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SHOW ME THE TAX DOLLARS PART II—IMPROPER PAYMENTS AND THE TENNCARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY AND FINANCIAL MANAGEMENT

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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CONTENTS

	Page
Hearing held on July 14, 2003	1
Statement of:	
Mathis, Barry Thomas, director of program integrity, TennCare; William A. Benson, special agent, Tennessee Bureau of Investigation, Medicaid Fraud Control Unit; and Holly E. Williams, director, Medicare Patrol Project, Upper Cumberland Area Agency on Aging	54
Williams, McCoy, Director, Financial Management and Assurance Team, U.S. General Accounting Office; and Kerry Weems, Acting Assistant Secretary for Budget, Technology and Finance, Department of Health and Human Services	6
Letters, statements, etc., submitted for the record by:	
Benson, William A., special agent, Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, prepared statement of	73
Mathis, Barry Thomas, director of program integrity, TennCare, prepared statement of	59
Platts, Hon. Todd Russell, a Representative in Congress from the State of Pennsylvania, prepared statement of	3
Weems, Kerry, Acting Assistant Secretary for Budget, Technology and Finance, Department of Health and Human Services:	
Information concerning annual reports	52
Information concerning provider debt	51
Prepared statement of	21
Williams, Holly E., director, Medicare Patrol Project, Upper Cumberland Area Agency on Aging, prepared statement of	82
Williams, McCoy, Director, Financial Management and Assurance Team, U.S. General Accounting Office, prepared statement of	8

SHOW ME THE TAX DOLLARS PART II—IMPROPER PAYMENTS AND THE TENNCARE PROGRAM

MONDAY, JULY 14, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY AND FINANCIAL MANAGEMENT,
COMMITTEE ON GOVERNMENT REFORM,
Bartlett, TN.

The subcommittee met, pursuant to notice, at 8:05 a.m., in the Bartlett City Hall, 6400 Stage Road, Bartlett, TN, Hon. Todd Platts (chairman of the subcommittee) presiding.

Present: Representatives Platts and Blackburn.

Staff present: Mike Hettinger, staff director; Dan Daly, counsel; and Tabetha Mueller, professional staff member.

Mr. PLATTS. A quorum being present, this hearing of the Subcommittee on Government Efficiency and Financial Management will come to order.

It is a pleasure to be here at Bartlett City Hall and I would like to thank the city of Bartlett for its hospitality this morning. Mayor McDonald and others, I appreciate all your work with the staff of the subcommittee in making this hearing possible here at Bartlett.

I would also like to recognize the committee's vice chair, Representative Marsha Blackburn who has worked throughout her career in elected office to ensure the efficient operation of government and we are certainly delighted to be here in your home district. We are honored to have you as our vice chair and your efforts, first here in the Tennessee State Senate and now in Washington, seeking to ensure that taxpayer funds are spent correctly and especially in programs such as Medicaid that we will be focusing on here today.

Representative Blackburn's efforts dovetail well with President Bush and his administration's efforts to make the reduction of improper payments a significant part of his management agenda in Washington.

In support of the President's agenda, this subcommittee believes that taxpayers have a fundamental right to know how their tax dollars are being spent. Improper payments by Federal agencies are a serious and growing problem that costs taxpayers billions of dollars each year. We have seen some estimates that put improper payments at $35 billion a year and many of us believe that is probably just the tip of the iceberg, when we get into the actual numbers of each of these programs.

While we do not have our arms around the total extent of the improper payment problem, what we do know is that these mistakes, which occur throughout government, are made because agencies do not have adequate internal financial controls and business process systems to protect against these types of errors. The Federal Government, led by the President and the Office of Management and Budget, the General Accounting Office and agency leaders such as the Department of Health and Human Services is making progress in identifying and reducing the rate of improper payments.

Here in Tennessee, waste, fraud and mismanagement in the TennCare program remain major concerns. Tennessee has in place a number of mechanisms aimed at reducing TennCare fraud. In addition to the Tennessee Bureau of Investigations Medicaid Fraud Control Unit, the State of Tennessee operates TennCare's Program Integrity Unit. The most identifiable form of fraud in the TennCare program is provider fraud, where providers commit fraud by seeking improper payment for services rendered—to TennCare recipients. With an annual budget of approximately $6 billion for TennCare, $4 billion of which is provided by the Federal Government with another $2 billion provided by the State, both HHS and the State of Tennessee have a significant fiduciary duty to taxpayers to remain vigilant in their struggle to control improper payments.

Today, we will first hear from McCoy Williams, Director of Financial Management and Assurance Team at the U.S. General Accounting Office, along with Mr. Kerry Weems, Acting Assistant Secretary for Budget Technology and Finance at the Department of Health and Human Services, regarding Federal efforts to reduce improper payments.

Our second panel will feature Mr. Barry Mathis, director of Program Integrity for TennCare; Mr. William A. Benson, special agent for the Tennessee Bureau of Investigation's Medical Fraud Control Unit and last but not least, Ms. Holly Williams, director of the Medicare Patrol Project, Upper Cumberland Area Agency on Aging, discussing specific aspects of the TennCare experience.

We certainly thank each of our witnesses for being here today and for your preparation regarding today's testimony, both written and verbal.

I am now delighted to yield to our subcommittee vice chair, Representative Blackburn, and again I want to thank you for hosting us here in Bartlett.

[The prepared statement of Hon. Todd Russell Platts follows:]

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Opening Statement
Congressman Todd R. Platts
July 14, 2003

President Bush has made the reduction of improper payments a significant part of his management agenda. In support of that agenda, this subcommittee believes that taxpayers have a fundamental right to know how their tax dollars are being spent. Improper payments by federal agencies are a serious and growing problem which costs taxpayers billions of dollars each year. We have seen some estimates that put the improper payment figure as high as $35 billion. Many believe this figure is likely just the tip of the iceberg.

The lack of consistency in calculating, defining and accounting for erroneous payments further complicates agencies' efforts to combat this problem. The "Improper Payments Information Act" signed into law late last year is designed to address these very concerns. An improper payment is any payment that should not have been made. It can be incorrect payment, an over- or under- payment, and can include, among other things, a payment to an ineligible recipient, a payment for an ineligible service, a duplicate payment or a payment for a service not received.

While we do not yet have our arms around the total extent of the problem, what we do know is that these mistakes, which occur throughout government, are made because agencies do not have adequate internal financial controls and business process systems to protect against these types of errors. The federal government, led by the President, the Office of Management and Budget, the General Accounting Office and agency leaders such as the Department of Health and Human Services is making progress in identifying and reducing the rate of improper payments.

Here in Tennessee, waste, fraud, and mismanagement in the TennCare program remain major concerns. Tennessee has been very aggressive in investigating potential fraud cases and has in place a number of mechanisms aimed at reducing TennCare fraud. In addition to the TBI's Medicaid Fraud Control Unit, the State of Tennessee operates the Bureau of TennCare's Program Integrity Unit. The most identifiable form of fraud in the

TennCare program is provider fraud, where providers commit fraud by lying to obtain an improper payment for services rendered (or allegedly rendered) to TennCare recipients. With an annual budget of approximately $6 billion dollars for TennCare, $4 billion of which is provided by the federal government with another $2 billion provided by the state, both HHS and the State of Tennessee have a fiduciary duty to taxpayers to remain vigilant in their struggle to control improper payments. The efforts to control fraud in the TennCare program provide an example from which other States and the federal government can learn important lessons.

Today we will hear from the U.S. General Accounting Office and the U.S. Department of Health and Human Services on federal efforts to identify and reduce improper payments. In addition, we are pleased to have witnesses from the TennCare program, the Tennessee Bureau of Investigation, and the Upper Cumberland Area Agency of Aging to discuss specific aspects of the TennCare program and efforts to reduce waste, fraud and mismanagement.

Ms. BLACKBURN. Thank you so much, Mr. Chairman.

I want to thank you for bringing the Government Reform Subcommittee on Government Efficient and Financial Management to Memphis to look at improper payments to Tennessee's TennCare program.

Since November 2002, Federal agencies have instituted methods to estimate improper payments in programs they manage. The current estimate of total improper payments in the Federal Government is $35 billion and, as you just said, there are many of us that believe that is just the tip of the iceberg.

One only needs to look at Medicare, where improper payments under that system are estimated at $13 billion a year, and this is only a partial examination of that program.

Medicaid, which provides health insurance for the poor, however, is administered by the State, making it very difficult to estimate improper payments in each system. Tennessee's expanded Medicaid program, known as TennCare, is now serving about 25 percent of Tennessee's population. This $6 billion a year program, out of a $21 billion a year State budget, consumes one third of that State budget, and since its inception in 1994, its financial management and lack of consistent payments to providers has been severely criticized.

Although waste, fraud and mismanagement occur in almost any State or Federal program, the magnitude of TennCare's expenditures most probably require extensive steps to be taken to control improper payments. Most notably, provider fraud has been identified as a serious drain of TennCare resources and should be addressed without delay.

Mr. Chairman, today here in Bartlett, we are going to hear from representatives of groups that have investigated and resolved cases that involve improper payments, both in TennCare and the Medicaid program. Their accomplishments may provide valuable guidance to Federal agencies and to Medicaid programs in other States that are wrestling with this issue.

I want to thank Barry Mathis from the Department of TennCare; William Benson from the Tennessee Bureau of Investigation and Holly Williams from the Upper Cumberland Area Agency on Aging for being here and testifying today before this committee.

I want to welcome Mr. Williams and Mr. Weems.

Thank you for the work that you do and I look forward to hearing your testimony.

Mr. PLATTS. Thank you, Representative Blackburn.

And before we begin with testimony, it is committee practice to swear in all of our witnesses. If we could have the witnesses for both panels stand at the same time and anyone who would be advising you regarding your testimony here today, to stand and take the oath with you. If you raise your right hand.

[Witnesses sworn.]

Mr. PLATTS. Thank you, the clerk will note that all witnesses affirmed the oath and we will proceed to our testimony.

Mr. Mathis, we understand it is Tom—I apologize for the misstatement—you go by your middle name.

We will proceed with our first panel. Mr. Williams, we will begin with you followed by Mr. Weems. And then following your testi-

mony and questions from Representative Blackburn and myself, we will proceed to panel two. Would you like to begin?

STATEMENTS OF MCCOY WILLIAMS, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE TEAM, U.S. GENERAL ACCOUNTING OFFICE; AND KERRY WEEMS, ACTING ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY AND FINANCE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. WILLIAMS. Mr. Chairman and Madam Vice Chairwoman, I am pleased to be here today to discuss OMB's guidance to Federal agencies on the implementation of the Improper Payments Information Act of 2002 and some strategies that Federal agencies should consider when planning and implementing actions to prevent improper payments.

Improper payments are a longstanding, widespread and significant problem in the Federal Government. As noted in our prior reports and testimonies on this topic, there is no clear picture of the extent of the problem. Historically, relatively few Federal agencies and their components have publicly reported improper payment information such as improper payment rates, causes, and strategies for better managing their programs to reduce or eliminate these payments. This past April, OMB estimated improper payments to be about $35 billion annually for major Federal benefit programs that made payments in excess of $1.2 trillion annually.

The Improper Payments Act, which this subcommittee sponsored, defines improper payments as any payment that should not have been made or that was made in an incorrect amount.

The act requires OMB to prescribe guidance for Federal agency use in implementing the act. OMB issued this guidance in May of this year. As with any legislation or implementing guidance, the ultimate success of the Improper Payments Act hinges on each agency's diligence and its commitment to identify, estimate, determine the causes of, take corrective actions and measure progress in reducing all improper payments.

OMB's guidance addresses the specific reporting requirements called for in the act and lays out the general steps agencies are to perform to meet those requirements.

For years, we have recommended that OMB develop and issue guidance to Federal executive agencies to assist them in developing and implementing a methodology for annually estimating and reporting improper payments and for developing goals and strategies to address improper payments. We believe the Improper Payments Act guidance is a good start in this area.

Because of the magnitude of improper payments and the actual and potential impact these payments can have on Federal programs, it is essential that agencies develop appropriate methodologies for identifying and measuring improper payments, identifying cost-effective actions to correct them, implementing those actions and periodically reporting improper payment-related information to agency managers, the Congress, and the public through publicly available documents. Our prior work has demonstrated that attacking improper payments problems requires a strategy appropriate to the organization involved and its particular risks, including a con-

sideration of the legal requirements surrounding security and privacy issues.

In October 2001, we issued an executive guide that provided information on strategies used successfully by public and private sector organizations to address their improper payment problems. We found that the Federal, private sector, State, as well as foreign entities using these best practices, shared a common focus of improving the internal control system over the program or activity that experienced improper payments.

We are seeing important leadership and action—both from the Congress and from the administration—to address the improper payment problem. However, the reduction or elimination of the government's improper payment problems will not be quick or easy. I want to emphasize our commitment to continuing our work with the Congress, the administration and Federal agencies to ensure that improper payments are fully addressed governmentwide, and that actions are taken to reduce or eliminate the government's vulnerabilities to the significant problem of improper payments.

Mr. Chairman, this completes my prepared statement and I will be happy to respond to any questions.

Mr. PLATTS. Thanks, Mr. Williams. Mr. Weems.

[The prepared statement of Mr. Williams follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Government Efficiency and Financial Management, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 8:00 a.m. CDT
Monday, July 14, 2003

FINANCIAL MANAGEMENT

Effective Implementation of the Improper Payments Information Act of 2002 Is Key to Reducing the Government's Improper Payments

Statement of McCoy Williams
Director, Financial Management and Assurance

GAO-03-991T

July 14, 2003

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Highlights

Highlights of GAO-03-991T, a testimony before the Subcommittee on Government Efficiency and Financial Management, Committee on Government Reform, House of Representatives

FINANCIAL MANAGEMENT

Effective Implementation of the Improper Payments Information Act of 2002 Is Key to Reducing the Government's Improper Payments

Why GAO Did This Study

The Subcommittee asked GAO to testify on the implementation of the Improper Payments Information Act of 2002 (PL 107-300) and related Office of Management and Budget (OMB) guidance, and on GAO's strategies to reduce improper payments.

What GAO Found

Improper payments are a longstanding, widespread, and significant problem in the federal government. This past April, OMB estimated improper payments of about $35 billion annually for major federal benefit programs that made payments in excess of $1.2 trillion annually. Importantly, this estimate does not account for all federal programs and activities.

The Improper Payments Information Act of 2002 contains requirements in the areas of improper payment identification and reporting. It requires agency heads to annually review all programs and activities, identify those that may be susceptible to significant improper payments, estimate annual improper payments in the susceptible programs and activities, and report the results of their improper payment activities. The legislation also requires OMB to prescribe guidance for federal agency use in implementing the act. OMB issued the guidance in May 2003.

OMB's guidance addresses the specific reporting requirements called for in the act and lays out the general steps agencies are to perform to meet those requirements. The guidance defines key terms used in the law, such as *programs and activities*, and offers criterion that clarify the meaning of the term *significant improper payments*. It requires that agencies use statistical sampling when estimating improper payments and sets statistical sampling confidence and precision levels for estimation purposes. It also requires that agencies report the results of their improper payment activities in their annual Performance and Accountability Report. As with any legislation or implementing guidance, the act's ultimate success hinges on each agency's diligence and commitment to identify, estimate, determine the causes of, take corrective actions, and measure progress in reducing all improper payments.

Our prior work has demonstrated that attacking improper payment problems requires a strategy appropriate to the organization involved and its particular risks. We have found that entities using successful strategies to address their improper payment problems shared a common focus of improving the internal control system—the first line of defense in safeguarding assets and preventing and detecting errors and fraud. The components of the control system are:

- control environment—creating a culture of accountability,
- risk assessment—performing analyses of program operations to determine if risks exist,
- control activities—taking actions to address identified risk areas,
- information and communications—using and sharing relevant, reliable, and timely information, and
- monitoring—tracking improvement initiatives and identifying additional actions needed to further improve program efficiency and effectiveness.

www.gao.gov/cgi-bin/getrpt?GAO-03-991T.

To view the full report, including the scope and methodology, click on the link above. For more information, contact McCoy Williams at 202-512-6906 or williamsm1@gao.gov.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss OMB's guidance[1] to federal agencies on the implementation of the Improper Payments Information Act of 2002 (Improper Payments Act) and some strategies that federal agencies should consider when planning and implementing actions to prevent improper payments.

Improper payments are a longstanding, widespread, and significant problem in the federal government and few would argue that the goal of reducing them is not a worthy one. As noted in our prior reports and testimonies on this topic, there is no clear picture of the extent of the problem. Historically, relatively few federal agencies and their components have publicly reported improper payment information such as improper payment rates, causes, and strategies for better managing their programs to reduce or eliminate these payments. This past April, OMB estimated improper payments to be about $35 billion annually for major federal benefit programs that made payments in excess of $1.2 trillion annually. Importantly, this estimate does not account for all federal programs and activities.

Further, the risk of improper payments and the government's ability to prevent them has important long-term implications. As the baby boom generation leaves the workforce, spending pressures will grow rapidly due to increased costs of programs such as Medicare, Medicaid, and Social Security. Other federal expenditures are also likely to increase. The increased size of federal programs and spending pressures, such as the implementation of new programs and changes in existing programs, all but guarantee that, absent improvement in internal controls and other proactive actions, the risk of even more improper payments will exist.

The Improper Payments Act, which this subcommittee sponsored, defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. They include payments to ineligible recipients or payments for ineligible services. Improper payments also

[1]OMB Memorandum M-03-13, *Improper Payments Information Act of 2002, Public Law 107-300* (May 21, 2003).

include duplicate payments, payments for services not received, and payments that do not appropriately reflect applicable discounts offered.

The act contains requirements in the areas of improper payment identification and reporting. It requires agency heads to annually review all programs and activities that they administer, identify those that may be susceptible to significant improper payments, and estimate annual improper payments for those programs and activities identified as susceptible to significant improper payments. Governmentwide implementation of these requirements will significantly increase the number of agencies analyzing their programs and activities for improper payments and coincides with our recommendation that the head of the CFO Act agencies assign responsibility to a senior official for establishing procedures for assessing agency and program risks of improper payments.

For programs for which estimated improper payments exceed $10 million, agencies are to report certain information to the Congress including the causes of the improper payments, actions taken to correct those causes, and the results of those actions. This provision coincides with our recommendation that CFO Act agencies report to the Congress, OMB, and the agency head on the progress made in achieving improper payment reduction targets and future action plans for controlling improper payments.

OMB's Guidance on Addressing Improper Payments

The Improper Payments Act requires OMB to prescribe guidance for federal agency use in implementing the act. OMB issued this guidance in May 2003. As with any legislation or implementing guidance, the ultimate success of the Improper Payments Act hinges on each agency's diligence and its commitment to identify, estimate, determine the causes of, take corrective actions, and measure progress in reducing all improper payments.

OMB's guidance addresses the specific reporting requirements called for in the act and lays out the general steps agencies are to perform to meet those requirements. The guidance defines key terms used in the law. For example, it defines the term *programs and activities* to include "activities or sets of activities recognized as programs by the public, OMB, or the Congress as well as those that entail program management or policy direction." The guidance specifies that grants include competitive grant programs, regulatory activities, research and development activities, direct federal programs, all procurements including capital assets and service

acquisition, and credit programs. Also included are agency activities that support its programs.

As I noted earlier, the act requires agencies to identify programs and activities that are susceptible to significant improper payments. OMB's guidance defines *significant erroneous payments* as annual erroneous payments in the program exceeding both 2.5 percent of program payments and $10 million. (GAO considers the terms improper payments and erroneous payments to be synonymous.) For those programs and activities susceptible to *significant erroneous payments*, the guidance instructs agencies to calculate annual improper payment estimates based on the gross total of both overpayments and underpayments, and to set statistical sampling confidence and precision levels for estimating those payments. It further requires agencies with estimated improper payments exceeding $10 million in any program or activity to include, along with the estimated amount, a discussion of the amount of actual improper payments the agency expects to recover and how it will go about recovering them in the Management Discussion and Analysis section of their annual Performance and Accountability Report. These actions will help ensure transparency in reporting for those agencies with programs and activities with significant risks for improper payments.

According to the guidance, information on the results of improper payment-related efforts will generally be first reported in agency Performance and Accountability Reports for fiscal years ending on or after September 30, 2004. These reports should be available in November 2004. However, the guidance calls for those federal agencies already required by OMB Circular No. A-11, *Preparation and Submission of Budget Estimates*, to report improper payment information in their initial budget submissions to OMB to also include that improper payment information in their fiscal year 2003 Performance and Accountability Reports. This will result in publicly available information on improper payments for about 50 major federal programs, such as Medicare and Food Stamps, about one year earlier than the reporting date for all other federal programs and activities.

