing, particularly in the documentation area. Durable medical equipment items are generally—not all of them, but many of them need to be accompanied by something called a “certificate of medical necessity,” which is a document that is executed by a prescribing physician that details what he believes an individual patient needs, and that that document must be present in the records to justify a claim for certain items of medical equipment and supplies.

We’ve had problems in documentation that have been pretty significant. As a matter of fact, I think this year’s audit indicates that that is a significant problem.

We have a select group of contractors who process only claims associated with durable medical equipment, and what we are going to do—we are going to eventually do this for all of our contractors, but, beginning this summer, we are going to put into place a procedure for calculating an error rate, and we are going to take the same approach that the Inspector General’s annual error rate activity on the national basis does—draw a sample of claims from each of these durable medical equipment contractors—intermediaries or carriers, I should say—and determine their error rate using the same statistical methodology that is being applied to generate the error data that we have been talking about here this morning.

That is really for two purposes: in order for us to be able to work with those contractors to improve and correct the reasons for the errors that we find, and it also gives us an opportunity to focus our oversight activity and contractor management on those areas where error rates are a significant performance problem.

Mr. TURNER. I’ve read that the total Medicare claims in this country are much lower than had previously been estimated. Is that because of the aggressive work that you have done to try to attack overpayments, or are there some other elements that resulted in the estimates of total Medicare payments being lower?

Mr. HASH. Mr. Turner, I think the answer to that is that it is a multi-faceted set of reasons for why estimates of Medicare expenditures have not, in reality, been as high as previously estimated.

A significant portion, we believe, is related to a greater scrutiny and intensity of our review of claims processing, which we think has had an effect of making providers more knowledgeable about proper ways to bill and more sensitive to the accuracy of their coding and those kinds of activities.

We also think that there are significant changes in the economy, in general, that have affected Medicare expenditure rates. For example, for the last several years we have had extraordinarily low

inflation rates, which means that the cost of medical care that Medicare pays for has not risen as rapidly as was anticipated a number of years ago.

We also have had some changes in our payment systems that have probably slowed down the processing of claims in some regards, and that has caused, in various accounting periods, for things to lag over into another accounting period and to produce a lower outlay of expenditures.

So I think the most accurate answer is that there are a number of factors that are contributing to the lower growth in Medicare expenditures. No one has been able to pull out from that experience exactly what portion is attributable to fraud and abuse activities, although we think it has played a significant role.

Mr. TURNER. Thank you. Thank you, Mr. Chairman.

Mr. HORN. I thank the gentleman for those good questions, and now I yield 13 minutes to the vice chairwoman of the committee and the gentlewoman from Illinois.

Mrs. BIGGERT. Thank you, Mr. Chairman. Is there something special about 13 today? [Laughter.]

We've heard testimony today focusing on the payment errors, incorrect coding, and non-covered services and the lack of medical necessity. Mr. Hash, you just said you don't know what part of some of these categories would be attributed to fraud. But I am concerned, in a report by the GAO which was done in October, I think, of 1999, that there is a growing trend in Medicare fraud that has a criminal element coming in with absolutely no medical experience, licenses, and training who are getting into the Medicare program for the sole purpose of bilking the system.

In this report that was released, it looked at fraud in three States—Florida, North Carolina, and my home State of Illinois—and they reviewed seven cases and found as many as 160 sham entities submitting fake Medicare claims, ranging from \$795,000 to more than \$120 million.

The GAO said, "Criminals previously involved in other types of crime are now migrating into the health care fraud arena."

I wonder if you could comment on this, and then I have just a couple of questions to ask you on that.

Mr. HASH. Yes, Mrs. Biggert. We have been trying to address that kind of problem by strengthening the enrollment process—that is to say, the process that providers and other people who are rendering services to Medicare beneficiaries must go through in order to obtain a billing number, a provider number, which allows them to bill the program.

We are, for example, doing site visits for certain kinds of providers where we think the prevalence of unscrupulous and unqualified providers is very high.

For example, we are now doing site visits for people who are applying to get a provider number as a durable medical equipment supplier. We are also putting into place a regulation which will allow us to, in effect, go back and recertify providers to make sure they continue to meet the requirements of the law and regulations.

So we have, I think, a significantly aggressive program to tighten up on the procedures for admission into billing into the program, and I would be happy to also furnish more detail about that.

I don't know if you want to add anything to that, but we figure the most important thing is to keep people out of the program who don't meet certain basic qualifications, and we have been trying to do a much more effective job of that.

Mrs. BIGGERT. Well, specifically, do you require background investigations on all new providers?

Mr. HASH. In the case of suppliers of durable medical equipment, we are doing the checks to determine whether they've had any record of fraud or abuse with our programs or any other criminal activity.

