

TESTIMONY OF

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AND FINANCIAL MANAGEMENT

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WRITTEN STATEMENT

Good morning, Chairman Platts, Madam Vice-Chairman and Members of the Committee.

I am honored to have been asked to provide testimony here today as a follow-on to my testimony before this Committee on, on May 13th, 2003 in which I addressed the Department of Health and Human Services (HHS) efforts to reduce the improper payments in the programs it administers. Today, at your request, I will be addressing the Department's efforts to reduce erroneous payments, fraud and abuse in the Department's Programs, especially those related to the Medicare and Medicaid programs. As you are aware, the partnering of the federal government and state governments is critical to achieving success in reducing erroneous payments, fraud and mismanagement. This forum is a wonderful opportunity to bring HHS together with some of our partners in the State of Tennessee in the Department's initiatives to ensure fiscal integrity in Medicare, Medicaid and other programs.

One of the Department's top strategic goals is achieving excellence in its management practices. The Department is committed to ensuring the highest measure of accountability to the American people. In fiscal year 2002, HHS was accountable for more than \$493.4 billion in gross outlays. Reducing improper payments and improving the related methods and systems have been and continue to be critical to meeting our management goals.

The Department consists of 12 Operating Divisions (OPDIVs) that manage more than 300 programs with diverse missions. You will note that seven of the Department's programs — Medicare, Medicaid, SCHIP, TANF, Child Care, Foster Care and Head Start — account for close to 90% of the Department's outlays. The Department expects to be reporting erroneous payment rates for these seven programs and is presently evaluating whether several other programs would be covered under the Improper Payment Information Act of 2002.

The success of the Health and Human Services improper payment reduction efforts can be traced to five fundamental elements. First and foremost, our leadership is committed to this initiative. Publicly identifying and correcting errors is not without political risk, but the public benefits are enormous. Second, creating partnerships with all parties with an interest in the program is critical for developing successful corrective actions. For instance, HHS works with states across a number of programs including Medicaid, SCHIP, and Child Care to name a few. Third, the Department has benefited from having one of the strongest Inspectors General in the Federal government and maintains a collaborative relationship between the Inspector General and the Assistant Secretary for Budget, Technology and Finance (ASBTF). Our two offices work closely to monitor programs and reduce errors. Fourth, we actively work with all parties to educate them on proper payment and program procedures, especially our clients and intermediaries, such as states and contractors, who in turn work with the ultimate client or beneficiary. Fifth, where there is a history of noncompliance with

statutory and regulatory authority, we have sought civil and other legal remedies. Between the effort to educate and legal remedies, there exists a spectrum of corrective actions the Department uses to identify and reduce improper payments. Finally, in the case of fraud, as opposed to errors, parties are prosecuted.

MEDICARE

Of these two programs, Medicare alone accounts for close to 50% of the Department's outlays. With the Medicare program, HHS has been a leader in the area of monitoring and mitigating improper payments. Medicare contractors annually process over one billion fee-for-service claims, answer 40 million inquiries, handle nearly eight million appeals, enroll and educate providers, and assist beneficiaries. HHS began measuring claims payment errors in the Medicare program in 1996 and has made progressive strides in reducing errors. The FY 2002 error rate of 6.3 percent is less than half the 13.8 percent error rate estimated in fiscal year 1996.

The sample size used to estimate the improper payments rate from 1996 to 2002 has been based on a small but statistically valid number of Medicare beneficiaries and claims. In 2002, OIG examined 4,985 claims filed on behalf of 610 beneficiaries nationwide. Beginning this fiscal year, however, the error rate will be calculated based on a sample of more than 120,000 claims nationwide, which will allow us to "drill down" in the error rate data. The Department is deploying the

Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP) to calculate improper Medicare payments. HPMP, funded under the Quality Improvement Organization (QIO) program, will perform the error rate work for most inpatient hospital settings. Unlike previous error rate calculations, the CERT program will allow the Department to estimate specific error rates for individual contractors, provider types and beneficiary services. The new information will continue to be aggregated to produce national level estimates like those calculated by the OIG, but with greater precision.

We have determined that substantially more detailed error data are necessary to bring down the error rate further. Although the OIG's national error rate provided an excellent basis for the work we have undertaken over the past five years, statistically significant information at the contractor, provider type, and Medicare service levels -- detailed management information -- is needed for the next phase of action to reduce the error rate further.