For years, we have recommended that OMB develop and issue guidance to federal executive agencies to assist them in developing and implementing a methodology for annually estimating and reporting improper payments, and for developing goals and strategies to address improper payments. This Improper Payments Act guidance is a good start in this area.

Strategies for Preventing Improper Payments

Because of the magnitude of improper payments and the actual and potential impact these payments can have on federal programs, it is essential that agencies develop appropriate methodologies for identifying and measuring improper payments, identifying cost-effective actions to correct them, implementing those actions, and periodically reporting improper payment-related information to agency managers, the Congress, and the public through publicly available documents. Our prior work has demonstrated that attacking improper payment problems requires a strategy appropriate to the organization involved and its particular risks, including a consideration of the legal requirements surrounding security and privacy issues.

In October 2001, we issued an executive guide[2] that provided information on strategies used successfully by public and private sector organizations to address their improper payment problems. We found that the federal, private sector, state, and foreign entities using these best practices shared a common focus of improving the internal control system over the program or activity that experienced improper payments. The components of thi control system and a brief definition of each follows.

- Control environment—create a culture of accountability by establishing a positive and supportive attitude toward improvement and the achievement of established program outcomes.
- Risk assessment—perform comprehensive reviews and analyses of program operations to determine if risks exist and the nature and extent of the risks identified.
- Control activities—address identified risk areas and help ensure that management's decisions and plans are carried out and program objectives are met.
- Information and communications—use and share relevant, reliable, and timely financial and nonfinancial information in managing improper payment-related activities.

[2]U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning From Public and Private Sector Organizations*, GAO-02-69G (Washington, D.C.: October 2001).

- Monitoring—track improvement initiatives, over time, and identify additional actions needed to further improve program efficiency and effectiveness.

The entities that participated in our study found that they could effectively and efficiently manage improper payments by focusing on the components of internal controls and (1) changing their organizations' control environments or cultures, (2) performing risk assessments, (3) implementing activities to reduce fraud and errors, (4) providing relevant, reliable, and timely information and communication of results to management, and (5) monitoring performance over time. It is important to note that the implementation of the improvement process that addresses these internal control components will likely not be easy or quick. It will require strong support, not just in words but in actions, from the President the Congress, top-level administration appointees, and agency managers. Once committed to a plan of action, they must remain steadfast supporters of the end goals and their support must be transparent to all.

Most recently, in a report issued last August,[3] we pointed out that existing guidance did not require or offer agencies a comprehensive approach to measuring improper payments, developing and implementing corrective actions, or reporting on the results of the actions taken. As a result of our findings, we recommended, among other things, that the head of each CFO Act agency assign responsibility to a senior agency official for taking actions to minimize improper payments and that the Director of OMB work with agency officials to provide all reasonable assistance in implementing the corrective action plans developed to reduce improper payments. We also presented matters for congressional consideration to assist agencies in addressing barriers to actions to better manage efforts to reduce improper payments and to help them with improvement efforts.

As this subcommittee requested in May, we will issue a report later this year on the status of actions the CFO Act agencies and OMB have taken in designing and implementing programs to address our previous recommendations. As a result of preliminary information received from those agencies, we have found that they have begun to assign responsibility to lead and coordinate actions to reduce improper payments. Some

[3]U.S. General Accounting Office, *Financial Management: Coordinated Approach Needed to Address the Government's Improper Payments Problems*, GAO-02-749 (Washington, D.C.: Aug. 9, 2002).

agencies have (1) developed detailed action plans to determine the nature and extent of improper payments, (2) set target goals for improper payment rates, and (3) reported progress in their annual accountability reports. For other agencies, methodologies for identifying risks, determining the nature and extent of improper payments, and developing corrective actions are in the early stages of implementation. As a part of our efforts, we will also discuss CFO Act agency progress in implementing the Improper Payments Act.

In closing, as the Congress and the American public have increased demands for accountability from corporations and their leaders, the federal government must demonstrate the same standards of accountability and responsibility expected from the private sector within its programs and activities. Areas vulnerable to fraud, waste, abuse, and mismanagement must be evaluated to ensure that scarce resources reach their intended beneficiaries and are not diverted for inappropriate, illegal, inefficient, or ineffective purposes.

We are seeing important leadership and action—both from the Congress and from the administration—to address the improper payment problem, but, as I mentioned earlier, the reduction or elimination of the government's improper payments problems will not be quick or easy. I want to emphasize our commitment to continuing our work with the Congress, the administration, and federal agencies to ensure that improper payments are fully addressed governmentwide, and that actions are taken to reduce or eliminate the government's vulnerabilities to the significant problem of improper payments.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

Contact and Acknowledgments

For information about this statement, please contact McCoy Williams, Director, Financial Management and Assurance, at (202) 512-6906 or at williamsm1@gao.gov. Individuals who made key contributions to this testimony include Tom Broderick, Bonnie McEwan, and Donell Ries. Numerous other individuals made contributions to the GAO reports cited in this testimony.

Related GAO Products

Financial Management: Challenges Remain in Addressing the Government's Improper Payments. GAO-03-750T. Washington, D.C.: May 13, 2003.

Financial Management: Coordinated Approach Needed to Address the Government's Improper Payments Problems. GAO-02-749. Washington, D.C.: August 9, 2002.

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Mr. WEEMS. Good morning, Mr. Chairman; good morning, Madam Vice Chairwoman and members of the committee.

I am honored to have been asked to provide testimony today as a followup to testimony before this committee on May 13. Today, I will be addressing HHS' efforts to reduce erroneous payments, fraud and abuse in the Department's programs, especially those related to Medicare and Medicaid. As you are aware, the partnering of the Federal Government and State governments is critical to achieving success in reducing erroneous payments in State-based programs. This is a wonderful forum to bring together some of our partners from the States. I look forward to hearing their testimony and learning from them.

One of HHS's foremost strategic goals is achieving excellence in management practices. Under Secretary Thompson's leadership, we have undertaken a robust program of identifying improper payments across many programs, taken appropriate management actions to reduce the incidents of improper payments and are exploring and developing innovative ways to increase compliance.

HHS consists of 12 operating divisions that manage more than 300 programs, all with diverse missions. In fiscal year 2002, HHS was held accountable for $493.4 billion in outlays. Seven of the Department's programs—Medicare, Medicaid, SCHIP, TANF, Child Care, Foster Care and Head Start—account for nearly 90 percent of those outlays. While the Department expects to be reporting erroneous payment rates for these seven programs, our initiatives related to Medicare and Medicaid are significant because these two programs together account for about 80 percent of our outlays.

Medicare is the largest program. For the Medicare program, we have been a leader in monitoring and mitigating improper payments. HHS, through our Office of Inspector General, began measuring errors in the Medicare program in 1996 and has made progressive strides in reducing errors. The fiscal year 2002 error rate of 6.3 percent is less than half of the 13.8 percent error rate estimated in 1996.

As you are aware, it is not sufficient to only identify improper payments. Action is needed to correct errors identified and to prevent their recurrence. When we first began measuring the Medicare fee-for-service error rate, we determined that in nearly all cases, the claim, as it was presented to the Federal Government, was processed correctly. That is important. The claim as presented to us, was processed correctly and accurately. Only through a comprehensive review of the sample of claims were we able to detect errors in the submitted claim. Because the claim was in error, payment based on the claim was also made in error. Our intention is to avoid improper by making sure that providers and suppliers are aware of Medicare's rules before they submit their claims.

We believe educating our partners contributed significantly to reducing the Medicare fee-for-service error rate by more than half over the last 6 years. To bring that error rate down further, we have determined that a substantially more detailed method is required. This year, the Department is employing the Comprehensive Error Rate Testing [CERT] program to calculate improper Medicare payments. This will provide a national error rate, which we have had in the past as well as an error rate by contractor, by pro-

vider type and by benefit. Such detailed information will allow the Department to more precisely measure the error rate, target the intervention at the provider or contractor level and better manage contractor performance.

Based on Medicare's success in measuring errors, the Department is well into the process of creating a payment accuracy measure in the Medicaid program. Medicaid accounts for about 30 percent of the Department's outlays. Federal outlays in the program are about $162 billion and the States' share is about $122 billion, so a total of about $284 billion is at risk.

Unlike Medicare, Medicaid is administered primarily through the States. Each of the States and territorial jurisdictions runs its own program. To account for program variation, we are taking an incremental approach to the Medicaid error rate. Nine States entered the program in the first year 12 States are participating this year, and 25 States are expected to participate in 2005. It is expected that we will implement this program nationwide in 2005.

In addition to development of the Program Accuracy Model [PAM], Medicaid program integrity efforts include use of the Medicaid fraud control units. Currently 47 States and the District of Columbia have Medicaid fraud control units. These fraud control units conduct investigations and prosecute providers charged with defrauding the Medicaid program or persons charged with patient neglect and abuse. Since the inception of the Medicaid fraud control program, the fraud control units have convicted thousands of Medicaid providers and recovered hundreds of millions of program dollars.

The Health Insurance Portability and Accountability Act of 1996 [HIPAA], established the health care fraud and abuse program, which funds the Medicare integrity program and activities of the FBI and provides an additional pool of funds shared between the Department of Justice and HHS.

In 2002, the Medicare Integrity Program returned $15 for every dollar spent in recoveries, claims denials and accounts receivable, a total of over $10 billion. Through the use of these funds, we have returned $1.4 billion to the Medicare Trust Fund in 2002 alone.

Funding through HIPAA has provided the Department and our Office of Inspector General with a stable, predictable funding source to detect and prevent errors and to combat Medicare and Medicaid waste, fraud and abuse. The funds for the Medicare integrity activities have also been used to support our activities on error rate methodologies in Medicare, Medicaid and SCHIP. Some of those funds also support the Administration on Aging initiatives, including the senior patrol projects, which you will hear about today in Tennessee.

The success of our improper payment efforts can be traced to five fundamental elements.

First and foremost, our leadership is committed to the initiative. Publicly identifying and correcting errors is not without political risk, but the public benefits are enormous.

Second, creating partnerships with all the parties with an interest in the program.

Third, the Department has a very strong Inspector General and a good relationship with the Inspector General.

Fourth, we actively work with all parties to educate them on proper payment and program procedures, especially our clients and intermediaries.

Fifth, where there has been a history of noncompliance with statutory and regulatory authority, we have sought civil and other legal remedies.

Between the effort to educate and legal remedies, there is a wide spectrum of corrective action that the Department has used to reduce improper payments.

Finally, in the case of fraud as opposed to error, parties are prosecuted.

I hope the information I have provided has been valuable today and at this time I would be happy to answer any questions that you might have. Thank you.

[The prepared statement of Mr. Weems follows:]

TESTIMONY OF

KERRY WEEMS

ACTING ASSISTANT SECRETARY FOR

BUDGET, TECHNOLOGY AND FINANCE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE COMMITTEE ON GOVERNMENT REFORM

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY

AND FINANCIAL MANAGEMENT

JULY 14, 2003

WRITTEN STATEMENT

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

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

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

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

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

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

MEDICARE

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID

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

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

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

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

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

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

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

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

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

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

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

FRAUD

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

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

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

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

OTHER STATE-BASED PROGRAMS

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

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

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

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

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

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

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

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

HEAD START

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

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

CONCLUSION

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

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

Mr. PLATTS. Thank you, Mr. Weems and my thanks again to both of you for your preparation here today as well as in the past and your daily efforts at the Department and at GAO and serving our citizens in a great fashion.

We are going to begin questioning with Ms. Blackburn. I yield to the gentlelady for the purpose of questioning.

Ms. BLACKBURN. Thank you, Mr. Chairman, and thank you both so much for being here with us.

I think that one of the things that we want to put our focus on as we talk with you today and then as the second panel comes forward is being sure that we preserve access to health care, as well as reducing the overall cost to the taxpayers. And one way to do that is to be sure that we are tracking and retrieving these improper payments.

Mr. Williams, a culture of accountability and strong internal controls are clearly ingredients of success in reducing the improper payments, and I appreciate very much the work that GAO has done in addressing that, and in your remarks also.

As part of the process of regularly reviewing and improving internal controls, do you think it would be valuable for Federal agencies to have audit plans on their internal controls?

Mr. WILLIAMS. Yes, I do. We at GAO have strongly supported an opinion on internal controls. We believe that this review would help identify weaknesses that might exist in the various programs that the auditors would be looking at. Our position has been that we strongly support it. Not only do we strongly support it, but in the audit that we received of GAO's financial statements, we received an opinion on the internal controls from our auditors.

Ms. BLACKBURN. Out of the Federal agencies, how many are going through a process of auditing their internal controls?

Mr. WILLIAMS. Well, they all have some form of an audit of their internal controls. It is just that there are relatively few that receive an opinion. Auditors typically look at those controls that they think are material to the financial statements or to the financial information that is being reported. By looking at those that they think are material, the type of report that they issue is less than the one that you would receive if you obtained an opinion. It is basically what we call negative assurance which means that the auditor is not guaranteeing that all of the controls are operating effectively, just those that they looked at.

I would say, to the best of my ability, I can think of maybe three or four agencies that receive opinions on internal controls. I am not aware of any of the major CFO agencies that are currently receiving an opinion on their internal controls.

Ms. BLACKBURN. OK. Now the OMB guidance and the new OMB guidance on improper payments, does that guidance on improper payments address how the agencies should communicate with the States that administer Federal programs like Medicaid?

Mr. WILLIAMS. It lays out some initial guidance as to how they should communicate. One of the things that we at GAO believe will need to take place first of all is that OMB must provide leadership in addressing this particular issue. As I stated in my testimony, we believe that the guidance that is currently out there is a good first step and, as part of that process, agencies as well as OMB, in its

leadership capacity, must work with the States to try to make sure that there are control procedures put in place to help reduce the improper payment rates and dollar amounts that are currently being reported.

One of the things about a lot of the programs that we have identified as having large amounts of improper payments is that a lot of the programs are administered by the States. The Federal Government must work very closely with those States to make sure that they have procedures in place, as we like to say at GAO, to first of all try to prevent improper payments from occurring. The second process would be to have procedures in place that could readily detect them if they have been made and have efforts underway to make sure those funds are collected.

Ms. BLACKBURN. With the OMB guidance, in your answer to me you just stated that "should try" or "should suggest," do you think that it would be too strong to require the States that are administering Federal programs to have an internal audit or an audit opinion on the internal controls, over the programs that they are administering?

Mr. WILLIAMS. No, I do not think that would be too strong. As I said earlier, we have always supported the opinion on internal controls and our belief is that would only improve the internal control environment from the standpoint of identifying those weaknesses. If that step is taken, I can only see improvement in the control environments at the Federal level, State level or any level that an organization is required to receive an opinion on its internal controls.

Ms. BLACKBURN. Annually?

Mr. WILLIAMS. Yes, that is correct.

Ms. BLACKBURN. Thank you, sir.

Mr. Weems, thank you for being here.

Mr. WEEMS. Thank you for asking us.

Ms. BLACKBURN. What kind of guidance do you provide the States on how to develop uniform methodologies to estimate their improper payments?

Mr. WEEMS. Right now in the Medicaid project that we have going on with the 9 States and the 12 States, we have just gotten back some data that shows some of the approaches that the States have taken. A particular State, for instance, took a beneficiary-based approach and tracked the beneficiaries through the various claims, to check for proper payments there.

Another State took a provider-based approach instead and checked through those providers. We are still examining those various approaches to see which might be best in the fee-for-service environment. And then there are several States that have come in and shown us methodologies for the managed care environment and we are looking at those.

As I said in the testimony, we are going to start with a few States and by 2005, we will be doing it with all States. I expect that by the time we get to 2005, we will have a firm methodology that will be appropriate for the Medicaid fee-for-service environment and for the Medicaid managed care environment I expect that we will also put those methods in place through rulemaking, so

there will be a requirement of the Medicaid program to follow the payment accuracy measures that we find appropriate.

We are taking a staged approach with our State partners, but as we refine and receive information from them, we expect to go to rulemaking for payment measures.

Ms. BLACKBURN. Let me ask you this, in your testimony, you mentioned that the error rate had gone from, I think it was 13.8 to 6.3.

Mr. WEEMS. Yes, ma'am.

Ms. BLACKBURN. What would be a—and of course, that seems so high. What do you think would be a more expected error rate? What is your goal for moving it down to and what is your time line for getting the error rate down? We know zero is where it ought to be, but what is your time line on that?

Mr. WEEMS. Our goal for 2002 was to be at 5 percent. We did not get there.

Ms. BLACKBURN. OK.

Mr. WEEMS. In 2008, our goal is 4 percent in the fee-for-service part of Medicare. We have laid out these goals and to achieve them, we are going to have to go to the more robust sampling environment that I described. Whereas before we were drawing between 4,000 and 7,000 cases to look at, now we are going to draw 120,000 cases. This will give us the ability to look at a particular Medicare contractor and say is there a problem with this contractor? Why does this contractor have a 2-percent error rate for the same set of services and this one has 8? The management tools that gives us are enormous.

It will also give us the ability to compare by type of provider. We will be able to look by type of provider and say what is it with this particular provider, this type of provider where our error rate is so high? Do we need some kind of intervention like better education, or additional financial controls? It gives us a depth and breadth of a look at the Medicare program that we have not had before.

Ms. BLACKBURN. In the work that you have done so far in looking at the beneficiary, the provider or the MCO, where do you find that the error most often does originate? Is it originating—where do you find the initial mistake?

Mr. WEEMS. Well, first of all, for managed care organizations in the Medicare program, we think that our financial controls are pretty good. We do not see a lot of errors there because since that is a capitated payment, we basically make sure that the enrollment is accurate.

A lot of our errors in the initial part of the program came from what we would call documentation errors. In the Medicare program, you submit a claim to the government, we do some prepayment review to make sure that there is not something really odd in it, such as somebody having their appendix removed twice in the prepayment part. And then we pay it. It is not like other government services where you order something and you get something in inventory and you can go check it. We pay the bill.

When we began testing, one of the biggest sources of error was documentation error. We would go to the provider and say OK, we have this claim, can we see the file to see if you actually did this. And there would be errors or missing documentation. The service

may have been provided correctly and it may have been paid correctly, but without documentation, it is classified as an error.

In 1996 provider documentation errors were about 47 percent of the total error rate. Now they are down to about 28 percent. So by working with them we have been able to move the medical establishment to provide better documentation. We find that to be quite exciting.

Right now, in 2002, having reduced those documentation errors, we are left with medically unnecessary services. In 2002, medically unnecessary services accounted for about 57 percent of the error rate. That is a place where we are going to have to do more to make sure that the services offered to Medicare beneficiaries are appropriate and that we pay for them appropriately. We expect to have even more information about that, maybe by the particular type of service, where we can target our efforts further.

Ms. BLACKBURN. You had mentioned education programs I guess with the providers.

Mr. WEEMS. Yes, ma'am.

Ms. BLACKBURN. If you would speak very briefly just to the type of education and outreach that you are doing to try to reduce the risk.

Mr. WEEMS. That outreach largely occurs through our Medicare contractors. The contractor itself will work with the providers in the area who are submitting claims, to tell them, sometimes through calls, sometimes through letters, exactly the kind of documentation that is required, to keep them informed of changes. In some cases it is not just working with the providers themselves, but it is also working with billing services to make sure the bill is coded correctly and that there is sufficient documentation behind it.

Ms. BLACKBURN. Thank you, sir.

Mr. WEEMS. Thank you, ma'am.

Ms. BLACKBURN. I yield to the Chair.

Mr. PLATTS. Thank you. Mr. Weems, continuing maybe where Ms. Blackburn left off on the error rates, you mentioned you are at 6.3 now, you were hoping to get to 5 percent and then 4 percent. Have you done an estimate—I mean, as Ms. Blackburn said, in the perfect world, it is zero, but that is not reality in the sense of, you know, unintended consequences, unintended acts will have some improper payments, but is there a number that you are shooting to ultimately as you progress, that you expect?

Mr. WEEMS. Well, I do not think that we have yet estimated what the irreducible minimum would be; 4 percent is a good goal. I think once we get back information from the sample of 120,000 claims we will be able to say can we go to 3 percent, can we go to 2 percent? What type of gaol is possible?

Right now our goal is 4 percent by 2008, but once we have a little more information, we will see what that irreducible minimum is.

Mr. PLATTS. My understanding—and I do not have all the details, but in the private sector, to use an example, Wal-Mart Co., what was found in their errors of payments to other businesses that they deal with, have it down to a 0.1 percent error rate, which

is about as close as you can get. That would mean a lot of dollars in savings if we ever got to that.

Mr. WEEMS. Yes, sir, that is certainly desirable. I just want to make sure that in doing that, we compare apples to apples. Even though we may have, as I said on the documentation errors, paid a claim correctly and the service was rendered, if the doctor or provider does not have the documentation, then we count that as an error. But certainly moving down to even below 1 percent is a challenge that we should give ourselves.

