Statement by

Charles E. Johnson

Assistant Secretary for Resources and Technology and

Chief Financial Officer

U.S. Department of Health and Human Services

on

HHS Improper Payment Initiatives

before the

Subcommittee on Federal Financial Management, Government Information, and International Security

Committee on Homeland Security and Government Affairs

United States Senate

Thursday, January 31, 2008

Good afternoon Mr. Chairman and distinguished Members of the Subcommittee. Thank you for inviting me to appear before you today. It is a pleasure for me to have the opportunity to testify about the U.S. Department of Health and Human Services (HHS or the Department) improper payment initiatives.

The Department is firmly committed to ensuring the highest measures of financial accountability to the American people. With the size and scope of HHS programs, we know that it is critical to prioritize, and be aggressive in our activities to identify and take action to reduce improper payments. Over the past several years, we have had many

successes and accomplishments in this area. I am pleased to share some of these with you today as well as some of the challenges we face.

As required under the Improper Payments Information Act of 2002 (IPIA) (P.L. 107-300) and related guidance issued by the Office of Management and Budget (OMB), the Department has methodologies to estimate improper payments for its seven high-risk programs: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Foster Care, Head Start and Child Care. These seven programs account for close to 90 percent of HHS' $708 billion total estimated FY 2008 outlays. In terms of both size and potential for growth, the risk and impact of improper payments is greatest for the two HHS programs that account for more than 85 percent of these total outlays - Medicare and Medicaid. Our improper payment activities have helped focus our efforts to strengthen HHS' stewardship over taxpayer dollars.

IPIA Compliance

HHS is expected to report an error rate for all seven of its high-risk programs in its FY 2008 Performance and Accountability Report (PAR), thereby fully complying with the IPIA. In addition, HHS has been very successful in continuously reducing its error rates over the past few years for the many programs we have been measuring. We began reporting on improper payments in FY 2004 for three of our seven high-risk programs, Medicare fee-for-service (FFS), Foster Care, and Head Start. In FY 2004, those rates

were 10.1 percent; 10.33 percent; and 3.9 percent, respectively. As a result of our corrective action efforts, those rates have declined dramatically. In the FY 2007 PAR, we reported a Medicare FFS rate of 3.9 percent; a Foster Care rate of 3.3 percent; and a Head Start rate of 1.3 percent. (See Exhibit 1.)

In addition to steadily reducing error rates for Medicare FFS, Foster Care, and Head Start, HHS has made tremendous progress in developing measurement methodologies for its other high-risk programs, Medicaid, SCHIP, TANF, and Child Care. In FY 2007, HHS reported, for the first time, a preliminary error rate for Medicaid and reported on the results of pilot projects for TANF and Child Care. In the FY 2008 PAR, error rates will be reported for each of these high-risk programs.

Medicare

Medicare is HHS' largest program, accounting for almost 60 percent of HHS' FY 2008 outlays. Medicare is the Federal health insurance program administered by the Department's Centers for Medicare & Medicaid Services (CMS) that provides medical insurance to roughly 44 million people. Approximately 75 percent of Medicare spending in FY 2008 will be for fee-for-service (FFS) hospital and physician services. The FFS component of Medicare covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. The CMS administers the Medicare FFS claims processing and payment systems through contracts with Carriers, Durable Medical Equipment Medicare Administrative Contractors

(formerly called Durable Medical Equipment Regional Carriers (DMERCs)), Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FI), and Quality Improvement Organizations (QIOs). These entities review claims submitted by providers to ensure payments are made only for medically necessary services covered by Medicare for eligible individuals. HHS estimates that the contractors processed over one billion claims last year from providers, physicians, and suppliers for items and services that Medicare covers.

In 1996, HHS' Office of the Inspector General (OIG) began estimating improper payments in the Medicare FFS program as part of the financial statement audit required by the Chief Financial Officer's Act of 1990 (P.L. 101-576). The OIG produced FFS error rates from FY 1996 through 2002. Beginning in FY 2003, CMS, working with the OIG, implemented a more robust process - the Comprehensive Error Rate Testing (CERT) program - to assess and measure improper payments for approximately 60 percent of the dollars covered by the Medicare FFS program. The CERT program not only produces a national paid claims error rate but also provides very specific improper payment rates, including contractor-specific improper payment rates that measure the accuracy of our claims processors; provider-type specific improper payment rates that measure how well the providers who care for our beneficiaries are preparing and submitting claims to the Program; and other management related information that provides insight into payment errors by region and reason. The Medicare FFS improper payment estimate is derived from two programs: the CERT Program, representing approximately 60 percent of the Medicare FFS dollars and Hospital Payment Monitoring Program (HPMP), representing

approximately 40 percent of the Medicare FFS dollars. The Medicare FFS measurement programs have provided HHS with powerful tools to identify problems in claims processing and address these problems through specific corrective action plans.