It is not sufficient to identify improper payments; we must correct the errors and prevent their recurrence. When we first began measuring the Medicare fee-for-service error rate, we determined that in nearly all cases, the claim as submitted was processed correctly. Only through the more comprehensive review of a sample of claims were we able to detect claims that were erroneous as submitted. Because the claim was in error, payment based on the claim was also made in error. Errors include insufficient or lack of proper documentation of a claim, medically

unnecessary claims, and incorrect diagnosis coding on a claim. As part of its initial corrective action plan, HHS embarked on an education and training campaign to improve provider and supplier knowledge of Medicare rules for submitting claims. Our intention is to avoid improper payments by making sure that providers and suppliers are fully aware of Medicare's rules before they submit their claim. For example, in December 2002, we released the Medicare Coverage Database on the CMS website. This database puts in one place all the National Coverage Determinations and Local Medical Review Policies making it easier than ever before for providers to find and search Medicare's coverage and coding rules. We believe educating our partners contributed significantly to reducing the Medicare fee-for-service error rate from 13.8 percent in FY 1996 to 6.3 percent in FY 2002.

Despite this progress, more work needs to be done to reduce the Medicare fee-for-service error rate to achieve the Department's performance goal for erroneous payments.

The Department has 47 contracts with over 34 insurance companies to process fee-for-service claims; however, HHS is responsible for overseeing these contractors and for ensuring claims are paid accurately and efficiently. Because of the critical role Medicare contractors play in helping facilitate efficient and effective health care delivery, it is important they be held accountable for their role in the health care financing and delivery system. Improving contractor oversight is key to how the Medicare funds are managed. We have been working to consolidate contractor

functions for some time within a statutory framework that forces the Department into an antiquated contracting system. In 1989, we had well over 100 fiscal intermediary and carrier contracts. Over the past decade, we have seen a substantial consolidation in the number of these contractors, so that, at present, Medicare claims are processed by 27 fiscal intermediaries and 19 carriers.

During FY 2001, the Department began developing its Unified Financial Management System (UFMS) initiative a critical component of the Department's efforts to modernize its financial management systems and information technology infrastructure and improve financial operations and performance. UFMS will replace the five core accounting systems currently in use across the Department using two primary sub-components. Part of this initiative includes testing and implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the Medicare contractors and the Department's Center for Medicare and Medicaid Services (CMS) regional and central offices. The HIGLAS will have capabilities to incorporate Medicare contractor's financial data, including claim activity, into the CMS internal accounting system. This system is expected to significantly enhance oversight of contractor accounting systems and be an important tool in improving financial management in the Medicare Program.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Medicare Integrity Program (MIP), which was funded at \$720 million in FY 2003. In FY 2002 MIP returned over \$10 billion in recoveries, claims

denials, and accounts receivable, a total savings amount of over \$10 billion. This translates into a \$15 return for every dollar spent in MIP funds. Under MIP, the Department funds a number of traditional payment safeguard programs to ensure that claims that are paid are medically necessary, that Medicare is the appropriate primary payer of a claim, that Medicare provider's cost reports are reviewed and audited, and that instances of fraud are identified and referred to the Office of Inspector General and the Department of Justice. MIP also funds the Comprehensive Error Rate Testing (CERT) program and activities to educate and train providers and suppliers on appropriate billing practices to avoid billing improperly.

MEDICAID

Building upon Medicare's success in measuring errors, the Department is well into the process of creating a payment accuracy measure [PAM] in the Medicaid program. Medicaid is a substantial program, accounting for over 30 percent of Department outlays. Federal outlays for the Medicaid program in Fiscal Year 2003 will be about \$162 billion dollars with a State share of \$122 billion. Therefore Medicaid's total outlays of \$284 billion and its 41.4 million beneficiaries served are both greater than the Medicare program. Unlike Medicare, Medicaid is administered primarily by the States. Each of the State and Territorial jurisdictions run their own unique program. To account for program variation, we are taking an incremental approach to development of the Medicaid error rate. Nine States entered the program in its first year (Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming),

twelve States are participating this year (Indiana, Florida, Nebraska, Louisiana, Mississippi, New York, North Carolina, North Dakota, Oklahoma, Texas, Washington, and Wyoming), 25 States are targeted for 2004, and it is expected that the program will be implemented nationwide in 2005. This collaborative approach will create a measure that is accurate and useful to both State and Federal agencies.

The payment accuracy measurement [PAM] model has been modified for 2004 to measure errors other than overpayments. The modifications include estimating payment errors attributable to both underpayments and ineligible recipients. The model will be used to estimate payment accuracy for both Medicaid and SCHIP. The resultant measure will give State governments the ability to identify and target existing and emerging vulnerabilities. For example, PAM will enable the Department and the States to identify the extent of problems in the claims payment system, study the causes of these problems, and better focus and strengthen internal controls. At the national level, PAM will enable the Department to estimate the size of potential problems and produce an overall payment accuracy estimate for Medicaid and SCHIP.

