Blowing Smoke on the Invisible Man: Measuring Fraud, Payment Errors in Medicare and Medicaid

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WEDNESDAY, JULY 12, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10 a.m. in room 210, Cannon House Office Building, Hon. Saxby Chambliss (chairman of the Task Force) presiding.

Chairman CHAMBLISS. We will call the hearing to order. And, Ms. Jarmon, Mr. Hamel, we will let you all take seats as we begin to make a few opening comments here.

This is another of our hearings in our process of reviewing waste, fraud and abuse in Medicare/Medicaid programs, and we are excited today to look at another aspect. We have talked about Medicare exclusively just about in each of the hearings that we have had thus far. We are going to continue to talk about Medicare to a certain extent today, but also look at Medicaid and what the Federal responsibility with respect to waste, fraud and abuse in Medicaid is and just as importantly what it should be.

So we have folks from the GAO as well as folks from HCFA back with us today, and also a gentleman who has had more practical experience at the State level to bring us some information about what is going on out there.

And he had—we have a chart over here that Dr. Sparrow, who was hired by HCFA to do some work—and I think Ms. Thompson referred to the work that he did with respect to coordinating some of the ideas at the State level and bringing all that together. And we have adopted one of the quotes from Dr. Sparrow here as somewhat of an underlying theme. And we have had a blowup of that quote made available here this morning.

It is—when we talk about waste, fraud and abuse with respect to Medicare and Medicaid, it is kind of like looking at the invisible man. I like his quote: “It is like in the Hollywood movies, trying to blow smoke on the invisible man. For a moment you see what is there, but only for a moment.” that literally is true because it is so hard to get your arms around the sheer volume of this program, and trying to pick out the real instances of waste, fraud and abuse is extremely difficult. You think you got it at one moment, then you turn around and it is gone.

Let’s put those other two charts up, too.

I just want to emphasize the real significance of what we are dealing with here. We have got an appropriation bill that is going to be coming to the floor here sometime, I guess, this week or next week, the foreign operations bill. In that bill we spend somewhere around $15 billion a year. If you look at the Medicare outlays, and we don't know what the waste, fraud and abuse number is, if it is 1 percent, it is 2.1 billion, but it goes all the way up to, if it is 15 percent, 32.55 billion. We could pass two foreign ops bills if it were 15 percent, and we could bring it within some sort of reasonable control. So that is the significance of Medicare waste, fraud and abuse.

Medicaid is not too far from that. We have total outlays last year of Medicaid of $203 billion. And again, if 1 percent of the Medicaid allocation is where the waste, fraud and abuse lies, then we are looking at 2.03 billion all the way to 30.45 if it turns out to be 15 percent of the program. So we are talking about real dollars, we are talking about significant money, and we are talking about dollars that ought to be used for the beneficiaries of those two programs and obviously not going out the back door.

I want to thank our witnesses in advance for being here. As I have said in each one of these hearings, we are not here to point fingers. It is not a partisan issue that we are dealing with. I think every administration has had the same problems with respect to trying to put their finger on waste, fraud and abuse. We just think we can do a better job with it. And we want to make sure that we understand from our end where the problems are, and if we need to participate from a legislative perspective and in helping solve that problem, we need to know that, and we need to get on board with you to try to help get to the bottom of this issue that we know is out there.

By the same token we want to make sure that our Federal agencies are doing everything they ought to be doing and in the most efficient manner possible to try to get to the bottom of the issue of waste, fraud and abuse.

So, again, we thank you for being here. We look forward to your testimony.

[The prepared statement of Saxby Chambliss follows:]

PREPARED STATEMENT OF HON. SAXBY CHAMBLISS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Today, the Health Task Force continues to focus on waste, fraud, abuse and mismanagement in the Federal health care system by investigating fraud measurement techniques in the Medicare and Medicaid programs.

As the title of the hearing—"Blowing Smoke on the Invisible Man"—implies, the key to determining the level of fraud and abuse in America's two largest public health care delivery programs is identifying criminals and fraudulent techniques designed to elude detection.

Or as health care fraud expert Malcolm Sparrow said: "There's a trap of circularity—you look for what you've seen before. Meanwhile other kinds of fraud are developing within the system that remain invisible because you're not familiar with them and you have no detection apparatus for that. * * * It's like in Hollywood movies, trying to blow smoke on the invisible man. For a moment you see what's there—but only for a moment."

To most properly allocate valuable resources to combat improper payments under Medicare and Medicaid, we need the best information available on areas of waste, fraud and abuse—identifying the invisible man in effect. The purpose of today's hearing, relative to Medicare, is to find out whether the current methodologies used by the Department of Health and Human Services to measure improper payments

provide the most accurate reflection of actual improper payments made under Medicare.

For example, the Department of Health and Human Services' Inspector General has estimated for Fiscal Year 1999 that "improper" Medicare fee-for-service payments totaled $13.5 billion, which is a dramatic decrease from the $23.2 billion in improper payments estimated in Fiscal Year 1996.

While the Department and the Clinton administration have publicly attributed the sharp decrease in improper payments to their efforts to combat waste, fraud and abuse, there is increasing dispute over the nature of such a claim as we learn that true Medicare fraud often goes unmeasured.

Even though the General Accounting Office has kept Medicare on its "high risk" list, meaning the program is exceptionally vulnerable to fraud and abuse, questions persist whether the Department has measurement techniques in place to accurately gauge the level of fraud and abuse within the program.

To help ascertain the extent of the government's Medicare fraud measurement techniques, the House Budget Committee called upon the GAO because numerous academics, government watchdog organizations, and concerned citizens have noted that audits, such as the type used by the HHS to arrive at the $13.5 billion figure in FY1999, do not detect fraud because they are not designed to. Instead of concentrating on fraud, the Task Force has heard from previous witnesses that the measurements are aimed at billing correctness, utilization review and policy coverage. Additionally, many of the so-called errors identified as "improper" may not result from abuse but from honest differences of opinion regarding how medicine ought to be practiced, what is "medically necessary."

More troubling is that recent accounts show that Medicare has attracted its own class of organized criminals, persons who specialize in defrauding health care and health insurance systems. I believe one of our witnesses, a special investigative agent with GAO, will be able to provide first-hand testimony regarding the sham medical entities, fictitious physician groups, and "post office box" clinics that organized criminals have created to defraud Medicare. Everyone would certainly agree that such fraudulent activities need to be included in a calculation of improper Medicare payments.

I anticipate the GAO witnesses will discuss the results of its study into fraud measurement techniques and will discuss how the existing methodology employed by HHS was not intended to detect fraudulent schemes such as kickbacks, services not actually provided, and those developed by organized criminals.

With that, I look forward to hearing GAO's critique of the current improper payment measurement methodology, and to learning GAO's recommendations on how government can best adopt a comprehensive methodology to measure fraudulent activities and allow for the best allocation of resources to combat waste, fraud and abuse.

Finally, the second panel will testify on payment error measurement rates relative to Medicaid. Currently there is no comprehensive Federal system in place to measure Medicaid improper payments. The witnesses on the second panel are here today to discuss both the pros and the cons of whether such a system would be feasible or effective in measuring Medicaid waste, fraud and abuse.

Chairman CHAMBLISS. And at this time, I would recognize the gentleman from Washington, the ranking member of the Task Force, Dr. McDermott. Jim.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I think the figures and the quote that the Chairman has put up on the board are sort of interesting. The man who wrote that quote also wrote a book called License to Steal. He works at the Kennedy School of Government. He is a very respected gentleman.

I think the issue here and I think the conundrum—and for those of you who aren't from the Northwest, that means puzzle—that we face here is that HCFA hires contractors to administer the program, and they pay the bills sent in by the providers. And the dilemma that faces this committee and faces all of us in the government, in the Congress, is the question of on whom do we put the responsibility for finding fraud, waste and abuse?

Now, I assume that North Dakota Blue Cross/Blue Shield, which administers the program in the State of Washington, when they

are dealing with their own claims are very vigorous in preventing fraud, waste and abuse. I wouldn't think that as a for-profit company they would be lax, otherwise their stockholders would eat their lunch, and their president would be gone. So, when they are doing that for themselves, the question then is are they doing the same for the government under the contracts that the HCFA writes with them?

Now I know we have had more than one contract in the State of Washington. We have had about three of them that I can remember in the last 10 years. And the question then, is the best place to go after fraud, waste and abuse by saying to HCFA, go and redo all the claims that North Dakota Blue Cross/Blue Shield did; or go out to all the hospitals in the State of Washington and all over the Northwest?

Actually North Dakota has three or four States for whom they examine claims or for whom they process claims, and the question is, should they go out there, should HCFA go out and examine all those claims? Well, we already had a hearing where we heard from providers who said there is too much of that coming out there looking at our records. So we are caught in a real conundrum, and that is if you are going to look for fraud, waste and abuse, how much pressure can you put on the providers, and who should do it, and where is the law of diminishing return? I mean, if HCFA wants to hire 100,000 people to go out and examine every hospital and every doctor's office, that is going to cost something. And if you are going to do that, on top of what is already being done apparently or presumably by the contractors who are hired, isn't that a duplication of effort?

It is those kinds of issues that I think this committee is struggling with. No one thinks that any human system is perfect. Especially in the United States where we have the free enterprise system and we value entrepreneurship, we are going to have some entrepreneurs who are going to skate too close to the line in trying to maximize their profits. No question. It happens everywhere. Whether you are talking about the defense industry or the health industry it doesn't really make any difference. Wherever there is money involved, some people are going to try to push the rules as far as they can.

As we had in the Defense Department recently, we had a wire manufacturer who was making the controls for airplanes who is saying that the wire is of a certain strength, and it turns out it is not of a certain strength, and you have every military aircraft had to be examined for whether or not they had that kind of steel in their controls. Now, that kind of thing goes on in the military industry. It certainly goes on in health care. But the question we have is who should we put the responsibility on to press, and how hard should they press?

So I am eager, Mr. Chairman, to hear what the GAO has to say on this whole issue. Thank you.

Chairman CHAMBLISS. Thank you.

Mr. Lucas, you care to make any statement?

Mr. LUCAS. Mr. Chairman, this last 4th of July district work period I had three health care roundtables in three different hospitals in my district. The one common thread through all these meetings

were the comments from the hospital administrators—two of them I have known personally for a long time and I think they are people of integrity. They complained that when honest mistakes were made in filing Medicare claims, the ultimatums that were issued were either fines or "we are going to sue you." I heard this clear across my district. So I am wondering if we aren't being overzealous in the pursuit of people who are making honest mistakes.

Chairman CHAMBLISS. There is no question but that is a real problem, and some of that will be addressed today I know.

Before we begin, let me just ask unanimous consent that all Members be given 5 days to submit written statements for the record.

Our first panel this morning comes from the General Accounting Office, Gloria L. Jarmon and William D. Hamel. Ms. Jarmon, Mr. Hamel, welcome to this Task Force hearing. We appreciate you being here today. We look forward to your testimony.

Ms. Jarmon.

STATEMENT OF GLORIA JARMON, DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES, ACCOUNTING AND INFORMATION MANAGEMENT DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY WILLIAM D. HAMEL, SPECIAL AGENT, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE

Ms. JARMON. Thank you.

Mr. Chairman and members of the Task Force, we are pleased to be here today to discuss our review of HCFA's efforts to improve the measurement of improper payments in the Medicare program. With me today is Bill Hamel from our Office of Special Investigations.

You asked us to provide suggested improvements to assist HCFA in its efforts to further estimate Medicare improper payments, including potential fraud and abuse. I will summarize our statement and ask that the full statement be made part of the record.

While we believe HCFA's efforts to measure Medicare fee-for-service improper payments can be further enhanced with the use of additional fraud detection techniques, we support the efforts they have taken thus far. Considering the challenges associated with identifying and measuring improper payments, the projects discussed in our statement represent important steps toward advancing the usefulness of HCFA's improper payment measurement efforts.

I will first briefly discuss the current methodology used by HCFA to estimate Medicare fee-for-service improper payments. Next I will mention HCFA's three planned projects to further measure improper payments. Then I will summarize our results.

The current methodology, which estimated fiscal year 1999 Medicare fee-for-service improper payments at $13.5 billion, was a significant step toward quantifying such payments. It was not designed to identify or measure the full extent of levels of fraud and abuse in the Medicare program. The methodology generally assumes that medical records received for review represent actual services provided. While this estimate has been useful for financial

statement information and as a performance measure for the program, given the size and complexity of the Medicare program, its usefulness as a tool for targeting specific corrective actions is limited.

To enhance its understanding of improper payments and help it develop targeted corrective actions, HCFA has recently begun three projects. These projects are shown in my statement in the charts on pages 16 and 20. I will briefly summarize the projects. The first one is the Comprehensive Error Rate Testing project, referred to as the CERT, C–E–R–T, project. It is similar to the current methodology; however, it is designed to produce a paid claims error rate at each contractor by provider type and service category levels. It is undergoing a phased implementation with a scheduled completion date of October 2001.

The second project on the charts is called the Payment Error Prevention Program, or the PEPP, P–E–P–P, project. This is also similar to the CERT project and the current methodology, but it is designed to develop payment error rates for each State and for each peer review organization area of responsibility. HCFA officials stated that this project is the furthest along in implementation, with the first quarterly reports expected in September of 2000.

The third project is the Model Fraud Rate project, or MFRP, and this is an effort to develop a potential fraud rate for a specific locality and specific benefit type. It has been tried in southern California. However, HCFA officials told us that they intend to eventually expand the scope of this project to provide a national potential fraud rate. However, the Medicare contractor assisting HCFA in developing this project is dropping out of the Medicare program in September of 2000 and has ceased work on the project.

Given the billions of dollars that are at risk, it is imperative that HCFA continue its efforts to develop timely and comprehensive payment error rate estimates that can be used to develop effective program integrity strategies for reducing errors and combating fraud and abuse. HCFA's projects could collectively address some of the limitations of the current methodology if properly executed. For example, expanding the scope of the Model Fraud Rate project to include studying provider visits and a more extensive assessment of the cause of improper payments and other techniques could help HCFA pinpoint additional high-risk areas and develop more effective corrective actions.

The chart to my right, which is also on page 7 of my statement, shows the six most common types of potential fraud and abuse cases from HCFA's fraud investigation database. It shows the relative frequency of these cases based on information gathered by HCFA from 1993 to April 2000. You can see that, based on information in their database, 37 percent of the errors relate to services not rendered, going down to, according to their database, about 7 percent relating to kickbacks and accepting/soliciting bribes. HCFA officials told us that while more complex types of fraud or abuse, such as fraudulent cost reporting and kickback arrangements, which on this chart show 7 percent each, may be less frequent than other types, such cases often involve significantly greater losses, especially fraudulent cost reporting.

The next chart that we have to my right, is a version of the chart on page 9 of our statement, which shows five of the most promising techniques identified by health care fraud experts and investigators. The chart we have here is a summary of some of the key questions that investigators try to answer by employing those techniques. Many of these techniques are currently performed by Medicare contractor fraud units to detect potential fraud and abuse. I will talk briefly about each of them.

First, the medical record review. It primarily tells you whether there is reasonable documentation for the services that were provided.

Secondly, data analysis. This often highlights unusual relationships between the data.

Third, beneficiary contact. This addresses whether services were actually received by the beneficiary.

Provider contact is important because it is done to ensure that the provider actually exists and has documentation on site that supports the billed amount.

And the fifth technique on that chart and on page 9 is third-party contact, which addresses whether entities, such as state licensing boards and a wide list of other third-party entities, can validate key information related to the claim, such as whether the doctor is licensed.

It is important to note, however, that no matter how sophisticated the techniques, not all fraud and abuse will be identified. Using a variety of techniques holds more promise for estimating the extent of potentially fraudulent and abusive activity and also provides a deterrent value to such illegal activity. The implementation of more extensive detection techniques is bound to be challenging and expensive. So using rigorous study methods and consulting with the people affected, such as beneficiary and provider advocacy groups, are essential steps to ensure success as well as considering the tangible and intangible benefits of using particular techniques.

Mr. Chairman, this concludes our statement. We would be happy to answer any questions that you or other members of the Task Force may have.

Chairman CHAMBLISS. Thank you very much, Ms. Jarmon.

[The prepared statement of Gloria Jarmon follows:]

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

Mr. Chairman and members of the Task Force, I am pleased to be here today to discuss our review of the Health Care Financing Administration's (HCFA) efforts to improve the measurement of improper payments in the Medicare fee-for-service program. Identifying the extent of improper payments and their causes, including those attributable to potential fraud and abuse, are the first steps toward implementing the most cost-effective ways to reduce losses. In my statement today, I would like to share with you the results of our review which is being conducted at the request of the Chairman of the House Committee on the Budget.

HCFA, an operating division within the Department of Health and Human Services (HHS), has designated ensuring the integrity of the Medicare program a top priority. It recognizes that inappropriate payments are a drain on the program's financial resources—resources intended to provide essential health care services to millions of elderly and disabled Americans. In conjunction with its audit of HCFA's annual financial statements since 1996, the HHS Office of the Inspector General (OIG) has conducted a nationwide study to estimate Medicare fee-for-service im-

proper payments.[1] The statistically projectable results cited in the OIG's study have provided valuable insights regarding the extent of Medicare vulnerabilities. Results from the most recent study indicate that, of the $164 billion in fiscal year 1999 Medicare fee-for-service claim payments, a projected $13.5 billion were paid improperly for various reasons ranging from inadvertent errors to outright fraud and abuse. The magnitude of these estimated losses has led to considerable concern regarding HCFA's efforts to protect Medicare dollars as well as the need to obtain a better understanding of the nature and extent of the problems.

The OIG's study was a major undertaking and, as we recently reported,[2] the development and implementation of the methodology (referred to as "current methodology ") it used as the basis for its estimates represents a significant step toward quantifying Medicare improper payments. It is important to note however, that this methodology was not intended to and would not detect all potentially fraudulent schemes perpetrated against the Medicare program. Rather, it was designed to provide users of HCFA's financial statements with an initial estimate of Medicare fee-for-service claims that may have been paid in error and has served as a performance measure for the program. However, given the size and complexity of the Medicare program, the usefulness of this estimate as a tool for targeting specific corrective actions is limited.

To demonstrate a commitment to improving payment safeguards, in January 2000, HCFA reaffirmed its goal of reducing the Medicare fee-for-service payment errors to 5 percent or less by the year 2002, about a 3 percent or $5 billion reduction from fiscal year 1999 levels. However, without additional information on the extent of improper payments[3] attributable to potential fraud and abuse, HCFA's ability to fully measure the success of its efforts remains limited. Accomplishing this goal will depend, in part, on HCFA's ability to further develop improper payment measures to enable it to more effectively target specific corrective actions. In response to this need, HCFA has begun three projects intended to enhance its understanding of improper payments and help it develop targeted corrective actions.

Given the importance of Medicare to millions of beneficiaries and concerns about the financial health of the program, you asked us to provide suggested improvements to assist HCFA in its efforts to further estimate Medicare improper payments, including potential fraud and abuse. In summary, we concluded that:

- Because it was not intended to include procedures designed specifically to identify all types of potential fraudulent and abusive activity, the current methodology does not provide an estimate of the full extent of improper Medicare fee-for-service payments;
- HCFA has initiated three projects designed to further its measurement efforts which offer some promise for determining the extent of improper payments attributable to potential fraud and abuse; and
- Based on careful evaluation of their effectiveness, performing additional potential fraud identification techniques as part of its efforts to measure improper payments could assist HCFA in arriving at a more comprehensive measurement and, ultimately, develop cost-effective internal controls to combat improper payments; however, no set of techniques, no matter how extensive, can be expected to measure all potential fraud and abuse.

We are making recommendations designed to assist HCFA in its efforts to further enhance its ability to measure the extent of losses emanating from Medicare fee-for-service payments. Although we believe HCFA's efforts to measure Medicare fee-for-service improper payments can be further enhanced with the use of additional fraud detection techniques, we support the efforts they have taken thus far. Considering the challenges associated with identifying and measuring improper payments,

[1] The Chief Financial Officers Act of 1990, as expanded by the Government Management Reform Act of 1994 (GMRA), requires 24 major departments and agencies, including HHS, to prepare and have audited agencywide financial statements. Major "components" of these 24 agencies, such as HCFA, may also be required to have audited financial statements.

[2] Efforts to Measure Medicare Fraud (GAO/AIMD–00–69R, February 4, 2000).

[3] Improper payments are defined as payments made for unauthorized purposes or excessive amounts. Improper payments can be caused by fraud and abuse, which involve a deliberate disregard for the truth or falsity of information or an intentional deception or misrepresentation that an individual knows or should know to be false or does not believe to be true and makes, knowing the deception could result in some unauthorized benefit to himself or some other person. Using information, such as the factors contributing to improper payments, to address fraudulent or abusive payments only as such payments are specifically identified and adjudicated unnecessarily limits and delays developing effective corrective actions. Accordingly, we believe that using these data as soon as practical to analyze and develop appropriate initiatives, represents effective management efforts to increase accountability over Federal assets.

the projects discussed in our statement represent important steps toward advancing the usefulness of its improper payment measurement efforts.

To fulfill our objectives, we analyzed the current methodology and HCFA's three planned projects related to improper payment measurement; related documents discussing the methodologies, designs, planned steps, and time frames for implementation of these initiatives; and relevant HHS OIG and GAO reports. We also interviewed HCFA officials and recognized experts in health care and fraud detection in academia, Federal and state government, and the private sector on the various types of improper payments and the techniques used to identify and measure them. We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards. See appendix 1 for a more detailed discussion of our objectives, scope, and methodology.

In my statement today, I will summarize our conclusions and recommendations regarding:

- The three HCFA projects that have been designed or initiated to measure Medicare fee-for-service improper payments;
- How such projects will potentially enhance HCFA's ability to comprehensively measure improper payments, including those attributable to potentially fraudulent and abusive provider practices based on the extent to which effective techniques used to detect common types of potential fraud and abuse are included in their design; and
- Actions HCFA should take to further enhance its efforts to measure the extent of improper Medicare fee-for-service payments and help HCFA better develop targeted corrective actions.

But, first I would like to begin with some relevant background about HCFA, the Medicare program, and the vulnerabilities of the Medicare program to fraud and abuse.

MEDICARE IS VULNERABLE TO FRAUDULENT AND ABUSIVE ACTIVITY

In 1990, we designated Medicare as a high-risk program,[4] and it continues to be one today. Many of Medicare's vulnerabilities are inherent due to its size and administrative structure, which make the largest health care program in the nation a perpetually attractive target for exploitation. Wrongdoers continue to find ways to dodge program safeguards. The dynamic nature of fraud and abuse requires constant vigilance and the development of increasingly sophisticated measures to detect fraudulent schemes and protect the program.