Mr. PLATTS. I imagine with the providers, as they know that you are looking at coming up with 120,000 instead of 4000, the more they know everything is going to be scrutinized, the more incentive for them to have all their documentation lined up and not able to be questioned.

Mr. WEEMS. Actually, Mr. Chairman, this is a source of some worry for us. Under the previous samples that we were drawing, the Inspector General was arriving at the provider's door and asking for that documentation. The incentives to respond to the Inspector General are high.

For our larger sample, CMS is managing that through a contractor. Whether or not a provider will say, I will go ahead and photocopy this file, take my office time, and send it to you, for a $25 office visit, we are not sure. It is possible that we will see an increase in documentation errors simply because we do not have the force majeure of the Inspector General standing at the provider's door. I think that once we get to November 15 and publish our error rate, we may have an increase in documentation errors for that reason. We are just going to have to look at that.

Mr. PLATTS. Those providers would be required to provide that documentation to the contractor the same as if the IG, but the threat of court action not being the same is your worry?

Mr. WEEMS. That is right.

Mr. PLATTS. And that is, I assume, part of your education efforts with those providers?

Mr. WEEMS. Yes, and we also expect after the first year to publish error rates by contractor. With that error rate, we expect to be able to point to a contractor and say you simply have to do a better job. You are going to have to go get this documentation.

Mr. PLATTS. That actually leads to my next question. With the error rate now being 6.3, the most recent number being 6.3, what would be your knowledge about the highest rate of any one contractor right now, that averaged out for that 6.3?

Mr. WEEMS. The 6.3, which came from 2002, was not statistically significant for any contractor. In fact, it did not give us the ability to impute an error rate by contractor.

Mr. PLATTS. OK, still in that small number of 4,000 or so?

Mr. WEEMS. That is right, so by the time we get to November 15 of this year, we will have the statistically significant data by contractor, by provider type.

Mr. PLATTS. Is there—as you get to that by contractor rate, is there a plan to have either incentives for low rates or specific repercussions if you are not meeting certain rates? Is that envisioned in the contracts for the future?

Mr. WEEMS. Mr. Chairman, we certainly will work with our contractors to reduce those rates, but we are not in what they call a FAR environment, the Federal Acquisition Regulations environment, for our Medicare contractors. They are covered separately under the statute and our requirements for them are quite different.

The administration has proposed contractor reform year after year which would give us the ability to use something other than cost contracts with our contractors. For instance, for the Part A contractors, to use something besides provider nomination, for us to be able to contract and compete on the open market for people who can provide contracts for us. So our ability to persuade our contractors to provide the kind of service that we need is not the same as if we were in a competitive Federal Acquisition Regulation environment.

Mr. PLATTS. And what would be your assessment of the opposition to giving you that change, that added flexibility?

Mr. WEEMS. It is difficult to say exactly why somebody might not want that. Many of the contractors we have are people that the providers know and trust and have worked with over many years and as with any change, people resist change.

Mr. PLATTS. The rate you have, the 6.3, is just for Medicare now and with your payment accuracy measure that you are now working through in the 9 States and 25 States coming up, I assume it is fair to guesstimate at this point that the error rate is at least equal to 6.3 percent in the Medicaid, or is it not fair to even make that assumption?

Mr. WEEMS. Mr. Chairman, it is difficult for me to say without really seeing the data. The last time that we ran a national error rate for Medicaid was with the old MEQC program, the Medicaid Eligibility Quality Control program. I believe the last time that we did it, it was in the 2-percent range, but I believe that was 1992.

A lot of changes have occurred in the Medicaid program since then, especially with the growth and advent of managed care, which creates different kinds of incentives for errors and for fraud.

So I would hate to speculate.

Mr. PLATTS. With it being 11 years since you have done a national, is there thought to doing a new one today to get a benchmark as you are working with the individual States or is it to focus on the individual States' efforts solely?

Mr. WEEMS. That is the purpose of our payment accuracy measure. At the end of 2005, we intend to have a national Medicaid error rate and one for each one of the States.

Mr. PLATTS. Under the payment process, is your goal at the end to have just worked with each State individually or to establish a uniform system for identifying improper payments in Medicaid?

Mr. WEEMS. I would say as uniform as possible, Mr. Chairman. Some States are in a fee-for-service environment, some are in managed care. So something that accounts for that variability. But as I said, we are considering doing this through regulation and that will not leave a lot of room for variation.

Mr. PLATTS. I take it that what you are looking at with States now is kind of just trying to get a handle on what is the best practice out there?

Mr. WEEMS. That is exactly right, sir.

Mr. PLATTS. In whatever State and then how that would perhaps apply to all 50?

Mr. WEEMS. That is exactly right. The States have a lot of good people working for them. The States have an almost equal financial interest in controlling improper payments. They are the ones that are going to have to administer this, so we wanted to start with a few, rely on their thinking, hone in on the ones that are best, most appropriate, and then go with those.

Mr. PLATTS. Following up on Ms. Blackburn's question about what guidance you are giving States with Medicare, how about with other programs, I guess it is seven in total that make up 90 percent of your disbursements through HHS. In response to the OMB guidance to you, are you now in the process of developing guidance that you are going to share with each of the States for the programs within HHS?

Mr. WEEMS. Yes, as PAM, the program accuracy measure, moves out, we will begin working with the States more to let them know the direction that we are headed. That will also apply to the SCHIP program, which will be covered.

Two of our programs require legislation for us to measure TANF, Temporary Assistance to Needy Families, and the Foster Care program.

The Head Start program as it is currently implemented is a direct grantee program, so we will work with those grantees. However if the President's proposal on Head Start passes, there will be significant State involvement and we will have to work with those States. So we are anxious to see the outcome of that as we move to improper payment measurements in Head Start.

In Child Care right now, we are relying on the single State audits. We have notified the States that this is at least our initial take with them on how we will do that.

Mr. PLATTS. With the Foster Care and TANF, I'm not aware of specific legislation——

Mr. WEEMS. The conference has not received it, sir. We are still working within the administration to finish up that legislation and send it to you.

Mr. PLATTS. That is something that this subcommittee certainly would be glad to work with to help promote and to really ensure that we have that authority to go out and do what we all want, which is to, whatever the program is, make sure we are being wise and responsible in the expenditure of those dollars.

Mr. PLATTS. Mr. Williams, I do not want you to think we forgot about you over here.

We have the guidance that is now out from OMB and we have the Improper Payments Act and through various departments, in this case HHS, going out to States, what do you see from the GAO perspective is going to be the greatest hurdle in actually achieving results for the individual departments or agencies in getting as definitive an assessment of improper payments and then how to control them as possible.

Mr. WILLIAMS. One of the key areas that we would look at would be to make sure that the agencies have the resources that they need to properly go about carrying out the regulations and the act.

I think that, in the OMB regulations, there was a provision that once agencies go through this process, they are to report back if they have various problems in carrying out the act, and one of the categories I think that is addressed in that is to identify if you have a resource need to implement the requirements of the act and the regulations that OMB has put out. So I think that is something in one area where I would anticipate that you would be getting some responses back—that we need the resources to carry out this process.

Mr. PLATTS. Just manpower, people in place to actually implement whatever the program is.

Mr. WILLIAMS. That is correct.

Mr. PLATTS. In the specific guidance that has been issued by OMB and where disclosure by the department or agency has to be made, the guidance talks about being I guess a mandatory reporting if the amount of overpayment or wrongful payment, improper payment exceeds $10 million and 2.5 percent of the threshold of the program's disbursements. The act only talks about the $10 million threshold. And the example is I guess the Old Age and Survivors Insurance and Disability Insurance programs have error rates of less than a percent, but in total amount, over $800 million.

What is GAO's position on the guidance, the language in the guidance that has been issued to HHS and everybody else, having that second qualifier in there, the 2.5 percent?

Mr. WILLIAMS. That is an area that in our response to OMB when it issued the draft, was that by having the "and" in there, that you could run into a scenario in which you would have a huge program of several billion dollars and you could have improper payments that exceeded $10 million but fell under that 2.5 percent criteria. So what I would suggest, given the current guidance, is that each agency should use what I would call good business management practices and while it might not fall within that 2.5 percent criteria, that you still should follow the intent of the legislation. In addition to that, I think that we at GAO and the Congress also probably need to work with OMB to take a look at this particular component, because there could be a huge gap there in a particular program.

I do not want to speak for OMB, but one of the things that comes to mind is that when the regulations were put together, there is the possibility that they were looking at a scenario in which you had a program that might have only had total obligations or outlays of $10 million or less and, when you start taking the 2.5 percent, you are hitting some programs that would be relatively small. I guess you do not want to get into that concept of I am going to spend a dollar just to collect 50 cents by hitting some of these smaller programs.

But you still want to make sure that every program is given an opportunity to go through this assessment and, if there is $1 that has been improperly spent, the goal should be to try to collect that money. But I think this is an area that we need to take a look at because there is the potential for a program to fall under that 2.5 percent but still be a huge dollar amount of improper payments.

Mr. PLATTS. "And" versus "or" is a huge difference.

Mr. WILLIAMS. That is correct.

Mr. PLATTS. And I do read the guidance as being contrary to the intent of the act, which was $10 million. If they wanted to broaden it by having "or" so that if it is a smaller program and"

Mr. WILLIAMS. Right.

Mr. PLATTS. —"Or" catches smaller programs, but excessive percentage, that would be within the intent of the act.

Mr. WILLIAMS. That is correct.

Mr. PLATTS. But to have an "and" is tightening it up not as anticipated or planned by Congress and is something we do need to look at. You know, if you look at DOD department-wide taking up a $400-plus billion budget, 1 percent would be, you know, $4 billion in total.

Mr. WILLIAMS. That is correct.

Mr. PLATTS. Which is well above $10 million, but only in percentage points below the 2.5. So it is something that I think we as a committee in working with GAO and OMB need to have them give some additional thought to that "and" versus "or" in that guidance.

Mr. WILLIAMS. I agree.

Mr. PLATTS. Ms. Blackburn, did you have further questions?

Ms. BLACKBURN. Yes, I think I would like to come back to Mr. Williams right there on this question talking about the OMB directive.

In looking at the best practices, in that memo of October 2001, to your knowledge, how many States or are any States implementing these best practices in administering their Medicaid programs?

Mr. WILLIAMS. I am not aware of the number as far as how many States are actually implementing the best practices, but our goal is to make sure that the information is provided as broad as possible because we believe that these techniques are going to be some of the things that every State will need to use in order to address this improper payments issue. I would like to say, not just from the States' standpoint, but, from other Federal agencies, I think HHS has taken a leadership role in addressing the improper payments issue. Just listening to the statement this morning, there are a lot of examples of best practices. I think other Federal agencies as well as State organizations should be provided with and implement as many of these best practices as possible, because, where entities have implemented these best practices, we have seen declines in the improper payment rates. Best practices should be as broadly disseminated as possible.

Ms. BLACKBURN. In one of your previous reports, in a previous GAO report and presentation, as we were talking about best practices and time lines and goals, it was mentioned that some of the agencies change their goals and objectives and that it makes it very difficult to track their progress.

Let me ask you this, is this a tactic that some of the agencies use to avoid reporting the true amount of improper payments that they have?

Mr. WILLIAMS. I think it was a process in which agencies were trying to figure out how best to report the information that was required under the Performance Act. I do not think it was an effort to mislead anyone on what the actual rate or amount of improper payments were at organizations. It was just an attempt to better report performance information. So I think that was more the focus

and as a result of improving the efforts to address the Performance Act, it caused some of these changes.

So I do not think it was an intent by the agencies.

Ms. BLACKBURN. To your knowledge is the TennCare program following the best practices in the October 2001 memo?

Mr. WILLIAMS. I am not aware of all of the components of it, but I would strongly encourage them to follow as many as they possibly can. That would be GAO's position, you know, that they should follow as many as possible in any area that is available to them.

Ms. BLACKBURN. Thank you, Mr. Williams.

Mr. Weems, as you know, I love to ask questions that point to technology and that is kind of your area. As we are talking about trying to get the error rates down and minimize the improper payments, is HHS looking at some type integrated technology that would allow immediate reporting or would allow to interface information from the States or from some of the contractors directly back into HHS? And if the answer to that is yes, then what is the time line for implementation? And the third part of this question is are you looking at a way to carry that back down to the beneficiaries in the States with any kind of electronic transmission or smart card or magnastrip of information and benefits?

Mr. WEEMS. Well, thank you for asking the question. It is rare that we get a question like that and it gives me the opportunity to talk about something that Secretary Thompson insisted on the moment he arrived in the Department. And that is, right now we have inside of HHS five different accounting systems. Getting a clean opinion every year means that we have to go through and produce a statement based on those five systems this requires a lot of manual work and a lot of compromises along the way.

We are building a unified financial management system inside of HHS. A key component of that is a piece called the Healthcare Integrated General Leger Accounting System [HIGLAS] which will be the health care component inside of CMS. That component will not only account for funds, but it will be the payment mechanism that the contractors will use. Therefore, each one of the contractors will be on the same accounting system, bringing information back to CMS central, back to a unified accounting and reporting system that is directly linked to the payments.

Ms. BLACKBURN. And that is shared with the States, they would be integrated?

Mr. WEEMS. This is on the Medicare side right now.

You asked about a time line. We will be piloting this with two of our big contractors this fall, so we are on a very aggressive schedule on this side. On the non-health side right now, the National Institutes of Health [NIH] are in the process of doing acceptance on their component of the system. The NIH System will be the system of record, starting October 1 for the next fiscal year. For the balance of the Department, we will be completing some pilot testing and begin implementation of the system in 2004.

We will have, for the Department, a completely integrated system that will comply with the financial reporting rules by 2007. 2007 seems perhaps a long ways away, but building a system like this is difficult, it is complex and unfortunately it is high risk. Something that we do not want, is a spectacular failure. Some

agencies have had some failures in building an accounting system. We do not want to be part of that. So we expect to be compliant in 2007 with our system.

With respect to the beneficiaries, it is not expected to reach that far. It will stop at the State and at the contractor level, but we will still be able to see and have better information about our beneficiaries in that system.

Ms. BLACKBURN. Thank you, Mr. Weems. Thank you, Mr. Chairman.

Mr. PLATTS. Mr. Weems, if I could followup on the testimony you just gave there. You said compliant by 2007?

Mr. WEEMS. Yes.

Mr. PLATTS. And that is within HHS, for all of your systems.

Mr. WEEMS. Yes.

Mr. PLATTS. But at this point, as to the Medicaid program, there is not thought at this point as far as having States be required to use the same accounting program that you are using for Medicaid, given that two thirds of the dollars are roughly coming from the Federal Government?

Mr. WEEMS. It will be linked to the States, but not to the State payments themselves. We provide grants to the States, the States actually draw the dollars on a daily basis, based on need, under the Cash Management Improvement Act.

Our ability to see beyond that in the accounting system is limited and States probably would ask that we draw the line there anyway. We will have to work with them through a measurement program to assess the overall accuracy of the program.

I think it would be difficult to extend a Federal system down into, for instance, State managed MCOs.

Mr. PLATTS. And the PAM system would relate more to the accuracy of whatever system they have in place.

Mr. WEEMS. Yes, correct, sir.

Mr. PLATTS. And I appreciate your caution about other agencies, that have not been as successful, as we discussed at dinner again last night, and our disbelief at some of the testimony—not the testimony, but the facts regarding DOD and the literally billions of dollars that have been spent on trying to come up with a consistent and uniform accounting system and them still being, as GAO has testified, probably 8, 10 years away, if all goes well.

We do not want to have that repeated and the fact that you are trying to be deliberate and thoughtful so that if it takes an extra year or two but you get it right, that is something that as a committee we certainly embrace and support that approach.

Mr. WEEMS. Thank you.

Mr. PLATTS. We do not want to be starting over 2 or 3 years down the road and saying well, let us try again.

I am going to jump back to Mr. Williams. With the focus in the release of the guidance from OMB in May and passage of the act last fall by Congress, the Improper Payments Act, there certainly is more scrutiny now, but it has really been an issue that has been part of the President's management agenda from the beginning of this administration. Is there any one agency that is kind of leading the charge, in GAO's opinion, in identifying improper payments?

And if you could point to it as a role model that is really out there and showing us how to do it?

Mr. WILLIAMS. Yes. As I stated earlier, I think HHS has taken the lead and is coming up with methods and procedures to identify their improper payments. I would say thats through the various councils and improper payment working groups OMB directs, some of the things that we have heard today, other agencies should be listening to and taking those concepts and thinking about how they can apply some of them to their particular operations. There are numerous types of programs in the Federal Government and you just can't take one example and move it to another agency in some situations, but you can take those concepts and those ideas that we have heard about, for example, this morning, and just think about it and say how can I apply that. How can I use that to get my agency to come up with a method in which I can try to identify my improper payments and come up with procedures and controls that I can put in place to help reduce my improper payment rate?

Mr. PLATTS. The working groups you are referencing are ones within HHS?

Mr. WILLIAMS. No. This is under the CFO council.

Mr. PLATTS. Oh, I see, the CFO working groups.

Mr. WILLIAMS. The CFO working groups, which would include OMB as well as the CFO agencies.

Mr. PLATTS. And that is some of the intent behind the Improper Payments Act and the identification of what the error rates are kind of goes to the same with providers, if it is public knowledge, there is scrutiny and pressure to improve those rates and that goes for our agencies and departments as well.

Mr. WILLIAMS. That is correct.

Mr. PLATTS. Secretary Thompson wants to not be sitting there with a higher rate than his colleagues around the Cabinet table.

Mr. WEEMS. Neither do I want that. [Laughter.]

Mr. PLATTS. I am sure.

Mr. WILLIAMS. Well, as I have stated in previous testimony, one of the things that you have to be careful with in just looking at an absolute grade, a 6-percent rate in one agency might be a tremendous story, whereas a 2-percent rate in another agency might not be all that great. So you have to take it on an individual basis and look at the inherent risks in various programs. You know, is this particular program more susceptible to an improper payment occurring. There are several factors that you would have to look at in addition to that absolute number or rate that agencies are reporting.

Mr. PLATTS. I think it is somewhat staggering where we are coming from, that 6.3, that it is half where we were 7 years ago, I think that was 1996, what you were comparing it to. And 13-plus percent in the size of the program of Medicaid, Medicare, is a huge sum and if it was that, from a dollar sense, you know, dramatic difference. I mean in HHS, you have most of the big disbursements and so error rates in your programs, from a taxpayer standpoint, have the greatest impact.

Mr. WEEMS. That is right.

Mr. PLATTS. What is the word, Mr. Williams, from GAO's perspective as we use technology, and Ms. Blackburn's question on

how technology is helping us and as you say, kind of drill into the detail more with technology and data mining.

Is there a concern from GAO as you use technology and the process of data mining, from the privacy standpoint, whether it be providers or beneficiaries, that we need to be very cautious about.

Mr. WILLIAMS. Well, one of the things that we think the agencies need to be aware of is that there are privacy issues. And agencies who face those barriers, such as privacy issues, should work with the Congress and work with OMB to see if there are alternatives or other things that could be done to work around these barriers. We definitely want the agencies to be cognizant and to take into consideration any laws and regulations that address privacy issues, but if there are things that can be done in order to work around them to help reduce the improper payment rate or dollar amount, then that is what we will be encouraging them to do.

Mr. PLATTS. Mr. Weems, could you touch on that as far as how you are looking to be cognizant of these privacy issues?

Mr. WEEMS. We are careful to protect the privacy issues, especially of our beneficiaries. And in the case of our providers, we certainly do not want to improperly accuse somebody. So we are going to be particularly careful with our providers as individuals. We are going to publish by provider type, not by individual provider, to start with. So we are going to be careful.

And also, as we move into other programs, we are going to require a high standard of care. For instance, in the Head Start program our challenge is going to be tracking a child's eligibility as their family's living and working circumstances change. For example, somebody got a job, somebody moved into unemployment or something like that—the eligibility of the child might change. We are certainly going to protect the privacy of the beneficiaries in that case as we work with our individual grantees to look at payment accuracy.

Mr. PLATTS. Question, Mr. Weems, it's related but it's a little bit maybe outside the realm of what we were envisioning today. With the amount of payments made by HHS to providers, whether it be Medicare or other programs, but especially Medicare, can you share with us—that goes to ensuring that payments that are being made to providers are not to providers who have debt to the Federal Government? Whether it be tax liabilities or other programs. We have tried to focus on that in a previous hearing as a committee in that if someone is owing taxpayers' money that we are not making a payment to them—that we are catching that payment to satisfy their debt. What are you able to share with us?

Mr. WEEMS. I cannot speak to other debts like a tax debt, but if providers owe us a debt, we just offset subsequent payments to them.