Mrs. BIGGERT. Is that for every provider, or is that a sampling?

Mr. HASH. In the case of durable medical equipment, I believe it is virtually all of the ones who are applying now to get a number for that.

We are also in the process of going back and reviewing durable medical equipment suppliers to make sure that they are a bona fide business entity, that they are, in fact, meeting appropriate requirements.

Mrs. BIGGERT. Is there, then, a requirement for site inspections of all new DMEs?

Mr. HASH. We are doing that now. Yes, ma'am. That's my understanding.

Mrs. BIGGERT. Of all sites?

Mr. HASH. All new ones who are applying for a Medicare provider number.

Mrs. BIGGERT. OK. And what about community health centers?

Mr. HASH. We are also doing site visits there, both for ones who are already billing us, as well as the ones who are applying to become a part of our program.

As you know, the statute has provided that these organizations must provide four core services laid out in the statute. We determined that a number of them have not met those requirements, and if they were already in the program, we have lifted their certification. If they were applying, we did not allow them to receive Medicare certification.

There are also some changes that need to be made in the design of the partial hospitalization benefit that community mental health centers are often providing, and in the President's 2001 budget proposals there are some important legislative recommendations to tighten up the design of this particular benefit.

Mrs. BIGGERT. Well, we have been talking about Medicare, but what about the Medicaid program? The Inspector General has reported the need for estimating the amount of improper payments being made in the Medicare program. Why isn't this being done?

Mr. HASH. Well, the payments under Medicaid, of course, are made by State agencies, and some of them have contractors who actually make the payments. We have, in fact, launched an effort, through our regional office in Atlanta, of Medicaid fraud and abuse activities around the country. We have a website that shares best practices in identifying waste, fraud, and abuse in Medicaid. We've run a number of national conferences associated with Medicaid fraud. We've tried to bring together the State fraud units, the attorneys general, as well as the Medicaid program administrators to work together to establish stronger protections against fraud.

With respect to your specific question, we are now working with the States to see if we can get them to apply a methodology of calculating an error rate in the administration of the Medicaid programs.

Mrs. BIGGERT. Thank you.

Ms. Brown, you were talking about the bank, and that's the Highland Community Bank? Is that the name of it?

Ms. BROWN. Yes.

Mrs. BIGGERT. OK. Do you believe that if you had criminal prosecutorial powers—in other words, if you had the laws that would allow you to prosecute criminally, would that help you?

Ms. BROWN. Well, we do, of course, prosecute a great many criminally every year, and also have civil settlements with many of those folks that, for one reason or another, good reason, they are meant to stay in the system to provide the service and there aren't other alternatives.

We not only get a monetary collection—

Mrs. BIGGERT. I guess I was thinking of full law enforcement authority within your agency. Do you have that now?

Ms. BROWN. We have law enforcement authority, but the full law enforcement is done through a blanket deputization from the Department of Justice. We have about 300 criminal investigators that are out doing this type of thing.

Between 1997 and 1999, while we were getting the HCFA funding, which was provided by Congress, we won or negotiated over \$2.2 billion in judgments, settlements, and administrative impositions of fines, and collected \$1.6 billion back to the trust fund from that amount.

We had 1,085 defendants that were convicted for health care fraud and related crimes, and 8,697 individuals and entities have been excluded. My office processes the exclusions, where those entities can no longer work in any government health care system. So it is effective not only with Medicare, Medicaid, but Tri-Care from Department of Defense, VA, and other types of medical programs.

Mrs. BIGGERT. When providers who are unscrupulous use recruiters to obtain beneficiary identification numbers so that these providers can bill for services, there is no statute to prohibit such a practice, is there?

Ms. BROWN. Well, we use a variety of statutes, even RICO, which would be conspiracy. We have found such things as a room about this size filled with medical records from floor to ceiling which we have subpoenaed. Not one of those medical records are true records. They have all been actually produced by this criminal element who were providing no services but were taking extensive care to actually develop medical records against which they could charge millions and millions of dollars to Medicare.

There are many cases like that. Many of them have nothing to do with honest providers. These are people who have found, in the past, at least, it was easy to get into the system and get a Medicaid number so that they could start billing, or Medicare number, and they could start billing as a provider.

We have a very small percentage who are not actually medical professionals who have been providing honest services, or even dishonest services. Most of these that we find that have conspiracies

are not medical folks or real providers, but people who have gotten into the system, as you mentioned.

Mrs. BIGGERT. How have you discovered them?

Ms. BROWN. We have a variety of ways, some even from our congressional Representatives that send us leads. We get about 50,000 calls a month on our hotline, which we screen. We have an active, large group of people who answer this hotline. They're really speaking to an individual, even with Spanish-speaking operators where that is appropriate.