The Department has a preliminary draft report outlining State methodologies and the results of the first year of these pilot programs. Initial results show that States created varied and innovative methodologies for the development of their preliminary State payment accuracy rates. Mississippi drew a statistically valid

sample of eligible beneficiaries and tracked the accuracy of claims payment for each of these individuals throughout the year. New York, on the other hand, drew a stratified, random sample of claim lines from the total universe of claims. The innovative and unique methodologies submitted by each State will allow HHS to accurately assess best practices in the development of a national PAM model. The core methodology is still being established, however, and findings to date are far from definitive.

During the third year of testing, States will be encouraged to pilot test the PAM model in both their Medicaid and SCHIP programs. Based on best practices found, the final specifications for the PAM Model will be produced at the conclusion of the third year of pilot testing. This standard will be used for a nationwide implementation in FY 2005. Requiring States to implement PAM will necessitate publishing a regulation. The earliest the Department will be able to estimate the rate of improper payments in Medicaid and SCHIP is FY 2005, pending the development of a final rule.

In addition to the development of the PAM model, Medicaid program integrity efforts also include the use of Medicaid Fraud Control Units. Currently 47 States and the District of Columbia have established Medicaid Fraud Control Units. These fraud control units conduct investigations and prosecute providers charged with defrauding the Medicaid program or persons charged with patient abuse and neglect. Since the inception of the Medicaid fraud control program, the fraud

control units have successfully convicted thousands of Medicaid providers and have recovered hundreds of millions of program dollars.

HIPAA provided the Department with a stable and predictable funding source to detect and prevent errors and to combat Medicare and Medicaid fraud, waste, and abuse. HIPAA established the Health Care Fraud and Abuse Control (HCFAC) Program, which funds the Medicare Integrity Program that I mentioned earlier, activities of the FBI, and an additional pool of funds shared between the Department of Justice (DOJ) and HHS. HHS and the DOJ joint-efforts returned \$1.4 billion to the Medicare Trust fund in FY2002 alone.

These funds are largely supporting our efforts to establish error rate methodologies in Medicare, Medicaid and SCHIP. This fund provides substantial stable funding to the Office of Inspector General for their efforts. In FY 2003 \$10 million from this fund will be used to strengthen financial management generally in the Medicaid program. Next year \$20 million will be spent for these same purposes. I would also note that this source of funds supports some Administration on Aging (AoA) initiatives, including Senior Patrol projects, such as the one Ms. Williams, Director, Medicare Patrol Project in Upper Cumberland, TN, will likely address in her testimony here today. AoA provided technical assistance to 51 Senior Medicare Patrol (SMP) projects, located in 45 states plus the District of Columbia and Puerto Rico. The purpose of these projects is to recruit and train retired individuals to educate seniors in their communities about how they can help prevent and detect

potential Medicare and Medicaid error, fraud, and abuse. In 2002, the projects trained 9,000 senior volunteers who directly educated 485,000 Medicare beneficiaries in their communities nationwide on topics such as how to read their Medicare summary notices.

FRAUD

My testimony today has focused on improper payments. I would briefly like to touch on one particular type of improper payment, fraud. An example of an actual fraud involved a New York physician who was sentenced to 37 months imprisonment and ordered to pay \$1.3 million in restitution for health care fraud. The licensed cardiologist, internist and certified acupuncturist billed for nerve block injections when he actually performed acupuncture, a service not covered by Medicare. An example of an improper payment involved a physician who was paid \$182 for an office visit and scanning diagnosis services. The physician acknowledged that the supporting medical records could not be located. Unless a pattern of similar abuse and the element of intent could be established, this case would not be identified as a fraud. A key element of a fraud is the intent to commit the unlawful practice.

In addition to the Department's initiatives described above to reduce improper payments, the Department's OIG continues to devote significant resources to investigating and monitoring the Department's programs, especially for the Medicare and Medicaid programs. These efforts have led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse. In FY 2001, OIG

reported for all HHS programs \$1.50 billion in investigative receivables and another \$1.49 billion in FY 2002.

The Department has and will continue to maximize the use of various resources in its initiatives to reduce improper payments, including considering the work of HHS OIG, GAO and non-Federal entity auditors. We value our relationship with our OIG and the OIG's superior work in addressing instances of fraud, waste and abuse in all of our programs. Because the great majority of providers are honest and wish to avoid fraud and abuse issues, the OIG has been actively working with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. The resulting audits range in scope from work at individual health care providers or grantees to nationwide audits of some aspect of a departmental program.