[The information referred to follows:]

CMS has financial controls and edits checks in place to recoup outstanding Medicare debt owed by providers. That debt is fully recovered before the provider is paid future payments. Also, debt that is 180 days old is referred to Treasury for further collection efforts. Treasury handles all other types of federal debt owed by a provider thru Treasury's Cross serving and Offset Program. Currently, CMS can only determine Medicare debt.

Mr. PLATTS. Is there an effort to try to work with Treasury—the testimony we had was about establishing a data base so that all agencies, governmentwide can tie into it, and if there is a tax liability here and you are providing a payment to this provider, but he is $100,000 or whatever institution or individual, that would catch that. Technology certainly should allow that to happen in a more straight-forward fashion.

Mr. WEEMS. None that I know of, but that certainly is something that the government has undertaken on loans and other things in the past. Even other responsibilities of being a citizen like signing up for selective service where that is a requirement for eligibility for certain benefits.

Mr. PLATTS. It is something that hopefully, as Treasury increases their efforts, it will get into, especially programs of the size of the payments we are talking about with HHS, that there is a close correlation.

Ms. Blackburn, did you have other questions?

Ms. BLACKBURN. I have a couple for Mr. Weems, if I can take just a moment of his time before we move to talking specifically about TennCare.

What monitoring has been done by CMS over the TennCare program?

Mr. WEEMS. CMS monitors the program largely through the regional office. That staff is in Atlanta. I am not prepared to speak specifically to any direct action that we have with respect to TennCare monitoring.

Ms. BLACKBURN. Has the Department of TennCare submitted annual reports on their waiver quality?

Mr. WEEMS. I do not know the answer to that. I will provide that for the record.

[The information referred to follows:]

Since the inception of the TennCare Demonstration Project, CMS has monitored it continuously, including quarterly and annual reports, submitted by TennCare, related to quality and all aspects of the program. The monitoring activities include onsite visits, discussions with beneficiary advocacy groups, participation on work groups to reform the program, and reviewing reports prepared by the state.

Ms. BLACKBURN. OK. Let me ask you this one, does the TennCare waiver meet the requirements of budget neutrality?

Mr. WEEMS. We believe it does. Otherwise, we would not have agreed to the waiver. The budget neutrality requirement is not a statutory requirement, it is an administrative requirement in granting waivers. We work with the States to look at a 5-year budget. The States are required within their waiver to stay within the budget that we have estimated for the State for that 5-year period.

Ms. BLACKBURN. Thank you.

Mr. PLATTS. Mr. Weems, I have a followup on that specific aspect. In assessing that compliance with that budget neutrality, my understanding it is 5 years so that at the end of 5 years, they have not received more than they otherwise would have received.

Mr. WEEMS. Correct.

Mr. PLATTS. Is there an annual assessment of that so that we do not get 5 years down the line and find out that we are way out of

balance? It is 5 years in total, but we can keep a pretty good track of it. Is that something again that is through the regional office?

Mr. WEEMS. We do look at it, but because of the changes in the program, changes in enrollment for example, we begin with an estimate and we look at it over a 5-year period. A year-to-year look, I am just not certain that we do that.

Mr. PLATTS. The reason I asked it, I will use an analogy with the program of Trade Adjustment Assistance where not HHS but the Department of Labor program in my home State, that in providing assistance in a great program that has benefited a lot of my citizens, the way Pennsylvania was administering it, they got basically way out in what they were spending or the type of programs and what was envisioned by Washington versus the State and that had a huge list of eligible recipients but they had already spent all their money because of the way they approached it. It seems like with it being 5 years, we need to have that annual review.

Mr. WEEMS. I agree.

Mr. PLATTS. And if there is some more information you could provide us after the hearing, that would be great, so that we are keeping a pretty good eye so that we do not get 5 years down the road and be way out of balance and then the pressure, you know, in whatever State it may be, would come to you and say we need some forgiveness here as opposed to fulfilling the actual agreement.

Mr. WEEMS. I will be happy to provide that.

Mr. PLATTS. OK. Well, if there are no other questions, again, Mr. Williams, Mr. Weems, we appreciate your testimony here today and very much your efforts day in and day out in trying to work with us as elected officials and serving our citizens well.

Safe travels back to Washington.

Mr. WILLIAMS. Thank you.

Mr. PLATTS. We will take about a 10-minute break and then we will let the second panel get situated and then we will begin.

[Recess.]

Mr. PLATTS. I would like to recognize Ms. Blackburn for some comments.

Ms. BLACKBURN. Thank you, Mr. Chairman.

As I was reviewing the items that we have just covered—as you know, 8 years ago, at the request of the House of Representatives and Energy and Commerce Committee, the GAO conducted an analysis of the TennCare program during its first year of operation in 1994 and that is a letter that I have that had gone to Congressman Dingell. And as part of this request, GAO examined TennCare's basic design and objectives, the degree to which the program was meeting those objectives and the experience of TennCare insurers and medical providers and their implications for TennCare's future.

GAO found that while the TennCare program had resulted in lowering costs per Medicaid beneficiary, that the medical providers were taking large losses under the new system and questioned their ability to provide quality service under the TennCare program.

GAO's report was issued 8 years ago and times have certainly changed. And in light of the current budget problems that many States are facing, the need to make the most effective and efficient

use of tax dollars and what we have heard from our witnesses today, I believe and I hope that you will agree that the time has come to ask GAO to take another look at the TennCare program and when we return to Washington this week, I would like to work with you in preparing a request that would go to GAO asking them to review the successes and the failures of the TennCare program.

Mr. PLATTS. Thank you, Ms. Blackburn, and as we are about to start talking about TennCare in specifics, I think the request is one that is appropriate. We heard from Mr. Weems about the Department of HHS in looking nationally at Medicaid from 1992, is the last national assessment of improper payments, and as they are working with Tennessee and other States through their PAM system to I guess have a Department assessment, it seems appropriate that we would come back and kind of update what GAO has done in the past, in this case specifically with TennCare. And I look forward to working with you that we can request GAO to bring up the speed that 1992 report or 1994 report to current status.

Ms. BLACKBURN. Thank you, I appreciate that.

Mr. PLATTS. And with that, we will move to our panel where we do get a chance to hear more specifics about the programs here in Tennessee and again, I appreciate all our witnesses for being with us and your preparation for your testimony here today and the testimony you have submitted in writing. I appreciate the substantive nature of that testimony and the insights you are sharing with both of us. Certainly Ms. Blackburn has more insights from her State Senate service and her current service than I do coming from Pennsylvania. But it reads like similar challenges and actually similar States with Pennsylvania having some large metropolitan areas, but a lot of very rural Appalachia area as well in my State. So I am glad to be here and appreciate your testimony.

I think what we are going to do is begin, Mr. Mathis, with you, Mr. Benson and then get to more kind of regional focus with Ms. Williams. So if you would like to begin.

STATEMENTS OF BARRY THOMAS MATHIS, DIRECTOR OF PROGRAM INTEGRITY, TENNCARE; WILLIAM A. BENSON, SPECIAL AGENT, TENNESSEE BUREAU OF INVESTIGATION, MEDICAID FRAUD CONTROL UNIT; AND HOLLY E. WILLIAMS, DIRECTOR, MEDICARE PATROL PROJECT, UPPER CUMBERLAND AREA AGENCY ON AGING

Mr. MATHIS. Good morning, Mr. Chairman and Madam Vice Chair. Thank you for the opportunity to be here today. My name is Tom Mathis, I am director of the TennCare Program Integrity Unit.

Part of the things I want to start out with is sort of laying out some background, give you the mission, who we are within Program Integrity, which is to help prevent, identify and investigate fraud/abuse and recover dollars within the TennCare system.

Also I think it is a good idea for us to start out by defining fraud as intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under the applicable Federal and State law.

Whereas, abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid/TennCare Program.

Types of recipient fraud and abuse that we see in Tennessee: Unreported income or insurance; access to insurance/has insurance; living out of State; drug diversion; unreported deaths; incarcerated felons; failure to probate estates relating to nursing home cost and recovery.

Types of provider fraud and abuse that we see: Billing for services never provided; duplicate billing; over and under utilization of health services; over prescribing narcotics; balance billing; short filling of prescriptions; billing for more expensive services, upcoding, unbundling.

The methods that we have set up in Tennessee for concerned citizens and individuals to report fraud is we have a hotline, of course we have a fax, we use a Web site that is interactive. They can report on line, they can print the form out and mail it to us—multiple ways of getting that information. We will take it however we can get it. The informant can remain anonymous if they so choose. They can e-mail it or send it to us through the U.S. mail.

One of the issues that I wanted to share with you is this bright orange flyer that I hold in my hand. Over 10,000 of these flyers have been distributed to health care professionals and concerned citizens over the past 3 years. Copies of this are available here this morning and we certainly can provide additional copies if they are needed.

This is part of our educational program and we ask the individuals that it is presented to that they post this in their offices or somewhere to have ready access to it.

Investigative tools that we use within Program Integrity: The Social Security On-Line Query; the Accent system which is the DHS MIS system; driver's license/wage files; Choicepoint, which is a national investigation data base; vital records; Federal Investigations Data base [FID]; the MED-OIG sanctions/exclusions; credit reporting bureaus; Department of Defense, Military, TRICARE; Medicare.

Some of the matches that we do in trying to identify individuals that may not be eligible to participate in the program: We use the Paris match—which is a Federal match program; employer matches for those employers who offer comprehensive medical insurance to their employees; contractors; Medicare; insurance carriers; Social Security Death Index; and Tomis which is the Department of Corrections in Tennessee's data base.

As I was listening this morning, I was pleased to hear discussions about internal control issues and one of the things that we have required in our MCC contracts, they are required to develop a fraud and abuse compliance plan.

I included that in the handout. I do not have the time this morning to go through it but as you can see it is quite detailed. It talks about all the requirements, the edits and responsibility of having

internal controls by the contractors and their responsibility to report those findings to us in Tennessee.

The other issue that is proactive is legislation updates that were needed to address managed care coming into Tennessee, the TennCare program. And Representative Blackburn, if I am not mistaken, I believe you helped move this legislation, or part of it, in 2000 when 71–5–118 was amended and it is now a felony offense to commit fraudulent offenses against TennCare. This legislation now allows us to go to the district attorneys for presenting cases for prosecution. I am going to talk about that a little bit more in a minute.

I also have included an extract from this piece of legislation that I wish I could take some credit for, but I was not—did not join this unit until June of that year and it went into effect in July 2000, but it was an excellent piece of legislation.

Program Integrity Stats, for the year ending June 30, 2003: Summary of enrollee cases, we had cases closed of 21,638; we recommended terminations of 6,487 recipients. We adjusted on other cases where they were eligible and could not be terminated, but we were able to adjust income on 171 cases causing the premiums to be increased and health insurance added on 388 cases, which allowed us to bill the private insurance first or the contractor to bill the private insurance first and TennCare would be the payor of last resort.

A summary relating to provider cases: We closed 176 cases, we currently have active 67. Cases that were validated and referred to the TBI Medicaid Fraud Control Unit was 14. Cases that were referred to Health Related Boards was three.

Success stories related to providers: (a) was revocation of a physician's license and $50,000 in civil penalties; (b) U.S. attorney's office indicted a physician on 516 counts of drug trafficking; physician has pled guilty and sentence is pending. This case also lead to two recipients and one pharmacist pleading guilty; (c) Probation of license for 1 year with supervision of practice and civil penalties and court costs on another provider; (d) Three cases are currently pending in Federal court; (e) Fourteen cases validated by Program Integrity and passed on to TBI Medicaid Fraud Control Unit. These cases are in various stages of investigation with several awaiting direction and action of the prosecutor; (f) Four cases are also being worked with other agencies such as the FBI, HHS-OIG and health related boards.

Success stories related to enrollees: Seven recipients have been prosecuted by the DA for drug diversion. Three of those were in a previous year. We are testing new legislation and moving it forward. This past year we were successful in having four prosecutions but it is moving forth again, we have four recipients that are currently under indictment.

We have 45 recipient cases validated and currently under investigation by the District Attorney's Drug Task Force Units for drug diversion.

We have one recipient/provider case that was indicted on 22 counts of fraud, impersonating a licensed insurance agent and selling letters of uninsurability.

Four recipients are currently under indictment for living out of State, never lived in the State of Tennessee but claimed to for TennCare purposes, and those are awaiting trial.

Success stories talking about recoveries. Estate recoveries relating to individuals in nursing homes who are deceased. We have collected $3,007,516. Overpayments to PA 68s which is again a nursing home overpayment claim, of $965,830. And something that we are just getting into is premium underpayments, and going back and doing collections of $30,301. That number I think will definitely increase in the years to come.

What I want to talk to you about last—and I was very pleased again to hear the interest of this Commission and especially of Madam Vice Chair, about technology. This is something that we have taken very, very seriously, and in the last 2 years have spent a lot of time on.

What I want to talk about is the fraud and abuse and the TPL sections of that. That is the area that my division has spent many hours, a lot of time on it and continuing through implementation. Very proactive, and I also believe this will address many internal control issues.

This is a most important tool in identifying and working fraud and abuse cases, second only to having personnel positions to work cases, is the MMIS system. Tennessee has been working for the past 2 years plus, as we first developed the RFP, bid out, evaluated response, awarded a contract to develop and implement a new state-of-the-art MMIS system which will include one of the best fraud and abuse identification packages in the country. Highlights of this new MMIS system are as follows: DSS profilers with utilization patterns, payment ranking profile and age and gender status profiling; ad hoc and predefined reporting; immediate access to data, and I cannot tell you how important that is, because currently we have to go back to programmers to run reports for us whereas our investigative staff will be able to immediately access the data; statistical analysis identifies providers who are four standard deviations from the norm; comparison reporting—specialty compare, professional group compare, pharmacy group compare, nursing home group compare, hospital compare; again, profiling and looking at individuals across the State or within various regions.

Targeted queries: Denied services; duplicated services; excessive daily billing; fee-for-service claims that may be submitted from a capitated provider; financial summaries; recipients with no encounters; services provided after date of death; upcoding; pharmacy claims without medical visits; transportation claims without medical visits; recipients with third party liability insurance coverage; recipients reported with out-of-state address.

The last area relates to TPL and subrogation, which the committee has not heard discussions on this morning, but I think is a very valuable tool because of recoveries of dollars that we can bring back in. This also is very, very important.

We are looking at carrier matches and validations with insurance carriers. Employer data matches; wage file matches; review of encounter claims to identify TPL; reports to monitor success of subrogation by contractors, going back to the contractors and asking

them to report back to us if they are not following up properly on subrogation; MCC electronic updates.

I could go on and on about that, but due to the timeframe this morning, I feel like I need to stop there, but this we think is extremely important and we are spending a lot of our staff time in the development stages. We are currently moving into testing and implementation is to occur before the end of this calendar year.

In closing, thank you for your time. I sincerely hope that this has been informative and I will be happy to answer any questions.

Mr. PLATTS. Thank you, Mr. Mathis. We will wait until we hear from all panelists and then come back to questions. Mr. Benson.

[The prepared statement of Mr. Mathis follows:]

House Committee on Government Reform
Subcommittee on Government Efficiency and Financial Management
Barlett, Tennessee
July 14, 2003

Mr. Chairman and Members of the Committee, thank you for the opportunity to share with you today about the TennCare Program Integrity Unit.

My name is Tom Mathis, director of the TennCare Program Integrity Unit,

Program Integrity Unit

WHY WE EXIST

To help prevent, identify and investigate fraud/abuse and recover dollars within the TennCare system.

FRAUD

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.

ABUSE

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes ***recipient practices*** that result in unnecessary cost to the Medicaid/TennCare Program.

TYPES OF FRAUD AND ABUSE

Recipients:

- Unreported income or insurance
- Access to insurance / has insurance
- TennCare recipients living out of state
- Drug seeking behavior (drug diversion)
- Unreported deaths
- Incarcerated felons – failure to report- continue use of services
- Failure to probate estate- nursing home cost recoveries
- Illegal transfer of property

TYPES OF FRAUD AND ABUSE

Provider:

Billing for services never provided
Duplicate billing
Over/under utilization of health services
Over prescribing narcotics
Balance billing
Short filling of prescriptions
Billing for more expensive services:
- upcoding
- unbundling

Methods of Reporting Fraud and Abuse

- HOTLINE 1-800-433-3982
- FAX 615-532-7509
- WEB www.state.tn.us/tenncare/fraudform.html
- Email TennCarefraud@state.tn.us
- MAIL

State of Tennessee
Office of TennCare
Audit, Investigations and Program Integrity
11th floor Andrew Johnson Tower
710 James Robertson Parkway

Nashville, Tennessee 37247-0110

OVER 10,000 OF THESE FLYERS HAVE BEEN DISTRIBUTED TO HEALTH CARE PROFESSIONALS AND CONCERNED CITIZENS OVER THE PAST 3 YEARS. COPIES OF THIS FLYER ARE AVAILABLE THIS MORNING AND WE WILL BE HAPPY TO PROVIDE ADDITIONAL COPIES AS REQUESTED.

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
OFFICE OF HEALTH SERVICES
PROGRAM INTEGRITY UNIT
TENNCARE
ENROLLEE / PROVIDER
FRAUD & ABUSE LINE
1-800-433-3982
615-253-4005 (Nashville)
FAX: 615-532-7519

If you suspect fraud or abuse in Tenncare, please call the Program Integrity Unit's toll-free number or the local Nashville number to report it.

You do not have to give your name and can remain anonymous.
Remember, we all share in the responsibility for the success of Tenncare.

Investigative Tools

SOLQ (Social Security On-line Query)
ACCENT (DHS MIS)
Driver's license/Wage files
CHOICEPOINT (National investigations data base)
Vital Records(State Birth, Death, Marriage Records)
FID (Federal Investigations Database)
MED-OIG Sanctions/Exclusions
Credit Reporting Bureau
DOD – Military- TRICARE
Medicare – (Public Safeguard Contractors)

Matches with:
PARIS (federal match program)
Employers
Contractors
Medicare
Insurance Carriers (future match)
Social Security Death Index
TOMIS (Tennessee Department of Correction data base)

- **Managed Care Contractors are required to develop and submit a fraud and abuse compliance plan. (See Contract language below) I don't have the time to go into detail; however the contract language is in your handout.**

1-5. a. Prevention/Detection of Provider Fraud and Abuse

The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

1-5. b. Fraud and Abuse Compliance Plan

1-5.b. 1. The CONTRACTOR shall have a written Fraud and Abuse compliance plan. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR for review and approval by TENNCARE and the Program Integrity Unit within ninety (90) days of the effective date of this Agreement. TENNCARE and the Program Integrity Unit shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) days of review. The CONTRACTOR shall make any requested updates or modifications available for review after modifications are completed as requested by TENNCARE and/or the Program Integrity Unit within thirty (30) days of a request. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

a. Claims edits;
b. Post-processing review of claims;
c. Provider profiling and credentialing;
d. Prior authorization;
e. Utilization management;

f. Relevant subcontractor and provider agreement provisions;
g. Written provider and enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;
v. Contain provisions for the investigation and follow-up of any compliance plan reports;
vi. Ensure that the identities of individuals reporting violations of the plan are protected;
vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to Program Integrity;
ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

1-5.b. 2. The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

1-5.b. 3. The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

➢ LEGISLATION UPDATES TO ADDRESS MANAGED CARE;

Tennessee Code Annotated (TCA) 71-5-118 amended 7-1-2000, stating that it is a felony offense to commit fraudulent offenses against TennCare. This legislation allows the District Attorney's to prosecute fraud cases when providers or recipients commit fraudulent acts under the managed care programs or FFS programs. AGAIN, I do not have time to review in detail; however we have inserted an extract from the law below for your review.