We have a lot of things that are referred from the auditors, when they go in and find that there not only are discrepancies, where they should get money back, but it appears there could be something more behind that. They turn that over to the investigative units who followup.

We do a lot of analysis of the payment trends. If we see something, for instance, that there is a 1,000 percent increase of a certain type of payment and not an epidemic that would give a reason for this kind of thing, we look into it and see whether it is an audit issue, whether or not it might be an investigative issue, or there is some new billing scam that is going on.

Mrs. BIGGERT. Would you agree that there is a growing criminal element trying to make a profit off of the Medicare?

Ms. BROWN. I think the Medicare program was developed by people who really wanted to provide service to the beneficiaries, and they did not take all of the precautions to keep everybody out who would want to bilk the program. It became well known that there is a lot of money here, and it was pretty easy to get a provider number and start billing. We even have cases where people learned about it in jail from jail mates, came out and did business together—had no medical background whatsoever, but learned about the ease of getting into this system.

Now, as we developed these cases, of course, we had extensive meetings with HCFA, and many of the precautions that HCFA is now undertaking, which were described by Mr. Hash, were as a result of that.

The first time I think it was HCFA folks that went out and checked about 10 new DME applicants they found about 7 of them were just fronts—you know, an entire store or something where somebody had an extra telephone in the back room that they used to answer any questions about their DME business. They had no business, no supplies, no legitimate contacts of any kind.

Mrs. BIGGERT. Is there anything else that you think that we can be doing legislatively to help?

Ms. BROWN. Well, we have presented different possibilities. Most of them take funding. And so if we can get the budget for them, there are a number of additional things that we can do that I think would certainly help a great deal.

We are getting back in my office in the last 2 years, \$98 and \$99 for every \$1 spent, or at least savings of that nature. And HCFA certainly has seen this decline in the inflation of what they have to pay out for Medicare.

So I think that the combined efforts are really producing a lot of results, and they are very cost effective, and for both of our of-

fices additional funding would allow us to do more. That is always the constraint.

Mrs. BIGGERT. Thank you.

Thank you, Mr. Chairman.

Mr. HORN. Thank you very much.

I am going to ask Ms. Jarmon, on behalf of the General Accounting Office, you stated that the Health Care Financing Administration has not yet established an adequate foundation for control and accountability over Medicare programs, financial operations, and you further stated that the Health Care Financing Administration lacked two key components to successful financial management reform. Could you elaborate on some of the problems you have found and what the Health Care Financing Administration should be doing in the short term to address those problems?

Mrs. JARMON. We believe there are several key initiatives that are ongoing, and, like we said, if successfully completed—

Mr. HORN. You might want to move that microphone closer.

Mrs. JARMON. OK. The two things that we were referring to there was the need for a very comprehensive plan or strategy to address the audit findings that have been reported over the past years, because, like I mentioned in my statement, several of their weaknesses have been reported since 1996, the key weaknesses that we saw related to oversight of the contractors, financial reporting and systems problems, and the problems with the EDP controls, and the computer security controls. But I know that HCFA has an initiative underway to develop a comprehensive plan to look at their human resource needs, and we just think it is very important that those initiatives are completed timely and that the results are seriously considered to address these longstanding problems so that we are not here next year talking about the same material weaknesses.

Mr. HORN. And you are saying, from GAO's eyes, that the administration there is taking the advice and implementing it; is that correct?

Mrs. JARMON. I think many of the initiatives that they have started are relatively recent or over the last 6 or 7 months, and we are encouraged by those, but I think it is too early for us to say what the results will be.

Mr. HORN. How about it, Mr. Hash? Are you going to address the GAO concerns?

Mr. HASH. Well, Mr. Chairman, we actually think the glass is at least half full. We have embarked on a number of efforts to address financial management concerns, both within the offices of HCFA, as well as, importantly, in our contractors.

On the longer-range track, because of our attention to Y2K, we have not been able to implement as quickly as we would like an automated dual entry accounting system at all the contractors, which can also interface with HCFA's systems in the central office, which would be a much more effective way of monitoring financial controls across our contractors.

We expect to have that in place by 2004, but, in the meantime, we have undertaken a number of efforts to put into place special automated systems related to accounts receivable. We are also particularly addressing, within that, the area of Medicare secondary

pay. These are liabilities owed by other insurance companies or employers because the Medicare is the payer of last resort. That is a significant part of our accounts receivable, and we are taking a number of steps to address that.

We are also hiring a number of CPA firms to go out and do independent reviews of financial controls at contractors. In the course of this year, I believe we will be visiting 25 of our contractors that represent over 80 percent of all the Medicare dollars, and we will be doing financial audits of their financial systems to ascertain what kinds of changes need to be put into place to be sure that they are accurately reflecting financial affairs and that they are following proper procedures.