With total benefit payments of $201 billion in fiscal year 1999, Medicare enrollment has doubled since 1967 to nearly 40 million beneficiaries today. Beneficiaries can elect to receive Medicare benefits through the program's fee-for-service or managed care options. With benefit payments of $164 billion in fiscal year 1999 and about 85 percent of participating beneficiaries, the fee-for-service option represents the most significant part of the program. The managed care option accounts for the remaining $37 billion and 15 percent of participating beneficiaries. The program is comprised of two components. Hospital Insurance or Medicare Part A covers hospital, skilled nursing facility, home health, and hospice care. Supplementary Medical Insurance, also known as Part B, covers physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy services, and some other services not covered by Part A.

HCFA's administration of the Medicare fee-for-service program is decentralized. Each year, about 1 million providers enrolled in the program submit about 900 million claims to about 56 Medicare contractors for payment. The bulk of the claims are submitted electronically and never touch human hands during the entire computer processing and payment cycle.

Ensuring the integrity of the Medicare fee-for-service program is a significant challenge for HCFA and its Medicare claims processing contractors and Peer Review Organizations (PROs). They are HCFA's front line defense against inappropriate payments including fraud and abuse and should ensure that the right amount is paid to a legitimate provider for covered and necessary services provided to eligible beneficiaries. Except for inpatient hospital claims, which are reviewed by the PROs, Medicare contractors perform both automated and manual prepayment and postpayment medical reviews of Medicare claims. Various types of pre- and postpayment reviews are available to contractors to assess whether claims are for covered services that are medically necessary and reasonable. These include automated reviews of submitted claims based on computerized edits within contractors' claims processing systems, routine manual reviews of claims submitted, and more

[4] High Risk Series: An Update (GAO/HR–99–1, January 1999).

complex manual reviews of submitted claims based on medical records obtained from providers.

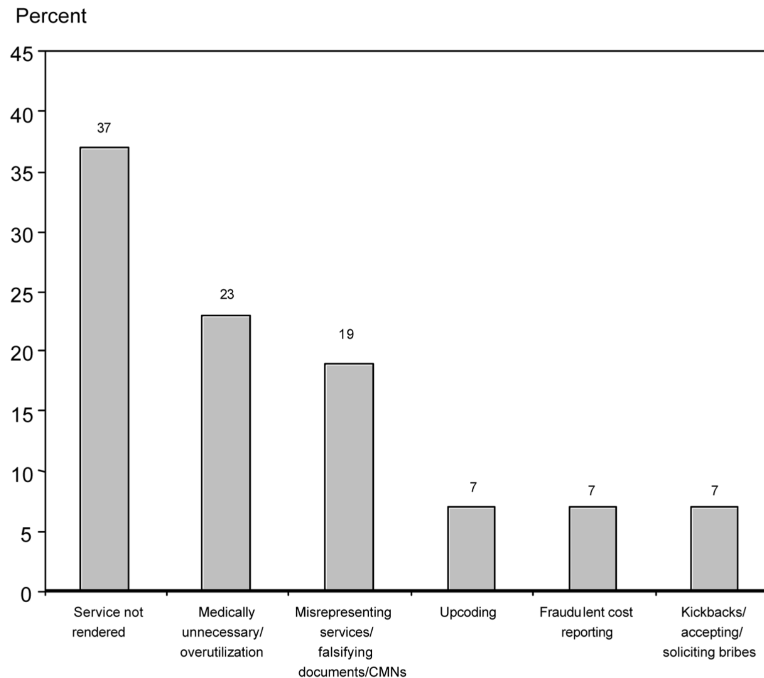
Reliance on postpayment utilization and medical record reviews to detect potential fraud and abuse has created opportunities for unscrupulous providers and suppliers to defraud the program with little fear of prompt detection. For example, a few providers—subjects of past health care fraud investigations in which they have pled guilty to or have been indicted for criminal charges—had set up storefront operations and fraudulently obtain millions of dollars from Medicare before their billing schemes were detected through postpayment reviews. HCFA is moving toward more extensive use of prepayment reviews, but contractors' efforts to prevent and detect improper payments are challenged due to the sheer volume of claims they are required to process and the need to pay providers timely. The program's vulnerabilities have been compounded by the emergence of some organized groups of criminals who specialize in defrauding and abusing Medicare, which has led to an array of fraudulent schemes that are diverse and vary in complexity. For example, based on our recent review of seven investigations of fraud or alleged fraud, we reported that the criminal groups involved had created as many as 160 sham medical entities—such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment companies—or used the names of legitimate providers to bill for services not provided.[5]

Medicare contractors and PROs are identifying thousands of improper payments each year due to mistakes, errors, and outright fraud and abuse. They refer the most flagrant cases of potential fraud and abuse to the OIG and Department of Justice (DOJ) so they can investigate further, and if appropriate, pursue criminal and civil sanctions. HCFA tracks the cases referred by Medicare contractors and PROs to the OIG and DOJ in its Fraud Investigation Database (FID).[6] Figure 1 shows the six most common types of potential fraud and abuse cases in the FID and the relative frequency of these cases. Definitions of these common types of fraud and abuse and examples are provided in appendix 2 to this testimony.

[5] Criminal Groups in Health Care Fraud (GAO/OSI–00–1R, October 5, 1999).

[6] The Fraud Investigation Database is a comprehensive nationwide system devoted to Medicare fraud and abuse data accumulation. The system was created in 1995, but contains data on potential fraud and abuse referrals going back to 1993.

Figure 1: Fraud Investigation Database Statistics for Cases Referred, 1993 to April 2000



Source: Prepared by GAO from data in HCFA's FID. We did not independently verify this information.

We were unable to assess the level of actual or potential program losses for the different types of potential fraud or abuse due to the limited financial data in the FID. However, HCFA officials told us that while more complex types of fraud or abuse, such as fraudulent cost reporting and kickback arrangements may be less frequent than other types, such cases often involve significantly greater losses.

EFFORTS TO MEASURE POTENTIAL FRAUD AND ABUSE RELY ON EFFECTIVE USE OF DIVERSE TECHNIQUES

Given the broad nature of health care fraud and abuse, efforts to measure its potential extent should incorporate carefully selected detection techniques into the overall measurement methodology. With billions of dollars at stake, health care fraud and abuse detection has become an emerging field of study among academics, private insurers, and HCFA officials charged with managing health care programs. A variety of methods and techniques are being utilized or suggested to improve efforts to uncover suspected health care fraud and abuse. Such variety is needed because one technique alone may not uncover all types of improper payments.

Although the vast majority of health care providers and suppliers are honest, unscrupulous persons and companies can be found in every health care profession and industry. Further, fraudulent schemes targeting health care patients and providers have occurred in every part of the country and involve a wide variety of medical services and products. Individual physicians, laboratories, hospitals, nursing homes, home health care agencies, and medical equipment suppliers have been found to perpetrate fraud and abuse.

Fraud and abuse detection is not an exact science. No matter how sophisticated the techniques or the fraud and abuse audit protocols, not all fraud and abuse can be expected to be identified. However, using a variety of techniques holds more promise for estimating the extent of potentially fraudulent and abusive activity and also provides a deterrent to such illegal activity. Health care fraud experts and in-

vestigators have identified techniques that can be used to detect fraudulent and abusive activity. According to OIG officials, these techniques are performed by Medicare contractor fraud units[7] to detect potential fraud and abuse. Table 1 summarizes the most promising techniques they identified along with some of their limitations.

TABLE 1.—TECHNIQUES FOR DETECTING POTENTIAL FRAUD AND ABUSE

Medical record review: Doctors and nurses review medical records to assess whether the services billed were allowable, reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations.

Limitations: Medical reviews may not uncover services that have not been rendered or billing for more expensive procedures when the medical records have been falsified to support the claim.

Beneficiary contact: Verify that the services billed were actually received through contacting the beneficiary either in person or over the phone, or by mailing a questionnaire.

Limitations: Beneficiary may be difficult to locate and not be fully aware of, or understand the nature of, all services provided. Contact may not reveal collusion between the beneficiary and provider to fraudulently bill for unneeded services or services not received. In some instances, medical necessity and quality of care may be difficult to judge.

Provider contact: Visit provider to confirm that a business actually exists, that the activity observed supports the number of claims being submitted by the provider, and that medical records and other documentation support the services billed.

Limitations: Provider contact may not reveal collusion between the provider and beneficiary to fraudulently bill for unneeded services or services not rendered. In some instances, medical necessity and quality of care may be difficult to judge.

Data analysis: Examine provider and beneficiary billing histories to identify unusual or suspicious claims. Provider focused data analysis attempts to identify unusual billing, utilization, and referral patterns relative to a provider's peer group. Beneficiary focused data analysis looks for unusual treatment patterns such as visiting several different providers for the same ailment or claims for duplicate or similar services.

Limitations: Data analysis may only identify the most flagrant cases of potential fraud and abuse because it relies on detecting unusual patterns relative to the norm. Application of additional techniques may be necessary to assess the appropriateness of unusual patterns identified.

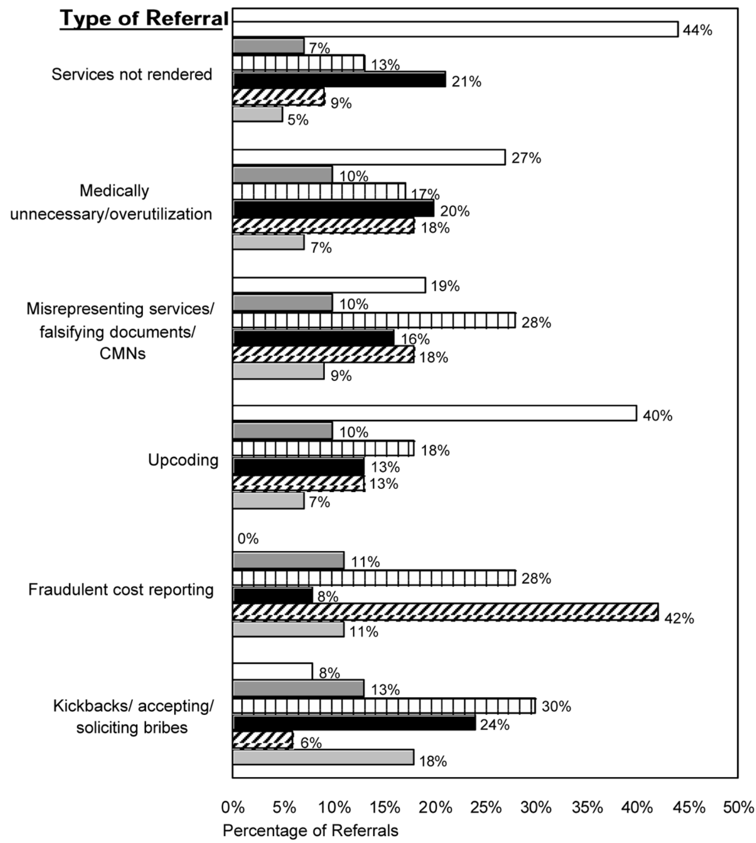
Third party contact/confirmation: Validate information relied on to pay claims with third parties to assist in identifying potential fraud and abuse. For example, verify that a provider is qualified to render medical services to Medicare beneficiaries through contacting state licensing boards or other professional organizations. Also, other entities, such as employers, private insurers, other governmental agencies (e.g., Internal Revenue Service, Social Security Administration, state Medicaid agencies) and law enforcement authorities represent valuable sources in determining the validity of claim payments when the reliability of data from primary sources (e.g., claims data, beneficiaries, and providers) is questionable.

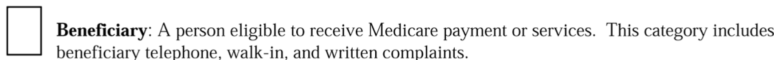
Limitations: Does not address utilization patterns, whether services were rendered, the need for services, or quality of services.

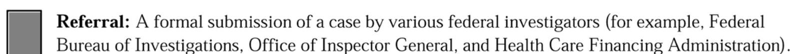
Consequently, health care experts and investigators also told us that effective detection of potential fraud and abuse necessarily involves the application of several of these techniques and considerable analysis, especially for the more sophisticated types of billing schemes and kickback arrangements. In addition, data on fraud referrals contained in the FID indicate that information necessary for identifying potential Medicare fraud and abuse comes from a variety of sources, as shown in figure 2. In particular, these data and the fraud experts we spoke with suggest that Medicare beneficiaries represent a valuable source for detecting certain types of potential fraud and abuse, especially services not rendered. HCFA officials told us that beneficiary complaints stem largely from the beneficiaries' review of their explanation of Medicare benefit (EOMB) statements received after health services and supplies are provided. These findings suggest that potential fraud and abuse can only be comprehensively measured by effectively applying a variety of investigation techniques using a variety of sources.

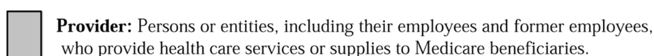
[7] Medicare contractor fraud units are located at each HCFA contractor and are responsible for preventing, detecting, and deterring Medicare fraud and abuse.

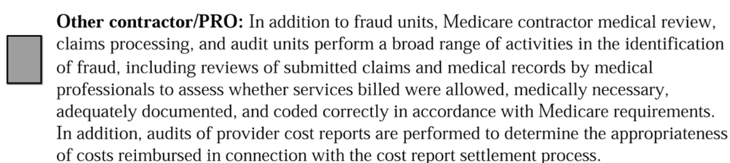
Figure 2: Sources of Common Fraud and Abuse Referrals, 1993 to April 2000

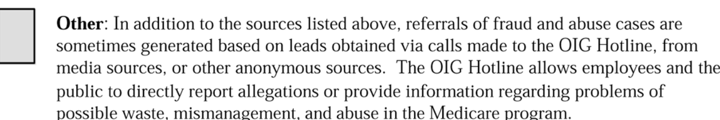












Source: Prepared by GAO from data in HCFA's FID and interviews with HCFA and contractor officials. We did not independently verify information contained in HCFA's FID.

PLANNED HCFA PROJECTS WILL PROVIDE SOME IMPROVEMENTS

The inherent vulnerabilities of the Medicare fee-for-service program have fueled debate over how extensively the measurement of potential fraud and abuse should be pursued to provide information that policymakers and HCFA managers need to effectively target program integrity efforts. Implementing the current methodology to estimate improper payments is a major undertaking and represents an attempt to give HCFA a national estimate of payment accuracy in the Medicare program. The current methodology focuses on estimating Medicare payments that do not comply with payment policies as spelled out in Medicare laws and regulations, but does not specifically attempt to identify potential fraud and abuse. In addition to the current methodology, HCFA has three projects in various stages of development that could somewhat enhance the capability to uncover potential fraud and abuse and help HCFA better target program safeguard efforts over the next few years.

CURRENT METHODOLOGY NOT DESIGNED TO MEASURE THE FULL EXTENT OF POTENTIAL FRAUD AND ABUSE

The primary purpose of the current methodology is to provide an estimate of improper payments that HCFA can use for financial statement reporting purposes, and it has served as a performance measure. The OIG is responsible for overseeing the annual audit of HCFA's financial statements, as required by the Chief Financial Officers Act of 1990 as expanded by the Government Management Reform Act of 1994. The current methodology has identified improper payments ranging from inadvertent mistakes to outright fraud and abuse. However, specifically identifying potentially fraudulent and abusive activity and quantifying the portion of the error rate attributable to such activity has been beyond the scope of the current methodology.

The focus of the current methodology is on procedures that verify that the claim payments made by Medicare contractors were in accordance with Medicare laws and regulations. The primary procedures used are medical record reviews and third party verifications. Medical professionals working for Medicare contractors and PROs review medical records submitted by providers and assess whether the medi-

cal services paid for were allowable, medically necessary, accurately coded, and sufficiently documented. OIG staff perform various procedures including third party verifications to ensure that health care providers are in "good standing" with state licensing and regulatory authorities and are properly enrolled in the Medicare program. They also verify with the Social Security Administration (SSA) that the beneficiaries receiving the services were eligible for them.

The OIG reported that the medical reviews conducted in the current methodology have been the most productive technique for identifying improper payments—detecting the overwhelming majority of the improper payments identified.[8] According to OIG officials, medical reviews have led to some major prosecutions. In addition, some of the health care fraud experts we talked with stated that such medical reviews are most effective in detecting unintentional errors. However, they also told us that medical reviews are less effective in identifying potentially fraudulent and abusive activity because clever providers can easily falsify supporting information in the medical records to avoid detection.

With respect to identifying potentially fraudulent or abusive activities, OIG officials indicated that medical reviews performed during the current methodology have resulted in referrals to its Investigations Office. However, they acknowledge that the current methodology generally assumes that all medical records received for review are valid and thus represent actual services provided. In addition, they agree that additional improper payments may have been detected had additional verification procedures been performed, such as first, confirming with the beneficiary whether the services or supplies billed were received and needed and second, confirming the nature of services or supplies provided through on-site visits and direct contact with current or former provider employees. Recognizing the potential for abuse based on past investigations—such as falsified certificates of medical necessity or where beneficiaries are not "homebound", a requirement for receiving home health benefits—the OIG has included face-to-face contact with beneficiaries and providers when reviewing sampled claims associated with home health agency services. Further, during the course of our review, OIG officials stated that they will conduct beneficiary interviews when reviewing DME claims selected in its fiscal year 2000 study. However, according to OIG officials, they have not extended this or certain other techniques to the other numerous types of claims included in its annual review because they consider them costly and time-consuming.

Accordingly, the OIG recognizes that the current methodology does not estimate the full extent of Medicare fee-for-service improper payments, especially those resulting from potentially fraudulent and abusive activity for which documentation, at least on the surface, appears to be valid and complete. In fact, the OIG testified[9] that its estimate of improper payments did not take into consideration numerous kinds of outright fraud such as phony records or kickback schemes. To identify potential fraud, the OIG also relies on tips received from informants and other investigative techniques.

A secondary benefit that has been derived from the current methodology is that it has prompted HCFA into developing additional strategies, as we discuss later, for reducing the types of improper payments identified. However, HCFA is limited in developing specific corrective actions to prevent such payments because the current methodology only produces an overall national estimate of improper payments. Having the ability to pinpoint problem areas by geographic areas below a national level (referred to as subnational), Medicare contractors, provider types, and services would make improper payment measures a more useful management tool.

HCFA PROJECTS ENHANCE ERROR RATE PRECISION AND SOME POTENTIAL FRAUD AND ABUSE DETECTION CAPABILITIES

HCFA has two projects that center on providing it with the capability of producing improper payment rates on a subnational and provider type basis—the Comprehensive Error Rate Testing (CERT) project and the surveillance portion of the Payment Error Prevention Program (PEPP). These projects are designed to improve the precision of future improper payment estimates and provide additional information to help develop corrective actions. However, since the methodologies associated with the CERT and PEPP projects incorporate techniques for identifying improper payments that are similar to those used in the current methodology, the extent to

[8] Improper Fiscal Year 1999 Medicare Fee-For-Service Payments, Department of Health and Human Services, Office of Inspector General, February 2000, A–17–99–01999.

[9] July 17, 1997, testimony of the HHS Inspector General in a hearing before the House Committee on Ways and Means, Subcommittee on Health, entitled Audit of HCFA Financial Statements.

which these two projects will enhance HCFA's potential fraud and abuse measurement efforts is limited.

HCFA has a third project in the concept phase that will test the viability of using a variety of investigative techniques to develop a potential fraud rate for a specific geographic area or for a specific benefit type. This project, called the Model Fraud Rate Project (MFRP), provides HCFA the opportunity to pilot test more extensive detection techniques that, if effective, could be incorporated into the other measurement methodologies to improve the measurement and, ultimately, prevention of potential fraudulent and abusive activity. Table 2 compares the scope and potential fraud and abuse detection capabilities of the current methodology to the HCFA projects.

Table 2: Comparison of HCFA Efforts to Measure Medicare Improper Payments

	Current methodology	Comprehensive Error Rate Testing (CERT)	Payment Error Prevention Program/Surveillance (PEPP)	Model Fraud Rate Project (MFRP)
Key design attributes	• First national statistically valid estimate for all types of fee-for-service claims, beneficiaries, and providers • Includes tests for: • medical necessity and reasonableness • proper documentation, • proper coding, • provider eligibility, • determination of whether providers are subject to current sanctions or investigations, • beneficiary eligibility, • duplicate payments, • medicare as secondary payer (MSP) compliance, • compliance with pricing, deductible, and coinsurance rules, & other selected rules	• Test procedures expected to be similar to current methodology • Independent medical review • Larger sample and on-going reporting improves analyses/utility • Statistically valid national error rates by contractor, provider type, benefit category, and claims processing, • Trend analysis to assist in targeting of integrity efforts, • Potential platform for testing claims software	• Designed to estimate payment error rates for inpatient Prospective Payment System (PPS) claims by state • Larger sample and frequent reporting designed to improve analyses and targeting of integrity efforts • Tests focus on: • medical necessity and reasonableness, • unnecessary admissions, • incorrect diagnostic coding, • some quality of care measures	• Pilot study to develop a model fraud rate • Scope focused on specific benefit or geographic area • Fraud investigative techniques will be used: • Beneficiary contact, • Medical records review, • provider and beneficiary profiling, • investigation of complaints • Results to be categorized under fraud types and causes
Limitations for detecting potential fraud and abuse	• Significant reliance on the integrity of medical records • Lacks provider-focused data analysis during testing • Limited provider or beneficiary validation • Not designed to identify certain types of fraud or abuse	• Similar to current methodology	• Similar to current methodology • Scope limited to inpatient PPS	• Plan for comprehensive nationwide study evolving • Limited provider or third party validation
Status	• Fourth annual review completed	• Contract awarded 5/00 • Phased implementation designed to be completed by 10/2001	• Contracts completed 3/00 • Baseline error rates and first quarterly report due by 9/00	• Concept currently under development • Pilot testing projects designed to be implemented by 10/2000
Costs	• 1999 review $4.7 million	Base year $2 million plus $4 million annually thereafter	$7.5 million annually	Not yet determined

Source: GAO testimony 7-12-2000.

The CERT project focuses on reviewing a random sample of all Part A and B claims processed by Medicare contractors each year except inpatient Prospective Payment System (PPS) hospital claims. It involves the review of a significantly larger random sample of claims and thus, according to HCFA officials, allowing HCFA to project subnational improper payment rates for each Medicare contractor and provider type. It is the largest of the projects and is undergoing a phased implementation with a scheduled completion date of October 2001. In addition to developing subnational error rates, HCFA officials stated that the CERT project will also be used to develop performance measures that will assist HCFA in monitoring contractor operations and provider compliance. For example, CERT is designed to produce a claim processing error rate for each contractor that will reflect the percentage of

claims paid incorrectly and denied incorrectly, and a provider compliance rate that indicates the percentage of claims submitted correctly.