(b) (1) (A) A person, including an enrollee, recipient or applicant, commits an offense who, knowingly, obtains, or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false statement, representation, or impersonation, or by concealment of any material fact, or by any other fraudulent means, or in any manner not authorized by this part or by the regulations or procedures issued or implemented by the department pursuant to this part, medical assistance benefits or any assistance provided

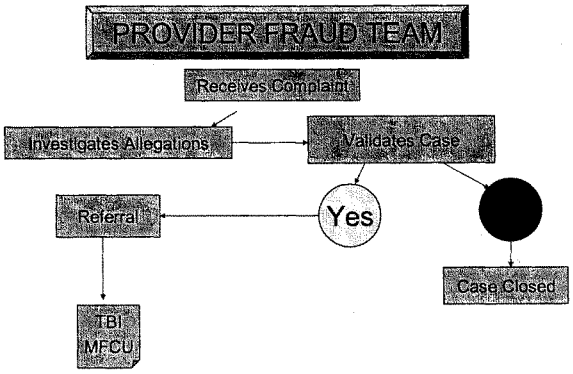
pursuant to this part to which such person is not entitled, or of a greater value than that to which such person is authorized.
(B) An offense under this subdivision is a Class E felony.
2) (A) A person, firm, corporation, partnership or any other entity, including a vendor, other than an enrollee, recipient, or applicant, commits an offense who, knowingly, obtains, or attempts to obtain, or aids or abets any person or entity to obtain, by means of a willfully false statement, report, representation, claim or impersonation, or by concealment of any material fact, or by any other fraudulent means, or in any manner not authorized by this part or by the regulations or procedures issued or implemented by the department pursuant to this part, medical assistance payments pursuant to this part to which such person or entity is not entitled, or of a greater value than that to which such person or entity is authorized. For purposes of this subsection, "attempts to obtain" includes making or presenting to any person a claim for any payment under this part, knowing such claim to be false, fictitious or fraudulent
(B) An offense under this subdivision is a Class D felony unless the value of the property or services obtained meets the threshold set for a Class B or Class C offense under § 39-14-105, in which case the appropriate higher class shall apply

YEAR ENDING 6/30/2003

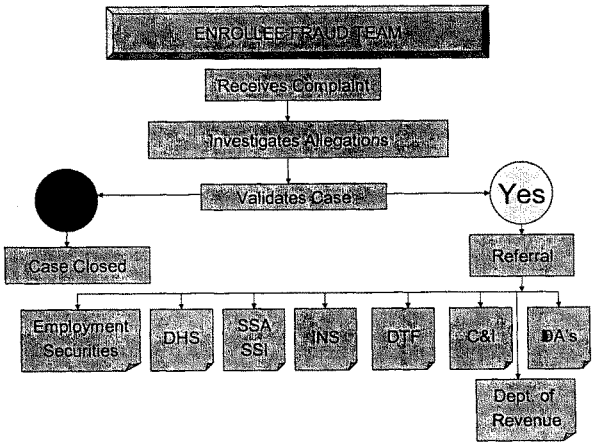
Summary of Enrollee Cases :	
a. Cases closed	21,638
b. Recommended Terminations	6,487
c. Adjustments to Cases not Terminated	
1. Income Adjusted	171
2. Health Ins. Added	388

Summary Relating to Provider Cases:	
a. Cases closed	176
b. Active Cases	67
c. Cases referred to TBI	14
d. Cases referred to HRB's (Health Related Boards)	3

- Program Integrity works very closely with the TBI- Medicaid Fraud Control Unit. Provider cases are worked as outlined in the diagram on page 8. However, before explaining, please allow me to say that we have a great working relationship between MFCU and PIU.



- Enrollee/recipient cases are worked and referred to various agencies as outlined below, with the majority of cases now being referred to the appropriate District Attorney's Office.



PIU Success Stories- Providers

PIU validated cases have resulted in the following actions during fiscal year 2002-2003:

I. Provider Cases

a. Revocation of physician's license and $50,000 in civil penalties
b. US Attorney's Office indicted physician on 516 counts of drug trafficking; physician has plead guilty and sentence is pending. This case also lead to two recipients and one pharmacist pleading guilty.
c. Probation of license for one year with supervision of practice, civil penalties, court cost, etc.
d. Three cases currently pending in Federal Court
e. 14 cases validated by Program Integrity, passed on to TBI-MFCU. These cases are in various stages of investigation with several awaiting direction/action of the prosecutor.
f. 4 cases are being worked with other agencies, ie, FBI, HHS-OIG, and HRB's.

PIU Success Stories- Enrollees

II. Enrollee Cases

a. Seven recipients prosecuted by D.A.'s for drug diversion (Three during fiscal year 2001-2002 and four during fiscal year 2002-2003)
b. Four recipients are currently under indictment for drug diversion.
c. 45 recipient cases validated and currently under investigation by the District Attorney Drug Task Force Units, for drug diversion.
d. Recipient/provider indicted on 22 counts of fraud, impersonating a licensed insurance agent and selling letters of un-insurability.
e. Four recipients currently under indictment - living out of state and obtaining TennCare fraudulently.
f. Other cases being worked with US Dept of Defense, Workers Comp, OIG and Attorney General Office, TRICARE and Medicare.

PIU Success Stories- Recovery

III. Recovery/Collections

a.	Estate Recovery	$3,077,516
b.	Overpayments (PA68's)	965,830
c.	Premium Underpayments	30,301
TOTAL		$4,073,647

➢ **THE FUTURE IS CHANGING; NEW UP TO DATE TECHNOLOGY IS A REQUIRED TOOL. I WILL ADDRESS WHAT TENNESSE IS DOING IN TWO AREAS, FRAUD/ABUSE AND TPL.**

FRAUD AND ABUSE:

The most important tool in identifing and working fraud, and abuse cases, second only to having the personnel positions to work case, is the MMIS system. Tennessee has been working for the past two years plus, as we first developed the RFP, bid out, evaluated response, awarded contract to develop and implement a new state of the art MMIS system will include one of the best fraud and abuse identification packages in the country. Highlights of this new MMIS system are as follows;

- DSS profiler
  - Utilization patterns
  - Payment ranking
  - Age/gender status
- Ad Hoc and predefined reporting
- Immediate access to data
- Statistical Analysis
  - Identifies providers who are 4 standard deviations from norm
- Comparison reporting
  - Specialty compare
  - Professional group compare

- Pharmacy group compare
- Nursing home group compare

- Targeted Queries
  - Denied services
  - Duplicate services
  - Excessive daily billing
  - FFS claims from Capitated Providers
  - Financial summaries
  - Recipients with no encounters
  - Services provided after date of death
  - Upcoding
  - Pharmacy claims without medical visits
  - Transportation claims without medical visits
  - Recipients with Third Party Liability insurance coverage
  - Recipients reported with out of state address

- TPL & SUBROGATION UPDATE:
  - 270-271 (electronic means of validating TPL)
  - Carrier matches and validation
  - Employer Data Match
  - Wage File Match
  - Review of Encounter Claims
  - Reports to monitor success of subrogation
  - MCC Electronic Updates
  - Etc, etc...

- **In closing, thank you for your time and I sincerely hope this has been informative. I will be happy to answer any questions.**

Mr. BENSON. Mr. Chairman, Madam Vice Chair, thank you for the opportunity to appear before you today to discuss the role of Medicaid Fraud Control Units in investigating and prosecuting Medicaid fraud and their successes and obstacles.

I am William Benson, director of the Tennessee Medicaid Fraud Control Unit and a member of the National Association of Medicaid Fraud Control Units Executive Committee.

In 1977, Congress enacted legislation creating the Medicaid Fraud Control Units to investigate and prosecute Medicaid provider fraud and abuse or neglect of patients. Currently all States and the District of Columbia, with the exception of Idaho, Nebraska and North Dakota have federally certified MFCUs. These 48 units police most of the Nation's Medicaid expenditures with combined staff of approximately 1,452 and a total Federal budget of $119 million. Since fiscal year 1993, when there were only 41 federally certified State units, and over the next 10 years, the MFCUs have successfully prosecuted over 8,700 corrupt medical providers and vendors and elder abusers. In fiscal year 2002, the MFCUs obtained 1,147 convictions and helped recover over $288 million.

While the MFCUs' success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is less well known that the units are the only law enforcement entities in the country specifically charged with investigating patient abuse and neglect.

Tennessee's Medicaid Fraud Control Unit was created in 1984 with a staff of 12, which included 8 investigators, and currently has a staff of 37 members including 20 investigators. At the time of the MFCU's creation, the Tennessee Medicaid program was a fee-for-service system operated by the Bureau of Medicaid, with the providers contracting directly with the Bureau of Medicaid. In 1994, Tennessee converted to a managed care system.

One change that came with the managed care system was the MFCU's need to change how it established and maintained relationships with the entities contracting with the providers. The MFCU could no longer meet with just the Bureau of Medicaid to address fraud issues. It became necessary to meet with the multiple TennCare managed care organizations or MCOs or MCCs as we call them now. To address this need, the MFCU assigned an investigator to meet regularly with the particular MCO to educate the MCO regarding fraud. This education has proven to be very important, as the MCFU observed a high level of ignorance concerning fraud among the TennCare MCOs and had to overcome the MCOs' reluctance to report suspected fraud.

Under the fee-for-service system, the MFCU had a close relationship with the Bureau of Medicaid's Surveillance and Utilization Review Subsystem [SURS]. The SURS reported aberrant billing patterns to the MFCU. Under the new managed care system, many of the Bureau of Medicaid's and SURS' responsibilities, including fraud detection, was transferred to the MCOs. In this system, providers submit claims for payment directly to the MCOs. In theory, the MCOs would replace the Bureau of Medicaid as the primary source of fraud referrals to the MFCU. In reality, this does not occur. While TennCare has had as many as 12 MCOs, only one has what could be described as a true fraud unit.

Under the managed care system, the remaining employees of the Medicaid programs' SURS became members of the Program Integrity Unity. The PIU evolved into a unit that the MFCU works extremely closely with and has come to depend on greatly.

The MFCU and PIU Directors meet with the drug task forces and local prosecutors to provide education about how the MFCU and PIU can work with the hem on drug diversion cases. Such training has been productive. For example—and this is the case that Tom referenced—the MFCU, PIU and various other agencies, including Health and Human Services, Office of Inspector General, DEA, U.S. Attorney's Office, TVA Inspector General's Office and the local sheriff's department worked a drug diversion case together which resulted in one doctor being charged on multiple counts of illegal distribution of prescription narcotics, including OxyContin, Adderall and Hydrocodone. To date, the investigation resulted in a guilty plea by the doctor, a guilty plea by one pharmacist on a count of obstruction of justice and guilty pleas by two recipients on narcotics charges.

Within the past couple of years, language has been included in the Bureau of TennCare/MCO contracts requiring the MCOs to have fraud compliance plans. Hopefully, if the MCOs adhere to the compliance plans, they will become more aggressive in identifying and reporting incidents of fraud.

In addition to investigators meeting with each MCO, the MFCU and PIU directors and staff members host quarterly round table meetings and annual fraud seminars for the MCOs to educate their employees about fraud.

Since one of the most important aspects of a Medicaid fraud investigation is getting complete and accurate data, one of MCFU's focuses has been working closely with the Program Integrity Unit and the Bureau of TennCare to establish a new computer system which better identifies aberrant patterns. It is expected that Tennessee will convert to a new Medicaid computer system in late 2003.

One of the greatest resources for the MCFU is the National Association of Medicaid Fraud Control Units. This organization provides specialized provider fraud training, information and advice to the MFCUs. Since 1992, States have especially benefited from the National Association of Medicaid Fraud Control Units' efforts on multi-jurisdictional cases with the Federal Government, which resulted in recoveries of over $360 million.

In closing, I want to emphasize that much of the Tennessee's Medical Fraud Control Unit's success is a result of its consistent efforts to foster cooperation with the Program Integrity Unit, the Bureau of TennCare, the TennCare managed care organizations and our State and Federal prosecutors and law enforcement agencies. I also want to emphasize that the Medicaid Fraud Control Units throughout the country are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The units have been successful in serving as a deterrent to health care fraud; in identifying pro-

gram savings; removing incompetent and fraudulent practitioners; and in preventing physical and financial abuse of patients.

Thank you again for the opportunity to testify today.

Mr. PLATTS. Thank you, Mr. Benson. Ms. Williams.

[The prepared statement of Mr. Benson follows:]

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you to discuss the role of the Medicaid Fraud Control Units in investigating and prosecuting Medicaid fraud, and their successes and obstacles. I am William Benson, Director of the Tennessee Medicaid Fraud Control Unit (MFCU) and a member of the National Association of Medicaid Fraud Control Units' (NAMFCU) Executive Committee.

In 1977, Congress enacted legislation, creating the Medicaid Fraud Control Units to investigate and prosecute Medicaid provider fraud and abuse or neglect of patients. Currently, all states and the District of Columbia, with exception of Idaho, Nebraska, and North Dakota, have federally certified MFCUs. These 48 Units police most of the nation's Medicaid expenditures with combined staff of approximately 1452 and a total federal budget of $119 million. Since FY 1993, when there were only 41 federally certified state units, and over the next ten years, the MFCUs have successfully prosecuted over 8700 corrupt medical providers and vendors and elder abusers. In FY 2002, the MFCUs obtained 1147 convictions and helped recover over $288 million.

While the MFCUs' success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is less well known that the Units are the only law enforcement entities in the country specifically charged with investigating patient abuse and neglect.

Tennessee's MFCU was created in 1984 with a staff of twelve, which included eight investigators, and has grown to thirty-seven staff members, including twenty investigators. At the time of the MFCU's creation, the Tennessee Medicaid program was a fee-for-service system operated by the Bureau of Medicaid, with the providers

contracting directly with the Bureau of Medicaid. In 1994, Tennessee converted to a managed care system.

One change that came with the managed care system was the MFCU's need to change how it established and maintained relationships with the entities contracting with the providers. The MFCU could no longer meet with just the Bureau of Medicaid to address fraud issues. It became necessary to meet with the multiple TennCare MCOs. To address this need, the MFCU assigned an investigator to meet regularly with a particular MCO to educate that MCO regarding fraud. This education has proven to be very important, as the MFCU observed a high level of ignorance concerning fraud among the TennCare MCOs and had to overcome the MCOs' reluctance to report suspected fraud.

Under the fee-for-service system, the MFCU had a close relationship with the Bureau of Medicaid's Surveillance and Utilization Review Subsystem (SURS). While in existence, the SURS would review claims and sample patient files. The SURS reported aberrant billing patterns to the MFCU. Under the new managed care system, many of the Bureau of Medicaid's and SURS' responsibilities, including fraud detection, was transferred to the MCOs. In this system, providers submit claims for payment directly to the MCOs. In theory, the MCOs would replace the Bureau of Medicaid as the primary source of fraud referrals to the MFCU. In reality, this does not occur. While TennCare has had as many as twelve MCOs, only one has what could be described as a fraud unit.

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MFCU and PIU Directors meet with drug task forces and local prosecutors to provide education about how the MFCU and PIU can work with them on drug diversion cases. Such training has been productive. For example, the MFCU, PIU and various other agencies, including the HHS OIG, DEA, U.S. Attorney's Office, TVA Inspector General's Office and the local Sheriff's Department worked a drug diversion case together, which resulted in one doctor being charged with multiple counts of illegal distribution of prescription narcotics, including OxyContin, Adderall, and Hydrocodone. To date, the investigation resulted in a guilty plea by the doctor, a guilty plea by one pharmacist on a count of obstruction of justice and guilty pleas by two recipients on narcotics charges.

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Since one of the most important aspects of a Medicaid fraud investigation is getting complete and accurate data, one of MFCU's focuses has been working closely with the PIU and the Bureau of TennCare to establish a new computer system which better identifies aberrant patterns. It is expected that Tennessee will convert to a new Medicaid computer system in late 2003.

One of the greatest resources for the MFCU is the National Association of Medicaid Fraud Control Units (NAMFCU). This organization provides specialized provider fraud training, information, and advice to the MFCUs. Since 1992, states have especially benefited from NAMFCU's efforts on multi-jurisdictional cases with the federal government, which resulted in the recoveries of over $360 million.

In closing, I want to emphasize that much of the Tennessee's Medicaid Fraud Control Unit's success is a result of its consistent efforts to foster cooperation with the Program Integrity Unit, the Bureau of TennCare, the TennCare MCOs, and our state and federal prosecutors and law enforcement agencies. I also want to emphasize that the Medicaid Fraud Control Units throughout the country are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud; in identifying program savings; removing incompetent and fraudulent practitioners; and in preventing physical and financial abuse of patients.

Thank you again for the opportunity to testify today.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Frequently Asked Questions About Medicaid Fraud Control Units

1. What is a Medicaid Fraud Control Unit?

A Medicaid Fraud Control Unit ("Unit" or "MFCU") is a single identifiable entity of state government, annually certified by the Secretary of the U.S. Department of Health and Human Services. The Unit has either statewide criminal prosecution authority or formal procedures for referring cases to local prosecutorial authorities with respect to the detection, investigation and prosecution of suspected criminal violations of the Medicaid program. *See* 42 U.S.C. §1396b(q). There are 48 state MFCUs. 41 are currently located in the office of the state Attorney General. Connecticut, D.C., Georgia, Illinois, Iowa, Tennessee and West Virginia have Units which are in other departments of state government. Idaho, Nebraska and North Dakota have received a waiver from the federal government and do not have Units.

2. Must each state have a MFCU?

Under federal law, each state must have a Unit unless the state demonstrates to the satisfaction of the Secretary of the Department of Health and Human Services that a Unit would not be cost effective because minimal fraud exists in the state's Medicaid program and Medicaid beneficiaries will be protected from abuse and neglect.

3. What is the jurisdiction of a MFCU?

A Unit's function is to conduct a statewide program for the investigation and prosecution of health care providers who defraud the Medicaid program. In addition, a Unit reviews complaints of abuse or neglect against patients in health care facilities receiving Medicaid funding and may review complaints of the theft of patients' private funds in these facilities. The Unit is also charged with investigating fraud in the administration of the program. The Ticket to Work and Work Incentives Improvement Act of 1999 authorizes the Units, with the approval of the Inspector General of the relevant agency, to investigate fraud in other federally-funded health care programs, if the case is primarily related to Medicaid. This section also authorizes the Units, on an optional basis, to investigate and prosecute resident abuse or neglect in non-Medicaid board and care facilities.

4. How are MFCUs funded?

MFCUs receive annual grants (Federal Financial Participation or "FFP") from the U.S. Department of Health and Human Services. Grant amounts must be matched with state funding. Initially, a Unit receives federal funding at a 90 percent level. After its first three years, the FFP is reduced to 75 percent.

5. What are the limitations on federal financial participation?

Federal financial participation is authorized for full-time attorneys, investigators and auditors involved in the investigation and prosecution of matters within the jurisdiction of a Unit. Full-time employees are required to be hired to perform full-time duty intended to last at least a year. Federal grant money may also be used for part-time support staff but only to the extent that these part-time employees participate in work activities that further the jurisdictional duties of the Unit. Finally, FFP is available to the Unit's parent agency to cover all indirect costs associated with the operation of the Unit.

6. What are MFCU minimal staffing levels?

A Unit is intended to operate using a "strike force" concept of investigators, auditors and attorneys working together full-time to develop Medicaid fraud investigations and prosecutions. The staff of the Unit must include attorneys experienced in the investigation and prosecution of civil fraud or criminal cases, auditors capable of reviewing financial records, and investigators with substantial experience in commercial or financial investigations. If a Unit lacks direct prosecutorial authority, it must have a formalized procedure in place for referring cases to the appropriate prosecutorial authority.

7. What is the extent of federal oversight over a MFCU?

Each Unit operates under the administrative oversight of the Inspector General of the U.S. Department of Health and Human Services and must be recertified annually. As part of the recertification process, the Inspector General reviews a Unit's application for recertification and may conduct on-site visits. Additionally, Units submit quarterly and annual reports to the Inspector General. These reports include statistical data on the number and type of cases under investigation, the number of convictions obtained and the number of dollar recoveries to the Medicaid program. The day-to-day supervision of a Unit rests with the parent agency.

8. How do Medicaid fraud cases typically arise?

While specifics may vary from state to state, a primary source of referrals is the agency responsible for auditing and reviewing Medicaid provider claims. Other significant sources of referrals are the MFCUs in other states as well as other law enforcement agencies.

9. How do the multi-state/federal global settlements arise and how are they handled?

Medicaid fraud global settlements generally arise in connection with a U.S. Department of Justice investigation against a Medicare provider. When resolving these Medicare cases, the federal government, often at the request of defense counsel, turns to the state MFCUs because it cannot settle the Medicaid portion of the case without the Units. Moreover, defense attorneys are unlikely to settle the case without the affected states because each state has the authority to exclude a convicted provider from its health care programs. The Department of Justice typically contacts the National Association of Medicaid Fraud Control Units about a potential settlement, and the President of the Association appoints a settlement team which usually consists of three to four members. All recoveries and negotiations are based upon a state's actual damages, calculated by analyzing the provider's billings. The Medicare cases are often filed as qui tam or whistleblower actions that are under seal. The seal is partially lifted to give the Units the opportunity to gather provider specific information in their states to give to the NAMFCU negotiating team.

10. What federal consequences follow a felony conviction for Medicaid fraud?

Under federal regulations, providers who are convicted of a program related offense are excluded for a minimum of five years from receiving funds from any federally funded health care program, either as a health care provider or employee. Often, this sanction has a greater impact on the convicted individual and the provider community at large than the criminal penalties assessed in the case.