In my longer written testimony, I outlined a number of significant initiatives to strengthen internal financial controls.

Mr. HORN. Ms. Brown, as Inspector General is there anything else you would like to see them do?

Ms. BROWN. Well, I think that HCFA is taking some good steps in the right direction. As Mrs. Jarmon said, it is too early to evaluate the results of those things.

I do want to add that I was quite appalled. I think, of the whole financial statement process, the most astonishing thing to me was that there was essentially no financial system at these contractors, because it was not specified expressly in the contracts. They do not even have double entry bookkeeping systems. They do not have subsidiary ledgers, so that if there are amounts owed back to the Government, they did not even have records, in some cases, of who owed that money. So, of course, it would be impossible to ever collect it.

I am sure the Congress had the intent of getting experienced, reliable people from the private sector when they set up the system of only using insurance companies to pay these claims. There must have been an assumption that they would use the same kinds of financial controls. They do not. And I think HCFA and the Department have, for a number of years now, asked for greater flexibility in who they contract with, and that would certainly go a long way in making this more competitive.

They are taking steps now to try to get the contractors, even though it might not be a specific provision in the contract, that they have to use generally accepted accounting principles, as would anybody in the private sector. Up until now, they are not available.

Mr. HORN. Mrs. Biggert asked the question on what laws do we need here, and I guess I would ask, can the administration implement that by administrative regulation so you do need legislation?

Mr. HASH. With respect to the financial control matters, I think we have administrative discretion to do contract changes. With respect to the broader issue that the Inspector General spoke to, which is the shrinking pool of contractors that, under the law, we are allowed to do business with, it is a real impediment for us. For, I think, 5 or 6 years running, the Administration has submitted to the Congress legislation asking for authority to have greater flexibility more like the Federal acquisition regulations that exist for other agencies to identify appropriate and qualified entities to contract with us for claims processing.

Mr. HORN. Well, I have never seen it, so do me the favor of getting together with the Inspector General and sending me the language you need.

Mr. HASH. I would be happy to do that, Mr. Chairman.

Mr. HORN. Because when it comes to economy and efficiency, we have got jurisdiction. I realize you have got authorizing committees and they sometimes, for one reason or another, have other things to do.

I think it is very important that you have the legislative language you need, so let us know about it.

Mr. HASH. Could I just followup, Mr. Chairman, for a moment about actions that were taken that I did not mention a moment ago that the Inspector General's comments triggered in my memory?

One of the things we are doing is amending our contracts with all of our contractors to make it a contractual obligation to submit to us detailed plans of corrections related to audit findings, to give us a plan with timeframes and milestones for meeting and correcting those deficiencies, and to actually make that a part of their contractual obligation, which has not been in the past and, I think, importantly, the development for all contractors of an error rate methodology that will help us to determine the performance level of our contractors by taking a sample and subjecting it to the kind of analysis that the Inspector General does on a national basis.

So those are, again, I think, important tools to strengthen accountability in financial management by our contractors.

Mr. HORN. Well, that is very helpful.

Now, you mentioned 2004. Why cannot we speed that up? What does it take to speed it up?

Mr. HASH. Let me ask Ms. Snyder to talk about what is involved in the design of this, but it will be a system that is double entry automated accounting system. It will also interface with the new financial management system within HCFA. So we are actually putting together both a new financial management system for contractors, as well as for HCFA.

And the goal here, of course, is to make sure that we can roll up in a comparative way information about performance of the contractors across the country. We can compare fairly one contractor to another.

Mr. HORN. So you would use the software, I take it, and develop it for all of the various intermediaries?

Mr. HASH. That is correct. And, unfortunately, Mr. Chairman, I do not believe it is an off-the-shelf product. It is one that has to be designed, and I think that accounts for the time.

Part of the delay is, of course, associated with our Y2K obligations, and obviously put us behind. We are looking at whether or not off-the-shelf products could meet our needs in this area, and therefore accelerate our time table, but maybe you would like to elaborate a little bit on the plans for this system.

Ms. SNYDER. The Administrator and the Deputy Administrator have charged me and the Chief Information Officer, Dr. Cristoff, who I know has appeared before you many times—

Mr. HORN. Right.

Ms. SNYDER [continuing]. To develop the integrated general ledger accounting system.

Dr. Cristoff and I are absolutely committed to doing this the right way, which I think has a lot to do with the schedule, the estimation of 2004.

We have pulled together that project team. We brought in a senior systems expert to head that team, someone who had had a lot of experience over at the Social Security Administration. So Dr. Cristoff and I think we have the right resources in place.

The thing that makes this a long-term problem is just the fact that we have business at so many different entities. If we had a central mainframe kind of operation, it would be a pretty easy thing, but what we have is distributed processing over many different locations and many different sites.