The PEPP project is similar to the CERT project and is designed to develop payment error rates for the Part A inpatient PPS hospital claims not covered by CERT. PEPP is designed to produce subnational error rates for each state and for each PRO area of responsibility. Claim reviews under PEPP are designed to be continuous in nature with results reported quarterly. HCFA officials stated that the project is the furthest along in implementation, with the first quarterly reports expected in September 2000. The contractors and PROs implementing the project are expected to identify the nature and extent of payment errors for these inpatient claims and implement appropriate interventions aimed at reducing them.

After their full implementation, HCFA intends to develop a national improper payment rate by combining the results of the CERT and PEPP projects. This rate will be compared to the rate produced by the current methodology to identify, and research reasons for, any significant variances among results. While the national estimate will continue to provide valuable information concerning the extent of improper payments, HCFA officials state that the availability of reliable estimates at the subnational levels contemplated by these efforts will greatly enhance the usefulness of these estimates as management tools.

While enhancing the precision of improper payment estimates will offer a richer basis for analyzing causes and designing corrective actions, conceptually, the MFRP holds the most promise for improving the measurement of potential fraud and abuse. However, the Medicare contractor assisting HCFA in developing this project is dropping out of the Medicare program in September 2000 and has ceased work on the project. Efforts to date have focused on developing a potential fraud rate for a specific locality and specific benefit type; however, HCFA intends to eventually expand the scope of the project to provide a national potential fraud rate. As currently conceived, the project involves studying the pros and cons of using various investigative techniques, such as beneficiary contact, to estimate the occurrence of potential fraud. HCFA officials informed us that before the contractor ceased work on this project, it conducted a small pilot test using beneficiary contact as a potential fraud detection technique that identified some of the challenges HCFA will face in implementing this technique. The results of the test are discussed later.

HCFA is seeking another contractor to take over implementation of the project. The contractor eventually selected will be expected to produce a report that identifies the specific potential fraud and abuse identification techniques used, the effectiveness of the techniques in identifying potential fraud and abuse, and recommendations for implementing the techniques nationally. The contractor will also be expected to develop a "how to manual" that Medicare contractors and other HCFA program safeguard contractors (PSC) can use to implement promising techniques. HCFA officials stated that promising techniques identified through MFRP could also be exported to the CERT and PEPP projects and the current methodology to enhance national and subnational estimates of potential fraud and abuse over time.

EXPANDING THE SCOPE OF THE HCFA PROJECTS COULD ENHANCE MEASUREMENT OF POTENTIAL FRAUD AND ABUSE

Collectively, HCFA's projects do not comprehensively attempt to measure potential fraud and abuse or evaluate the specific vulnerabilities in the claims processing process that may be allowing fraud and abuse to be perpetrated. Table 3 shows the limited use of selected identification elements among the current methodology and the HCFA projects. The MFRP project's scope, for example, does not include studying the viability of making provider and supplier contact or using third party confirmations to detect potential fraud and abuse.

Contacting beneficiaries and checking providers are valuable investigative techniques used to develop potential fraud and abuse cases. For example, California officials recently visited all Medicaid[10] Durable Medical Equipment (DME) suppliers as part of a statewide Medicaid provider enrollment effort and found that 40 percent of the dollars paid to the suppliers was potentially fraudulent. The on-site visits not only helped to identify the fraudulent activity, but also to obtain sufficient evidence to support criminal prosecutions for fraud.

[10] The Medicaid program represents the primary source of health care for medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. Medicaid is administered in partnership with the states pursuant to Title XIX of the Social Security Act with combined state and Federal medical assistance outlays in fiscal year 1999 totaling $180.8 billion.

Table 3: Methodologies for Estimating Medicare Improper Payments

	Key characteristics	Current methodology	CERT	PEPP	MFRP
Measurement elements	**Scope -**				
	• Geographical	Nationwide	Nationwide [a]	Nationwide [a]	Evolving [b]
	• Claim type	All	All but Inpatient	Inpatient only	
	Measurement-				
	• Technique used	Sampling	Sampling	Sampling	Sampling
	• Annual claims sample size	5,000 – 8,000	100,000+	55,000+	Not yet determined
	Classification of errors [c]				
	• Cause	○	○	○	●
	• Type	●	●	●	●
Identification elements	**Claims Validation:**				
	• Medical record and claims processing review	●	●	●	●
	• Beneficiary contact	○[d]	○d	○	●
	• Provider/Supplier contact [e]	○[d]	○	○	○
	• Third party contact/confirmation [f]	●	○	○	○
	• Data analysis [g]				
	• Provider focused [h]	○	○	○	●
	• Beneficiary focused	●	○	○	●

Legend: ● Element included ○ Element not included

[a] The CERT and PEPP projects also provide for estimates of improper payments at the subnational and provider type levels.

[b] The scope of the MFRP is still conceptual. Efforts to date have focused on developing a potential fraud rate for specific benefit types and specific localities and to eventually expand efforts to provide a national rate.

[c] Errors can be classified in many ways; table 3 shows two types of categories. For example, cause classifications may include inadvertent billing errors or possible fraud and abuse errors. Type categories may include documentation errors or lack of medical necessity errors.

[d] Methodology includes face-to-face contact with beneficiaries and providers for home health agency claims only.

[e] Other than requests for medical records.

[f] Third part contact/confirmation, for example, may include contact with State licensing boards or other professional organizations to verify provider standing. This example represents only one of the numerous methods of utilizing third party confirmation to identify improper payments.

[g] See table 1 for a discussion of data analysis techniques for detecting potential fraud and abuse.

[h] OIG officials recently told us that each year at the end of their review, after all data has been entered in their national database, they profile each provider type in the claims sample.

Including an assessment of the likely causes of specific payment errors could help HCFA better develop effective strategies to mitigate them. The current methodology classifies errors by type, such as lack of documentation or medically unnecessary services, which is used to show the relative magnitude of the problems. Knowing the relative magnitude of a problem offers perspective on what issues need to be addressed. For example, based on its review of errors identified in the current methodology, HCFA recently issued a letter to physicians emphasizing the need to pay close attention when assigning Current Procedural Terminology (CPT) codes[11] and

[11] CPT consists of a list of 5-digit codes for most of the services performed by physicians as well as instructions for using them for billing purposes.

billing Medicare for two closely related, yet differing, types of evaluation and management services.

Further analysis of identified improper payments that provide additional insights into possible root causes for their occurrence is essential for developing effective corrective actions. For example, if errors are resulting from intentionally abusive activity, specific circumstances or reasons that permit the abuse to be perpetrated can be analyzed to develop and implement additional prepayment edits to detect and prevent their occurrence. In this regard, GAO has long advocated enhancing automated claims auditing systems to more effectively detect inappropriate payments due to inadvertent mistakes or deliberate abuse of Medicare billing systems.[12] Also, developing or strengthening specific enforcement sanctions offer an additional tool to deter providers or suppliers from submitting inappropriate claims.

Likewise, numerous individuals and entities are involved throughout the entire Medicare claims payment process, including providers, suppliers, employees (caregivers, clerical, and management), Medicare claims processing contractors, HCFA, beneficiaries (and their relatives), and others. Interestingly, in its review of Illinois Medicaid payments,[13] the Illinois Department of Public Aid (IDPA) determined that over 45 percent of the errors it identified were inadvertent or caused by the IDPA itself during the process of approving services or adjudicating claims, and that 55 percent appeared to be caused by questionable billing practices. IDPA officials told us that having a clear understanding of the root causes for these errors has been instrumental in developing effective corrective actions. Similarly, attributing the causes of Medicare fee-for-service improper payments to those responsible for them could provide HCFA with useful information for developing specific corrective actions.

Certain third party validation techniques are included and have been successfully implemented in the current methodology. For example, OIG staff confirm a provider's eligibility to bill the Medicare program by contacting state licensing boards to ensure that the doctors billing Medicare have active licenses. They also verify that beneficiaries are eligible to receive medical services under the Medicare program with the SSA. However, as currently conceived, none of the HCFA projects include third party contact as a potential fraud detection technique.

IMPLEMENTING MORE AGGRESSIVE FRAUD DETECTION TECHNIQUES WILL REQUIRE CAREFUL STUDY AND ADDITIONAL RESOURCES

The experiences of recent efforts to apply more aggressive fraud detection techniques coupled with our discussions with patient and provider advocacy groups indicate that finding successful protocols for implementing some detection techniques may require careful study. Our review of three studies that have attempted to use beneficiary contact as a measurement device—the MFRP and two Medicaid studies in Texas and Illinois—indicate that, while useful, it is a challenging technique to implement.

- The initial contractor for the MFRP conducted a small pilot test using beneficiary contact to verify Medicare billed services and found that making contact was more difficult than anticipated. Telephone contact was the most cost-effective approach for contacting beneficiaries, but the contractor could only reach 46 percent of them due to difficulty in obtaining valid phone numbers and difficulty in actually talking to the beneficiary or his or her representative once a valid number was located. Using more costly and time-consuming approaches, such as mailing written surveys and conducting face-to-face interviews only increased the success rate to 64 percent. To maximize the effectiveness of these alternative approaches, the contractor noted that it was important to obtain valid addresses and ensure that the written survey instrument was concise, easy to understand, and complete for beneficiaries to take the time to respond.
- The state of Texas experienced similar difficulties contacting Medicaid recipients in a recent statewide fraud study.[14] Telephone numbers for more than half of the 700 recipients that the state attempted to contact were not available or were incorrect. The state attempted to make face-to-face contact if telephone contact was not possible, and by the study's end, over 85 percent of the recipients were contacted. The state concluded that contacting a recipient by telephone is the only cost-

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[12] Medicare Billing: Commercial System Could Save Hundreds of Millions Annually (GAO/AIMD–98–91, April 15, 1998) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD–95–135, May 5, 1995).

[13] Payment Accuracy Review of the Illinois Medical Assistance Program, Illinois Department of Public Aid, August 1998.

[14] Final Staff Draft Report on Health Care Claims Study and Comments from Affected State Agencies, Texas Comptroller of Public Accounts, December 1998.

effective way to verify that services had been delivered. It also found that delays in making contact could impact the results since recipients' ability to accurately recall events appeared to diminish over time.

- For the Illinois Medicaid study, the IDPA found other problems in using beneficiary contact as a detection technique in the payment accuracy study of its program.[15] Department investigators met with almost 600 recipients or their representatives to verify that selected medical services had been received. The investigators found that while recipient interviews were an overall useful step in the study's methodology, they did not always produce the desired results. For example, investigators found cases where caretaker relatives could not verify the receipt of services. They also found other cases where recipients were unaware of the services received, such as lab tests, or could not reliably verify the receipt of services because they were mentally challenged.

Illinois officials involved with implementing the Medicaid study told us that direct provider contact is also challenging. For example, an important consideration is whether or not to make unannounced visits. According to the Illinois officials, unannounced visits can be disruptive to medical practices and inappropriately harm the reputations of honest providers by giving patients and staff the impression that suspicious activities are taking place. Announced visits, on the other hand, can give the provider time to falsify medical records, especially if they know which medical records are going to be reviewed. The Illinois officials resolved this dilemma by announcing visits 2 days in advance and requesting records for 50 recipients so it would be difficult for the provider to falsify all the records on such short notice.

Data on fraud referrals included in HCFA's FID indicates that health care providers and beneficiaries represent important sources for identifying improper payments, particularly for certain types of potential fraud and abuse. Moreover, the application of more extensive fraud detection techniques into efforts to measure improper payments will require their cooperation. Our discussions with patient and health care provider advocacy groups indicated they may oppose the application of more extensive detection techniques due to concerns with violating doctor-patient confidentiality, protecting the privacy of sensitive medical information, and added administrative burdens. For example, officials from the Administration on Aging, an HHS operating division, told us that they discourage elders from responding to telephone requests for medical and other sensitive information. Similarly, the American Medical Association and American Hospital Association emphasize the adverse impact that meeting what they consider to be complex regulations and responding to regulatory inquiries has on health care providers' ability to focus on meeting patient needs. They also voiced concerns with the added cost that would have to be absorbed by providers to comply with even more requests for medical information in an era of declining Medicare reimbursements. Further, some of the health care experts we talked with cautioned that there are practical limits to the amount of potentially fraudulent and abusive activity that can be measured. These experts emphasize that no set of techniques, no matter how extensive, can be expected to identify and measure all potential fraud and abuse.

In addition to beneficiary and provider contact, the health and fraud experts we spoke with told us that validating the information that Medicare contractors are relying on to pay claims, including provider and supplier assertions concerning the appropriateness of those claims, with third parties could also help to identify potential fraudulent or abusive activity. The current methodology incorporates such procedures to confirm providers' current standing with state licensing authorities and beneficiaries' eligibility status with SSA. Other sources—such as beneficiary employers, beneficiary relatives or personal caregivers, State Medicaid agencies, and employees of providers and suppliers—could also offer useful information for assessing the appropriateness of claims. However, determining the appropriate nature and extent of third party verification procedures to incorporate into efforts to measure improper payments should be considered carefully. Excluding third party verification efforts, and therefore placing greater reliance on the accuracy of data developed internally or provided independently, should be based on risks determined through analysis of reliable indicators.

The Comptroller General's *Standards for Internal Control in the Federal Government* stresses the importance of performing comprehensive risk assessments and implementing control activities, including efforts to monitor the effectiveness of corrective actions to help managers consistently achieve their goals. While the annual cost of the current methodology and the HCFA projects involve several million dollars, these efforts represent a needed investment toward avoiding significant future losses through better understanding the nature and extent of improper payments—

[15] See footnote 13.

including potential fraud and abuse. As shown in table 2, the current methodology costs $4.7 million, not counting the cost of medical review staff time at contractors. PEPP is estimated to cost $7.5 million annually, and CERT costs are expected to be over $4 million annually once fully implemented. While these may seem to be expensive efforts, when considered in relation to the size and vulnerability of the Medicare program and the known improper payments that are occurring, they represent prudent, needed outlays to help ensure program integrity.

In our recent report on improper payments across the Federal Government,[16] we discussed the importance of ascertaining the full extent of improper payments and understanding their causes to establish more effective preventive measures and to help curb improper use of Federal resources. However, as we recently testified,[17] HCFA's ability to protect against fraud and abuse depends on adequate administrative funding. Therefore, in developing effective strategies for measuring improper payments, consideration of the most effective techniques to apply in the most efficient manner is essential to maximize the value of administrative resources. While HCFA faces significant challenges for ensuring the integrity of the Medicare fee-for-service program, importantly, HCFA can use the results of these efforts to more effectively assess corrective actions, target high-risk areas, and better meet its role as steward of Medicare dollars.

MFRP HOLDS SOME PROMISE FOR ADVANCING POTENTIAL FRAUD AND ABUSE MANAGEMENT

HCFA plans to expand its efforts to measure Medicare improper payments by assessing the usefulness of performing additional fraud detection techniques with the MFRP. Meanwhile, since the current methodology and the CERT and PEPP projects do not incorporate the use of some techniques considered effective in identifying potential fraud and abuse, HCFA's ability to fully measure the success of its efforts to reduce fraud and abuse remains limited.

Health care fraud experts told us that the ability of these projects to measure potential fraud and abuse are somewhat dependent on the nature, extent, and level of fraud sophistication that may be involved. For example, the introduction of beneficiary contact, in conjunction with other techniques, should improve the ability to determine whether services were actually rendered. However, if the beneficiary is a willing participant in the potential fraud and abuse scheme, these additional techniques may not lead to an accurate determination.

CONCLUSIONS

The size and administrative complexity of the Medicare fee-for-service program make it vulnerable to inadvertent error and exploitation by unscrupulous providers and suppliers. Given the billions of dollars that are at risk, it is imperative that HCFA continue its efforts to develop timely and comprehensive payment error rate estimates that can be used to develop effective program integrity strategies for reducing errors and combating fraud and abuse. The current methodology represented a significant first step in obtaining such information, but the lack of key fraud and abuse detection techniques limit its effective use as a management tool to estimate potential fraud and abuse and ultimately achieve important program integrity goals. HCFA's projects could collectively address some of the limitations of the current methodology if properly executed, but do not appear to go far enough. Expanding the scope of the Model Fraud Rate Project to include studying provider visits and a more extensive assessment of the cause of improper payments and other promising techniques could help HCFA pinpoint additional high-risk areas and develop more effective corrective actions. The implementation of more extensive detection techniques is bound to be challenging and expensive, so using rigorous study methods and consulting with the people affected, such as beneficiary and provider advocacy groups, are essential steps to ensure success, as well as considering the tangible and intangible benefits of using particular techniques. Given the delays and potential challenges associated with implementing the Model Fraud Rate Project, substantial improvements in the measurement of improper payments, especially those stemming from potential fraudulent and abusive activity, will probably not be realized for a few years.

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[16] Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments (GAO/AIMD–00–10, October 29, 1999).

[17] Medicare: HCFA Faces Challenges to Control Improper Payments (GAO/T–HEHS–00–74, March 9, 2000).

RECOMMENDATIONS

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse, we recommend that the HCFA Administrator take the following actions:

- Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify and measure improper payments and then evaluate their effectiveness. In determining the nature and extent of additional specific procedures to perform, the overall measurement approach should first, recognize the types of fraud and abuse perpetrated against the Medicare program, second, consider the relative risks of potential fraud or abuse that stem from the various types of claims, third, identify the advantages and limitations of common fraud detection techniques and use an effective combination of these techniques to detect improper payments, and fourth, consider, in consultation with advocacy groups, concerns of those potentially affected by their use, including beneficiaries and health care providers.
- Include in the methodologies' design, sufficient scope and evaluation to more effectively identify underlying causes of improper payments, including potential fraud and abuse, to develop appropriate corrective actions.

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

APPENDIX I—OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to identify additional improvements to the Medicare improper payments measurement projects that were recently designed by HCFA to further estimate improper payments including potential fraud and abuse.

Through interviews with HCFA Program Integrity Group officials and reviews of HCFA documentation including program integrity plans, project descriptions, statements of work, and requests for proposals, we identified HCFA projects that could improve the measurement of Medicare fee-for-service improper payments.

Through interviews with health care fraud and investigation experts, we gained an understanding of the vulnerabilities in the Medicare fee-for-service program that create opportunities for improper payments, especially those stemming from fraudulent and abusive activity, and the most promising detection techniques to identify these payments. Specifically, we talked with officials from the Department of Health and Human Service's Office of the Inspector General (OIG) and Office of Investigations (OI), Department of Justice (DOJ), Federal Bureau of Investigation (FBI), HCFA's program integrity group, HCFA's Atlanta Regional Office unit specializing in fraud detection efforts, a Medicare claims processing contractor, Association of Certified Fraud Examiners, three private health insurance organizations, National Health Care Anti-Fraud Association (NHCAA), Health Insurance Association of America (HIAA), three states in connection with their Medicaid program, and two academicians with notable fraud investigation experience. We also reviewed various documents including HCFA and OIG Fraud Alerts, prior GAO, OIG, and other studies on health care fraud and abuse, particularly those related to the Medicare fee-for-service program.

We analyzed HCFA's Fraud Investigation Database (FID) to identify the most common types of potential fraud referred to the OI and DOJ for further investigation and possible criminal and civil sanctions. We also analyzed the FID to determine the most frequent sources for identifying potential fraud. The FID was created in 1995, but has data on fraud referral going back to 1993. We did not attempt to validate the database.

To assess the potential effectiveness of the techniques planned for the HCFA projects for identifying improper payments attributable to potential fraud and abuse, we first performed a comparative analysis of common types and sources of referrals of fraud and abuse occurring in the Medicare program, the types of techniques identified by investigative experts as most effective for identifying them, and the extent to which identified techniques are incorporated in the respective methodologies and second, discussed the results of our analysis with officials in HCFA's Program Integrity Group and OIG.

To gain an understanding of how the implementation of additional procedures to identify and measure improper payments attributable to potential fraud and abuse could affect providers, suppliers, and recipients of health care services and supplies, we interviewed officials from patient and health care provider advocacy groups, including the American Medical Association, American Hospital Association, HHS Administration on Aging (AOA), American Association of Retired Persons (AARP), and the Health Care Compliance Association (HCCA).

We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards.

APPENDIX II—DEFINITIONS AND EXAMPLES OF COMMON TYPES OF POTENTIAL FRAUD AND ABUSE REFERRALS

SERVICES NOT RENDERED

As the category indicates, cases involving billing for services not rendered occur when health care providers bill Medicare for services they never provided. Potential fraud and abuse is usually detected by statements received from the provider's patients or their custodians and the lack of supporting documents in the medical records.

For example, a provider routinely submitted claims to Medicare and CHAMPUS[1] for cancer care operations for services not rendered or not ordered; upcoded procedures, as defined below, to gain improper high reimbursement; and double billed Medicare for certain procedures. As a result of the fraudulent submissions, the provider allegedly obtained millions of dollars to which they were not entitled.

MEDICALLY UNNECESSARY SERVICES AND SUPPLIES AND OVERUTILIZATION

Cases involving medically unnecessary services, supplies, or overutilization occur when providers or suppliers bill Medicare for items and services that are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a body part. They include incidents or practices of provider, physicians, or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to Medicare, improper payments, or payments for services that fail to meet professionally recognized standards of care or are medically unnecessary.

For example, a provider ordered magnetic resonance imaging tests (MRIs) and neurological tests which investigators questioned whether the tests were medically necessary, and whether the neurological tests were actually performed. Most of the tests were performed on patients who responded to the provider's advertisements in the yellow pages. After a 5 to 10 minute consultation, the provider would diagnose almost every patient with the same disorder—radiculopathy, a disease involving compression of, or injury to the roots of spinal nerves.

MISREPRESENTATION OF SERVICES AND PRODUCTS/FALSIFYING CERTIFICATES OF MEDICAL NECESSITY (CMNS)/OTHER DOCUMENTS

Medicare publishes coverage rules on what goods and services the program will pay for and under what circumstances it will pay or not pay for certain goods and services. Providers sometimes bill Medicare, showing a billing code for a covered item or service when, in fact, a noncovered item or service was provided. Further, providers sometimes intentionally falsify statements or other required documentation when asked to support payments for claimed services or supplies. In particular, investigators have determined that falsification of CMNs—documents evidencing appropriately authorized health care professionals' assertions regarding the beneficiaries' needs for certain types of care or supplies, such as home health and hospice services or certain durable medical equipment—occur, providing unscrupulous providers and suppliers additional opportunities to abuse Medicare.