11. What is the National Association of Medicaid Fraud Control Units (NAMFCU)?

The National Association of Medicaid Fraud Control Units (NAMFCU) was founded in 1978 to provide a forum for a nationwide sharing of information concerning the problems of Medicaid fraud, to improve the quality of Medicaid prosecutions by conducting training programs, to provide technical assistance to Association members and to provide the public with information about the MFCU program. All 48 MFCUs are members of the Association. NAMFCU is headquartered in Washington, D.C. and is staffed by a Counsel and a Paralegal.

Ms. WILLIAMS. Good morning, Chairman and Madam Vice Chair. I want to thank you for the opportunity to speak with you this morning about the Tennessee Senior Medicare Patrol Program here in the State of Tennessee. I am Holly Heneger-Williams and I am the program coordinator.

The Upper Cumberland Development District Area Agency on Aging and Disability was the recipient of the Tennessee Senior Medicare Patrol Project Federal grant from the Administration on Aging beginning July 1, 2001 for a 3-year period. At the end of this period, which will be June 30, 2004, we will be eligible to apply for an additional 3-year project period.

The Tennessee Senior Medicare Patrol Project's mission is to reduce Medicare, Medicaid and TennCare fraud, waste and abuse by increasing public awareness on monitoring what is paid on behalf of the beneficiaries and how to report suspicious claims.

The program recruits and trains retired professionals and others to serve as expert community resources to provide individual counseling and conduct group session presentations.

Since July 2001, the program has recruited and trained approximately 250 individuals, provided one-on-one counseling to approximately 250 beneficiaries, presented to approximately 1,250 beneficiaries and their caregivers in small group sessions and has reached approximately 273,500 individuals through media activity.

Because education is the key to prevention and recoupment of these lost funds, Senior Medicare Patrol has spent the first 2 years focusing on conducting activities that are educational in nature. As a result of these programs' efforts through December 2002, 39 allegations of potential fraud, waste and abuse have been reported, with 22 of those having been referred to the Medicare contractors for followup. Nationwide the Senior Medicare Patrol Programs have retrieved $7 for every $1 invested in their implementation.

Within the past year, the program has taken a large step by integrating all volunteer training sessions and activities in conjunction with Tennessee State Health Insurance Assistance Program. Because both SHIP and SMP are designed to operate through the work of volunteers while focusing on assisting beneficiaries of the Medicare/Medicaid program, it seemed to only make sense to combine our efforts in this perspective. Prior to this initiative, Senior Medicare Patrol volunteers were being asked these SHIP-related questions while they were out performing their Senior Medicare Patrol work, yet the Senior Medicare Patrol training was not comprehensive enough in order for them to be able to provide that area of counseling.

As a component of this initiative, SHIP has taken the step to contract out with the same nine area agencies on aging and disability across the State, as the Senior Medicare Patrol in order to fund nine full time Tennessee Senior Medicare Patrol SHIP volunteer coordinators. All these volunteer coordinators were cross trained this past October for both programs. These volunteer coordinators are responsible for recruiting, assisting in training and maintaining all the volunteers' activities for both programs within their region.

Since March 2003, there have been six 2-day SHIP/SMP volunteer training sessions held across the State with approximately 115

individuals becoming certified as Tennessee SHIP/SMP volunteer counselors.

The major segments of these training sessions' Medicare, Medicaid and TennCare fraud, waste and abuse components are being conducted by the Tennessee Bureau of Investigations, Office of Inspector General Office of Investigations and Tennessee Department of Finance Administration Office of Audits and Investigations. These partnering organizations are critical to Tennessee's Senior Medicare Patrol implementation and success.

In regard to challenges, the most difficult challenge we have seen to overcome has been to convince the beneficiaries that if they question charges about their billing statement, that the relationship between them and their doctor will not be jeopardized because the information can remain anonymous. Since Tennessee is a very rural State, in these small communities where everyone knows everyone, beneficiaries fear being a "troublemaker" and raising these issues would result in their doctor not providing the care they need. So many of them have gone to the same doctor for decades and they simply find it not worth risking jeopardizing that relationship.

Thank you.

[The prepared statement of Ms. Williams follows:]

July 11, 2003

Testimony by:
Holly Heneger-Williams
Tennessee Senior Medicare Patrol Project Coordinator

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The Tennessee SMP Project's mission is to reduce Medicare, Medicaid, and TennCare fraud, waste, and abuse by increasing public awareness on monitoring what is paid on the behalf of a beneficiary and how to report suspicious claims. The program recruits and trains retired professionals and others to serve as expert community resources who provide individual counseling and conduct group session presentations. Since July 2001, the program has recruited and trained approximately 250 individuals, provided one-on-one counseling to approximately 250 beneficiaries, presented to approximately 1250 beneficiaries and their caregivers in small group sessions, and has reached approximately 273,500 individuals through media activities. Because education is the key to prevention and recoupment of these lost funds, SMP has spent the first two years focussing on conducting activities that are educational in nature. As a result of the programs' efforts through December 2002, 39 allegations of potential fraud, waste, and abuse have been reported with 22 of those having been referred to the Medicare contractors for follow-up. Nationwide, the SMP programs have retrieved $7 for every $1 invested in their implementation.

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As a component of this initiative, SHIP has taken the step to contract out with the same nine Area Agencies on Aging and Disability across the state as SMP in order to fund nine full-time, Tennessee SMP/SHIP Volunteer Coordinators. All of these Volunteer Coordinators were cross-trained in October 2002 for both programs. These Volunteer Coordinators are responsible for recruiting, assisting in training, and maintaining all of the SHIP/SMP Volunteers' activities within their region. Since March 2003, six two-day SHIP/SMP Volunteer training sessions have been held across the state with

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In regards to challenges, the most difficult challenge to overcome has been to convince beneficiaries that if they question charges about their billing statements, that the relationship between them and their doctor will not be jeopardized because the information can be anonymous. Since Tennessee is a very rural state, in these small communities where everyone knows everyone, beneficiaries fear being a "trouble-maker" and raising these issues would result in their doctor not providing the care they need. So many of them have gone to the same doctor for decades and they simply find it not worth risking jeopardizing that relationship.

Mr. PLATTS. Thank you and I stand corrected, I think it should be Ms. Heneger-Williams.

Ms. WILLIAMS. That is correct.

Mr. PLATTS. By the end of the day, we will get all the names right.

I want to again thank you for your testimony and we will now get into questions for the panel and Ms. Blackburn, if you would like to begin.

Ms. BLACKBURN. Thank you, Mr. Chairman. I would like to begin and I also want to thank each of you for being here. As I said when we started the hearing, one of our objectives is to be sure that health care remains accessible, that it remains affordable and one of the ways to make that happen is to be sure that we search out and implement the efficiencies that are necessary. And it is no secret to anyone involved that TennCare has had more than its share of problems.

Mr. Mathis, I think that I will begin with you, and thank you for your well-prepared testimony, I appreciate that.

Audits have found problems with TennCare's internal controls over eligibility determination, and I understand that their unit has an RFP out for a new information system. And we know that is a problem that has dogged TennCare since its inception, is not having a workable information system.

Is this system going to be one that will allow you to address some of the need for some way to address these internal controls?

Mr. MATHIS. Yes, it has many, many features built into it that will help us address internal control issues.

You touched on, to start with, your question relating to eligibility and the eligibility piece over the last year was moved—it was divided, being worked through the Department of Health and the Department of Human Services. A revision was made to make a one-stop shopping type of process and require the TennCare recipients to report annually to the Department of Human Services at the local county level for their reviews and evaluations. That is the beginning of a process that does not relate to the new MMIS system. Once it is fed into the system, then we begin to capture by doing profiles on individuals and looking at individual recipients and helping to identify those individuals that may or may not be eligible, helping to identify those individuals that may have other insurance that they have failed to tell us about, we will capture that through multiple means.

I can go into that if you would like, but I do not know how much detail you would like.

Ms. BLACKBURN. I think I can ask the question and get the answer this way. So the system that is being designed for you, or for TennCare, is a system that will allow data input from both the health and the human services side and then it will allow reading of that information from both the health and human services side.

Mr. MATHIS. Well, the Department of Health at this point is basically removed as far as eligibility. It is all being processed through the Department of Human Services. There are a few loopholes, but for the most part it is all being processed through the Human Services Department. And yes, ma'am, that information is uploaded

into—or will be uploaded into the TennCare data base and available then for evaluation, comparison reports, review, analysis, etc.

Ms. BLACKBURN. OK. With your unit—let me see, I was looking through your report last night and I was having a tough time, maybe you can help me with this—how many reports of possible fraud have you all received since your unit's inception?

Mr. MATHIS. Since our inception would be very difficult for me to respond to. I have been there since June 2000. The unit, prior to TennCare was a fairly significant number of individuals working in the unit. I do not want this to sound funny in any way, but in looking at it, I can understand why that leadership would have felt this way—but there was a thought that there would be no fraud in managed care. So basically the SURS unit was basically eliminated. And then they began, through realization, the concept being that it would be shifted to the managed care contractors and the managed care contractors would be the ones evaluating and working the fraud and abuse and would be the ones ultimately that would incur the loss if they did not respond to it and identify it and recover it—fraud.

As the time periods went on, it was obvious that was not the total picture, that there needed to be a fraud and abuse unit within State government and it needed to be restructured. At that point in time, in July 2000, there were roughly seven individuals in that unit. When I came over, they gave me 3 additional people and since that time we have picked up an additional 13 staff positions. So the growth has occurred.

Does that help answer?

Ms. BLACKBURN. No, sir, that really is not—let us take it this way then, how many reports have you had of fraud this year?

Mr. MATHIS. This year, the fiscal year just ended, was—let me refer back—at June 30, 2003, we had 21,638 cases referred to us.

Ms. BLACKBURN. OK, so that was—on this, it says cases closed. So in other words, you took care of every single——

Mr. MATHIS. No, ma'am, you are correct, I answered you incorrectly. At the end of the year, we still had roughly 2,400 of those cases open.

Ms. BLACKBURN. OK, so there are 2,400 still open.

Mr. MATHIS. Yes, ma'am.

Ms. BLACKBURN. So basically what you are looking at is 21,000 cases a year that come your way.

Mr. MATHIS. With those numbers, we usually run around 23,000 cases, and that is pretty consistent with what it was the previous year, total cases coming in. I am sorry, I failed to understand your question.

Ms. BLACKBURN. OK. Now your next number was the recommended terminations, 6,487. How successful have you or has the program been, has the State of Tennessee been in removing those individuals who were declared or found to be ineligible by the PIU? How successful are you in removing those from the TennCare roles?

Mr. MATHIS. We have been—the State has been successful. There is a process or a lag time of between 90 and 120 days to allow us the process, the appeal process that is allowed to take place for these individuals. What we have started to do is to develop an in-

ternal tracking system. We allow 4 months worth of delay and then we send a listing for that 30-day period of time or 31 day period of time that has just ended prior to the 120 day lag time, over to the Bureau. We run it against the eligibility listing and get a report back that reflects those people who have not been terminated. We then follow back up—I assign someone to follow back up on those cases to see why they have not been terminated, and there are individuals that fall into the category, sometimes if they have filed an appeal, successful appeal, it is sitting there waiting in the Office of General Counsel, and therefore, they cannot be terminated until that appeal has been officially heard.

But for the most part, we have been successful and sometimes we do followup. I am not going to tell you that we have not had any errors and some have not fallen through the cracks, but if that occurs, we resubmit them for a second time.

Ms. BLACKBURN. So adding that up, this particular checklist, what you are telling me is it takes anywhere from 6 months to a year to get somebody off the program.

Mr. MATHIS. It could take—I am saying it takes roughly 120 days. There are cases, if they have filed an appeal, it can take longer.

Ms. BLACKBURN. OK. After you have found them to be ineligible for the program and they remain on the program and go through this process and then it is deemed that they are indeed ineligible, are they responsible for reimbursing the program for the services that they have used during that period of time?

Mr. MATHIS. No, ma'am, but I certainly would like for them to have to reimburse the program.

Ms. BLACKBURN. All right. In the provider cases, let us go to that on your chart. It says cases closed, 176. So how many provider cases did you have submitted to you this year?

Mr. MATHIS. I do not have that number with me today. I can certainly get it to you, but I am going to give you an estimate. Is that OK or would you prefer——

Ms. BLACKBURN. What I would like to do is get your estimate right now for the sake of discussion and then have you submit for the record. I think it would be helpful to us, knowing that you all have a check up every 5 years on this, and as we look at health care and the health care delivery and the 1,115 waivers, Mr. Chairman, I think what we would like to do is while we are talking with those who have overseen TennCare, is collect the data of the number of cases that are reported to them every year, the number that are closed, what the decision is on that, what the penalties, etc.

Mr. PLATTS. Mr. Mathis, could you supply that after the fact, both with the recipients and the providers, so we get a complete picture for the fiscal year just closed?

Mr. MATHIS. Yes.

Mr. PLATTS. Thank you.

Ms. BLACKBURN. That would be great. And now for the sake of discussion if we could just have the total number that you think are submitted to you all each year.

Mr. MATHIS. I am going to project it would be somewhere between 200 and 225.

Ms. BLACKBURN. OK. Now under the legislation that we had a tough time passing, that you referenced, and I appreciate your appreciation of that law and making it a felony offense—how many convictions have you had? You pointed out a few of what you called your success stories. So of course we are sad that there is the need for there to be those success stories, but we are pleased to see that, you know, it is bearing some fruit. How many are you seeing actually get a conviction and then are we seeing people removed from participating in the program because of this?

Mr. MATHIS. The answer, as I have touched on earlier, a total of seven have been convicted thus far.

Ms. BLACKBURN. Seven. And that is the total.

Mr. MATHIS. That is total, but now let me, if I can, if you will bear with me, it is very important because that is very young legislation, and William Benson and myself have been traveling across the State meeting with district attorneys, we have been talking with them about this piece of legislation and making them aware. That is paying dividends, because as they become aware of that legislation and the options there, and they begin to work with us, their staff begins to work with us, particularly the drug task force units where we are focusing heavily on drug diversions, then we talk about this piece of legislation. We give them copies of this piece of legislation and we ask them to work with us and we ask them to use that legislation that says if you are convicted of a fraudulent offense against TennCare, you can be excluded from the program for 12 months on the first offense, 24 on the second, lifetime on the third.

However, there is a conflict between that piece of legislation and the Federal rules. The Federal rules say that they can be taken off for a maximum of 12 months if they are part of the true Medicaid population. Waiver population, we believe we can use that legislation (H–S–118). The Federal legislation, however, does have—if they are a true Medicaid recipient, has the 12 months, I believe. So we try to make them aware of that as well and use that language, put that language into the judgment order, and when the judgment order comes through we submit it to the Bureau with our recommendations for termination.

Ms. BLACKBURN. OK, thank you, sir.

This may be a question for both you and Mr. Benson to answer. Speaking of the education that you were doing with the MCOs. I know there have been as many as nine MCOs and as few as four in the TennCare program. Are you all holding the meetings with the administrators of the MCOs or what is the education process that you are working through?

Mr. BENSON. We do have a fraud seminar once a year, usually in May where we invite those people that would be closest related to the fraud identification within the MCOs. The invitations go out to those individuals at each of the MCOs that they have selected as the people that would be coming. We have had, like Blue Cross/Blue Shield does have a true fraud unit, they have nurse investigators to the investigators, to the heads of the special investigations unit staff, and the other MCOs or behavior health organizations. The invitation will go out to those representatives in their fraud sections or quality improvement sections, for them to reach out to

anybody within the organization that wants to come to the meeting. That is once a year.

We also have quarterly round table meetings that Mr. Mathis and I host where we invite the MCOs to come and talk and it is usually a dozen to 20 representatives from all of the MCOs. And we discuss not necessarily problem providers because we in that case may be talking about a provider that is not in one of the other MCO networks and would not have any dealings with that provider, but we may talk about problem provider groups. For instance, maybe the drug diversion issues or transportation issues, whatever they think they are having problems with. We give them the opportunity to come forward to us and say we are having a problem in our MCO, and generally what we find is the other MCOs are having similar problems. But we kind of leave it up to the MCOs to bring to the meetings the staff members they think are appropriate.

Ms. BLACKBURN. Mr. Benson, let us talk for a second about identity theft, because you mentioned that in your report, as being a problem, and we know in Tennessee that has been a problem with some individuals acquiring multiple identities.

And of course, in the Medicaid program the potential for the abuse of identity of Medicaid patients is substantial. What are you seeing with respect to identity theft in the Medicaid program and what tools have been effective in limiting identity theft in Tennessee?

Mr. BENSON. We have been fortunate so far that since what I will call the startup part of TennCare, we have not seen much in Tennessee. As a matter of fact, after about 1996 or 1995, we really have not had too many identity fraud cases come to our attention. In the beginning with TennCare, we did have, particularly one MCO, that was contracting with independent marketing representatives and they would pay them so much per head for who they enrolled or for who they signed up. We had one individual that—or actually three individuals that created names and Social Security numbers to go with these names and listed them as being residents of a homeless shelter here in Memphis actually, about 4,500 names. And when that MCO was getting paid $100 a month, we are talking about $450,000 in fraud a month. It did take several months for it to come to our attention and TennCare did collect back about $1.8 million.

We also had another individual that was enrolling people at the Saturn plant that—and these individuals did not know that they were being enrolled and did not give their permission to be enrolled. That was to the tune of about $70,000 something I believe, and we had several people go to prison on that.

We have not seen much since then. I cannot say it is because it is not going on and may not be being reported to us. California in particular has seen a lot of identity fraud issues, and some of the other States as well, but to date, we have not seen much in Tennessee.

Ms. BLACKBURN. OK. Let me ask you this, how has the due process requirements of TennCare affected your efforts to prosecute fraud?

Mr. BENSON. Could you be more specific as far as——

Ms. BLACKBURN. Going through the process that Mr. Mathis was stepping through.

Mr. MATHIS. I think you are referring to the appeal process relating to the recipients' appeal. As far as prosecuting fraud itself, we can still present those cases to a prosecutor. We do not have to wait until such time as that appeal or that due process has been completely—you know, completed through all levels that are necessary.

Ms. BLACKBURN. Are you receiving support from the Attorney General?

Mr. MATHIS. Basically the way we are set up is we prosecute those through the District Attorney's Office instead of the Attorney General's Office, but we have received support when we have requested it through the Attorney General's Office, we have actually had them to come and provide some training to our staff and some technical assistance. And in fact, they really have made offers if we encounter problems with particular District Attorneys, then in moving our cases, they will be happy to go with us jointly and do education and training and try to persuade the DAs for assistance. We have not had to do that at this point, but the AG's office has certainly been there and offered assistance to us.

Ms. BLACKBURN. Are you receiving the assistance you need from HHS or have you had to call on them for assistance with any of the fraud cases?

Mr. MATHIS. There are a few cases that we have worked with HHS-OIG on, but primarily our role when we work a case, particularly if we are talking about provider cases, we do the validation and that case then moves over to the TBI Medicaid Fraud Control Unit and they take the lead in it and we just assist them in any way. At that level, William would be more suitable to answer that question relating to working with them.

But from the recipient side, there are a few cases that we have had discussions with HHS-OIG, but their caseload at this time is usually so heavy that they are limited pretty much to working with provider cases.

Ms. BLACKBURN. OK, thank you. Thank you, Mr. Chairman.

Mr. PLATTS. Thank you, Ms. Blackburn.

I am going to give the two of you a respite for a few minutes while I go in a little different direction.

Ms. Heneger-Williams, your program—first I want to make sure I understand that the seniors who participate are volunteering, right, there is no compensation to the individuals?

Ms. WILLIAMS. Correct.

Mr. PLATTS. In essence, you are really calling on the civic duty of these individuals to participate and to be watchdogs out there for us.

Ms. WILLIAMS. Yes.

Mr. PLATTS. In our conversation during the break, given the area that Upper Cumberland includes, being very rural, what are you trying to do to overcome that barrier that you are dealing with individuals who only maybe have that one provider to go to or have that long history, that they maybe are aware of some misconduct but are just real hesitant to report it. What efforts or what is your strategy to overcome that?

Ms. WILLIAMS. Yes, as we talked about, that is a huge area to overcome. Basically we have relied on speaking with these beneficiaries and informing them on the benefits—how beneficial it is for them to provide us any information that may relate to fraud, waste or abuse. As we were discussing, in these very rural areas, which most of Tennessee is comprised of, these individuals have gone to the same physicians for years and years and years and probably the current physicians they go to, they were going to their father who was maybe a physician when they were younger. This relationship is very strong and they do not want to jeopardize that relationship.

So that is a huge challenge that we do have. On the flip side, the way we have in the last year and a half that we have really had the program and tried to work with these individuals to show them the benefits of it, is taking the aspect of here is the amount of fraud and abuse that is reported out there. If we do not all work together to combat these problems, your health care is going to be jeopardized, not only for you but for generations to come. We take that approach as to comforting them, letting them know, you know, if you see something like this, most of the time these are simple errors even, simple billing errors and that is not going to jeopardize your relationship with your physician. That is pretty much the standpoint we have tried to take with those.