We are going about this very carefully. We are using Clinger Cohen to estimate what is the best way to go about this, how should we do it. We are looking very, very carefully at the commercial, off-the-shelf software that is out there that has been approved and certified by the joint Federal management improvement program.

We do not want to reinvent the wheel. If we can get functionality out of something that is already there, we are going to use it. In fact, as an interim step we are going to try to look at, over the next year, commercial, off-the-shelf software that is on the schedule so that we can get some control over the accounts receivable in an automated fashion sooner than 2004.

But I think the reason for the longevity is the complexity of the project, the fact we just want to do it right, and we want to follow all the technology guidelines.

And it is a two-part—I think this is important, too. At the same time we are doing the contractor piece, we are looking at our financial accounting system in our headquarters and in the HCFA system, itself, because those two things have got to be able to work together if we are going to be able to produce the audited financial statements from an accrual perspective.

Mr. HORN. Well, I am glad to hear that you are going to try to get it off the shelf, because I think I can go back to my freshman year here in 1993–1994, where the FAA blew \$4 billion before the plug was pulled. There was no management in that project. I could walk through the door and you could tell right away there was no management. Everybody had their new bright idea at 7 a.m., the next morning and there was no focus, no time table, no nothing.

And then, of course, the IRS blew \$4 billion and did not get anything out of it.

So I wish you well, but what it takes is on-the-site management that says, “Folks, we just cannot have every idea in here. We have got to do this by this time, et cetera.”

If you manage it well, it ought to work. But I know what you are going through, and we have asked the General Accounting Office to go look throughout the executive branch on both the capacity, the generation that both the hard frames as well as the software is and see if we cannot upgrade the executive branch, and we ought to do that.

You mentioned, Mr. Hash, that you said the Y2K obviously held you up a little, but I would hope in that Y2K exercise that you would say, “Hey, do we really need this? Get rid of that system,

and merge this,” and so forth. I would hope it would be a constructive exercise when you look at it from that perspective.

Mr. HASH. Absolutely, Mr. Horn. We clearly learned—I think there are a lot of silver linings to the Y2K experience, particularly in the ADP area, and I think the extensive attention, renovation, testing, and retesting has really helped renovate all of this in a way that hopefully this kind of project will benefit from, just as you indicated, because I think our systems, claims processing systems, have never been so thoroughly renovated as over the last 2 years, and that has got to—will pay dividends, I think, in putting in this management information system for financial controls.

Mr. HORN. Before I yield to Mr. Ose, let me ask, you mentioned the Atlanta website. Is that just for waste, fraud, and abuse in that area?

Mr. HASH. No, sir. It is a website, a national website, and it is not just in Atlanta, by any means. Atlanta happens to be the regional office that heads up our efforts on Medicaid waste, fraud, and abuse.

That website has been contributed to by State fraud units, by Medicaid agencies, by States attorneys general, and a host of law enforcement and programmatic people, and what it includes are information about successful investigations, best practices, ways in which you can more appropriately target your law enforcement and oversight responsibilities to get the most yield from the resources that are available.

So it is a tool to actually bring together and strengthen the efforts of a multiple group of folks who are involved in waste, fraud, and abuse for Medicaid.

Mr. HORN. Besides WWW or whatever, what comes next in access to it? Or just send it to us.

Mr. HASH. I will send it to you for the record. I do not want to misstate it.

Mr. HORN. Thank you.

Mr. HASH. It also has a compilation, importantly, of State laws that have been passed to address fraud and abuse in Medicaid, and that is very important, because other States, who are trying to strengthen their Medicaid fraud activities, want the benefit of the laws, themselves, as tools, and this website includes information about laws that States have passed to provide more effective tools to law enforcement.

Mr. HORN. Well, let us know what the access is on it.

The gentleman from California, Mr. Ose?

Mr. OSE. Thank you, Mr. Chairman.

I think I would like to direct my questions to Mr. Hash, initially.

One of the things we struggle with up here is that oftentimes it seems that the interpretations HCFA puts out for Congress' intentions diverge from what we on the Hill think might have been the point. I am trying to find out—and I did not see it in the testimony—who is responsible for making such interpretations? In other words, who do I call up and say, “No, I disagree with your interpretation”?

Mr. HASH. Well, in our regulation or in our guidance, where we exercise administrative discretion under the law, then the account-

able individuals are the administrator of our agency and the Secretary of the Department.

Mr. OSE. Pardon my ignorance. What would those people's names be?

Mr. HASH. Secretary Shalala and Administrator DeParro.