For example, a provider billed for an orthotic knee brace, when in fact the provider was providing Medicare beneficiaries with nonelastic compression garments and leggings. Although knee orthotics are reimbursed by Medicare and Medi-Cal[2] for a total of over $650 per brace, the nonelastic compression garment is not reimbursed by Medicare. The total billings totaled approximately $332,055.

UPCODING

One type of incorrect coding is called "upcoding." Upcoding cases result from health care providers changing codes on claim forms submitted to Medicare, causing reimbursements to be paid at higher rates than are warranted by the service actually provided. Upcoding can also result from providers billing for services actually provided by nonphysicians, which would be paid at a lower reimbursement rate.

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[1] CHAMPUS, or the Civilian Health and Medical Program of the Uniformed Services, is a fee-for-service health insurance program that pays for a substantial part of the health care that civilian hospitals, physicians, and others provide to nonactive duty Department of Defense beneficiaries.

[2] The Medicaid program for the State of California is known as the Medi-Cal program.

For example, a provider allegedly submitted false claims for services provided by physicians in training and inflated (upcoded) claims in connection with patient admissions services. The provider paid the U.S. Government $825,000 primarily to settle allegations resulting from an audit performed by the HHS OIG. The audit was triggered by a lawsuit filed by private citizens as authorized by the False Claims Act (31 U.S.C. sections 3729–3733).

FRAUDULENT COST REPORTING

Falsifying any portion of the annual report submitted by all institutional providers participating in the Medicare program. The report is submitted on prescribed forms, depending on the type of provider (e.g., hospital, skilled nursing facility, etc.). The cost information and statistical data reported must be current, accurate and in sufficient detail to support an accurate determination of payments made for the services rendered.

For example, a provider billed Medicare for hundreds of thousands of dollars for personal expenses disguised as legitimate healthcare expenses. The personal expenses billed included an addition to a private home, vacations, and beauty pageant gowns. The provider was fined over $500,000 for the fraudulent billings.

KICKBACKS AND ACCEPTING/SOLICITING BRIBES, GRATUITIES OR REBATES

Section 1128B of the Social Security Act, 42 U.S.C. § 1320a–7b(b), makes it a felony to solicit, receive, offer, or pay a kickback, bribe, or rebate in connection with the provision of goods, facilities, or services under a Federal health care program, including Medicare.

For example, a provider agreed to plead guilty to conspiracy, mail fraud, and violating the anti-kickback provision and to pay $10.8 million in criminal fines in connection with its scheme to defraud Medicare. The pleas relate to kickbacks and false Medicare billings made in connection with the provider's receipt of fees from another company for the provider's management of certain home health agencies.

Chairman CHAMBLISS. How much direct contact did your office have with providers out there? Did you all actually go out and visit with any of the providers with respect to the procedure that is now used to examine waste, fraud and abuse?

Ms. JARMON. We talked to some organizations that cover providers. I think we did talk to some providers.

Chairman CHAMBLISS. I am just curious what the reaction was to the—from the Medical Association of Illinois or Georgia or whoever you talked to. What reaction do you get from those folks with respect to your investigation into this?

Ms. JARMON. Their reaction was there is no way that you would ever get a handle on all the fraud because the schemes are continually changing, so that it would probably be impossible to ever come up with a fraud rate. They were concerned about more contact with the providers and how it would affect their operations.

They do understand that there is a fraud problem, and they were sympathetic to the fact that something needs to be done to address it, but they feel like most providers are honest, which is what we believe also, and that there needs to be targeted efforts to address where the problems are rather than make it an invasive procedure to all providers or many providers.

Chairman CHAMBLISS. Do you find within the Medicare review process is there any correlation between State licensing boards and the investigators from HCFA with respect to just determining the simple—something simple, like requiring notification from State licensing boards of all persons who are licensed in that State as well as all persons who are, for disciplinary reasons, becoming unlicensed, die or whatever; is there any correlation there, is that information being shared back and forth between State licensing boards and Medicare—I mean and HCFA, excuse me.

Ms. JARMON. The Medicare fraud units within the different contractors within HCFA, and I believe there are about 56 Medicare contractors throughout the country, do get information from the State licensing boards, but I am not sure of how and how often the information is shared. But they do receive information. They do perform third-party verification of information with the State licensing boards.

Chairman CHAMBLISS. Right. I think a little bit later on we are going to hear a statement with respect to the way in which most waste, fraud and abuse is uncovered is through review of medical records, which presents some problems in and of itself with respect to privacy issues. But would you agree with that, that based on y'all's research, that reviewing independent medical records of Medicare beneficiaries is, in fact, the best way to try to discover these problems?

Ms. JARMON. I will answer that briefly, then I will let Mr. Hamel answer it, because he has been more involved hands on in looking at some of this information. We found that all five of the techniques that we have here are important. Medical record review is one of the five techniques. Many of the experts we talked to who are fraud investigators have said it is important to combine the techniques. Any one technique in and of itself would not be effective. It is important if you are doing a medical record review to also do data analysis and combine some techniques if the emphasis is to try to determine potential fraud.

Mr. Hamel, anything you want to add?

Mr. HAMEL. No, I think that is a fair assessment.

Chairman CHAMBLISS. You didn't make reference either in your written statement or in your oral statement to where you think the scale of waste, fraud and abuse in Medicare is. Is there any way to get any kind of accurate number on pure waste, fraud and abuse; not errors, but waste, fraud and abuse?

Ms. JARMON. I don't think it is possible to know exactly how much waste, fraud and abuse is in the Medicare program. We do know, like I mentioned in the statement, that the estimate that the IG comes up with, doesn't include efforts to identify all the fraud and abuse. So we know that total improper payments, including the actual fraud and abuse is probably something more than the $13.5 billion that was estimated for fiscal year 1999. How much more we don't know.

Chairman CHAMBLISS. Well, and their numbers actually refer more to errors made by suppliers rather than by what we refer to as true waste, fraud and abuse though; isn't that correct?

Ms. JARMON. Right. They don't know how much of it is just errors or how much of it might be fraud. Right.

Chairman CHAMBLISS. As a layman, I have a little bit of a difficult time understanding the way some of these schemes evolve. For example, I keep reading and hearing about the fact that waste, fraud and abuse organizers, I guess, is a way I would categorize them, create false files, and they just have a mailbox out there, and they send claim forms in to HCFA, and they wind up getting paid. And I don't understand how that happens from a practical standpoint. Can you all talk a little bit about that and somewhat educate

me and maybe some other Members here that don't understand exactly how that can happen?

Ms. JARMON. I will let Bill talk about that. He has some hands-on experience with seeing some of it.

Mr. HAMEL. We also issued a report in October 1999 having to do with organized criminal groups that were engaging in health care fraud. What we found was that, generically speaking, individuals with criminal histories for non-health-care-related violations, such as securities fraud, weapons, drugs and narcotics, assembled themselves and organized themselves into groups for the specific purpose of defrauding the Medicare program and other health care insurers.

Some of the things that they would do would be to establish a drop box, for example. They would rent a mailbox and call it an office suite, and they would obtain Medicare beneficiary numbers, by either stealing them or paying people to steal them, or they would purchase them. They would rummage through garbage and use all kinds of various illicit means to get numbers without the consent of the beneficiary and then just submit claims for bogus services. The checks from Medicare would be sent to the mailbox, or in some cases electronically transmitted to a bank account, and after they had concluded enough billings, they would just close up shop and move elsewhere.

Chairman CHAMBLISS. So are they using falsified supplier numbers also? I am assuming that a physician, for example, has a number out there that Medicare has on file or HCFA has on file, and he has got to give that number when he submits his claim.

Mr. HAMEL. In the cases that we examined—actually some of them had legitimate numbers, and some of them had numbers that were no good.

Chairman CHAMBLISS. I guess that is what I can't understand. In this life of high tech that we now live in or this era of high tech, why we can't detect that as part of an electronic filing? If there is a false number there, why we can't correlate that to a claim that comes in? Is there any answer to that?

Mr. HAMEL. My understanding is that there are controls; as a result of some of these scams being identified, controls are being put in place to prevent bogus numbers or inactive numbers from becoming activated, and that HCFA has implemented controls to go by addresses and try and do physical verification to determine whether it is a legitimate organization or provider.

Chairman CHAMBLISS. Well, in y'all's examination, both from HCFA's perspective as well as the provider's perspective, do we have the appropriate software, hardware or whatever we need out there to try to develop this further, improve this further? Are we lacking in that respect? Or is it people not doing their job? Or what is causing the dropping through the cracks on that?

Mr. HAMEL. I would say that from my experience, there is always evolving computer software technology, but some of the data analysis that I worked with at Medicare contractors was sophisticated enough to be able to identify unusual utilization patterns, referral patterns, spike analysis. For example, if there was an uncommon ailment, and there was no known epidemic, and suddenly a pro-

vider was treating that particular condition, they had audits in place to be able to identify those.

Chairman CHAMBLISS. I guess what I can't understand is that if Dr. Joe Smith in Atlanta, Georgia, is supplier number Smith 2000, and he puts that on his requisition form, he gets a check to Dr. Joe Smith in Atlanta, Georgia. If somebody falsifies a name of Dr. James Smith with the number Smith 2001, why we can't pick that up as opposed to sending a check to him or depositing a check in his account? I have a very difficult time understanding that, and maybe some of our other witnesses who are dealing with it on the other side can help straighten that out a little later on.

Ms. JARMON. Some of those fraud schemes——

Chairman CHAMBLISS. Go ahead.

Ms. JARMON [continuing]. Are being picked up. The problem seems to be that the fraud is evolving. Sometimes, as HCFA builds in controls to address certain types of fraud, another type evolves. So it seems like it is a change in environment as fraud schemes change.

Chairman CHAMBLISS. So this is that moving target, that invisible man that Dr. Sparrow is talking about here.

Ms. JARMON. Yes.

Chairman CHAMBLISS. OK. Jim.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

From your testimony and from reading it, it doesn't seem like you found any fault with what HCFA was doing, you just said they ought to do more. Is that a fair assessment?

Ms. JARMON. We said they need to continue experimenting with different techniques, and that they need to do more analysis to determine the causes of the improper payments. But we are encouraging them to continue what they are doing as far as experimenting with different techniques.

Mr. MCDERMOTT. So the $10 billion they saved and 42 percent reduction in payment errors is not—you are not saying that there is anything wrong with that, they just haven't done enough; they should do 100 percent, huh? Or close to it.

Ms. JARMON. We aren't saying they should do 100 percent. We are saying they should continue to evaluate the different approaches. We aren't saying anything about the 42 percent decrease.

Mr. MCDERMOTT. Besides doing more of what they are doing, does GAO have any other fraud detection models that they are saying they should be using?

Ms. JARMON. We don't have any fraud detection models we are saying they should be using.

Mr. HAMEL. I can say that the five techniques that are on the chart that Ms. Jarmon spoke to before are all useful tools and powerful tools in the detection of potential and actual fraud. What we are saying is that you can't use them in isolation of one another. That greatly diminishes their usefulness and their reliability from a measurement perspective, and that when you use them in combination of one another, and, having done health care fraud investigations, always using at least two or three of these techniques at one time, it greatly increases the reliability of identifying potential fraud.

Mr. McDERMOTT. In looking at those, I know you don't want to take them individually, but I just want to take one of them, which is the one that says provider contact. My understanding is that the budget that was just put out by the House of Representatives cut that section of the budget by 6 percent. Now, if I understand what you are saying, you actually need to have more people going out, in part to answer Mr. Chambliss's question about does a place actually exist, is there actually a business at 411 Elm Street or not. And that is what I understand that whole question of provider contact to be about.

Is there something I am missing when we are cutting the budget to the section that, in fact, is the one that you say ought to be done here?

Ms. JARMON. We are saying that there needs to be some assessment of the risk. In areas where they determine there is a riskier population or there have been a lot of problems, they should evaluate the need to perform additional testing. For example, investigations in California have shown many problems in the area of durable medical equipment supplies. They did some work, and in 40 percent of the items, there were problems as far as, the providers weren't there, or there were significant errors. So utilizing this information, in determining improper payments on Medicare fee-for-service, the IG is planning to actually visit the DME suppliers and beneficiaries when they do the medical equipment part of their sample.

So we are saying that they need to determine where the risks are for a higher probability of errors. They need to do more contacting the beneficiaries and providers. We aren't saying it should be done overall, because we agree it would be costly if it was done on an overall basis.

Mr. McDERMOTT. So you would be in agreement with the cut of the budget of that section of the appropriation?

Ms. JARMON. No, we aren't saying that.

Mr. McDERMOTT. You don't think that they are doing too many, you are just saying they ought to emphasize more in certain areas.

Ms. JARMON. And determine where the risk is. Right.

Mr. McDERMOTT. The other question I have that sort of puzzles me is this business about how you do it without casting a wider net, or do you believe that they ought to be doing unannounced audits?

Ms. JARMON. In some cases where there is a lot of risk, an unannounced audit may be necessary. Rather than casting a wider net, I know some of their approaches that they are looking at are larger samples. The IG's methodology that they were doing on behalf of HCFA, which is called the current methodology in our statement, that sample included reviewing 5,000 to 8,000 claims. Some of the approaches they are looking at are going to be much larger samplings. So I guess there is a broader net. But what we are suggesting is to go deeper into the areas where there is potential risks rather than having it broader.

Mr. McDERMOTT. When I was in the State, in the State legislature, we had a program called WISPRO, an MRO organization that looked at claims. We always announced to a hospital, we are coming in on the 12th of August, and they had a month in advance to

get themselves—we didn't tell them what cases we were going do look at, but we told them a month in advance we were coming.

Now, it seems to me that one way that you get around that is to say we are not going to announce to anybody we are coming. We will just show up in the record room and start pulling charts that we think look bad. Is there—do you have any problem with that as an approach?

Ms. JARMON. I will talk briefly about this because I know some of this will be discussed further in the next panel. One of the studies we did look at was the Illinois study, and I know Mr. Miller is here, so you can talk further with him about that.

I know there were some problems with contacting providers such as, if you just show up unannounced. There would be concerns as far as whether the government is questioning a particular provider—who might be an honest provider. Then if you give a lot of notice, if it is not an honest provider, you give them time to falsify the documentation.

I think what Illinois eventually did was they gave the providers, the doctors, 2 days' notice. They would say, we are going to come in 2 days and look at 50 documents. In most cases 2 days may not be enough time for someone to falsify records if they aren't honest. I think that is what they decided to do instead of the unannounced visits. Like I said, he could talk further about that.

Did you want to add anything?

Mr. HAMEL. I was just going to say Ms. Jarmon said and in our statement we are suggesting to consider the risks to the program in using these techniques, and what is most appropriate when you consider what those risks are. If you are in a high-risk area where there has been a lot of fraud, perhaps durable medical equipment, then you would consider using an unannounced site visit to see if the business is really a viable entity. In other situations you would assess the risk and make a determination of what is appropriate.

Mr. MCDERMOTT. And HCFA is not now doing that?

Ms. JARMON. They may be doing some of it, and Ms. Thompson can talk further about that, we don't think they have done a broad enough risk analysis.

Mr. MCDERMOTT. I am sorry, I have to leave and go vote. We have got about 2 minutes. So thank you.

Chairman CHAMBLISS. I have asked Mr. Ryan to go vote and come back and resume the hearing. So we will try to keep going. As soon as he gets back, we will resume.

[Recess.]

Chairman CHAMBLISS. Mr. Ryan.

Mr. RYAN. Good morning. Thank you for coming. Appreciate all your work on this issue.

I just want to ask you a couple of quick questions. I think it was a little while ago when Secretary Shalala said that, quote, we have witnessed an enormous improvement with an estimated rate of improper payments in the Medicare fee-for-service drop from 14 percent in fiscal year 1996 to less than 8 percent in fiscal year 1999. Is it the case, Ms. Jarmon, that the largest portion of this decline has come from the area of documentation, and is it possible really to know whether the decline in this area reflects a real drop in improper payments or simply just better paperwork?

Ms. JARMON. Right. A large part of that error rate does relate to the lack of documentation. And since the model used to come up with that error rate doesn't identify or doesn't attempt to measure fraud, you really don't know whether there really has been a decrease or how much the decrease has been.

Mr. RYAN. So it is more kind of a clerical error measure rather than a real fraudulent measurement.

Ms. JARMON. It is not a fraud measurement, right.

Mr. RYAN. So without really knowing the true level of fraud and abuse in Medicare, it is tough to determine whether an enormous improvement has been made, isn't it?

Ms. JARMON. Yes, it is difficult to determine what the improvement has been when there hasn't been a fraud rate.

Mr. RYAN. I assume you have reviewed the three HCFA projects that are under way right now. Do you believe in your opinion and from your analysis whether any of the three HCFA projects currently under way employ all of the techniques that the GAO would recommend to get the best total measurement possible for improper payments in fee-for-service?

Ms. JARMON. Two of the projects that we talked about, CERT and PEPP, are very similar to the methodology that is used in the current methodology. And the one that comes closest to including all of the techniques that we think need to be looked into or included is the Model Fraud Rate project. But that one is also limited as far as provider contact and verification with third parties. So, right now, none of those three projects include all of the techniques that we talk about in our statement.

Mr. RYAN. So you think we could do a better job in actually getting at real fraud, and that these projects may be more going down the road toward kind of a clerical error instead of actual fraud.

Ms. JARMON. We think more can be done using the techniques. HCFA already uses some of them to identify fraud. More could be done to use the techniques to try to measure potential fraud.

Mr. RYAN. I come from Wisconsin, and in Wisconsin there is kind of an old saying when looking at the fraud and abuse in the United States that we are being penalized for being good. We are being penalized for being efficient; that in many ways in going after fraud, we kind of went after the whole country with the same approach, kind of with a meat axe rather than going after fraud with a scalpel or a laser focusing on where fraud actually occurs. Home health agencies is one of those examples that leaps to mind.

How dependent is a measurement of and how dependent is the enforcement of fraud reduction dependent on State insurance regulatory regimes? Louisiana clearly had a lot more real fraud in home health than did Wisconsin, but in Wisconsin home health agencies, which I think are pretty efficient, well-run, honest organizations, are clearly on the losing end of these efforts. And do you think that there is, A, a better way to go after this more, and in a way of not going after all of the actors in the system, but actually finding a way to go after the actual fraud that is occurring without unnecessarily and needlessly hurting the good actors in the system; and, B, how dependent is this on State insurance regimes and State enforcement?

Ms. JARMON. Yes. I think what we refer to as a risk-based approach would try to focus on the areas where there is more risk, including parts of the country where for some reason, there is more risk. We are suggesting that the HCFA look at a risk-based approach to determine where additional techniques should be used.

Like you mention with home health agencies and with durable medical equipment, in certain parts of the country it has been shown there is more risk in those areas. So we think there should be a use of all of the five techniques in those areas, but to do it globally throughout the country in all the States would be very costly. I don't think that is the best use of resources. But a risk-based approach and which involves determining high-risk areas and using possibly all the techniques is probably a good use of resources because we are talking about a very large program.

Mr. RYAN. That way we can leave the good actors in the system to go on with their business, and we can actually focus our effort where fraud actually does exist. Thank you.

Mr. MCDERMOTT. Would the gentleman yield for a question? Would you define, either one of you, who you mean by more risk? I mean, we want HCFA to focus on the areas of more risk. What criteria would you use for that investigation? What does "more risk" mean?

Ms. JARMON. I can use an example of a study in California where they really looked at all of the suppliers there of durable medical equipment, and based on their work, they concluded that there was about 40 percent errors in that population.

I think the Medicare contractors are doing some work and using all of these techniques to identify some cases of fraud. They aren't using them to measure fraud. I think some of the work that they are already doing are showing where there is a risk in the population. So, I think using some of the information that is available from some of the work that they have done in identifying fraud, can be used to determine where the risk is and where they found more errors, or where they found fraud.

Mr. MCDERMOTT. But they discovered that by looking at every durable medical equipment provider in California?

Ms. JARMON. In California, yes.

Mr. MCDERMOTT. How would you know if Wisconsin or Washington or Georgia—what ways to go about that? I mean, from learning whatever you learned from the California study, how would you know who to go for?

Ms. JARMON. The people who did the work in California talked to the fraud units in other States, and a best practices or lessons learned approach can be used. They can talk about what they did and what they found. They can use their prior experience regarding where there have been problems in the past. So communication among the different parties or the different entities that are involved in trying to manage this program can be effective.

Mr. RYAN. I yield.

Chairman CHAMBLISS. You talked about the methodology, current methodology, plus the new systems that HCFA is using now, the—I will refer to the acronyms as CERT and PEPP. The way I understand what you have said about those programs is that those programs are designed more to catch errors as opposed to being fo-

cused on true waste, fraud and abuse. Am I wrong in that perception, or is there some more direct focus in those methodologies on waste, fraud and abuse?

Ms. JARMON. You are right. The CERT and the PEPP are focused on payment claim errors rather than focusing on fraud.

Chairman CHAMBLISS. What bothers me about that is I am still not sure that I get any feeling that there is a real concentrated effort being made to strike at the heart of what we are talking about, and that being not penalizing honest suppliers who just simply make mistakes, but going after whatever that amount of waste, fraud and abuse is that exists out there. Am I wrong in that perception, or are we not really focusing in on that from a HCFA perspective?

Ms. JARMON. The third project that we mentioned that HCFA is looking into is the Model Fraud Rate project. It is a project where they are trying to focus on fraud. That project is very much in the infancy stage, but it is our understanding that it is their plan to try to focus on fraud through that project.

Chairman CHAMBLISS. OK. Mr. Hamel, you referred to that report in October of '99, which did point out several specific instances of schemes that were in place that were being carried out by certain organizations. Since that date, since that report of October of '99, have you come across any additional schemes that are being carried out today?

Mr. HAMEL. We are working on one investigation, but because it is under way, I am not comfortable discussing the details of it in an open forum.

Chairman CHAMBLISS. Sure. OK.

We have been talking primarily about Medicare, but let me ask a question about Medicaid. Does the GAO or the IG Office get involved in any audits of Medicaid?

Ms. JARMON. We can't speak for the IG. We have done limited work related to Medicaid.

Chairman CHAMBLISS. OK.

Ms. JARMON. We did visit Illinois and Texas and looked at what they were doing to try to estimate Medicaid error rate, but our work has been limited in that area.

Chairman CHAMBLISS. OK. Anything additional, Jim?

Mr. MCDERMOTT. I wanted—your statistical basis for your cases reviewed, if you could put that chart back up again, where you found them. I forget, you told us page 20, was that——

Ms. JARMON. The first chart is from page 7. That information came from HCFA's fraud investigation database, which is the database where they track the cases that have been referred.