Mr. PLATTS. The 250 volunteers that you have enrolled are for that 14-county area?

Ms. WILLIAMS. No, that is Statewide.

Mr. PLATTS. Are most of those more in the rural areas or in the urban areas?

Ms. WILLIAMS. We have some representatives in probably about 85 of the counties in Tennessee.

Mr. PLATTS. So about 15 percent have no senior participants?

Ms. WILLIAMS. Yes. But—and when I say 85 percent, I need to be more specific. Those are the individuals that actually reside in the county they do the volunteer work for. We probably have, oh gosh, maybe seven or eight counties that do not actually have someone that goes to that county to provide one-on-one counseling, but that is a goal that we have within the next year, to make sure that we are available in each county.

And if I can go back, another thing that we also—a way to comfort these beneficiaries, to let them know that the relationship between them and their doctor may not be jeopardized is letting them know that they can remain anonymous.

Mr. PLATTS. Uh-huh. Is there—are you familiar with how it is working in other States versus Tennessee or is it more just the Tennessee—is there a national——

Ms. WILLIAMS. As far as the rule issue goes?

Mr. PLATTS. Yeah, in getting people to participate.

Ms. WILLIAMS. I know in Kentucky that they face the same barriers. Actually the Administration on Aging just about a month ago produced a video that is to address this issue with reaching those rural areas. So, you know, nationwide even, the Administration on Aging is tackling this as a major challenge that we do have.

Mr. PLATTS. For seniors and that generation having such a strong and thankfully intense civic duty in general, it would be

natural to solicit them, but if they are in these areas where there is one provider or with TennCare one participant in the program, it is also understandable that they are going to be hesitant to risk losing their own health care because of the misconduct of the provider.

Ms. WILLIAMS. We have tried to be flexible in trying to figure out what is going to work best and any opportunity that we have to try something new, we take those opportunities.

Mr. PLATTS. Let me come back to the TennCare representatives. We heard in the previous panel in looking at national numbers and the effort of Mr. Weems' staff of developing the improper payments program, the PAM system, the payment accuracy measure. TennCare is currently not one of the States participating, is my understanding. But is there something already in place to try to get a Statewide assessment? We heard that in 1992, if I remember correctly, the last time that HHS did it nationally, it was perhaps 2 percent, but there has been a dramatic change like here in Tennessee where we now have managed care. Is there a Statewide number where you can estimate of improper payments for TennCare in Tennessee?

Mr MATHIS. No, there is not. If you will allow me to, I will respond on where we are. Looking at the PAM project, I serve on the national committee and am very much aware and staying up to date with the PAM project in talking with my peers across the country where those tests or pilots are ongoing.

We continue to look at it, we would like to at some point take on that task. However, I will tell you that it is tremendously burdening on our resources and staff to develop and implement a new IS system. For example, we are in the process of starting to assign staff to work in the testing phases. We have developed the guidelines, the requirements that went into the bid process, evaluated the bids that have been awarded and have been working through what is called requirement validation with many, many hours of discussion to ensure that we are getting what we asked for. And now we are going into the testing stages of it.

And again, tying up resources and staff time to be sure that again the program is going to be there. We just simply are strapped for resource time. We do think it is an excellent program. I am not at this point telling you that we are not going to pursue it. I have discussed it with senior management, it is on the table, we are just trying to figure out is it possible to take on another project at this point in time.

But Mr. Chairman, I was going to say that many of the features, of course certainly we believe that the new system will identify many, many things for us other than just payment issues. It will profile, it will look at the providers, it will look at the recipients, who are outside the norms. It will give us opportunities to target those individuals for possible review and investigations or going back to our MCC contractors and asking them to re-evaluate.

But I do think that the PAM project is a very valuable project, would like to see us pursue it. Just not enough staff.

Mr. PLATTS. The fact that you are looking at it and following it—in Mr. Weems' testimony, he talked about the nine States that are currently in, 25 States that are coming on board with the expecta-

tion that it will be national by 2005, which is not far away, it sounds like for HHS with TennCare, there is a long way to go to get to that participation by 2005.

If we use the numbers, the error rate, in applying percentages, in your testimony in talking about recovery, about $4 million in recovery—if we had even a—using that 2 percent number from very old, 1 percent, if my math is correct, for TennCare being a $6 billion program would be about $60 million, that there is overpayment in that amount, whether it be intentional or unintentional, but some form of overpayment or wrongful, improper payment; 2 percent would be $120 million. So your $4 million is great in identifying, but that would translate to about a 0.067 percent, less than 1 percent of—well less than 1 percent.

It seems like there were a lot of improper payments out there that we are not identifying currently. And I understand that would take more manpower, more resources, but it seems that the return on that investment would be huge, if we get there and HHS seems to be making the effort on a national level, but for it to really work in programs like Medicaid, it is a partnership. I would hope that looking at doing this becomes more of actually moving forward and actually doing it. And while there would be some initial outlays and costs, it certainly seems that the return would be far in excess of what you put out.

The examples that were given, and Mr. Benson, it was in your testimony where you talked about the identity theft, and you mentioned in your verbal statements as well, that 4,500 that were—that was under the original setup, is my understanding, from a time standpoint, prior to putting in the contracts where they had to have fraud units?

Mr. BENSON. That is correct, that was back in—actually that fraud was committed back in 1994 and one of the things we did was work with the Bureau of TennCare to help revise the contract language with the managed care organizations, to preclude them from paying their representatives in that manner. So one of the first things we did was work with them to try to keep that from happening. And while I would call that kind of a startup type of fraud, as long as they were enrolling people after that time period, by precluding them from being able to do it in that manner, I think we stopped the ability for them to commit that type of fraud.

Mr. PLATTS. How did that particular fraud come to your attention, to TennCare's attention, do you know?

Mr. BENSON. In that case, the homeless shelter called up the Bureau of TennCare and said we have 17,000 pieces of mail down here that we do not think belong to us. We went out and picked up those—TennCare called us, we went up and picked up the 17,000 pieces of mail and what we found was that a lot of them were duplicate mailings from the Bureau of TennCare and that particular managed care organization, to individuals that the homeless shelter said do not belong there. We only have 100 people that usually get mail here, not 4,500 people.

So we were able to take those names, match it up against the Social Security listing and find out that they didn't exist.

Mr. PLATTS. Now the hope is today with the contract language where the MCOs have to have a more active fraud and abuse unit in place, that will not happen.

Mr. BENSON. Right.

Mr. PLATTS. The contract language seems pretty clear and detailed as to what they have to have. What oversight does TennCare do with the MCOs that they do not just have a plan in place, but they are actually implementing that plan and there is something being done, not just written about?

Mr. MATHIS. We were successful in getting that language added about 18 months ago, if memory serves me right. In the last few months we have gone back and are visiting with the contract folks and are amending the language again, that will require the MCCs to give us an annual progress report. It was sort of an implementation of moving to phase one and then moving into phase two and we are at the phase two level.

Mr. PLATTS. Is there oversight in the sense of, I will use the example with the Federal Government, GAO goes out and does in essence undercover operations to test whether an agency is really doing what it says it is doing. Is that part of the oversight? Or is it still really just relying on what the MCOs give you versus going out and not waiting for a homeless shelter to call and say we have all this mail, but is there an effort to go out there and through independent investigations get a benchmark for this MCO is doing a good job, this one is not?

Mr. MATHIS. No, sir, we currently do not have the staffing to go out and do that. I think it would be an excellent—we have discussed it and believe it is an excellent tool that should occur but the staffing and resources are currently not there. However, I will switch and go back again to the proactive means of the new MMIS system. That will identify those cases where we can then refer back to each of the MCCs and ask them to do the in-depth review and letting them know that we are looking over their shoulder because these individuals are coming off of the pages as outlyers and exceptions from the norm. And we believe that is certainly a good proactive measure.

Mr. PLATTS. And yes, you are kind of heading in the right direction, although that would still be after the fact.

Mr. MATHIS. That is correct.

Mr. PLATTS. And that goes to the question about recovery and the ability to get the money back.

Mr. MATHIS. That is correct.

Mr. PLATTS. It is one thing when it is the MCO itself—or I guess MCC now, but where it is an individual, the actual recipient, it is going to be a lot harder to get that money back. It seems it comes back again to resources.

Mr. MATHIS. Yes, sir.

Mr. PLATTS. If I understood some of the background information, in looking at fraud prevention and the number of staff that actually review the eligibility, some of the data we have or was provided is that in 2002 there was about 1,000 applications per week for TennCare and just two staff people who were assigned to review the eligibility—was that——

Mr. MATHIS. I am not familiar with where that information may have come from, I did not provide that. The eligibility review occurs in the DHS office, which there are 95 offices Statewide and I am told that number is over 2,000 eligibility caseworkers. Now they do more than just Medicaid, they do food stamps and TANF, etc.

Mr. PLATTS. OK.

Mr. MATHIS. But they are out there. I am just not familiar with that information.

Mr. PLATTS. OK. With the national organization, I guess Mr. Benson, this is for you, you mentioned that the national President right now being from Pennsylvania with the Medicare Fraud Unit—is there a sharing of kind of best practices State to State? Like you hear something worth seeing, you know, with a new fraud, type of fraud, that is shared and you kind of learn from each other State by State?

Mr. BENSON. I think that is one of the greatest advantages of that association, because there is such a sharing of information and knowledge and the education process. The NAMFCU, the National Association of Medicaid Fraud Control Units, puts out a newsletter 10 times a year. Essentially every time we get a conviction, we report to the Association and they put it in a newsletter that is sent to all of the units. So we are able to see what successes and what types of cases the other States are seeing. And it will be divided up by provider group. It may be a listing of the convictions that occur or indictments that occur under—for patient abuse or under transportation or hospitals, whatever. So somebody—as a unit director, when I see those, I go through it to see if it looks like any type of case that is similar to ours or maybe in an area that we should be looking at. For instance, Georgia had a lot of success in prosecuting transportation vendors a few years back. A lot of States gleaned a lot of information from the types of cases that they worked.

We have an annual conference every year that provides a lot of training to the different disciplines within our units, such as we have breakout sessions for auditors, investigators, nurses, attorneys, so that they can learn from each other. We also have a mid-year conference to where we have similar training like that primarily for the investigators. In a lot of cases it is aimed at patient abuse for the last couple of years. We also have an advanced training program for those that have been in the unit for over 3 years and we have an introductory class for those that are new to the units. So we provide a lot of training.

Mr. PLATTS. National training seminars?

Mr. BENSON. National training seminars, that is correct. We have these that—all of the units are invited to all of these and we really push for the units to participate. As a matter of fact, I am a cochairman of our training committee and one of the things we are doing is putting the final touches of our annual conference coming up in September. We do those every year, the advanced, the introduction, the mid-year and the annual conferences. We also have a director symposium every spring where the unit directors get together to discuss common issues. Problems that we may be seeing in Tennessee, we share it with other States.

When managed care first started in Tennessee, I was going around speaking at a lot of the national association conferences, telling them what we are seeing, particularly these startup types of fraud, so that they could experience from us and hopefully—we tapped into Arizona, for instance, because they had managed care before we did. We were in communication with their fraud unit to try to find out what we would be experiencing. And some of the things that they told us about came to fruition.

So we do a lot of the training with that and a lot of information sharing and I think that is one of the greatest tools that our association has.

Mr. PLATTS. Now the system of trying to identify the improper payments, again, whatever type, that would be something that the association would share—I mean the nine States that are already in the program, with HHS, would they share that and say here is what we are doing with HHS now?

Mr. BENSON. Well, I think to some degree we would be sharing that information as well. I mean we do a lot—a few years ago, I participated with HCFA or CMS, to develop the guidelines on fraud in Medicaid managed care. That was something that several of the MFCU directors participated in with SURS directors and Medicaid Bureau personnel, to put that out there that we shared with all the units. We came up with best practices or model criminal and statutory language a few years ago in dealing with Medicaid fraud issues so that the States could learn from other States. If they have a good statute in another State, we try to look at our State for it.

Mr. PLATTS. Your focus though is where it is really fraud more so than if it was just unintentional wrongful payments.

Mr. BENSON. Right.

Mr. PLATTS. That would not fall in your unit.

Mr. BENSON. That is correct, ours would—and it is on the provider side. We are—the Health and Human Services Office of Inspector General oversees us and mandates that we work the provider side.

Mr. PLATTS. Only the provider side.

Mr. BENSON. That is correct, and one of the things that I want to throw out is that one of the great advantages to our unit is the Program Integrity Unit. In the past, when a referral came in or we started looking at a certain provider, sometimes it took an investigation to determine if there was anything to the allegation. A lot of work would go into it and in a lot of cases it turned out that there was nothing—the allegation was unfounded.

We have the ability now as an allegation comes in, to hand it off to the Program Integrity Unit. They do their validation process, can find out if there is a pattern of—if there is one person that calls up and complains that my mother went to the doctor and I think he billed for x-rays that he did not do—well, for us to investigate that one event might not be that cost-effective. But we can hand it off to the Program Integrity Unit, they can look for that type of billing and may find a pattern of that, then refer it back to us and by the time we get it back the preliminary work has already been done and we can focus on, as you said, the surveillance, the undercover work, the interviews rather than trying to determine is there something we really should be looking at here.

Mr. PLATTS. And so you are actively doing those type of investigations out in the field, but it is more focused on the provider.

Mr. BENSON. It is all provider, that is correct.

Mr. PLATTS. Where the efforts on the beneficiary, the recipient, is more challenged as far as the resources to be out there identifying the efforts, your resources versus the unit Mr. Benson has.

Mr. MATHIS. That is correct.

Mr. PLATTS. Ms. Blackburn, did you have further questions?

Ms. BLACKBURN. Yes, I did have a few questions, and I have one statement. Ms. Heneger-Williams, I appreciated in your testimony that you all are returning $7 for every $1 that you spend. And I certainly think that when you look at the public/private, non-profit sectors, to see cooperation and volunteers, I hope that you are willing to help other States to put these programs in place because that is the kind of support that these programs needs in order to remain viable.

Ms. WILLIAMS. We are more than willing.

Ms. BLACKBURN. And we appreciate very much that good work and your statement of such for the record.

Mr. Benson, it would be my hope that if they are building the MMIS, that you are participating and that you and Mr. Mathis both are working to put some type of framework in place for internal controls to be able to stop some of the problems before they occur, but then also to enable audit opinions to take place and easily fund those mechanisms.

This program that you are building, now is it going to interface with the HHS program that Mr. Williams spoke of? Are you all making plans or is your—you know, one of the things that frustrates us, and Mr. Chairman spoke of this earlier, we have been doing some review of Department of Defense, and they build a program and then it is obsolete. And so they go back and they start and they build another one. And if my memory serves me correct, I think that since TennCare's inception, we have spent over $100 million trying to get an information service program to work for the TennCare program.

So are you all in communication with HHS to be sure that you are building a program that can be integrated or can share information, are you looking at that?

Mr. MATHIS. Let me answer it in this way, if I may, before we could bid the package out, we had to obtain CMS' approval, so the RFP was sent to them for review and analysis and they gave us their approval because in a system such as this, they participate at a 90 percent reimbursement rate, so therefore, you definitely want their approval up front. They gave us their approval, so it would be our hope that all the language that was there that needed to be for them was there.

Does that answer your question? I cannot go further than that.

Ms. BLACKBURN. Yes, sir. That will tell us who does need to answer that question, to say that is so.

Now for the record, I want to be sure that I have my numbers correct. Tennessee now has 1,428,000 TennCare enrollees, correct?

Mr. MATHIS. I do not know the current number, I believe the current number is a little lower than that, but I did not bring that

with me. I think it is 1.3 million, because it is going through the process of reviews and terminations.

Ms. BLACKBURN. OK, and TennCare now has 700 employees, correct?

Mr. MATHIS. I do not have that number with me. I would be happy to get it, but that is not something I brought.

Ms. BLACKBURN. OK, I was just pulling that from some newspaper reports where TennCare was looking for the 200,000 square feet of office space and they—whomever was giving that information, I think your public information officer, had stated that TennCare now had 700 employees.

Mr. MATHIS. If that is the case, it would be the equivalent of. Many of those are contract employees such as the fiscal intermediary or the EDS.

Ms. BLACKBURN. So that would include your outsourced?

Mr. MATHIS. Outsourced, yes.

Ms. BLACKBURN. OK. Let me see, Mr. Benson, 75 percent of your budget comes from the Federal Government, correct?

Mr. BENSON. That is correct.

Ms. BLACKBURN. Are you all drawing down or using all the dollars that are allocated to you from the feds or are you leaving some money aside each year?

Mr. BENSON. There is—we always come in under budget and it is usually pretty close to the total amount. This year our budget is $2.8 million, of which the Federal Government will pay 75 percent and we will spend the majority of that. As you know, Tennessee has been under a budget crunch for the last couple of years, so there has been sometimes that things we had budgeted, particularly out-of-state travel for training, that has not been approved by the State government, so we are not able to utilize all of that we may have budgeted for out-of-state training or travel or whatever. And subsequently, if we are not able to use the State funding, the Federal match is not used as well.

But for the most part, we have been able to use the vast majority of the funding that we have.

Ms. BLACKBURN. And the other 25 percent of your budget, is it general fund or does it comes through the State portion of the TennCare budget?

Mr. BENSON. It is general fund, it does not come from TennCare at all. We have to be totally separate as far as funding from the Bureau of TennCare.

Ms. BLACKBURN. OK, and the money that you all retrieve through the fraud unit, where does that money go?

Mr. BENSON. It depends on the type of—between a criminal or civil conviction—the money primarily goes back to the Bureau of TennCare. There have been criminal cases where the Judge, the court awarded the money back to the managed care organization, but the majority of the time it goes back to the Bureau of TennCare.

The civil settlements that we do, we may work a criminal case through the U.S. Attorney's Office that the U.S. Attorney determines that it does not warrant a criminal conviction or criminal proceeding and they will go civilly with it. That civil money, depending on how the agreement is worked out or the case is worked

out, generally the money goes through the Attorney General's Office. They have to sign off on all the civil cases in Tennessee, the Attorney General does, so we work with them a lot on the civil cases. The money goes through the Attorney General's Office to the Bureau of TennCare.

Ms. BLACKBURN. OK, and the total number of cases that you all have had since TennCare's inception?

Mr. BENSON. I do not have the answers on that right now. I can get those for you. We have to file quarterly reports with HHS-OIG that identifies the number of cases that we have worked, but I do not have the total number with me today.

Ms. BLACKBURN. Now your department was in place in 1984?

Mr. BENSON. It was created in 1984.

Ms. BLACKBURN. So you had 10 years of experience before TennCare came into being.

Mr. BENSON. That is correct.

Ms. BLACKBURN. Can you elaborate for just a moment on how TennCare's creation affected your ability and your department's ability to do its job?

Mr. BENSON. Prior to managed care, our primary contact was the Bureau of Medicaid; at that time, it became Bureau of TennCare. The vast majority of referrals came from that agency. The SURS unit would essentially check 10 percent of each of the different provider groups per year, that was their goal—10 percent of the hospitals, 10 percent of the clinics, 10 percent of transportation companies. They would do a sampling of their patient files. They would get the billing information, they would go actually into the provider's office, business, and they would pull out those patient files and compare them to the billings. If they saw a pattern of abuse or potential fraud, they would refer it to our unit.

When our unit would do the investigations, the Bureau of Medicaid was our primary source to get all the information we needed. We could get the claims, they were submitted directly to the Bureau of Medicaid by the provider, so all we had to go was go to them to get the claims, to get the checks, to match up the checks to the claims, which in a criminal case you have to be able to do. We have to be able to show that this fraudulent claim resulted in this payment.

With the advent of managed care, that has changed tremendously because the claims are not submitted to the Bureau of Medicaid any more. They go to the managed care organization or the behavioral health organizations. So when we get the information and we can still have—we still have access to the computer system that in comparison to what we anticipate is going to happen in the future is an antiquated system. We have two programmers on staff and rather than taking minutes or hours to pull up the information, it takes days or weeks to pull up the information. That was under the old system and it is still in place now, but we do not anticipate it will be with the new system.

But once we get that information, that is a starting point, that data is a starting point, but we have to go get the claims information. We can no longer go to the Bureau of Medicaid to get it, that claim information is out at the different MCOs. Now if you have a provider contracting with more than one MCO, we have to com-

municate with more than one MCO. Some of them are more effective than others in getting the information to us quickly. In dealing with one MCO, we may get the claims information within a matter of days and it may take another 1 week or months.