I mean that in the sense of, when we make regulations in the Medicare program, they are technically regulations of the Secretary. Under her authority, under the law, she is issuing them, so the process of developing those regulations, while they start in the Health Care Financing Administration if it is on Medicare—and we are certainly accountable for that—they are also reviewed by the Department of HHS, as well, because they represent the Secretary's use of her authority under the law to implement the Medicare program.

Mr. OSE. The reason I bring it up, there is not a single Member of Congress on any side of any aisle who has not heard the horror stories that constituents or their parents have been faced with when various service providers say, such as Vencor or other convalescent hospital and nursing home facilities, are put in a position where they have to cut therapeutic services and the like in order to continue to cover their basic housing costs of operation.

I do not believe it was the intention of Congress to, in effect, provide with one hand various services and take away by administrative fiat with another hand, and I am just curious what your audit—what role the audit process plays in reconciling congressional intent with administrative ruling on these reimbursement rates.

Mr. HASH. Well, in terms of the audit, I would yield to my colleagues from Inspector General's office, but, with respect to implementation, for example, of the prospective payment system for skilled nursing facilities that you may have been referring to, Congress included a very significant change in the Balanced Budget Act to how we pay for services in nursing facilities. That law was quite prescriptive in its design of what the payment system is.

For the most part, I think you would find that, in publishing the regulation that implemented that payment change, the law was largely self-executing. In other words, the law was very specific about exactly how that new payment system should be operated, and we did not exercise discretion. We did not have under the law very much discretion at all with respect to that payment system.

Mr. OSE. I am also aware of Congresswoman Northup's letter last fall that, in the space of about 2 hours, collected over 180 signatures on the floor of the House, challenging the interpretations that had been implemented relative to the 1996 BBA, and I think was a great contributor to the additional funding the House put forward last fall in the—I do not recall if it was the BBRA, or whatever you call it. I lose the acronyms after a while.

But it is my intention to inspect congressional intention there so that you will respect congressional intention there. I appreciate the information that you have provided so far.

I want to move on to the other two questions I have.

One of the things we struggle with, particularly in my District, is that being so efficient to date, as it relates to the operational side of various providers, our cost base is relatively low, compared

to, say, New York or Florida or whatever, and I am wondering whether or not—and this might be more accurately directed to Ms. Brown—I am wondering whether or not you have any data comparing reimbursement rates for Medicare services amongst such regions—for instance, this one. I apologize for picking on Illinois. It is not my intention to pick on Illinois, but do you have a comparison of the reimbursement rates provided in California with, say, Illinois or Alaska or New Mexico for any given service?

Ms. BROWN. That would be HCFA's responsibility to determine the rates by region.

Mr. OSE. Back to you, Mr. Hash.

Mr. HASH. Yes, sir. We do have information about the rates that are paid in different parts of the country. Obviously, each one of the provider categories has, generally, its own payment policies, and they vary quite dramatically, but—

Mr. OSE. By region?

Mr. HASH. No, no. I mean just the basic way we pay hospitals or nursing homes or home health agencies or physicians or the durable medical equipment suppliers. All of those are different payment systems, but all of them have embedded within them procedures for adjusting them to reflect the various costs that are associated geographically, usually on the basis of wage cost, because wage costs frequently make up such a large portion of the cost of the service. We have a national wage index that provides for payment adjustments in many areas, based on the cost of labor to provide the services.

So we do not have in the Medicare program uniform national rates where we pay the same amount for a service everywhere in the country.

Mr. OSE. Do the adjustments accurately reflect inflation or the ability of a region, for instance, where they have had significant HMO investment and involvement, significant savings generated by that—I guess I am more accurately asking what are the adjustments based on.

Mr. HASH. The adjustments typically are based on either the relative cost of wages in the particular locality—and we have a wage index that does that—and they are adjusted with respect to inflation, as measured by several different indices—the CPI, or there is a medical care inflation index. Those are typically the kinds of adjustments that payments get made, or that are made to payments.

I am trying to answer this in the most specific way I can. If you are asking why typically there are differences in payments between rural and urban areas, much of that is the result of, in the Medicare program, historic differences in the costs that have been reported for those services in those different areas, and that has been kind of the basis.

As you look around the country and compare costs for medical care in different marketplaces, they vary, as I know you know, very dramatically from one area to another.

One of the best illustrations of the range of variation is we calculate a per capita cost for Medicare in each of the counties, over 3,000 counties around the country. We have done that for purposes of the method for paying for managed care organizations. But what that number shows to you is that on a monthly basis the range is

from something like \$230 a month to as much as nearly \$800 a month per person in terms of the Medicare expenditures that are made on a county-by-county basis. So that produces different payment rates.

Mr. OSE. I would submit to you, at least as it relates to the seven rural counties that I represent, that the algorithm you use to come to that payment level does not equitably reflect, if you will, a minimum survival level for provision of adequate medical services. That has resulted in a reduction in the level of medical care available in many of the rural counties that I represent.