Mr. MCDERMOTT. Now, when you look at that, what I ask myself is where would I put my resources, what areas do you think there are problems that are not being assessed because of lack of resources being put into them?

Mr. HAMEL. I would say that while that chart demonstrates the types of schemes for referrals, it doesn't address the volume of dollars for those schemes. For example, fraudulent cost reporting may only represent 7 percent of the referrals, but these cases represent a significantly disproportionately larger number of dollars. For example, it was in the newspaper that the Columbia HCA case in-

volved three-quarters of a billion dollars. So I think one has to consider how much the impact is on the program financially with respect to those schemes, not just what the schemes are.

Mr. MCDERMOTT. Explain to us, it would be interesting for the committee, I think, to understand how they caught HCA.

Mr. HAMEL. That was the result of a qui tam lawsuit, which is a lawsuit that is filed by a citizen under the False Claims Act. A whistleblower in which——

Mr. MCDERMOTT. Somebody working inside the organization blew the whistle?

Mr. HAMEL. Yes.

Mr. MCDERMOTT. So they were going to get some benefit from whatever the settlement was, they get some portion of that $750 million?

Mr. HAMEL. That is correct.

Mr. MCDERMOTT. How much did they get?

Mr. HAMEL. They only announced a partial settlement. It has not been completely settled, so I don't know what—they are called relators—what the relator's share will be. But generally, it is somewhere between 10 and 25 percent.

Mr. MCDERMOTT. It is not described in the law?

Mr. HAMEL. The percentage—I think this is a sliding scale and is described in the statute. I think the maximum, I believe, is 25 percent.

Mr. MCDERMOTT. So in that case, they shouldn't be given credit at all for finding that, should they?

Mr. HAMEL. We are not suggesting that HCFA is taking credit for that.

Mr. MCDERMOTT. So that is just where the reports are, but they don't get credit for it as a result of their fraud, waste and abuse issue, or their fraud, waste and abuse program.

Mr. HAMEL. The chart only demonstrates statistically where the sources or the types of fraud referrals come from.

Mr. MCDERMOTT. Did you analyze what they were doing inside in terms of what it had actually produced?

Mr. HAMEL. I am not sure I quite understand, "it" referring to the database?

Mr. MCDERMOTT. HCFA. Did you look at the database and decide what HCFA had found in there, or what was found from the kind of thing—I guess one of those 7 percent, or half of 1 percent or whatever was HCA, but it is up there as though they had discovered this.

Ms. JARMON. It is not clear as far as who identifies the information in their fraud database. It just shows that these are cases that are potential fraud, and in some cases, are being referred to the IG to further investigate. In some cases, they are referred to the Department of Justice. So the database just shows information that has come to their attention, through their own reviews, as being referred. I don't think it had detail as far as the ultimate resolution of those cases. This was just to give a picture as to where some of the potential fraud exists that they are aware of.

Mr. MCDERMOTT. Presumably, in all the big operations where there is fraud, I mean, we talk about these organizations, sort of anonymous or kind of unnamed organizations, it would seem there

would be somebody inside who would know what is going on. It would seem to be that protecting whistleblowers would be a really important thing to do to make qui tam suits more likely; would it?

Mr. HAMEL. They are not uncommon.

Mr. MCDERMOTT. You mean, that is a way to get the big ones, right?

Mr. HAMEL. Well, I am saying that qui tam lawsuits are not uncommon. There are many of them filed.

Mr. MCDERMOTT. Most of them are won by the person who brings the case?

Mr. HAMEL. The government intervenes on their behalf if they determine that there is a reason to intervene. And then when there is a resulting action, if the government recovers money, then they stand to receive a share of that. So there is an incentive in qui tams for someone to blow the whistle.

Mr. MCDERMOTT. Is there protection for people who bring these suits?

Mr. HAMEL. I can't answer to the specifics about that.

Mr. MCDERMOTT. Because one of the problems you have, it seems to me, in fraud, the people who perpetrate fraud generally are not stupid. They generally are pretty shrewd at having figured out the system and having figured out that there is a loophole here, and there is a hole I can drive a Mack truck through and fill it with money. Those organizations you are talking about are doing that because there is money there. And they back their truck up to it with fraud written on the side and drive away with it. And it strikes me that that is very hard to get on a systematic basis, that you could ever set up a unit that is going to find fraud itself. You might take these referrals from other people to get them. But just throwing a wide net over all the providers out in the United States is not going to get very much fraud.

Mr. HAMEL. Some of the criminal groups that we referred to, some of the ways that the conduct is identified is through, for example, data analysis where you know there is unusual utilization for certain kinds of billing procedure codes, where suddenly there is a dramatic increase. Those are the kinds of things that help identify red flags for problems for which other kinds of techniques can be used to determine whether or not it is just a billing error or where there is something more to it, such as fraud.

Mr. MCDERMOTT. Wouldn't those be in the screens that the intermediary has? If suddenly you get a big blip of, I don't know, whatever, whatever kind of—abdominal surgery, suddenly you have a 50 percent increase in a given area for abdominal surgery, shouldn't that show in the database or the records of the HCFA intermediary that is looking at those cases and paying those claims?

Mr. HAMEL. For the Medicare contractors I have worked with, it does. They have computer edits in place to identify some of those situations. But, I couldn't speak to how they design them.

Mr. MCDERMOTT. You didn't look at those, you didn't look at what was being done by the intermediaries; you only looked at what was being done by HCFA; is that correct?

Ms. JARMON. We looked at some intermediaries also. You are right. Some of that information is there that is being used by them

in their database to identify fraud. The techniques that we had on the other chart, include data analysis which you are talking about. The qui tam instances, would relate to the third party contacts. While they are being used to identify fraud, they aren't being used to try to measure it.

Mr. MCDERMOTT. When you looked at their records, are they using the same screens and the same techniques that they use on their private business?

Ms. JARMON. I am not sure about whether they are using the same screens, because I know the Medicare program is so different from the private health programs. I am not sure if they are.

Mr. MCDERMOTT. They are paying claims they have got—the insurance company, Blue Cross Blue Shield pays claim. They take in premiums and pay claims. On this one, they don't take in the premiums, they just pay claims. Why wouldn't they have the same mechanism in place to detect whether they were paying a fraudulent claim or not? Is it because their own money isn't involved? Is that what you are saying?

Ms. JARMON. I am not saying that. I am not sure why it is not the same mechanism, because they do use the same fraud techniques on the private side and on the public side. But why the results are different, I am not sure.

Mr. MCDERMOTT. OK. Maybe we will find out later.

Thank you, Mr. Chairman.

Chairman CHAMBLISS. I think you have seized on a good point there, that we keep looking to HCFA and seem to stop there. And obviously, I think we need to think in terms of maybe looking beyond HCFA. I want to make sure that I have fixed in my mind, before we let you go about this issue of when we hear that there has been an enormous improvement in the area of determining waste fraud and abuse in the Medicare program, that we really can't say that as a fact, because we don't know what the waste fraud and abuse number is. So whether we are improving it or whether it is getting worse, we really can't say; is that a fair statement?

Ms. JARMON. That is true.

Chairman CHAMBLISS. Yeah, the other thing I wanted to make sure, I had a clarification on, and we had in the record, we talked a little bit earlier about some privacy issues and whether we ought to have unannounced audits, announced audits or whatever. In your testimony, you talked about some advocacy groups that oppose more extensive measurement techniques on the ground of confidentiality, privacy problems, as well as administrative problems. Is there anything that HCFA or any other government organization can do a better job of to try to make sure that we can do a better job of doing our audits without allowing the supplier the opportunity to falsify records, but at the same time, satisfy these advocacy groups?

Ms. JARMON. I think it is going to be important that HCFA has the advocacy groups at the table with them and is consulting with them on ways to address the problem.

Chairman CHAMBLISS. And do you find that the case now? Is AMA or the Medical Association of Georgia or the Medical Association of Washington, are they involved in the process now?

Ms. JARMON. I think there has been much more communication between those groups and HCFA.

Chairman CHAMBLISS. OK. All right. Thank you all very much. We appreciate your testimony. We will ask our second panel of Penny Thompson, who is director of program integrity group of Office of Financial Management from HCFA and Mr. Robb Miller, inspector general, Department of Public Aid from the State of Illinois.

STATEMENTS OF PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY GROUP OF OFFICE OF FINANCIAL MANAGEMENT, HEALTH CARE FINANCING ADMINISTRATION; AND ROBB MILLER, INSPECTOR GENERAL, DEPARTMENT OF PUBLIC AID, STATE OF ILLINOIS

Chairman CHAMBLISS. Again, we appreciate you two folks waiting patiently and being here, and we look forward to your testimony. And Ms. Thompson we will start with you.

STATEMENT OF PENNY THOMPSON

Ms. THOMPSON. Chairman Chambliss, Representative McDermott, Task Force members, thank you for the opportunity to discuss our efforts to promote and protect program integrity in Medicare and Medicaid. I would also like to thank our General Accounting Office and HHS/IG colleagues for their ongoing assistance in these efforts.

Since the Clinton administration took office, we have made paying right and fighting fraud waste and abuse one of our top priorities. We have implemented an agencywide comprehensive plan for program integrity, and we are committed to learning and refining our efforts to make further improvements. Some relate to some of the issues that you discussed with the first panel about the way that we enroll providers, about the way that we use technology, about how we contract and oversee intermediaries and carriers that work for Medicare, activities involving our enhanced and increased collaboration with law enforcement and with providers, physicians and suppliers.

Efforts to measure payment errors are an integral part of our overall efforts. While no measurement tool is perfect, findings from the national Medicare error rate estimate conducted each year since 1996 by the HHS inspector general have played an essential role in directing us to areas that most need attention and help guide our corrective actions. We are now increasing efforts to measure errors in both Medicare and Medicaid.

In Medicare, we are developing error rates for each of the contractors who process claims better to target and focus our corrective actions and our resources.

In Medicaid, we are working with States as they begin to conduct error rate measurement, and we are working to determine whether a common methodology that would allow for valid State-to-State comparisons and national estimate is feasible. We have several other efforts underway to assist States in promoting Medicaid program integrity. We hired a nationally recognized expert in health care fraud issues, Dr. Malcomb Sparrow of Harvard University's Kennedy School of Government, to conduct a series of seminars

across the country where State program integrity personnel came together to discuss their successes, their challenges, and their concerns.

And just last month, we held a special conference on how information technology can help fight fraud waste and abuse and prevent improper payments. Better data systems are key to improving efforts to fight Medicaid and Medicare fraud waste and abuse. But many States have inadequate technological infrastructures and a basic inability to interrogate their databases efficiently to ferret out improper claims.

In all these efforts, it is essential to stress that measurement of payment errors is a developing science, and we are learning as we proceed. Error rates are essential for accurately determining the extent of improper payments and assessing any improvement and preventing them. But it is important to understand and acknowledge as there has been discussion of this morning that acknowledged payment errors, most of which are honest mistakes, is not the same of measurement of fraud. That would be far more challenging, given the covert nature and legal definition of fraud. And States such as Illinois, that have about begun to measure payment errors, agree that measuring fraud is a much greater challenge.

There is also a critical need to overcome the common tendency to shoot the messenger, which can complicate and hinder efforts to measure and address payment errors. We are encouraged that a number of States have agreed to work with us on these issues and participated in discussions on this topic at our recent information technology conference. We look forward to continuing to work with our GAO and IG colleagues, other experts in Congress, to meet these detection measurement and administrative challenges. We welcome your assistance. Specific answers to the questions that you asked us to address at this hearing are attached to my written testimony. And I am happy to answer additional questions. Thank you.

Chairman CHAMBLISS. Thank you.

[The prepared statement of Penny Thompson follows:]

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

Chairman Chambliss, Representative McDermott, distinguished Task Force members, thank you for the opportunity to discuss our efforts to promote and protect program integrity in Medicare and Medicaid. I would also like to thank our General Accounting Office (GAO) and HHS Inspector General (IG) colleagues for their ongoing assistance in these efforts.

Since the Clinton Administration took office, we have made paying right and fighting fraud, waste, and abuse one of our top priorities. We began with the Operation Restore Trust initiative to coordinate efforts among Medicare, Medicaid, and law enforcement agencies on known problem areas. Lessons learned in that highly successful project are now standard operating procedure throughout our agency. The result is record success in assuring proper payments to honest providers and penalties for problem providers. To build on this success, we have implemented an agency-wide Comprehensive Plan for Program Integrity with clear objectives, such as increasing the effectiveness of medical review, targeting known problem areas, and increasing efforts to help providers comply with program rules.

Efforts to measure payment errors are an integral part of our program integrity agenda. While no measurement tool is perfect, findings from the national Medicare error rate estimate conducted each year since 1996 have played an essential role in directing us to areas that most need attention and guiding our corrective actions. We are now increasing efforts to measure errors in both Medicare and Medicaid. In

Medicare, we are developing error rates for each of the contractors who process claims.

In Medicaid, we are working with States as they begin to conduct error rate measurements, and to determine whether a common methodology that would allow for valid State-to-State comparisons and national estimates is feasible. We have several other efforts underway to assist States in promoting Medicaid program integrity. We have conducted seminars around the country to explore the challenges States face in these efforts. And just last month we held a special conference on how information technology can help fight fraud, waste, and abuse.

In all these efforts it is essential to stress that measurement of payment errors is a developing science, and we are learning as we proceed. It is also important to understand that measurement of payment errors, most of which are honest mistakes, is not measurement of fraud, which would be far more challenging given the covert nature and legal definition of fraud. There also is a critical need to overcome the common tendency to "shoot the messenger," which can complicate and hinder efforts to measure and address payment errors.

Promoting Medicaid Program Integrity

We fight fraud, waste, and abuse in Medicaid in partnership with States, beneficiaries, providers, contractors, and Federal agencies. We provide funding and technical assistance and oversee States in their efforts to ensure that taxpayer dollars are spent appropriately. Special Federal matching funds are available for State Medicaid fraud control units. These fraud control units are usually located in the State Attorney General's office and generally perform both investigatory and prosecutorial functions. Forty-seven States have established such units to investigate allegations. In States without fraud control units, the Medicaid agency is responsible for investigating allegations and referring cases to the appropriate authorities.

Some States are making good progress in making sure that their Medicaid programs protect taxpayer dollars. However, we all agree that more needs to be done, and we are committed to repeating and building upon this success across the country. To that end, we have established a Medicaid Fraud and Abuse Control Technical Advisory Group, in which State and Federal technical staff work together to advance program integrity issues.

To further these efforts, we hired a nationally recognized expert in health care fraud issues, Dr. Malcolm Sparrow of Harvard University's Kennedy School of Government, to conduct a series of seminars across the country where State program integrity personnel came together to discuss their successes, challenges, and concerns. High-level representatives from 49 States and numerous Federal agencies and Departments participated, and Dr. Sparrow produced a report on what we learned at the seminars. On May 2 of this year we held a Medicaid Fraud and Abuse Commitment Conference to focus on Dr. Sparrow's findings. Three essential themes emerged from the seminars:

- There are unique issues within managed care.
- There are substantial information technology issues.
- There is a need for building commitment at the State level.

Managed Care

More than half of Medicaid beneficiaries across the country are now in some form of managed care, and managed care presents unique program integrity challenges. Many States are still learning how to address these challenges, and some are fighting the misconception that managed care somehow does away with program integrity issues. And there is a well-recognized need to improve the quality of managed care contracts to promote and protect program integrity.

To help States address these issues, we have sponsored a series of workshops, dating back to 1997, to bring State managed care staff together with utilization and review directors and fraud control unit directors. These workshops focused on how fraud manifests differently within the managed care setting and how programs to address it should be structured. They also featured "negotiating sessions" among State delegations and resulted in written agreements on how to work more cooperatively and effectively together.

We also have worked with State Medicaid agencies and fraud control units to develop Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care. The guidelines focus on:

- Key components of an effective managed care fraud control program;
- Data needed to detect and prosecute managed care fraud;
- How to report managed care fraud;
- Suggested language for managed care contracts and waivers; and

• The roles of HCFA, State Medicaid agencies and fraud control units, managed care organizations, and the IG.

We hope to have these guidelines to the States later this year.

We also have developed a draft model Medicaid Managed Care Compliance Plan for States that is similar to our compliance plan for Medicare+Choice plans. Compliance programs help establish and promote awareness of applicable program regulations and to define a standard of organizational values regarding regulatory compliance. Effective compliance programs include:

Standards and Procedures: The organization must establish relevant compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal conduct.

High Level Oversight and Delegation of Authority: Specific high-level personnel must be assigned overall responsibility to oversee compliance with such standards and procedures.

Employee Training: The organization must communicate effectively its standards and procedures to all employees and agents, for example by requiring participation in training programs or by disseminating publications that explain what is required.

Monitoring and Auditing: The organization must take reasonable steps to achieve compliance with its standards, for example by utilizing monitoring and auditing systems and by having a system for reporting criminal conduct without fear of retribution.

Enforcement and Disciplinary Mechanisms: The standards must be consistently enforced through appropriate disciplinary mechanisms, including discipline for the failure to detect an offense.

Corrective Actions and Prevention: After an offense has been detected, the organization must take all reasonable steps to respond appropriately and prevent similar offenses.

We are considering whether to mandate, in final Medicaid managed care regulations, that plans participating in Medicaid have compliance programs in place.

INFORMATION TECHNOLOGY

Better data systems are key to improving efforts to fight Medicaid fraud, waste, and abuse. But many States have inadequate technological infrastructures and a basic inability to interrogate databases efficiently to ferret out improper claims. A number of States indicate that they need better, more targeted data, to pinpoint areas most likely to foster problems, as well as guidance and technical assistance on acquiring new data systems and other fraud and abuse detection tools.

To address this, we collaborated last month with the Department of Justice to conduct a conference on the role of information technology in promoting Medicaid program integrity. The conference had nearly 300 attendees from all across the country, and served as a highly interactive information exchange on electronic tools, techniques, and approaches for combating health care fraud and abuse. Robust discussions focused on the need for wider understanding of the technological tools available, funding to procure such tools, sources of data and how to access them, legal means for sharing data, and privacy issues. Nearly 30 vendors displayed some of the latest fraud detection tools available in the marketplace. We plan to follow up on this conference by producing a report of the proceedings with recommendations for future steps, including the possibility of forming regional or national technology user groups.

In addition, our Technical Advisory Group is addressing data issues. It is preparing an educational packet that identifies various reporting requirements and suggestions for how States can implement them. It also will disseminate information to all States on Medicare-Medicaid data sharing rules.

We also recently developed a national fraud and abuse electronic bulletin board, co-sponsored by the American Public Human Services Association, to allow States to exchange and share information on fraud and abuse related issues. And we are modifying our National Fraud Investigation Database to include Medicaid cases, which will further help in tracking down and stopping unscrupulous providers across the country.

COMMITMENT

States have primary responsibility for protecting Medicaid program integrity. While some States are having success, the seminars made clear that, in many States, the nature and magnitude of the Medicaid fraud problem is still not properly understood. In some States it may not even be treated as a serious or central issue in program administration.

We are taking several steps to help States meet this challenge and understand their obligation to ensure that taxpayer dollars are spent properly. For example, we have developed and posted on our *www.hcfa.gov* website a comprehensive listing of State statutes that target Medicaid fraud. This allows States to access and share innovative and effective program integrity legislation. The website also includes detailed contact information for State program integrity personnel and individual State legislation web sites.

We also have worked closely with the IG to clarify how States can ensure that payments are not made to providers who have been "excluded" from Medicare and Medicaid because of program integrity or other problems. Guidance for States now clearly addresses the specifics of what must be reported to whom, when, and where, as well as how to enforce exclusions, and the consequences for States that fail to comply. We are also working to help States enhance their processes for identifying excluded providers.

MEASURING PAYMENT ERRORS

Still, each State needs to be held accountable for protecting taxpayer dollars and meeting concrete goals and objectives for improvement in the fight against fraud, waste, and abuse. Error rates are essential for accurately determining the extent of improper payments and assessing any improvement in preventing them.

Four years ago, we worked with the IG to break new ground in developing a systematic, statistically valid estimate to assess the accuracy of payments. We did not want to merely examine whether claims processing systems were working correctly—avoiding duplicate payments, payments to ineligible providers or beneficiaries, or incorrectly calculated payment amounts. We wanted to examine in a statistically valid way whether payment was made for a service that met all requirements for documenting the service, coding it correctly, and representing medically necessary care. To do this, obtaining medical records is key. Other kinds of verification, such as contact with the Social Security Administration to verify beneficiary enrollment, and visits with beneficiaries designated as "homebound," also are important.

This systematic, statistically valid estimate was a great leap forward. Estimates of Medicare payment errors, done by the IG each year since 1996, have greatly aided us in improving our management of the program. They have provided us with a meaningful benchmark from which we have tracked our success—showing a decrease in improper payments of almost half since 1996. We also found interesting results that confirmed the validity of this approach. Indeed, the vast majority of errors we detect using this approach are found only through examination of medical records. Few errors are related to our claims processing systems, or detectable based on the data on the face of the claim. Few are related to third party verification or beneficiary contact.

In fact, medical records are by far the most important source of information on whether payment is made properly. While this methodology is not perfect or the only one we could have devised, it has been a valuable tool to evaluate and measure the effectiveness of our internal controls.

However, every methodology has its limitations. One limitation is that the national estimate is too broad to allow discrete judgments about where the largest problems reside, or what targeted interventions would have the most impact. As a result, after several years of experience with the national error rate program, we developed two new projects for Medicare—the Payment Error Prevention Program (PEPP) and the Comprehensive Error Rate Testing program (CERT). We designed PEPP and CERT to develop more targeted error rate estimates in States (for inpatient hospital discharges) and at claims processing contractors (for all other services). They are largely consistent with the way we calculate errors in the overall national error rate, but contain some important adjustments.

For example, rather than measuring only net errors (overpayments minus underpayments), we want to measure absolute errors (overpayments plus underpayments). In implementing CERT, we will use just one national contractor to review medical records, to ensure consistency and facilitate our oversight. These additional efforts will provide us additional useful information for making interventions to address payment problems, and represent step-by-step building on our collective efforts over time.

MEASURING FRAUD

It is essential to stress that these measurements are of payment errors, most of which are honest mistakes by well-intentioned providers. These are not measurements of fraud. Certain kinds of fraud—such as falsification of medical records—

probably would not be detected through current methodology. And other kinds of fraud—on cost reports, for example—are not detectable in a claims-based sampling environment.

Fraud measurement is, in fact, uncharted territory. Our progress in pioneering payment accuracy projects might not even be directly relevant to helping us navigate this new territory. Some experts suggest that a statistically valid estimate of fraud might not be possible at all, given the covert nature and level of evidence necessary to meet the legal definition of fraud. And methods to establish fraud might be considerably different than those used to detect other payment errors.