OTHER STATE-BASED PROGRAMS

In addition to Medicaid and SCHIP, the Department administers numerous state-based programs that promote the economic and social well being of children, families, and communities. The States and HHS operate these programs in partnership and give special attention to vulnerable populations. These programs account for \$48 billion in outlays within the President's FY 2004 Budget. Notably, this budget request includes \$5 million to augment our efforts to identify and reduce erroneous payments. These funds will be focused on three programs - Temporary

Assistance for Needy Families (TANF), Foster Care, and Head Start. Working with the States, we are committed to maintaining the integrity of these programs.

The Department closely monitors improper payments in these programs through Single Audit Act activities, reviews of financial data, and program-specific mechanisms. Through the Single Audit Act, the vast majority of these programs are audited at least once every three years if not more frequently. The Single Audit Act, as amended, establishes requirements for audits of States, local governments, Indian tribal governments and non-profit organizations administering Federal financial assistance programs. Most non-Federal entities expending \$300,000 or more in a year in Federal awards are required to have a single or program-specific audit conducted for that year in accordance with OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. The Department will use the information from audits required by the Single Audit Act amendments of 1996, to the extent possible, in determining the error rates and identifying the causes. Total HHS dollars covered by these audits totaled approximately \$194.3 billion in FY 2002.

In 2002, for the institutions subject to the audit as described above, \$20.6 million out of \$194.3 billion were classified as misspent funds by the Office of the Inspector General's review of Single Audit reports. A sample of State auditors verified that States have systems in place to identify, report and reimburse the Federal Government for improper payments. HHS has provided technical assistance and

financial oversight for many of their grant programs, which has helped prevent improper payments.

In addition to these program integrity activities, the Department is taking steps to strengthen and establish erroneous payment rates for several programs. Currently, the Foster Care program conducts eligibility reviews on a sample of cases to determine the amount of maintenance payments made in error and takes disallowances on those cases that are reviewed and found to be ineligible. We are working on a methodology to strengthen the statistical validity of the error rate methodology.

We are also considering legislation to authorize the collection of data necessary for determining an error rate in the Temporary Aid for Needy Families (TANF) program. The error rate will be an important tool in maintaining financial accountability from States. It will help ensure that the \$16.9 billion in TANF funds are being spent appropriately in accordance State TANF laws and regulations. Our objective is to develop a statistically valid error rate on cash assistance payments while working to minimize burden on States.

The Child Care and Development Block grant totals \$4.8 billion in both mandatory and discretionary funds. The Department currently holds States accountable for these funds mainly through the Single State Audit system. Last year, we began to take a more systematic approach to reviewing audit activity in order to see if there are any systemic problems or patterns that are causes for concern. Because of the highly flexible and extremely varied State-to-State nature of this program, developing a meaningful error rate poses some significant challenges. Therefore, we are carefully considering how we might undertake this effort in the most cost-effective way that would be useful to both the States and the Federal Government.

HEAD START

Head Start provides grants to local public and non-profit agencies to provide comprehensive child development services to children and families, primarily preschoolers from low-income families. The FY 2004 budget for Head Start is \$6.8 billion and supports 923,000 children. The Head Start network consists of 1,570 grantees; with 200,000 staff; assisted by nearly 1.5 million volunteers; and housed in over 50,000 classrooms. Head Start grants are reviewed and approved for funding, as well as project oversight, through one of the ten regional offices of the Department or a specialized branch which focuses on grantees serving American Indian/Alaskan Natives and migrant/seasonal farm workers' children.

Head Start regulations allow Head Start programs to serve up to 10% of their enrolled children (49% in certain situations for tribal Head Start programs) from families who do not meet Head Start's income requirements. The real challenge will be in estimating an error rate as changes in employment, income and family status occur during the school year. In developing the Head Start error rate, the Department will be using findings contained in audits required under the Single Audit Act, and from information collected in site visits. It is expected that HHS will have an estimated error rate for the Head Start program as of September 30, 2003. The Department has also begun to look at other programs in light of the Improper Payment Information Act of 2002 requirement that programs susceptible to more than \$10 million in erroneous payments report on amounts of and efforts to reduce improper payments.

CONCLUSION

Ms. Blackburn, in conclusion, HHS has a robust program for identifying improper payments across its many programs, taking appropriate management actions to reduce the incidence of improper payments, and exploring and developing innovative ways to increase compliance as evidenced with the Medicaid pilot program and Head Start. We attribute our success to the strong commitment of our leadership; the focus on building and maintaining close partnerships with the Inspector General, the States, and our contractors; and the wide range of initiatives that support program integrity.

I hope that the information I have provided here today will be of value to this committee in their oversight efforts related to the implementation of the “Improper Payment Information Act of 2002.” At this time, I will be happy to answer any questions.