I would hope that you would convey that back to your colleagues, and perhaps we could have some attention focused on that.

Mr. HASH. I agree. It is an important issue, and one which we need to pay attention to, because providing access to our beneficiaries who reside in rural areas is an important concern and objective of our program, and we definitely want to work to make sure that there is not only adequate access, but that the quality of care that beneficiaries receive who live in rural areas also meets the highest standards.

I think in some of these cases, if I may, the differences relate to the way in which the statute is designed, and that really calls on all of us to take a look at those payment systems and see whether they need to be revised in light of the experience that some rural health care providers are having.

Mr. OSE. I appreciate your comments. The reason I broach this subject is that I would hate to get us in a position where, for financial reasons, we find ourselves quite literally denying medical service to those folks who live in rural areas.

Mr. OSE. Mr. Chairman, if I may, one other question and observation.

In my District, we have a very efficient number of HMOs, and you can like them or dislike them, but they are a fact of life. Oftentimes, under the prospective payment system, they end up in a situation where they will self-report having received an overpayment from Medicare and attempt to return such funds to Medicare, as the law requires.

The thing that I find most incredible is that, in the situation I am familiar with related to some \$7 million, the provider has proffered the money back to—having identified it by themselves, proposed returning the money, and they find themselves in a dispute with Medicare over whether they can return the money and the circumstances under which they can.

The thing that is so aggravating is that, instead of being able to return the money and going on about business, having self-identified it—it had gotten past all the other auditors—they now find themselves in the position of spending scarce resources battling with Medicare over legal issues that they brought to the table in a good faith effort, rather than providing medical services to their participants.

I cannot tell you how aggravating—I mean, I love attorneys. Do not get me wrong. But I cannot tell you how aggravating it is to take scarce resources and quibble over this, that, or the other thing when we could use those resources to provide medical care.

So I am curious whether or not, either in the course of the regular audit or the operational side, Mr. Hash, whether we have any information regarding the aggregate cost that arises in circumstances of this nature across the country, where a provider has self-reported overpayment and then ends up in the position of battling to return the money, having to spend money to battle rather than money to provide medical service.

Mr. HASH. Well, I share the frustration that you have just voiced on behalf of folks in your District, because there has been, I think, in the past an issue about the procedures for the acceptance, on the traditional fee-for-service side of Medicare, by our contractors of voluntarily returned amounts.

What we did last year—in fact, it will be a year next month—in April 1999 we sent out guidance to our contractors, the fiscal intermediaries and carriers, and informed them that they were to take checks or cash or whatever the instrument was to convey the money and to deposit it into their account, and then, subsequently, we would determine the proper allocation or crediting of that to the proper trust fund, and so forth.

But the failure of contractors to have had procedures in place to accept and deposit such refunds or voluntarily submitted funds is something we have tried to correct, and we believe that now there is an understanding among our contractors that these returned moneys are to be deposited into their accounts and that they are to be recorded, and then we will make a determination later about the appropriateness of where they should be credited.

Mr. OSE. I think my question was more oriented toward do you have any sense of the amount of money that is being expended to battle over this between, say, Medicare or HCFA and the providers, contractors? Do you have any—

Mr. HASH. In the case of voluntary returns, I would hope that there are no fights going on. Once it was—my understanding was the fight was the contractors were not accepting the checks. I think we have gotten past that.

There may be issues about overpayments that have come up in the Inspector General's experience with respect to compliance plans that have been entered into by organizations because of settlement agreements or one kind of thing that may result in disputes about returned money, but a voluntarily self-disclosed, self-returned amount should be accepted by our contractors and should not be the occasion of an ongoing dispute about it.

Mr. OSE. Perhaps we could visit more about this privately.

Mr. Chairman, my last observation would be—and I am not normally given to this, but as recently as 14 months ago I was on the private side dealing with all these questions emanating from Congress and the State legislature.

My private experience tells me that, as a buyer of goods and services, you tend to get what you pay for. And I have to take exception. I know it does not emanate from the distinguished persons testifying here, but I have to take exception to some of the claims emanating from other parts of the Administration that the medical community is not doing its job.

The reality is that the medical community is in a position where they are receiving less and less for their services, and the spin, if

you will, that is coming out of that, from some portions of the Administration, is that doctors are not providing the same level of care that they have historically provided, and it has resulted in a higher mortality rate because of errors or omissions or what have you.

Well, the reality is that if HCFA, by virtue of its interpretations of Congress' intentions, reduces reimbursement rates to providers. The doctors are going to be in a position where they cannot provide therapy or they cannot have nurse assistants in the operating rooms for thoracic surgery and the like, and the result is a higher mortality rate.