Accuracy depends on each of the MCOs, as far as being able to find all the claims information, and also to be able to provide—they have to provide us the payment information that goes out. The data that we get from TennCare is the starting point, but it is the claims, the computer transmissions or the hard copies that are sent in are what makes our criminal cases. We have to have those checks, we have to have those claims.

Ms. BLACKBURN. Would you say that fraud has been easier or harder to track under TennCare as related to your experience with Medicaid?

Mr. BENSON. Much harder.

Ms. BLACKBURN. Much harder under TennCare?

Mr. BENSON. That is correct. Part of it I think is due to the providers I think are becoming more savvy on how they commit the fraud, they know that—I have heard it quoted sometimes that if they submit the claim accurately—and I heard a statement this morning that, you know, most of the claims that are submitted, they are reading them accurately, but if it is accurate, that does not mean that event actually occurred. When a provider submits that claim for payment, that does not necessarily mean that he actually did the service that he billed for. And you also have, especially when we are dealing with the pharmacy issues now, you may have a provider that knows that if he is what we call an over-prescriber, a patient can come in and all he has to do is ask for a prescription and it is filled, that provider knows that if he turns around and bills for that service—because the way he is going to get reimbursed is by billing an office visit or for a certain procedure. If that drug addict or that diverter, somebody that is selling the drugs, if they come in once a week to get their hydrocodone or whatever other drug and that doctor is billing once a week for that visit, it is going to raise a red flag somewhere in the system. So what he may do is charge the patient cash so that it does not show up in a billing to Medicaid. And that is a very hard thing to track sometimes. And again, depending on the MCO's quality to identify these things, we have to rely a lot on them in the past. Under this new computer system, we feel like we are going to be able to look at that and identify these things. But that is another difficult thing we have had.

Mr. MATHIS. May I respond to that as well?

Ms. BLACKBURN. Yes, sir.

Mr. MATHIS. From the standpoint of putting it in a little different perspective. And William, if you disagree, please speak up.

But with an MCC, which is our frontline of defense—you know, we talked about having our compliance plan. They may see a provider billing for 5 hours a day, nothing jumps off the chart. But when that provider is a contractor with five MCCs and they are billing each one of them 5 hours a day, then we are above 24 hours a day worth of billing. That is where the new system—certainly we can go in today and extract that information, but the new system will certainly pull it all together and identify it for us. That is why

we need to certainly have a system that is very flexible, to support the managed care contractors that are out there on the front lines as well.

So that is a very important issue from our point.

Mr. BENSON. That is correct.

Ms. BLACKBURN. Mr. Mathis, I am aware that each Governor, including our Governor here in Tennessee, received a letter in June from the House Energy and Commerce Committee requesting information on waste, fraud and abuse in the State. Have you all submitted your answers to that letter?

Mr. MATHIS. We have. There was a couple of questions that directly related to program integrity and those were sent to us and we have responded back to those. One of the major issues, if I remember correctly, it asked us about the staffing, how many staff positions we had several years ago versus where we are at today and what kind of resources that we have and what kinds of recoveries have taken place.

Ms. BLACKBURN. OK, thank you very much.

Mr. PLATTS. Thank you, Ms. Blackburn. We are going to need to wrap up here fairly quickly. Unfortunately, Ms. Blackburn and I both have to catch a flight to get back to D.C. for session later this afternoon.

I do want to, with all three of you, ask one final question and it relates to—Mr. Mathis, I think you talked about your kind of three strikes and you are out, if a recipient commits fraud. First it is 12 months, then I think 2 years and then permanent. And you understand that under Federal law, the bar can only be for a maximum of 1 year. So that is something specific we need to look at as to whether we need to adjust Federal law to give you the authority to hold people accountable. And I appreciate that is what you are seeking to do and we will look at that.

Is there anything else that you would like to bring to our attention, whether it be with the seniors and how to have a program that allows you to be more effective, you know, encouraging seniors to participate, whether it be with your fraud units, whether it be the Program Integrity Unit, something in Washington that you want us to take back with us from your State and regional perspective?

Mr. MATHIS. Would you like for me to go first? I am not sure you have enough time, but—[laughter]—there are a couple of issues along those same lines I certainly would share. Maybe the subcommittee should take a look at the State residency laws and rules because currently that is—when we work out-of-state cases, those are the most difficult cases on recipient fraud that we have to work. The reason that it is so difficult is the Federal guideline says that it is the intent of the recipient. I can intend to live in Tennessee today and intend to live in Kentucky tomorrow and intend to live in North Carolina the next day. So it is very difficult for us to handle and work those kinds of cases, which I reported we have four under indictment because we have shown they never lived in Tennessee. They rented post office boxes and forwarded their mail, and those are going forward and they are very interesting cases. I do not have time to share the details with you.

Another one—and I am sharing these, not on behalf of TennCare, you have asked the question and I am sharing them on behalf of Tom Mathis and how I feel.

Illegal alien is another issue that you may want to take a look at because that is an issue—if an illegal alien comes into this country and goes to the hospital, they are automatically covered under the Medicaid program until they are released. We receive many complaints about that from individuals who are citizens of this country of ours that are not able to get on and they go to the hospital and they are certainly not covered. And it is difficult for me to sit and defend that certainly.

The other issue I will mention and then I will hush, is possibly some assistance—and this may be partially my fault, but in doing—we have been doing matches against State prisons and county jails for convicted felons. I have not been able to find an avenue to get access to do matches against the Federal prisons nationwide, and it would be of assistance. I would like to run that match because if someone is convicted out of Tennessee, they may be placed in a Federal prison in any of the States, wherever they have room. And I would certainly like to run that match because we have had a high level of success in terminating individuals in State prisons and in county jails where you are housing felons.

Mr. PLATTS. You have made a request to the Federal Bureau of Prisons or to someone to try to get that but have not been able to get it?

Mr. MATHIS. I have not made an official request, I have made several phone calls and had some conversations. Coming out of the prison environment where I worked for over 22 years, I had knowledge of that and tried to bring that in, but I am told that we are not—they are restricted in being able to give that to us at this point.

Mr. PLATTS. OK. Well, we appreciate those suggestions and we will gladly take a look at them. Mr. Benson and Ms. Williams?

Mr. BENSON. The only thing I would throw out is just the financial—the Federal financial participation is so important to the States, the need for that to continue. Without that 75 percent funding, it would be extremely detrimental to the units to say the least.

The other thing is the emphasis to the States, even the ones that are in financial constraints, to release all of the State funding that is available to match that for the Federal funds is very important. For those States that do not have updated fraud detection systems, we know from experience in Tennessee, the difficulties we have had, the emphasis to those States to create those data warehouse systems like we are going to in Tennessee, I think are very important.

I cannot stress enough the importance of the Medicaid Fraud Control Units and SURS and Program Integrity Units working together. I cannot imagine how difficult my job would be, more difficult my job would be, if we did not have an excellent relationship. And for those States that do not, I think the emphasis should be put on those States to create and maintain an excellent relationship as best they can.

Mr. PLATTS. I appreciate the comments. And I do hope that as you develop the information system, that—we talked a lot about

fraud, but that it is again going to capture, in a broader sense, what HHS is trying to do with improper payments of all types, whether it is intentional fraud or just other errors, because to the taxpayer, wrongful payment of any kind is still going to hurt the taxpayer.

Mr. BENSON. Right.

Mr. PLATTS. I realize to your specific unit, fraud is your focus, but to the Program Integrity Unit, it is the big picture.

Ms. Heneger-Williams.

Ms. WILLIAMS. The request that I have to take back to Washington would be nothing more than the continuation for the Senior Medicare Patrol program nationwide. It is obviously a very needed program to get the educational aspect out there very effectively and efficiently.

Mr. PLATTS. We appreciate that, and also to engage our seniors and have the benefit of that civic duty, as we talked about.

Ms. Blackburn, did you want to make a closing statement?

Ms. BLACKBURN. Only one thought as we are closing. Just with the question that you had asked on the lessons learned and I think Mr. Mathis probably has an additional list of those that he would recommend to us. I just think that over the next couple of days if you all would like to submit in writing for the record, that would be very helpful to us as we look at the waiver program and the Medicaid program, those lessons learned here in Tennessee would be important. And I would ask you to submit those. Thank you.

Mr. PLATTS. Thank you, Ms. Blackburn, an excellent point. And because of time constraints today, anything you would like to add. We will keep the official record open for 2 weeks for things you want to share, from suggestions standpoint or some of the specific followups that we have requested from you, that you will be forwarding, and we appreciate you doing that.

I will add my thanks to each of you for your participation, and as with our Federal officials, your work day in and day out in trying to serve our citizens well, we appreciate your efforts.

Certainly I think Mayor McDonald was in the room but I think he has stepped out now, we appreciate the city of Bartlett hosting us here.

Ms. Blackburn, we are delighted to be here in your district and giving us hands-on information both with our Federal colleagues but also with your State and local efforts out here in the State of Tennessee.

The focus is certainly one that we all share, the goal, of ensuring the taxpayers are getting the return on their investment in whatever the program may be. In this case, especially Medicaid. My one hope is with Tennessee and the TennCare program, as you are developing your system, that coordination with HHS becomes tighter and not just something that is being, as I said earlier, thought about, but actually acted on so that we can get that comprehensive national picture of how we are doing and how responsible we are being with the taxpayer funds for all American citizens.

I appreciate everyone's participation. Our thanks to all of our staff for their work in setting up this hearing and working with not just the elected officials here in Bartlett, but staff that may be

present here in the room, for your assistance to our staff in putting this hearing together.

This hearing stands adjourned.

[Whereupon, at 11:06 a.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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July 23, 2003

Honorable Todd R. Platts
Representative, 19th District
Subcommittee on Government Efficiency and Financial Management
Government Reform Committee
U.S. House of Representatives
B-349C Rayburn House Office Building
Washington DC 20515

Dear Representative Platts:

Thank you again for the opportunity to appear before the Subcommittee last week. During the hearing, the question was asked as to the number of fraud referrals the Tennessee Medicaid Fraud Control Unit (MFCU) has received. I apologize for not having that answer readily available during the hearing. In reviewing our records, we have identified a total of 1653 fraud referrals from FFY 1993 through June 30, 2003, of which 268 came from the SURS/Program Integrity Unit and 102 came from the Managed Care Organizations. During this same timeframe, the MFCU has opened a total of 315 fraud investigations.

The Committee also asked if the witnesses had any suggestions or recommendations. While I appreciate having had the opportunity to provide input during the hearing, I do have one additional suggestion that I would also like to share. In addition to state prosecutions, several of the MFCUs conduct investigations that are referred to federal prosecutors. While the MFCUs manage (or share management duties in joint cases) the investigative stage, often prosecutions hinge on the availability of federal prosecutors. Joint investigations with federal agencies such as Health and Human Services' Office of Inspector General, FBI, IRS, or U.S. Postal Service often result in criminal convictions and the recovery of millions of dollars. Having additional prosecutors who focus solely on health care fraud cases would logically lead to the culmination of more cases and provide a deterrent to criminal behavior.

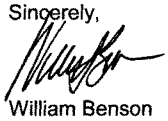
I would also like to clarify an answer given to the question of who receives the proceeds of the fraud recoveries. In Tennessee, courts have awarded restitution to either the Bureau of TennCare or the respective MCOs (and sometimes, both). A number of cases have resulted in civil settlements in which the MFCU conducted an

investigation, assisted other agencies in the investigation, or provided requested data. While the MFCU usually has the role of providing the investigative work on these cases, the Tennessee Attorney General has the responsibility for signing these settlement agreements. These cases often result in a settlement check being distributed to the Bureau of TennCare, by the Attorney General's Office.

In rare occasions, the MFCU has been awarded investigative costs from an investigation. These costs are returned to the MFCU only after the Bureau of TennCare has been made whole from its losses. In even more rare occasions, the MFCU has been awarded asset forfeiture funds. These instances have occurred when the MFCU assisted federal agencies and money and/or property was seized during the investigation. The U.S. Department of Justice determines the amount of the seized assets that are to be awarded to the MFCU. The focus of the MFCU concerning recoveries is to return the overpayments to the Medicaid (or Medicare, where appropriate) program and there have been less than a half dozen cases which resulted in the MFCU receiving investigative costs or asset forfeiture awards.

Thank you again for the opportunity to participate in the hearing.

Sincerely,



William Benson
Special-Agent-in-Charge

WB/dga

cc: Director Larry Wallace
Deputy Director David Jennings

The following is information provided by the Department of Health and Human Services for the record:

August 8, 2003

The Centers for Medicare and Medicaid Services (CMS) Atlanta Regional and Central Offices monitor the payments made for the Tennessee Title XIX Program, including the TennCare Demonstration and home and community based waivers programs, through several processes. A brief overview of the primary ones is provided below.

1. **Quarterly Budget Reports (Form CMS-37 Reviews)**

   CMS requires that Tennessee electronically submit Quarterly Budget Reports (QBR) (Form CMS-37) that project its Medicaid funding requirements for two fiscal years (current and budget). A CMS Atlanta Regional Office (RO) Financial Management Analyst reviews these budget estimates quarterly for completeness and accuracy, compliance with Federal laws and regulations, and claiming at the appropriate Federal match rate. CMS uses the quarterly budget requests established through this process to determine the amount of the quarterly grant awards to be advanced to the TennCare Bureau for its Title XIX program.

2. **Quarterly Expenditure Report (Form CMS-64 Reviews)**

   Each quarter, Tennessee electronically submits a Quarterly Expenditure Report (QER) (Form CMS-64) to CMS of its actual expenditures derived from source documents such as paid claims, invoices, cost reports and eligibility records. This report is used to reconcile the Medicaid funding advanced to the State based on the Expenditure Report (Form CMS-37) to the actual amount of expenditures reported. This accounting statement must represent actual expenditures and supporting documentation. The supporting documentation must be in readily reviewable form and must be available at the time expenditures are claimed.

   The CMS Regional Office Financial Management Analyst conducts an on-site review of the expenditure report and analyzes samples of selected supporting documentation. This review includes a variance analysis of the quarterly expenditure fluctuations in the different categories of service (COS). Expenditure reporting errors are frequently caught during the analyst's review of the State's supporting documentation and, whenever possible, corrections are negotiated with the State staff who then submit revised QERs. When satisfactory corrections are not agreed to by the State staff, CMS must decide whether to defer, or possibly disallow, the Federal financial participation (FFP) claimed for the questionable expenditures. A deferral action allows CMS to withhold the Federal funds claimed by the State whenever CMS needs to review additional supporting documentation before making a formal decision as to whether the amount of FFP was allowable as claimed by the State. If CMS decides that the FFP claimed for the deferred expenditures is allowable, then CMS so notifies the State and the previously withheld

amount of FFP is issued to the State in a subsequent grant award. Whenever CMS reaches a formal decision that the FFP claimed by the State is **not** allowable, then CMS issues a formal disallowance action which (i) notifies the State that the unallowable FFP will not be provided by CMS and (ii) informs the State of its formal appeal rights.

4. Financial Management Reviews (FMRs)

The CMS Regional Office Financial Management Analyst identifies and targets program areas where the risks are believed to justify conducting financial management reviews, on-site focused reviews of reported expenditures in those areas, known as FMRs. These reviews ensure that expenditures are claimed in accordance with the applicable laws, regulations, policies, and waiver requirements.

5. Annual Single Audit Report (SAR) Findings Resolution

Under the terms of the Single Audit Act, each year a thorough audit of the entire Tennessee Medicaid program is performed by the Tennessee Division of State Audit. Usually, a team of 6 or 7 State auditors work on-site at the State Medicaid agency (SMA) for about 7 months of each year reviewing samples of all the transactions for compliance with Federal requirements. Since the intent of the Single Audit Act is to preclude duplicative audits and reviews of the same program expenditures by multiple State and Federal auditing entities, CMS places heavy reliance on the State auditors' results.

Upon receipt of these annual SARs, the Federal DHHS Office of the Inspector General (OIG) forwards the reports to CMS and assigns to CMS the responsibility for ensuring that appropriate corrective actions are implemented by the State.

6. State Plan Amendment (SPA) Review & Approval Process

CMS thoroughly reviews all SPAs submitted by the SMAs for compliance with Federal statutes, published regulations, and CMS program policies before approval is granted in an effort to prevent claims for unallowable FFP and/or State practices prior to the SPA being implemented.

7. OIG Cooperative Reviews

CMS often sends requests to the OIG to solicit their help in reviewing some aspects of the programs under CMS. We ask the OIG to target specific program or financial issues in the State to ensure that those areas are in compliance with applicable laws, regulations, policies, and waiver requirements.

CMS Monitoring of the TennCare Demonstration Project

Since the inception of the TennCare Demonstration Project, CMS has monitored it continuously, including quarterly and annual reports, submitted by TennCare, related to quality and all aspects of the program. The monitoring activities include onsite visits, discussions with beneficiary advocacy groups, participation on work groups to reform the program, and reviewing reports prepared by the state.

TennCare II (the current version that was approved effective beginning July 1, 2002) is a Tennessee Statewide Healthcare Demonstration Project approved under section 1115 of the Social Security Act (SSA) to provide health care benefits to Medicaid beneficiaries, uninsured State residents with income below specified limits, and uninsured residents at any income level if they have medical conditions that make them uninsurable. Medicaid enrollees who are also enrolled in Medicare are not included in this demonstration. All enrollees are served in capitated managed care organizations (MCOs) that are health maintenance organizations (HMOs). In addition to covering Medicaid eligibles and uninsured women under age 65 who have been certified by the Centers for Disease Control (CDC) as needing treatment for breast or cervical cancer, the State has been approved to cover the following populations up to the income levels indicated (subject to the State's budget appropriation):

- Uninsured, without access to group health insurance, up to 200 percent of the Federal Poverty Level (FPL). (Currently State appropriations allow uninsured children, up to age 19, up to 200 percent FPL and uninsured adults, up to 100 percent FPL.)
- Medically eligible, uninsured, at any income level who meet the medical criteria.
- Grandfathered - children, enrolled in the previous demonstration as uninsured, as of 12/31/01, who have access to group health insurance, under 19, under 200 percent FPL. (Will move to the Employer Sponsored Insurance (ESI) program when implemented.)
- Grandfathered - with Medicare but not Medicaid, enrolled as of 12/31/01 as uninsurable, at any income level.

No open enrollment period is held other than for Medicaid coverage and for Medically eligible with incomes below 100 percent FPL, both of which have continuous enrollment.

As with all section 1115 demonstrations, the TennCare II approval by CMS was contingent upon the State's agreement to abide by or be constrained by about 27 Special Terms and Conditions (STCs). CMS writes the STCs for each demonstration to ensure that the State has sufficient controls and reporting mechanisms in place to provide the Secretary of HHS and the CMS Administrator with the comfort level they need for approval of the requisite waivers of the SSA. As a result of these STCs, the CMS Regional and Central Office's staff must also perform many significant additional monitoring processes for the payments made for the TennCare II section 1115 demonstration project. The most significant of these is explained below.

TennCare II Budget Neutrality Monitoring

The Regional Office and the Central Office will monitor the budget neutrality of the TennCare II demonstration cumulatively for the 5 years of the demonstration based on the agreed upon annual per member per month (PMPM) targets, plus the annual disproportionate share hospital (DSH) adjustment amounts. The State must provide quarterly reports to CMS that contain the number of member months of eligibility that were covered for the TennCare II enrollees. The number of member months must be reported by group type (Medicaid eligibles, enrollees who could be eligible if Tennessee amended its State Plan, those who could not be eligible without the Section 1115 waiver authority, and Medicare / Medicaid Dual Eligibles) and age groupings (children, disabled, adults over 65, and other adults). The cumulative member months covered by category for the Medicaid eligibles (plus those who could have been eligible) each year of the demonstration will then be multiplied by the agreed upon PMPM target amounts. Then, we will add to that total amount an annual DSH adjustment for each year to arrive at the total estimated amount that the State could have spent for its Medicaid program in the absence of the demonstration. Then, these estimated annual Medicaid targets are finally compared to the State's actual cumulative annual TennCare II expenditures that are reported. Although CMS enforces budget neutrality over the 5-year approval period, CMS reviews these annual target comparisons in order to work with the State to resolve potential overages.

Home and Community Based Waiver (HCBW) Program Monitoring

The State of Tennessee operates two home and community-based waiver (HCBW) programs for persons with mental retardation and developmental disabilities, the Waiver for Adults and Children with Mental Retardation and Development Disabilities (Control Number 0128.90.R1) and the Waiver for Individuals with Mental Retardation (Control Number 0357). These waivers, authorized under Section 1915(c) of the Social Security Act, provide services in community-based settings to individuals who would otherwise require institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). CMS conducts a review of each HCBW during the given waiver approval period. Waivers are approved for a 3 or 5-year period.

In addition, CMS has provided extensive technical assistance resources directed at revising Tennessee's quality assurance and improvement system.