For example, given the importance of establishing patterns, it might be more reliable to sample providers rather than individual claims. And, to minimize the concern about manufactured records, it might be necessary to conduct unannounced visits to providers, or provide very little notice. More direct contact with beneficiaries to verify the provision of the services billed also may be warranted.

All of these approaches, while potentially useful, are themselves unproven as reliable, valid measures in establishing the probability of fraud. The State of Illinois did establish direct contact with beneficiaries to verify claims as part of its 1998 payment accuracy project. But in reporting on this effort, the investigators stressed that "this study was designed to measure payment accuracy. It was never intended to measure a fraud rate. Indeed, we are not sure that is even possible." They go on to say that establishing a fraud rate "would have required, at a minimum, conducting a criminal investigation on each service in the sample. Even then, we would not have been certain that every potentially fraudulent claim would be detected * * *"

We have found beneficiary contact in known Medicare problem areas, such as durable medical equipment or home health, to be quite useful. However, few investigations based on the hundreds of thousands of beneficiary calls we receive regarding suspected fraud result in any payment adjustments because discussion with the beneficiary and/or provider sufficiently explain the situation. Since these contacts with beneficiaries are initiated by them, we could expect "cold calls" outside of known problem areas to yield fewer instances of potential fraud.

Provider-based sampling has certain advantages methodologically, but creates great tension in the provider community, especially when combined with unannounced visits or interviews with employees. The benefits of such an approach, as weighed against the actual and unintended costs, have not yet been thoroughly researched, and care must be taken in assessing how such efforts would be viewed by providers. Already sensitive to random review of claims, in which we ask for additional documentation to support the claim, providers are very likely to object strenuously to greater invasions.

Also, since most providers are honest, the number of providers to be randomly sampled and the depth of investigation necessary to establish a statistically valid fraud rate would entail substantial costs. Profiling, i.e., the use of analytical tools to detect patterns which might be indicative of fraud, might provide an alternative to random sampling. And it is a valuable tool that we already use to detect fraud in both Medicare and Medicaid. However, it is not clear that it could provide a statistically valid measurement of fraud.

Error Measurement in Medicaid

All of this experience has provided a backdrop to informing our approach to dealing with States on Medicaid payment accuracy projects. We are very supportive of States' efforts in this arena, and believe that measurement programs are an essential part of proper fiscal management of Medicaid. Some States have already attempted such measurement. The Illinois Department of Public Aid, in 1998, conducted what it believes was the first comprehensive payment accuracy review of any State Medicaid program. The Kansas Medicaid agency conducted a similar review in 1999. And, pursuant to State law, the Texas Comptroller, in 1998, conducted the first of what will be biennial Medicaid payment accuracy reviews. In addition, Alabama, North Carolina, Missouri, and Ohio State audit agencies have performed limited reviews in one or several recent years to measure the accuracy of Medicaid payments.

To advance these efforts, we sent a national review team to conduct a targeted evaluation of anti-fraud efforts in eight States (Illinois, Wyoming, Oklahoma, Virginia, Vermont, Georgia, Nebraska and Nevada) selected to represent a cross-section of State Medicaid programs. These reviews were completed last month and will help provide an accurate assessment of where States are, what barriers may hinder their progress, and what most needs to be done to ensure substantial, measurable improvement.

However, it is clear from that start that the nature and structure of the Medicaid program presents different challenges and opportunities for both Federal and State partners in such measurements. Each State Medicaid program has unique eligibility and coverage rules, and other variables.

That makes development of a statistically valid, common methodology that could be used by all States particularly challenging. Such a common methodology would have substantial advantages in allowing State-to-State comparisons and a national payment accuracy rate to be constructed. Determining whether a common methodology is feasible is a high priority for us, and we have made it one of our Government Performance and Results Act goals.

To help us in this effort, we are requesting $3.5 million from the Health Care Fraud and Abuse Control Program for FY 2001 to:

- Provide incentive grants to several States to conduct payment accuracy studies and assess the feasibility of establishing a standard methodology;
- Contract with an outside audit/consulting firm to assess State and Medicare program payment accuracy study experience to date, work with the pilot States, and develop appropriate measurement methodologies; and
- Hire expert analysts to staff this initiative.

If development of a common methodology does not prove to be feasible, we want to help States develop measurement tools that they can tailor to their own programs to help reduce inaccurate payments, recover overpayments, and target reviews on the specific providers or services that are most problematic.

At the least, guiding principles, definitions, and reporting protocols should be developed so that stakeholders can easily understand, interpret, and draw proper conclusions about each State's approach. We expect that our Technical Advisory Group can help develop these important tools.

We also would like to see groups of States bind together to assess certain benefit areas. For example, it would be very useful for several States with differing payment rules, provider enrollment processes, and administrative review procedures to examine payment errors in a given benefit area, such as transportation or home health. The results would not only be useful for each individual State, but also to the system as a whole. Regression analysis and other techniques could be used to isolate variables that are most, or least, related to payment accuracy.

We also believe it is very important that States understand that they will be rewarded and respected for undertaking these long overdue efforts to measure and prevent payment errors. Unfortunately, as we have found in Medicare, such efforts are sometimes greeted with scorn and retribution despite the large amounts of taxpayer dollars in need of protection. We are encouraged that a number of States have agreed to work with us on these issues and participated in discussions on this topic at our recent information technology conference.

CONCLUSION

We have been working diligently to improve our payment error measurement systems and to help States fight Medicaid fraud, waste, and abuse. We are providing States with information, tools, and training to build effective program integrity infrastructures. And we are building a basis for holding States accountable for measurable improvement.

We look forward to continuing to work with our GAO and IG colleagues, other experts, and Congress to meet these detection, measurement, and administrative challenges. We welcome your assistance. Specific answers to the questions you asked us to address at this hearing are attached, and I am happy to answer any additional questions.

1. What is HCFA's role in guiding/developing error rate and/or fraud rate measurement methodologies? Is there a need for a common methodology for error rate measurement? Or do variations in the Medicaid programs across the States argue against a common approach?

We have a central role to play, particularly in determining whether a common methodology can be developed and used by all States. Such a common methodology would allow State-to-State comparisons to be made and a national payment accuracy rate to be constructed. We are now exploring whether and how such a common methodology might be developed. Our preliminary discussions with State officials experienced in this area suggest that developing a common methodology will be difficult because each Medicaid program is unique, in terms of eligibility, service coverage, reimbursement methodologies, managed care penetration, and other variables.

Determining whether a common methodology is feasible is a high priority for us, and we have made it one of our Government Performance and Results Act goals.

To help us in this effort, we are requesting $3.5 million from the Health Care Fraud and Abuse Control Program for FY 2001 to:

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- Contract with an outside audit/consulting firm to assess State and Medicare program payment accuracy study experience to date, work with the pilot States, and develop appropriate measurement methodologies; and
- Hire expert analysts to staff this initiative.

If development of a common methodology does not prove to be feasible, we will continue to have a key role in providing guidance and sharing best practices that States find to be successful in developing measurement tools that they can tailor to their own programs to help reduce inaccurate payments, recover overpayments, and target reviews on the specific providers or services that are most problematic.

2. Do States have statutory authority to use Medicaid funds to measure error rates?

Yes. The Social Security Act authorizes Federal matching of State expenditures the Secretary finds necessary for the proper and efficient administration of the State's Medicaid Plan. State costs incurred in performing Medicaid payment accuracy studies qualify for Federal matching.

3. Which States are measuring error rates?

The Illinois Department of Public Aid in 1998 conducted what it believes was the first comprehensive payment accuracy review of any State Medicaid program. The Kansas Medicaid agency conducted a similar review in 1999. And, pursuant to State law, the Texas Comptroller in 1998 conducted the first of what will be biennial Medicaid payment accuracy reviews. In addition, Alabama, North Carolina, Missouri and Ohio State audit agencies have performed limited reviews in one or several recent years to measure the accuracy of Medicaid payments.

4. What are the findings of recent error rate measurements in Texas, Illinois, Kansas, and other States?

The payment accuracy rates were:

- 95 percent in Illinois;
- 77 to 92 percent in Kansas (depending upon whether a claim for which the provider might have complete documentation but failed to mail it in was counted as an error);
- 89.5 percent in Texas; and
- 97 to 98 percent in North Carolina.

We do not have rates for Alabama, Missouri or Ohio. It is important to stress that the review methodologies differed from State to State. Illinois reviewed 599 individual medical services billed and approved for payment, while Texas examined all paid claims related to 1200 patient days. Some States visited provider offices to obtain documentation, while others merely asked the provider to mail in the requested documentation. Several States interviewed the sample beneficiaries, others did not.

5. What is the status of the HCFA working group which is reviewing the issue of Medicaid error rates? What are the goals and time frames of the working group?

We have established a Payment Accuracy Measurement Workgroup that includes HCFA Medicaid and Program Integrity Group staff, members of the Medicaid Fraud & Abuse Technical Advisory Group from Illinois, Alabama, Louisiana and North Carolina, and the American Public Human Services Association. We also expect to work closely with the HHS Office of Inspector General.

The working group's goal for FY 2001 and 2002 is to evaluate the payment accuracy methodologies used by States to date, provide incentive funding to several States for additional pilots, and assess the feasibility of developing a common measurement methodology suitable for use by all States. What we and our State partners learn over the next 2 years will suggest options for FY 2003 and beyond.

6. Do the States believe that error rate measurement is a good use of federal/state funds? Within a State, who should have the responsibility to conduct error rate measures?

Some States are interested in exploring error rate measurement and have already attempted to conduct measurement studies. Other States may see more value in focusing on suspect providers or services than on conducting comprehensive payment accuracy studies. Who within a State should have responsibility for conducting error rate measurement is a question we want to explore as we work to determine whether a common methodology is feasible for all States.

7. How expensive is it to conduct error rate measurement? If it is to be done, how frequently should it be done? What are the implementation difficulties?

The cost would vary dramatically depending upon the scale and depth of the review performed, for example, the size of the sample, whether the State visits providers to obtain claim documentation or simply ask providers to mail it in, whether

beneficiaries are interviewed face-to-face and, most significantly, whether full medical record reviews are conducted by medical professionals.

The optimal frequency for error rate measurement is a question we want to explore as we study this issue. For Medicare, measurement of the error rate on an annual basis has proven to be useful in assessing progress and the need for the further corrective actions. But there is, at this time, insufficient evidence to conclude that annual measurement would be optimal in Medicaid.

8. Is there a reliable estimate of the level of Medicaid fraud? If so, how much fraud is there in this program?

No. And it is important to stress the substantial difference between measurement of payment errors, which the HHS Inspector General and some States have been doing, and measurement of fraud, which is probably far more challenging given the nature and legal definition of fraud.

9. What is the Federal match rate for error rate measurement efforts in the states?

The Federal match rate for most State Medicaid administrative costs is 50 percent. For skilled professional medical personnel, such as those used to review medical records in error rate measurement efforts, 75 percent matching is available.

10. If a common methodology is justified, what can the Congress or this Task Force do to promote this effort? Has GAO or the IG issued any reports, letters, or testimony on error rate measurement? If so, what recommendations were made, if any?

If a common methodology proves to be a technically viable option, implementing it in every State will likely require a statutory mandate. We are not aware of any GAO or IG reports that evaluate or compare State Medicaid payment accuracy studies conducted to date, or that attempt to devise a Medicaid payment accuracy measurement methodology. However, the IG has for several years has recommended that we construct a national Medicaid payment accuracy rate.

Chairman CHAMBLISS. Mr. Miller.

STATEMENT OF ROBB MILLER

Mr. MILLER. Good morning, Mr. Chairman, and Representative McDermott and distinguished members of the Task Force. Thank you for the opportunity to be here today. As one of the messengers, I am always worried about being shot at, but I think I am fairly safe here this morning.

Chairman CHAMBLISS. We are bad shots up here anyway, Mr. Miller, don't worry about it.

Mr. MILLER. We were the first Medicaid program to buy Kevlar. I think it is important to get a little background on how we came to do payment accuracy measurement in Illinois, so that you can kind of understand the context in which we work. The State of Illinois Medicaid program has a long history, in my opinion, at least during the 9 years I have been there I know it does, of being a proactive, preventive organization, as well as being reactive to problems that occur. We have a long-standing commitment to empirical research. For example, for more than 5 years, we have had a full-time fraud research bureau in my office. We have published 21 reports on various aspects of program integrity since 1994. Many of these are on our Web site. I only share that with you so that you understand we are a State that is very interested in getting down to finding out what the real facts are, and not every State necessarily has that ability or has the resources to do that.

I think it is also important to understand that we have an excellent working relationship with our Medicaid policy and program staff, even though I am the inspector general, and that can be kind of an adversarial role. Often we work very well together—not often, but we always work very well together. I also think it is important to understand that I have benefited a lot, and the State of Illinois

has benefited a lot, from HCFA's leadership in fraud and abuse control; I have been a member of their technical advisory group. I am chairing that group's subgroup on measurement and have been working with HCFA closely on this.

I think that we are all making a lot of progress here. And I also think it would be appropriate to make sure we recognize, as you did, Dr. Sparrow's work. His work has been seminal in this area and it is a body of work that I have come to respect.

I'd like to briefly describe what I, at least, think are the goals of payment accuracy measurement. And first, you will notice I haven't used the word "error" yet. We measure payment accuracy in Illinois. I think that accentuating the positive is the first step toward getting other States and everyone involved in this toward acceptance. There will be plenty of people that will emphasize the errors and the negatives of this. We measured accuracy in Illinois. It established a baseline for us to know where we started. It will allow us to judge future program integrity initiatives and their success. In Illinois, our baseline is 95.28 percent accuracy in the payments we reviewed. It helps us identify specific problem areas. Even though we didn't stratify by provider type, it became quickly clear to us that nonemergency transportation in Illinois was a troubled area. 31 percent of the money we spent on nonemergency transportation was being misspent, and that has helped us then allocate resources. Payment accuracy measurement allows you to rationally allocate resources in an intelligent, thoughtful way.

For example, we are now ready to award a contract to a private firm that will more closely monitor nonemergency transportation, will handle the prior approvals for all these services, and also institute additional integrity checks, both pre- and post service. We went out and looked at the top 64 paid providers in Illinois. We did that in about 6 weeks. And six of them, or 10 percent, are now on their way out of the Medicaid program.

We have implemented a program where we are now monitoring newly enrolled providers more closely. We are getting out there within 60 days of their enrollment. We are trying to educate them, but we are also watching to make sure they are not on the wrong track. If they are, we'll be happy to explain the error of their ways. But there is a cost of payment accuracy measurement. To do it right, in my opinion, and my opinion only, it is very expensive. It is labor intensive. We spent 14,000 staff hours conducting the study that is on our Web site, payment accuracy review. And a large part of that came from client interviews, or what GAO refers to as bene, or beneficiary interviews. We went out and we found all but 14 of the recipients in our study, and we interviewed them personally. Those interviews were of great service to us as an old investigator, because I am an ex cop, I would not do a study like this without having a face-to-face contact with the person who supposedly received the service. We went out and physically collected the medical records. That was time-consuming, but it was also worthwhile. And you heard GAO describe a little bit about how we did it. And basically, and direct and indirect costs we think estimated costs to the State of Illinois and the Medicaid program about $1.7 million to conduct this study, but the benefits are going to be reaped many fold from that as we clean up various areas.

I wanted to take this opportunity to say from one State's perspective and one man's perspective what I think we need in terms of payment accuracy measurement. We need your encouragement. We need—not every State sees the value in measurement. Many of my counterparts around the country, and I have gotten to know a number of them, question expending the resources on measure payment accuracy and trying to establish a base line, and targeting problem areas when they are confident, and may be so, that they already know what those problems are, and they can expend their resources more directly. We need financial incentives. I am sure that is not shocking that somebody comes here and says we need more money. But most of our efforts are matched at just the base rate instead of a higher FFP matching rate. I think if Congress and if HCFA are serious about payment accuracy measurement, we need to be encouraged through a higher matching rate. And most importantly, we need flexibility. One size does not fit all. You have probably heard this before, but there are 56 Medicaid programs, you know, and there is an old saying if you have seen one Medicaid program you have seen one Medicaid program. There are no two that are exactly alike. Every one is different enough that to say one methodology will work will, I think, be a prescription for problems.

For example, earlier you mentioned providers that are more at risk. Some States might want to do targeted reviews, whether it is home health or transportation or some other problem area, and get at those providers that are more at risk of being fraudulent rather than measure their entire population, the vast majority of whom are honest providers.

I am also very leery, frankly, of the establishment of a national fraud rate. I don't know that it is possible. It would take, in my opinion, a criminal investigation of every service in the service sample that we studied in our project to determine intent. We determine accuracy, but we did not determine intent. I am not sure that that is possible. I am not sure that that does anything but titillate frankly, and sound like a good sound byte or a headline. Payment accuracy, determining what payment accuracy is, serves the goals that we are trying to get to, which are improving program integrity and improving payment accuracy. And I think, as Ms. Thompson alluded to, State-by-State comparisons create some fear and apprehension amongst us, frankly because somebody will be below average and those of us that are below average find probably that to be an unpleasant experience.

Finally, annual reviews. I don't think doing this every year is possible or practicable. We should, at the worst, so to speak, not do a payment accuracy measurement more than every 2 years. Because frankly, you need the timing between those periods to implement the changes that your study promulgated. It will be 2 years in August since we published this report, and we are still working on issues that were identified through that. I certainly hope that no one ever looks at quality control like goals and penalties where States are punished financially for not reaching their goals. Please don't mandate a common methodology. You know, encourage us to do it, but use incentives to do it. And I certainly appreciate the opportunity to having been here today. It has been an honor, Mr.

Chairman, Mr. McDermott, Mr. Lucas. If there are any questions I would be happy to answer them.

Chairman CHAMBLISS. Thank you, Mr. Miller.

[The prepared statement of Robb Miller follows:]

PREPARED STATEMENT OF ROBB MILLER, INSPECTOR GENERAL, ILLINOIS DEPARTMENT OF PUBLIC AID

Good morning. My name is Robb Miller and I am the inspector general for the Illinois Department of Public Aid. I have been responsible for Medicaid program integrity in Illinois since 1991. I am pleased to be able to testify today on the value of Medicaid payment accuracy measurement. In Illinois, we have seen the benefits of measurement and believe that those benefits outweigh the cost and effort it takes to conduct such a study. Nonetheless, I have misgivings over the potential that measurement might be mandated upon the states. I think it is critical that each state be allowed to find its own way through this new world of measurement.

I believe Illinois was the first state to independently measure the accuracy of its Medicaid program and publish the results. While our Payment Accuracy Review (PAR) was not a perfect effort, we conducted it in a professional manner and elicited the two primary outcomes we sought. Those were to establish a baseline against which we can measure the success of future program integrity initiatives and to identify specific problem areas upon which we would focus our attention.

Our interest in measurement is reflected in our long-standing commitment to empirical research. For more than 5 years, we had a full-time fraud research staff within the Office of Inspector General. Since 1994, we have published 21 reports on various aspects of program integrity. We combine preventive and reactive strategies in combating Medicaid fraud and abuse in Illinois. In the Office of Inspector General, we have more than 300 staff, the vast majority of whom are dedicated full-time to Medicaid program integrity.

We also had prior measurement experience. In 1994, we examined a statistically valid sample of hospital inpatient stays to identify the frequency of up coding. The results indicated that down coding occurred to almost the same extent as up coding and was statistically a near wash.

I would be remiss if I did not mention the valuable insights and guidance I have received through Illinois' participation in HCFA's Medicaid Fraud and Abuse Control Technical Advisory Group (TAG). Over the last 3 years, the TAG has brought together program integrity directors from around the country to identify common challenges and develop effective solutions. I am proud to be the chair of its National Measurement working group. We are working closely with HCFA to share the states' perspective on the value and challenges of payment accuracy measurement.

It is also important to note that our Payment Accuracy Review was the joint effort of the department's Medicaid staff and the Office of Inspector General. It simply would not have been possible to successfully complete if we were not already in a longstanding and effective partnership to combat fraud and abuse. We work closely together on a daily basis. We jointly created the Medicaid Fraud and Abuse Executive Workgroup which has met monthly for more than 3 years to identify and eliminate challenges to the integrity of the Medicaid program. Finally, any success PAR achieved is also directly attributable to the commitment demonstrated by the former agency and Medicaid directors. That commitment continues today through the current agency and Medicaid directors' support of program integrity efforts.

In brief, the Payment Accuracy Review studied 599 randomly selected paid services from January 1998. Our four part review consisted of a client interview, medical record examination, contextual review of all other services during the 7 days before and after the sample service and a multi-stage expert review. Payments in error were categorized as "agency," "inadvertent" and "questionable."

Questionable errors represented 54.7 percent of the overpayments followed by agency (23.4 percent) and inadvertent (21.9 percent). Up coding caused 45.6 percent of dollars overpaid. Nonexistent or incomplete documentation represented 33.2 percent of the overpayments.

The universe included fee for service and inpatient hospital and hospice stays. Planning for the study began in late 1997 and the report was published in August 1998. (The entire report can be obtained from our web site at *www.state.il.us/agency/oig.)* Illinois' payment accuracy rate was 95.28 percent and represented estimated annualized errors of $113 million on a base universe of approximately $2.4 billion.

Even though we did not stratify our sample by provider type, PAR readily confirmed our worst fears in one specific area. Nearly one-third of all payments to non-

emergency transportation providers were in error. As the result of PAR and other analysis efforts, the Illinois Department of Public Aid has been able to take a number of steps that will improve the overall integrity of this provider type.

For example, we are preparing to award a contract for nonemergency transportation prior approvals and integrity checks. Late last year, we conducted an examination of the top 64 providers which resulted in our seeking to terminate six of them. We are currently piloting a project to physically visit and inspect all transportation providers within 60 days of enrollment to more closely monitor them. We are also working on an RFP to obtain additional automated code review software and planning a random claims selection project.

The Payment Accuracy Review also validated our ongoing program integrity efforts. For example, 29 providers were identified through PAR as having submitted questionable claims for payment. Of those 29, 28 were already under some form of scrutiny by our department.

The insights we gained from PAR are also being incorporated into other initiatives that will continue to build on this knowledge base. We are now planning what we expect will be our ongoing payment accuracy measurement system for the future. Through the examination of approximately 1,800 randomly selected claims each year, we expect to continue to assess our payment accuracy, identify additional problem areas and make even better management decisions on the allocation of scarce program integrity resources.