There is an inescapable connection between what we are willing to pay for inservices and the level of service that a doctor can provide. It is inescapable.

I submit that for the record.

Mr. HORN. Well, I agree with what the gentleman has said so eloquently. There is no question about it, as far as I am concerned.

I now yield 16 minutes to the gentleman from Texas, the ranking member, Mr. Turner. See, you get more and more time with the more time my colleagues take.

Mr. TURNER. I am going to yield to you, Mr. Chairman. At this time, I do not have any further questions.

Mr. HORN. OK. Are there any other questions then? The gentleman from Illinois?

Mrs. BIGGERT. OK. I just want to go back to the issue of site inspections and provider numbers.

An example is that two doctors submitted in excess of \$690,000 in Medicare claims and listed nothing more than a Brooklyn, NY, Laundromat as their office location. In Florida, over \$6 million in Medicaid funds were sent to a medical equipment company that provided no services whatsoever, and one of these companies listed their address that would have put the business in the middle of the Miami International Airport. I know we have all heard about that.

Another one, a medical equipment company, provided adult diapers, which were not covered under Medicaid and were priced at 30 cents apiece, to nursing home patients, but they billed Medicare \$8 an item after coding these diapers as an item under Medicaid.

So my question is: is there mandatory site inspection? Now, you said you do have it. Is it mandatory, or is it just that you could do it if it looks like it is necessary?

Mr. HASH. It is my understanding that we are currently site visiting any applicant who applies for a provider number as a durable medical equipment supplier.

Mrs. BIGGERT. And that is only the new ones?

Mr. HASH. And we are putting into place a process whereby we will be visiting current ones to validate that they are, in fact, bona fide businesses and appropriately qualified.

Mrs. BIGGERT. Well, then, why did these happen?

Mr. HASH. I beg your pardon?

Mrs. BIGGERT. Well, then, why would these cases come up?

Mr. HASH. I am speaking also specifically of Medicare. I do not know how many of your examples related to Medicaid.

Mrs. BIGGERT. They were all Medicare.

Mr. HASH. Medicare?

Mrs. BIGGERT. Yes.

Mr. HASH. Then they should not be happening now. I think we have been working on this. We started, actually, the stepped-up attention to provider qualifications as a part of the operation to restore trust that the Inspector General's office and our agency entered into back in 1995, and part of the outgrowth of that was that we identified several. Perhaps some of the ones you named are ones that we actually identified and removed from the program and instigated collection procedures for.

We are, obviously, zero tolerance for letting people into the program who are not qualified and who are intent to defraud the taxpayers and the Medicare beneficiaries, and we think we are making progress on that.

As I say, I think many of those examples are ones that we actually identified, ourselves, through our stepped-up attention to the qualification of suppliers.

Mrs. BIGGERT. And then I think in the paper just yesterday was the Medicare program paid an estimated \$20.6 million for health care to people that are dead. How is this found?

Mr. HASH. That was a systems problem that related to the notification of the death of beneficiaries and the failure of that notification to have triggered the timely suspension of capitation payments to HMOs. We have, we believe, corrected that systems problem, and we have collected all of the overpayments, or are in the process of collecting the overpayments associated with that mistake.

Mrs. BIGGERT. Thank you.

Mr. Chairman, before we conclude—I do not know if you have more questions—I think that I would like to thank all the participants for their testimony, but I still believe that we need to really address the issue of the Medicare and Medicaid fraud and abuse at a different time, so I would ask at some time that we do schedule a hearing on this issue separately and look at the GAO report that was issued in October.

Mr. HORN. Thank you. That is a good suggestion. We will do that.

Any other questions?

[No response.]

Mr. HORN. OK. I want to thank you all for coming. There have been very good questions here that have gotten a lot of these important issues. I particularly thank all of you that have been so knowledgeable in this, and we are depending on you to be the ones that figure out a way that we do not defraud the government, in particular.

Obviously, we want to help you, if it takes additional legislative language.

I want to also thank the staff on both the Democratic side and the Republican side for putting things together for this hearing: J. Russell George is the staff director and chief counsel for the majority; Louise DiBenedetto is the chief auditor on loan from the General Accounting Office for the subcommittee and the counsel for this hearing, and that is the distinguished member of the staff on my left and your right; Bonnie Heald, director of communications; Bryan Sisk, clerk to the subcommittee; and Ryan McKee, staff assistant.

And for the democratic staff we have Trey Henderson, counsel to Mr. Turner and the subcommittee there, and Jean Gosa, minority clerk, and our faithful court reporter, who I think can now hear what people are saying. Thank you. That is Mike Willsey.

Thank you very much for coming.

With that, we are adjourned.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned.]