I believe that most states could expect to achieve these same outcomes by conducting similar studies of their programs. Establishing a baseline is important. If you don't know where you started your journey, you won't know when you reach your destination. Developing empirical evidence about specific risks allows you to rationally allocate your resources. It also strengthens your resolve to address those risks head on.

SPECIFIC QUESTIONS

To offer more specific information to the members of the Committee, I have listed below ten questions posed to me and my responses to them. Please understand these represent my opinions only. I hope you find this information useful.

1. What is HCFA's role in guiding/developing error rate and/or fraud rate measurement methodologies? HCFA should have the lead role in educating states on the benefits of measurement and encouraging them, through incentives, to measure payment accuracy. I consider HCFA to be our partner in program integrity and improving payment accuracy. Partners should work together toward mutually agreed upon goals.

Is there a need for a common methodology for error rate measurement? Or do variations in the Medicaid programs across the states argue against a common approach? Not only is there not a need for a common methodology, my experience tells me that mandating one would be a terrible idea. As the question acknowledges, if you have seen one Medicaid program, you have seen just that—one Medicaid program. Each of the 56 states and territories have different payment rules, hearing procedures, enrollment practices, etc. Even within states, payment systems vary dramatically among fee for service, managed care and long term care.

Through my TAG participation, I know many of my Medicaid counterparts around the country. It is fair to say that a number of them have reservations about the value of measurement. Some of them would argue that they already have sufficient experience and knowledge to effectively allocate their resources without expending the time and money on measurement. They would posit that those resources are better expended attacking problems directly. I also do not think I would be overstating the case by adding that a common measurement methodology would be of great concern to all of us.

Each state needs to decide how to measure its payment accuracy. Every state should be free to determine for itself whether to study its entire Medicaid program or only components thereof. Some programs might want to zero in on specific programs within Medicaid, such as pharmacy, home health or durable medical goods. A uniform methodology would likely preclude targeted reviews.

Illinois' experience in measurement is just that—Illinois' experience. Each Medicaid program is unique. This was demonstrated in the different approaches that Kansas, Texas and Illinois employed to achieve the same goals.

A common methodology could even hinder states' efforts to address problems unique to each of their situations. For example, Illinois' payment accuracy review did not include any managed care payments. In the bigger fiscal picture, managed care does not represent a significant issue in the Illinois Medicaid program. But it

certainly does in Arizona and Tennessee. How could one methodology address all of our needs?

A common methodology might seem desirable on the Federal level. It would allow, on its face, for state by state comparisons and the establishment of a national Medicaid payment accuracy rate. But neither of those goals support the real value of payment accuracy measurement. Frankly, comparing the states to each other would likely lead to even greater apprehension about the value of measurement.

I question the value of establishing a national Medicaid payment accuracy rate. If one accepts the premise that there are no two identical Medicaid programs, then each needs to be able to establish its own baseline and identify the problems unique to each of them. A national rate would likely be used to pummel states that fall below that rate. This would be a further disincentive to most of us. While I support the need to measure payment accuracy, there are many different ways to skin this cat. The liabilities of a uniform methodology far outweigh any benefits.

2. Do states have the statutory authority to use Medicaid funds to measure error rates?

Yes.

3. Which States are measuring error rates? The only states that I am aware of which have conducted comprehensive measurements are Illinois, Texas and Kansas.

4. What are the findings of recent error rate measurements in Texas, Illinois, Kansas, and other States? Illinois' payment accuracy rate was 95.28 percent for the universe it examined (fee for service and inpatient hospital and hospice services).

5. What is the status of the HCFA working group which is reviewing the issue of Medicaid error rates? I cannot speak for HCFA on this but I can advise you that the TAG is working closely with HCFA on this issue. We have shared our concerns about mandatory measurement requirements.

What are the goals and time frames of the working group? Defer to HCFA.

6. Do the states believe that error rate measurement is a good use of federal/state funds? I can only speak for Illinois but it has been a very positive experience for us. Besides establishing a baseline measurement, PAR provided us with the evidence we needed to address serious problems in nonemergency transportation. Arguably, we could have taken some or all of these steps without the analysis of payment accuracy. PAR, however, eliminated nay sayers and strengthened our resolve to tackle this issue directly.

There is one potential area of measurement, though, that would definitely not be a good use of Federal and state funds. States should never be required to collect the overpayments discovered through payment accuracy measurement. In the vast majority of cases, the overpayment is insignificant. In addition, the due process required to adjudicate the collection in most states would so bog down the measurement process as to make it virtually unworkable.

Within a state, who should have the responsibility to conduct error rate measures? There is no question in my mind that the Medicaid agency should be responsible for this. Making measurement part of the Single Audit Act would serve as a disincentive to the states. The long term goal of measurement is program integrity and payment accuracy improvements. The best way to achieve that is for each Medicaid program to buy into the value of measurement. Reaching that consensus will not be likely if the Medicaid agency is not responsible for measuring itself. Mandating the state auditor to conduct these studies will inherently cause tension that can be avoided by encouraging states to explore the benefits of measurement. It would also be more difficult to accomplish because of the strict time frames under the Single Audit Act. Sufficient safeguards to prevent over-reporting payment accuracy rates can be designed into the measurement projects.

7. How expensive is it to conduct error rate measurement? Measuring payment accuracy is an expensive and laborious process. In Illinois, we devoted nearly 11,000 staff hours to conducting this study ($335,000 in salary and benefits). We estimated that we likely lost an additional $1,300,000 in collections from audits that were not conducted during that time period. Replicating our study alone would consume more than half of what I understand HCFA is seeking in next year's budget to encourage other states to conduct measurements.

The bulk of the staff hours resulted from conducting 585 client interviews and visits to almost every provider to personally collect the medical records. We spent $14,000 in travel costs alone on these tasks. This effort is necessary, though, for several reasons.

Client interviews are key, in my opinion, because they place a human face on what would otherwise be a document review. It would be presumptuous to declare a service was not delivered without asking the recipient if he or she did, in fact, receive the service. In future reviews, we will use client interviews more selectively but they will continue to be an important part of the process. For example, there

may be limited utility to interviewing a client for whom the service was a consult or arcane lab test. Nonetheless, a number of client interviews provided us with assurance that the payment was erroneous. They were also very helpful in making the final determination as to whether the error was "inadvertent" on the part of the provider or if it was "questionable."

The physical collection of medical records ensured that we did not have any payments declared in error because the provider simply neglected or refused to provide the documentation. We accomplished this by first asking the provider, on short notice, to have the records of 50 patients (we were only seeking the records of one patient) available to us within the next 72 hours. An auditor or nurse reviewed the record in question at the provider's site and copied the relevant documents. Our theory was that asking for one record would have led to falsification of the documentation. By asking for 50 records on short notice, we were pretty sure that the provider would have neither the time nor the energy to forge so many documents.

Our commitment of staff, time and other resources was significant. However, I do not regret making that commitment. It was necessary to carry out the project in the most professional manner we could.

If it is to be done, how frequently should it be done? I do not believe it needs to be conducted more often than every 2 years. If conducted thoroughly and on an annual basis, the current measurement project would barely be finished before the next one would have to start. When would you have time to analyze your results and plan your next program integrity initiatives to address the problems that measurement identified?

What are the implementation difficulties? Training and staff resources are always a challenge. Drawing a statistically valid sample soon after the period you are studying is closed can also be difficult. If you are committed to client interviews, the trick is to use a period of time for which you are fairly confident that all claims have been adjudicated. At the same time, that period has to be pretty recent so that client memories have not significantly faded.

8. Is there a reliable estimate of the level of Medicaid fraud? If so, how much fraud is there in this program? I am not aware of any reliable fraud estimates. Moreover, I am unconvinced of the value of trying to establish one even if you could. The reason is simple. To establish fraud, you have to establish intent. At a minimum, that would require interviewing every provider in the sample and probably many others. It would essentially call for a full criminal investigation of each service in the sample. The additional resources necessary to establish intent would be better directed toward other areas. To establish a fraud rate just to have one does not serve the interests of program integrity. Measuring payment accuracy, on the other hand, achieves the goals we are seeking without going to the extremes necessary to establish intent.

Finally, in Illinois, we measured payment accuracy, not payment errors. Accentuating the positive is a first step toward de-stigmatizing the entire process.

9. What is the Federal match rate for error rate measurement efforts in the states? I believe it is eligible for the standard match rate for each state. Specialized medical staff reviews are eligible for 75 percent match, however.

10. If a common methodology is justified, what can the Congress or this Task Force do to promote this effort? I want to reiterate that I believe a common methodology is the wrong approach to this challenge. Congress and this Task Force can and I hope will play a leading role in encouraging payment accuracy measurement. Measurement is a strange, new world to many of us. The appropriate way to encourage states to explore this world is through incentives, not penalties. Two approaches immediately come to mind. First, Congress should appropriate additional funds to HCFA for grants to states to begin their own pilot measurement projects. Second, measurement activities should be matched at an increased rate of at least 75 percent to encourage us to continue this commitment. Use the carrot, not the stick.

Has GAO or the IG issued any reports, letters, or testimony on error rate measurement? If so, what recommendations were made, if any? Defer to GAO or the IG.

Other Issues I also want to briefly touch on two final issues that merit consideration in measurement. Neither medical necessity nor client eligibility should be considered when making a determination on payment accuracy. Judging the medical necessity of a service calls for extensive medical consultant review and, in Illinois at least, extensive due process. This is an area better left for quality of care peer review processes. Secondly, the client eligibility determinations are often made by other state agencies. The measurement process would be better served if eligibility is not considered a factor in measurement.

CONCLUSION

Thank you for the opportunity to share my thoughts on this important topic. I look forward to our successful partnership to combat fraud and abuse in the Medicaid program.

Chairman CHAMBLISS. We do appreciate you both being here. Ms. Thompson made the statement that it has been a top priority of this administration to look after the taxpayer dollar and try to improve the situation regarding waste fraud and abuse. I hope you found that to be the case when this administration came in. And I don't say that in a political way, because obviously, that ought to be a top priority of every administration. And I am assuming that was probably the case. You also said in your written testimony that when it comes to looking at taxpayer dollars, that this is a top priority and that you had certain goals and objectives with respect to weight fraud and abuse. And I just like to know what those goals and objectives are, how you have been going about reaching those goals and objectives, and how far have you gotten?

Ms. THOMPSON. Well, we have a number of different and interlocking goals. We, of course, have goals under the Government and Performance Results Act, which we have published, about our desire to get our error rate down to 5 percent by the year 2002.

Chairman CHAMBLISS. Well, let me interrupt you just a minute. I appreciate what you are saying with respect to error rate. But we have talked both with Dr. Berenson when he was here a couple of weeks ago, we talked again today about error rate versus waste fraud and abuse. And I'd like for you to concentrate on true waste fraud and abuse.

Ms. THOMPSON. If I can speak to that too, because I was interested to hear that conversation earlier. I often talk to people about this and say, tell me what your definition is when you think of waste, fraud, and abuse. Is that all improper payments or is that improper payments classified by the source of the error? In other words, if we make an improper payment to someone for whatever reason, clearly that is wasteful. That is not a payment that we should have made, and it is not a payment that was intended to be made, and it was not a payment that supports the goals and objectives of the program.

It may also be abuse, depending, again, on what the rules are and what people intended to do. It may also be fraud. When we look at improper payments, we are looking at a cross section of fraud, waste, and abuse. What we haven't done, and it's a fair criticism, is that in looking at our assessment of improper payments, we have not attempted to classify them. We have not attempted to say, in this case, this improper payment occurred because someone was honest in trying to do the right thing and was simply confused. In this case, this improper payment occurred because someone was being an aggressive entrepreneur, was trying to push the envelope and they pushed it a little too hard. In this case, an improper payment occurred because someone knew they weren't entitled to a payment but submitted a claim. It was only as a result of asking for a medical record, going deeper beyond the claim, that we identified the improper payment itself.

Chairman CHAMBLISS. Well, unfortunately, it looks like we are going to cut short due to votes. I want to very quickly and give an

opportunity for Dr. McDermott and Dr. Fletcher to ask questions, because this may be it. But with respect to Medicaid, I have a little bit of a problem in the fact that we send this money out to the States without any oversight, and I think it is a good idea to block grant that money, let the States control it.

I agree with what Mr. Miller says, that you are not going to find a cookie-cutter approach to looking at waste fraud and abuse with 47 different programs out there. But I think there must be some commonality that can be achieved in all of those programs. And I think, also, that there has got to be some oversight on the part of GAO, IG, HCFA, whoever it needs to be, I mean, the States have got to report back to us on some kind of basis as to how they are spending this money. Now, I don't see that being done from anything that I have read, or anything we have talked about. And I will just make that in the form of a comment. And what I'd really like to do is to have both of you submit written comments back to the committee with respect to how you think we can improve the oversight in the Medicaid program. How we can have the States be more accountable to the taxpayer for the dollars that we are sending out. If I could just ask you to do that in writing rather than trying to do it today and taking this time. So with that, I will defer to Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I also have a kind of a general question. Ms. Thompson, you were responsible for both Medicare and Medicaid?

Ms. THOMPSON. For coordinating program integrity activities in both those programs, right.

Mr. MCDERMOTT. In the Medicaid area, it sounds like you have given it to the States and said since you guys got half the money in the bag here, you look after it; is that correct?

Ms. THOMPSON. There is absolutely no doubt that the States are primarily accountable for the Medicaid program in a variety of different matters.

Mr. MCDERMOTT. I asked the question of the previous panel of whether or not the intermediates on the Medicare side had the same standards for their private businesses as they did for what they were doing in Medicare. Do you know the answer to that?

Ms. THOMPSON. It is a very interesting question and one that we have looked at in a variety of different settings. And it cuts both ways. We do have specific program requirements under Medicare that we want contractors to apply. But of course, one of the reasons that we contract with private insurers when the program was first started, 35 years ago—today is actually a celebration of the 35th anniversary of both Medicare and Medicaid—was the idea that private insurers knew how to do this. They already had the capacity, they already had the infrastructure, they already had the experience. Why did the Federal Government need to recreate a claims processing or health insurance capacity at the Federal level when there were private insurers more than capable of doing that? I think over time, what we have come to realize is that, we can't simply walk away from our responsibility and say it is theirs.

But we do need to hold them accountable for their decisions. We need to make sure that the resources we give them to do the job are adequate, which has been an issue that they have raised with

us. We need to make sure that our instructions to them are clear, which is another issue that they have raised to us, and that we make tools available to them. But clearly, it is not HCFA employees or Federal employees who are there actually touching those claims and processing them through. So without a good partnership with our contractors, and without a robust oversight on our part, we are not going to be successful.

Mr. MCDERMOTT. One of the things that has happened in the State of Washington, I know because I was in the State legislature for a long time, we have changed intermediaries several times. What is the process by which you come in and suddenly saying to these people, hey look, you folks aren't doing the job, you are out and these folks are in.

Ms. THOMPSON. As you can imagine that is a rarely invoked provision. It is very traumatic, actually, for providers and suppliers and physicians that are doing business with an insurer. Obviously, the stakes are very high for that insurer. And so the program has sought to try to work out problems, to try to develop corrective action plans for identified deficiencies.

For the most part, contractors that have left the program have done so voluntarily. And in many of those transitions that you are discussing, that is a result of the contractor deciding that the Medicare business was no longer worthwhile for them or was not a line of business they wished to pursue.

Mr. MCDERMOTT. So you put so much pressure on them to perform that they decide we would rather do something else.

Ms. THOMPSON. That sometimes has happened.

Mr. MCDERMOTT. Sometimes. Maybe just one other thing, and I guess maybe the two of you can do this in writing for the committee. And that is, I'd like to know what other experts besides Illinois are on the books and who is doing it, and who is doing it in a different way, because I concur with Mr. Miller's suggestion that one plan may not work everywhere, but if laboratories of democracy are State legislatures and they have half the money on the line, they have come up with different ways, in different places, some may be sharable. So if you have any ideas about that, I think it would be helpful to us in part, because maybe you know some right here off the top of your head that are also as good as Illinois. I don't know how Illinois got here. I think it is a good State, but having been born there——

Mr. MILLER. I like to think so.

Ms. THOMPSON. There have been a couple of other States—off the top of my head, Texas and Kansas—the methodologies have not been entirely similar. They have come up with some different results, and had some different kinds of experiences in terms of the reaction in their communities to those findings and so forth. Part of the group that we have established in HCFA is with the States, some of the States that have had those experiences in trying to develop some information about how people approach things differently. Talking to beneficiaries, was that useful? How was that done? Was it costly? Did that actually add information that was not readily apparent through other mechanisms such as getting information directly from the provider? Did you go and see the provider on site? Did you review medical records? Who was in the universe?

Were all claims possible to be selected from the universe or were there certain kinds of claims that were excluded specifically?

So some of those dimensions which I think are very useful to start with are, what are the differences in what people have done, and obviously also bringing in the experience that Medicare has had doing 4 years worth of this kind of measurement and what we consider to be the benefits and the disadvantages of the way that we have approached it. So we would be happy to provide further information on that. And certainly, as the group continues its deliberations and issues any products, we would be happy to share those with the committee also.

Mr. MILLER. One, I guess, demonstration of our commitment to research is in our report, we put exactly how we did this. So it could be replicatable, and also so we wouldn't forget the next time we would have it right there, documented. We even have the formulas.

Mr. MCDERMOTT. You don't think you'll be there forever?

Mr. MILLER. I am the messenger, remember. But I think it's important that we learn from each other and we share these results with each other. I think that's why it is important that Texas and Kansas reports are out there, HHS OIG's work is out there for us to all learn from.

Mr. MCDERMOTT. I think you will make that available to the committee. I have one question of you as a good cop. You go into some doctors office you ask for his sheet, his appointment sheet, and you look at that. How do you tell whether he saw 30 minutes with Mrs. Johnson or he only saw her for 5 and billed for 30?

Mr. MILLER. Well, that is very difficult, obviously. The more, the smarter the crook is, the better their documentation. Sometimes perfect documentation is your best clue that you should look at this more closely. But that is why a multi-part review was so important to us. We interviewed clients. We looked at the medical record. We did a contextual analysis. We looked at all of the services 7 days on either side of the claim. Then we brought in our own internal experts and had a multi-layer review; that is the chart the GAO had up here, we did almost all those things to every one of those claims, so that we could be confident that we were making the best decision possible. And also that, for example, the client interview was very helpful to us in categorizing whether this service or the error was inadvertent by an honest provider, or whether it was questionable. That was the term we used for——

Mr. MCDERMOTT. On the cost benefit analysis, you said you spent a million 4, what did you get back, or what do you estimate as having been saved as a result of this process?

Mr. MILLER. Actually, we spent out of pocket less than 400,000, but we lost about a million 3 in audit revenue that we would have collected from audits we didn't do during that period. I don't have a good number for you representative on what we expect to save. But we are working toward that because like I say, we have tightened transportation up dramatically already, and we think to bring a much tighter, and that alone, probably more than offset the cost of the study, plus everything else we have learned from it.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Very quickly, Dr. Fletcher.

Mr. FLETCHER. Let me go quickly because we do have to run to vote. We have a chart up here that those $203 billion expenditure Medicaid in the range of fraud, 1 percent to 15 showing the amount that it cost; 2 billion to over $3 billion. Let me ask kind of a combined question. Are we putting enough resources waste and fraud abuse, first of all? And what additional incentives could the Federal Government provide to States to conduct a periodic rate study? Let me leave that, if you can answer that very quickly, we would appreciate it.

Ms. THOMPSON. The first question, again, enough resources. I am one of those people that tends to believe that you make resource choices depending on what you think is important. If you think something is important enough, you have the resources, and you will make the choices to implement those resources. For Medicaid programs, they have to come up with half the money basically to perform an error rate study. The Federal Government chips in the other half. And the kind, of course, that Mr. Miller is talking about are not, you know——

Mr. FLETCHER. Are we putting enough in, do you feel like or not?

Ms. THOMPSON. Throughout the States I don't think our investments are there in the way that they should be, no. In terms of incentives for States, I keep asking the question, and I asked the question of the States at a session a few weeks ago in which I said why isn't the incentive to save your own money enough incentive?

Mr. FLETCHER. I have one other question I would like to submit it. I will submit that to you.

Chairman CHAMBLISS. What I will conclude with is, and I have a number of questions also, and am sure other panel members do that we will submit to you in writing. I apologize for having to cut this short. Thank you all for being here. Your testimony has been very enlightening. And we will submit written questions to you that we would like to get answered as soon as possible. Thank you very much.

[The prepared statement of the Office of Inspector General, HHS, follows:]

PREPARED STATEMENT OF THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Pursuant to our discussions with Budget Committee staff, the Office of Inspector General (OIG) of the Department of Health and Human Services offers the following thoughts on identifying improper payments and fraud in the Medicare program. This statement focuses on the development and purpose of the annual Medicare fee-for-service error rate and describes the numerous methods we use to detect fraud and some of the results we have achieved in our continuing fight against fraud, waste, and abuse.

First, we would like to express our belief that the vast majority of health care providers are honest in their dealings with Medicare. When we talk about fraud, we are not talking about providers who make innocent billing errors, but rather those who intentionally set out to defraud the Medicare program or abuse Medicare beneficiaries. The importance of our ongoing work is not only to protect the taxpayers and ensure quality healthcare for Medicare beneficiaries but also to make the Medicare environment one in which honest providers can operate on a level playing field and do not find themselves in unfair competition with criminals.

At the same time, we are concerned about all errors, even those that are totally innocent. The complexity of the Medicare program places an obligation on health care providers, beneficiaries, fiscal intermediaries, carriers, and the Health Care Financing Administration (HCFA) to take reasonable care to comply with its rules.

Thus, our audits and studies are also intended to identify vulnerabilities to administrative errors and to the related dollar losses, which can be quite significant.

BACKGROUND

The HCFA is the single largest purchaser of health care in the world. With expenditures of approximately $316 billion, assets of $212 billion, and liabilities of $39 billion, HCFA is also the largest component of the Department. 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 and fraudulent schemes.

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.

The OIG is statutorily charged with protecting the integrity of our Department's programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this mandate through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department; to detect and prevent waste, fraud, and abuse; and to ensure that beneficiaries receive high-quality, necessary services at appropriate payment levels. As part of this effort, we conduct annual audits of the Department's and HCFA's financial statements, as required by the Chief Financial Officers Act, as amended by the Government Management Reform Act of 1994.

ANNUAL ESTIMATE OF IMPROPER PAYMENTS

One objective of a financial statement audit is to determine whether there are material instances of noncompliance with laws and regulations. To that end, for the Fiscal Year (FY) 1996 financial statement audit period, we developed the first methodology to measure noncompliance in the Medicare fee-for-service program, which included reviewing supporting medical records. This work resulted in the first-ever, statistically valid, national rate of improper Medicare payments. 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.

This past year, we completed our fourth annual review, covering FY 1999, of the extent of fee-for-service payments that did not comply with laws and regulations. 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 examine 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. Our objective is not to determine the extent of fraud in the Medicare program.

METHODOLOGY

To accomplish our objective, we begin with a statistically valid sample. For FY 1999, our multistage, stratified sample design resulted in a sample of 600 beneficiaries with 5,223 claims valued at $5.4 million. For each selected beneficiary, we review all claims processed for payment. We first contact each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we do not receive a response, we make 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 peer review organizations assess 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 make 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.

RESULTS IN BRIEF

These audit procedures have enabled us to determine the extent of sampled claims that did not comply with Medicare laws and regulations. By projecting the sample results, we have estimated an annual national error rate. In FY 1999, for instance, net payment errors totaled an estimated $13.5 billion, or about 7.97 percent of total Medicare fee-for-service benefit payments. As in past years, the payment errors could range from inadvertent mistakes to abuse or outright fraud, such as phony records or kickbacks. We cannot quantify what portion of the error rate is attributable to fraud.

Our historical analysis of payment errors from FY 1996 through FY 1999 identified four major error categories: unsupported services, medically unnecessary services, incorrect coding, and noncovered services and miscellaneous errors. Where appropriate, we also identified specific trends by the types of health care providers whose claims were erroneous. For example, this past year's estimated $5.5 billion in unsupported services was largely attributable to home health agencies ($1.7 billion), durable medical equipment (DME) suppliers ($1.6 billion), and physicians ($1.1 billion).

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the 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. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments.

Summing up, our error rate methodology enables us to quantify, with statistical certainty, the extent of improper payments and to clearly see the pervasiveness of these improper payments across the various types of Medicare services. The methodology also identifies the types of errors and the types of providers accountable for these errors. More importantly, it provides a performance measure for HCFA's use in reducing improper payments. We have seen significant progress in this area; the FY 1999 $13.5 billion estimate represents a 42 percent reduction since the FY 1996 estimate of $23.2 billion.

USING THE ERROR RATE PROCESS AS AN INTERNAL CONTROL

The HCFA subsequently incorporated the error rate process as part of its internal control structure. It intends to further expand the scope of this technique through two processes: Comprehensive Error Rate Testing (CERT) and the surveillance portion of the Payment Error Prevention Program (PEPP). The PEPP is designed to produce an error rate on inpatient hospital services, and CERT, while similar to the current methodology, provides more detail on error causes at specific Medicare contractors.

The current error rate process has been endorsed by the General Accounting Office (GAO) for several years and is consistent with its report, "Increased Attention Needed to Prevent Billions in Improper Payments" (GAO/AIMD–00–10), calling for agencies to establish processes to determine compliance with laws and regulations. The GAO states that "cost-effective internal controls should be designed to provide reasonable assurance regarding prevention of or prompt detection of unauthorized acquisition, use, or disposition of an agency's assets." We concur with GAO and believe that HCFA's current and proposed error rate processes will do exactly that.

EXPANDING THE ERROR RATE METHODOLOGY TO MEASURE FRAUD

With respect to incorporating into the error rate methodology the additional techniques being discussed at this hearing, we believe that beneficiary interviews and provider profiling are appropriate tools in certain circumstances. While medical reviews clearly were the primary identifier of improper payments in all 4 years' error rate samples, we also conducted beneficiary and/or caregiver interviews concerning services billed by high-risk providers. For example, we contacted beneficiaries who had received home health services to determine whether they were, in fact, homebound—a requirement for Medicare reimbursement of these services. In FY 1996, when problems in meeting this requirement were more prevalent, beneficiary and caregiver visits were quite valuable in establishing whether beneficiaries were homebound. However, when errors shifted in the following years to problems with beneficiaries' plans of care, these types of contacts had limited value in determining improper payments.

This observation is shared by Medicare contractor fraud control units, which find that beneficiary interviews generally are not a valuable resource for detecting fraud. According to fraud control officials, beneficiaries (like any other patients) do not always remember what services were rendered, do not understand the usual/customary charges associated with surgeries, or do not recognize the scope of certain therapy services. Recalling specific details of time spent or services performed by the physician during an office visit 6 or 8 months ago would be a major challenge for anybody, with often questionable results. We therefore believe that beneficiary contacts should be used on a case-by-case basis for selected high-risk Medicare services. For instance, because of the high risk of abusive billing practices by DME providers, we are expanding our ongoing FY 2000 error rate methodology to include contacts with beneficiaries who received DME services.

On the other hand, the fraud control units we contacted found provider profiling an excellent technique for identifying fraud. This technique highlights irregular billing patterns and other anomalies so that a provider's claims can be targeted for more detailed review of medical records. We, too, apply this technique, not as part of our error rate methodology but in in-depth reviews of individual providers. These reviews often follow our multi-State reviews used to develop a "national" error rate for specific provider types or services. Through individual provider audits, we can identify patterns of misconduct or multiple questionable actions that may be referred for investigation. It is interesting to note that a review at one provider often takes as many, if not more, resources than a multi-State error rate review.

We do not devote investigative resources to cases unless we have a proper predication, such as a particularly egregious situation or a strongly suspected pattern of abuse based on a sample. For example, in the current error rate process, if we find a claim for services that were not performed, we cannot conclude that there is a pattern of abuse or fraud. If we were to expand the audit scope as suggested by GAO, we would have to review a significant number of additional provider claims to establish such a pattern. In addition, substantial evidence must be developed before an investigation can be initiated. For instance, to obtain a search warrant, both the U.S. Attorney and the Federal magistrate must be convinced that there is probable cause, based on the evidence, that a crime has occurred. Thus, determining fraud is extremely time-consuming, often taking several years and thousands of staff-hours to prove intentional deception or misrepresentation on the part of just one provider. Additionally, expanding the current error rate methodology in an attempt to determine actual or potential fraud would go substantially beyond what is expected in a normal internal control process, and it is unclear whether cost-effective corrective actions could be developed to preclude the types of schemes discussed below.

FRAUD DETECTION

As we have stated, the error rate methodology does not detect fraud, such as kickbacks, deliberate forgery of bills or supporting documents, or violations of the Stark law regarding the financial relationship between an entity and a physician or an immediate family member. To fulfill this function of our legislative mandate, we look to sources and techniques outside the error rate process. And we know from our investigations and from complaints we receive that waste, fraud, and abuse are still pervasive in the health care sector. We are therefore continuing to watch all areas of Medicare through our audits, inspections, and investigations, as well as to encourage and receive support from industry and beneficiary groups in our efforts.

Before we describe these efforts, it may be useful to define what we mean by "fraud." The Government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard of the truth or falsity of the claim, or deliberate ignorance of the truth or falsity of the claim. The other major civil remedy available to the Government, the Civil Monetary Penalties Law, has the same standard of proof. Neither statute covers mistakes, errors, misunderstanding of the rules, or negligence, and we are very mindful of the difference between innocent errors ("erroneous claims ") and reckless or intentional conduct ("fraudulent claims ").

To actually determine fraud, we typically obtain information through a combination of investigative techniques tailored to each case. These tools include subpoenas of medical and billing records, use of search warrants, investigative interviews of provider employees, surveillance, and undercover operations. For example, establishing that a claim is tainted by an illegal kickback often requires an analysis of contracts in the context of safe harbors as well as a review of the provider's Medicare and private billings over time. Once this information is gathered, it is presented to a U.S. Attorney whose office will evaluate the information and, with input

from the OIG, make a final decision on whether the conduct constitutes criminal or civil fraud. If the evidence demonstrates an intentional violation of the law, the U.S. Attorney may opt to present the case to a Federal grand jury for potential criminal action. If no criminal intent can be shown, but there is evidence of provider knowledge that false claims were submitted, a civil False Claims Act case may be authorized.

Now let us describe the sources and techniques that we use to detect and combat fraud, along with some related accomplishments.

Allegations of Wrongdoing

The OIG receives allegations of wrongdoing from a number of sources, including beneficiaries, ex-employees of providers, competitors, contractors, and Qui Tam complaints. Each of these allegations is taken seriously and is evaluated as quickly and thoroughly as possible. Because Qui Tams are based on insider information, they have proved most useful in terms of identifying large-dollar vulnerabilities. In fact, since Calendar Year 1996, we have received 1,074 Qui Tam allegations, of which over 300 are under active investigation.

For example, one case that began with a Qui Tam complaint centered on misconduct engaged in by National Medical Care, a nationwide dialysis company, and various of its subsidiaries before a 1996 merger with Fresenius Medical Care Holdings, Inc., the Nation's largest provider of kidney dialysis products and services. The Government recently reached a record-breaking Medicare fraud settlement with Fresenius. As a result of a joint investigation by OIG and multiple law enforcement agencies, the company agreed to a global resolution under which three subsidiaries pled guilty, and it agreed to pay $486 million to resolve the criminal and civil aspects of the case. As part of the civil settlement agreement on credit balances, the company paid directly to HCFA $11 million for overpayments that were previously reported to the fiscal intermediaries but never recouped. The alleged criminal misconduct involved illegal kickback activity, submission of false claims for dialysis-related nutrition therapy services, improper billing for laboratory services, and false reporting of credit balances. As part of the settlement, the company also entered into the most comprehensive corporate integrity agreement ever imposed by OIG.

Medicare Contractor Fraud Control Units

Medicare contractor fraud control units, which are a required part of the Medicare claim processing contractors' operations, are used in the effort to prevent, detect, and deter Medicare fraud and abuse. They employ a number of techniques, including sampling claims to determine propriety of payments, contacting beneficiaries to verify delivery of services, reviewing DME certificates of medical necessity, analyzing high-cost procedures and items, and analyzing local billing trends against national and regional trends for the top 30 national procedures. Unusual trends are targeted for focused medical review. Potential fraud is also identified by researching complaints and referrals received from beneficiaries, providers, and industry insiders and through various data analysis techniques. One proactive technique profiles providers using special software designed to highlight irregular billing patterns and other anomalies to target a provider's claims for more detailed review.

If fraud is indicated, the fraud control units refer cases to the OIG and other law enforcement authorities for consideration of civil or criminal prosecution and application of administrative sanctions. Over a third of the more than 1,600 referrals in FYs 1998 and 1999 were developed using proactive techniques.

Audits and Evaluations

Many of our leads on potential fraud are developed through audits and evaluations of various aspects of the Medicare program, most often on a provider-by-provider basis. Some significant examples are summarized below:

Home Health Care. Looking behind the explosive growth in Medicare expenditures for home health care since 1990, OIG, using claim data from 1995 through part of 1996, found that 40 percent of the payments were improper. We also determined that many home health agencies shared characteristics that could undermine the Department's ability to recover overpayments or levy sanctions. Our recommendations to strengthen the Medicare certification process and to otherwise protect the trust fund were adopted in the Balanced Budget Act of 1997. Conducted at the Department's request, our follow-up work, which examined 1998 claim data, noted that the payment error rate had fallen to 19 percent.

Additional reviews at individual home health agencies have led to 420 investigations of potential fraud since October 1997, and 130 of these investigations are ongo-

ing. A particularly egregious case of misappropriated Medicare funds and potential abuse of Medicare patients was noted at St. John's Home Health Agency, the highest paid home health agency in South Florida. We found that St. John's billed Medicare for nonrendered or upcoded home health services, that nurses and home health aides permitted subcontracting groups to use their names and/or create fraudulent documents to support nonrendered services, and that some nursing visits were provided by unlicensed persons. Further, subcontractors paid kickbacks to St. John's employees in order to do business with them. In December 1999, 26 people were indicted for racketeering, conspiring to racketeer, conspiring to launder money, and conspiring to submit false claims to the Medicare program. Subsequent to plea or trial, there were 24 guilty verdicts (1 individual became a fugitive and 1 was acquitted); all 24 of those found guilty are in the process of being excluded from Federal health care programs.

Durable Medical Equipment. After sampling 36 new durable medical equipment applicants in the Miami, Florida, area, HCFA reported in 1996 that 32 were not bona fide businesses. Among other problems, some bogus applicants did not have a physical address or an inventory of DME. According to HCFA, those companies should not have been issued a supplier number because they were not operational entities. To determine the prevalence of this problem, we sampled suppliers and applicants in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California at HCFA's request. Our inspection found that 1 of every 14 suppliers and 1 of every 9 new applicants did not have a required physical address. When we checked questionable addresses, we usually found that the business had closed or had a questionable presence at the address. Some addresses were merely mail drop locations or were nonexistent or could not be located. These types of problems with physical addresses often indicate potentially illegitimate business arrangements.

A classic example is a case we uncovered in New York. The OIG was drawn into investigating this scheme after numerous Medicare beneficiaries complained to their carriers that they had not received the services for which Medicare was billed. We interviewed the beneficiaries and verified that claims had been submitted for services that were not actually rendered. These companies billed Medicare for millions in fraudulent claims. In one instance, three of the companies billing for ear implants received checks from Medicare totaling approximately $1 million in less than a month. The bank where the money was being deposited became suspicious and called the carrier which, in turn, stopped payment on the checks. The carrier had placed a system alert on these companies if they submitted claims for MRI services, so the fictitious companies began submitting claims for ear implants and were paid.

Partial Hospitalization and Community Mental Health Centers. In collaboration with HCFA, we examined the growth of Medicare expenditures to community mental health centers for partial hospitalization services (highly intensive outpatient psychiatric services). We found that Medicare was paying for services to beneficiaries who had no history of mental illness and for therapy sessions that consisted of only recreational and diversionary activities, such as watching television, dancing, and playing games. Our review in five States, which accounted for 77 percent of partial hospitalization payments to mental health centers nationally during 1996, disclosed that over 90 percent of the services, or $229 million in Medicare payments, were unallowable or highly questionable. From that review, we were able to identify potentially abusive centers for in-depth audits and, based on our results, referred all of these centers for investigation of potential fraud. Currently, investigations are underway at 18 centers identified from this work and from other sources.

Hospital Outpatient Psychiatric Services. The OIG conducted a 10-State review of outpatient psychiatric services which accounted for 77 percent of the value of partial hospitalization and other outpatient psychiatric claims at acute care hospitals nationally. We estimated that almost 60 percent of the $382 million in 1997 outpatient psychiatric claims made by hospitals did not meet Medicare reimbursement requirements. These unallowable services were not reasonable and necessary for the patient's condition, not authorized and/or supervised by a physician, not adequately documented or not documented at all, or rendered by unlicensed personnel. Our reviews at individual hospitals found similar problems, as well as alteration of medical records after we selected the records for review. To determine whether fraud was a factor in these cases, additional work is being performed. Overall, we have 69 ongoing investigations.

Undercover Operations

We occasionally conduct undercover operations to identify potential fraud. Past undercover operations have targeted podiatrists, opthalmologists, chiropractors, medical doctors, DME companies, billing companies, and laboratories for various

Medicare billing fraud schemes, such as billing for medically unnecessary services, billing for services not provided, soliciting and receiving kickbacks, upcoding services, unbundling services, and misusing provider Medicare billing numbers. Many of these undercover operations are conducted jointly with other Federal agencies, including the Federal Bureau of Investigations (FBI), the Internal Revenue Service (IRS), and the Drug Enforcement Agency, since violations often fall within their jurisdictions as well.

For example, an ongoing multiagency undercover project targeted certain DME providers. The DME companies offered cash kickbacks to undercover operatives (Federal agents) in exchange for patient referrals. In addition, some companies billed Medicare and/or Medicaid for medically unnecessary services, services not provided, and/or upcoded services. The operation also identified physicians involved in the scheme. To date, this project has resulted in 20 convictions with nearly $1 million in restitutions, fines, and savings. Additional cases are currently being adjudicated, and more convictions are expected.

In conclusion, we would like to commend HCFA for incorporating an improper payment methodology into its internal control structure for Medicare, and we note that it was one of the first health care programs to develop such a technique. Modifications to the methodology being made by HCFA would further enhance its ability to identify areas in need of corrective action. With respect to other techniques being discussed today to expand the error rate process, we believe they are currently being used to the extent appropriate. For example, we have used beneficiary contacts in high-risk areas for the past 4 years. Such techniques as provider profiling have long been used as a means for targeting providers for fraud investigations and, as we have noted, have led to a significant number of investigative referrals. To incorporate additional fraud development techniques into the error rate methodology, in our opinion, would be cost prohibitive and extremely time-consuming and would divert substantial resources from the Department's highly successful fraud-fighting efforts. We believe that all the techniques discussed have their appropriate uses in a comprehensive, flexible anti-fraud system. We, HCFA, the Department of Justice, the FBI, and other enforcement entities will continue to apply these techniques in the most cost-effective manner that ensures the best outcomes for Medicare and other Federal health care programs.

[The responses to followup questions from Robb Miller follow:]

RESPONSES TO FOLLOWUP QUESTIONS SUBMITTED TO ROBB MILLER, INSPECTOR GENERAL, ILLINOIS DEPARTMENT OF PUBLIC AID

Question: What factors lead Illinois to conduct an error rate study?

The Illinois Department of Public Aid's Office of Inspector General has had a longstanding interest in empirical research to identify the causes of and solutions to Medicaid fraud and abuse. We had internal discussions years ago about the viability of measuring payment accuracy.

However, there were several events tied to our decision to conduct the Payment Accuracy Review (PAR). The first was becoming involved with HCFA's Medicaid Fraud and Abuse Technical Advisory Group (TAG). The TAG has provided a valuable forum of program integrity administrators from around the country who were grappling with the same issues.

The second was the challenge laid down in Sparrow's License to Steal. He clearly articulated the value and worth of establishing the payment accuracy baseline.

Finally, both the agency head and Medicaid director at that time believed it was also important to establish the baseline. Their support for the project and their willingness to deal with whatever the outcomes might have been were critical to embarking on this course.

We recognized that this study would be challenging. We were equally convinced that it would be invaluable for problem identification and the development of solutions. We felt that measurement was necessary to determine our effectiveness over time. As a consequence, we saw it as our responsibility to the taxpayers.

Question: What were the key implementation difficulties that Illinois experienced when measuring Medicaid error rates?

There are almost too many challenges to enumerate. Their volume and complexity serve to highlight why payment accuracy measurement has not been universally embraced. Effective payment accuracy is very difficult, time-consuming and expensive. Below please find a partial list of the challenges we encountered:

Six-month project period—once consensus was reached on conducting the project, we wanted to get it done in as timely a manner as possible.

Medicaid Management Information System (MMIS)—at that time, our data warehouse was not in existence. MMIS was not designed to support analytical needs as

much as operational ones, and it was not designed for rapid response projects like this.

Sampling methodologies—We held many hours of discussion before we settled on a service (as opposed to a claim or a patient day) as the unit of measurement and developed our particular stratified sample design.

Identifying which provider areas would be reviewed—while long term care and capitated payment services are also important, we focused on fee for service and inpatient payments.

Coordinating activities of multiple disciplines across organizational lines—no one entity within the department had all the expertise necessary.

Identification, extraction, and use of MMIS (internal) data—we had to rapidly develop, test and use a series of programs to select the stratified sample, develop field reports and develop the contextual data analysis reports, all in a legacy mainframe system. We also had to rapidly develope a complementary PC system that used these and other data to perform the statistical analysis and reporting.

Drawing the sample soon after service—this was done to ensure fresher client recollections during the interview but it also meant that there may have been services that had not been submitted for payment yet which might have affected the contextual analysis.

Data analysis—there were multiple levels of review; producing error rates required weighting because the sample was stratified and records in each strata had different probabilities of selection.

Medical record collection—on site visits were critical to preventing errors based simply on records not submitted.

Client interviews—they were particularly valuable in confirming that service was not provided but challenging to identify the vast majority clients.

Staff commitment—14,000 hours of staff time.

Lost audit revenue—because staff were redirected from other activities, including provider audits, we projected that the Department lost $1.3 million in audit revenues.

Question: You expressed concern about States being required by the Federal Government to use a common Medicaid error rate methodology. But, surely, there must be a common basic approach that could be modified to accommodate an individual State's needs. Don't you agree?

As you know, I am on the record as opposing a "one size fits all" approach to payment accuracy. There are major differences in:

A. The ways states determine client eligibility;

B. The types of providers allowed to be enrolled, and

C. The administration of the Medicaid program.

These differences would make a common methodology difficult if not impossible.

I would hope Congress and HCFA would focus on the outcome, not the process. If they are interested in payment accuracy and program integrity improvements, states need the flexibility to address the areas with which they are most concerned. A state's progress toward this goal should be measured only against itself, not some artificial national average.

Having said all that, my opinions are based only on my experiences and beliefs. I need to be just as willing to test them as we were to measure payment accuracy in the first place. I would suggest that more study and experimentation be conducted to determine whether a common methodology is feasible and if so, what that methodology is. HCFA and states could collaborate on efforts to deploy and evaluate different measurement approaches. A workgroup of state and Federal officials and members of the research community could then examine these experiences and advise HCFA and Congress on the question how best to proceed.

As part of these efforts, HCFA and states might first attempt to identify a universe of services and populations present in all Medicaid programs, and then determine the significance of that common universe to each state program. It would be unfortunate for states to feel compelled to focus their program integrity efforts on areas that constitute a minority of their expenditures or on areas where a minority of the problems are to be found. While allowing states the ability to initiate targeted measurement reviews would help, states would still have a strong incentive to focus their program integrity operations on only those services included within the common universe.

HCFA and states might also carefully examine the value of alternative strategies for conducting contextual record reviews, third-party verification, and client interviews. Such an examination might help identify best practices that could become part of a national methodology.

Question: In your testimony you urge the use of "the carrot, not the stick." Medicaid payments to those not eligible for Medicaid and failure of a State to collect from third party insurers would seem to (be) areas were both repayment and a penalty might be appropriate. Would you comment please?

Both of these are challenging areas for state Medicaid agency operations. However, I am not clear on their connection to the overall topic of payment accuracy measurement. Nonetheless, I agree that states need to be diligent in: a) preventing ineligible providers from enrolling or receiving payments, and b) collecting as much as possible from private insurers who provide additional coverage to Medicaid patients. At the same time, I am sure you also understand that every state has different laws that limit its abilities in both of these areas.

I believe that we are already required to return the FFP for payments to providers which should not have been made for whatever reason, including that they were excluded at the time of the service. I am not sure what value there would be to an additional sanction against the state.

Third party liability collections are more of an art than a science. The only way we should be required to return the FFP is if we know of the insurance in the first place. If we know that, we will have already made every reasonable effort to collect and, consequently, return the FFP. Again, I do not see any value in additional penalties for states.

[Whereupon, at 11:50 a.m., the Task Force was adjourned.]