In FY 2007, HHS reported a Medicare FFS paid claims error rate of 3.9 percent, which is a full half-point reduction from the 4.4 percent rate reported in FY 2006. Further, this 3.9 percent rate is less than half of the 10.1 percent rate measured and reported just three years ago. (See Exhibit 2.) The significant drop in this rate is primarily attributable to the aggressive measures that were taken by the Department to ensure that the necessary documentation was submitted by the providers to support the payments made.

While CERT and HPMP have been useful for guiding our efforts in the Medicare FFS program, they do not provide a measure for payments in Medicare Advantage or the Medicare Prescription Drug Benefit Program (also referred to as Medicare Part C and Medicare Part D, respectively). These programs added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173) represent about 32 percent of the Medicare benefit gross outlays for FY 2008. In FY 2007, the Department measured a component rate for Medicare Advantage and the Medicare Prescription Drug Benefit programs. In FY 2007, the Department measured a component rate for Medicare Advantage and the Medicare Prescription Drug Benefit programs. Each of these programs reported less than a one percent component rate. HHS anticipates expanding its payment error rate reporting for Medicare Advantage and the Medicare Prescription Drug programs in the FY 2008 PAR.

Medicaid and SCHIP

The Department's second largest program, Medicaid, accounts for over 25 percent of Department outlays. Unlike Medicare, this program is administered primarily by State Governments. While the Federal Government provides matching payments to the States, each State is responsible for overseeing its Medicaid program. Each State essentially designs and runs its own program within Federal guidelines. The Federal Government pays the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that currently ranges between 50 and 76 percent.

In FY 2000, HHS adopted a Government Performance and Results Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments in the Medicaid program. Beginning in 2001, HHS formally solicited States to participate in the development of a model to estimate payment accuracy. Only three States, Illinois, Texas, and Kansas, had attempted to estimate payment error in their respective State Medicaid programs prior to HHS initiating the pilot project.

From FY 2002 through 2005, HHS conducted the Payment Accuracy Measurement (PAM) and Payment Error Rate Measurement (PERM) pilot projects with extensive collaboration from participating States to determine a systematic means of measuring payment errors at the State and national levels. From these pilot projects, HHS was able

to develop a methodology to estimate a State-specific payment error rate that would be the model for the national Medicaid and SCHIP error rate methodologies.

In FY 2007, HHS measured a national Medicaid FFS error rate for FY 2006 claims in 17 States based on medical reviews and data processing reviews. Although limited in scope, HHS was able to report a 6 month preliminary error rate, based on 6 months of data from each of the 17 participating-States. The preliminary error rate was 18.45 percent. It is important to note that approximately 80 percent of this error rate is attributable to providers not submitting adequate documentation, a problem similar to what we experienced in the early years of the Medicare program. (See Exhibit 3.) We hope to see a reduction in this rate. This preliminary error rate does not reflect the late implementation of some new policies in the measurement cycle, particularly with respect to HHS' increased efforts to obtain documentation. These factors should be considered when reviewing the preliminary rate and the results of these new policies may impact the final calculation of the annual error rate. HHS is in the process of completing the error rate measurement for the FY 2006 claims and will report the full-year Medicaid fee-for-service error rate in the FY 2008 PAR.

In addition, HHS expects to report a comprehensive error rate for both the Medicaid and the SCHIP programs based on FY 2007 data. The comprehensive measurement will include measuring the FFS, managed care, and eligibility components for both the Medicaid program and SCHIP.

TANF

The TANF program provides an annual block grant to States, Territories and eligible Tribal programs to help families transition from welfare to self-sufficiency. Due to the statutory limitations with regard to the TANF information that HHS can request of States, HHS has faced many challenges in the development of a TANF error rate methodology. After pilot testing two different methodologies, I am pleased to report that HHS has identified a viable approach to measuring the TANF error rate.

HHS has been working to develop an approach to measure the error rate in the TANF program since the inception of IPIA. Between FY 2002 and 2005, we conducted a pilot project with four States. This project focused on obtaining an improper payment estimate using the existing OMB Circular A-133 audit process. The A-133 audit process is used to audit States, local government, tribes, non-profits, and colleges and universities that receive federal funds. The auditors reported error rates that ranged from 2.3 percent to 24.6 percent. Due to a number of factors, including the lack of standardization and varying audit approaches, the Department concluded that this method did not yield a viable means to producing a TANF error rate.

In FY 2007, HHS' OIG conducted a pilot review of TANF cash assistance payments in three states. The OIG tested cash assistance payments, in accordance with Federal rules and with the States' own policies, to ensure that eligible families were receiving the TANF benefits and that the benefits were calculated properly. The error rates for the

pilots ranged from 11.5 percent to 40 percent. A portion of the errors in each pilot is attributable to documentation errors. While HHS lacks the legislative authority to require States to develop or implement corrective action plans, HHS will develop a corrective action plan that States will be requested to implement. HHS believes this standard approach, based on a State's own standards and conducted by the same independent party in all States is a viable approach to meeting the requirements of the IPIA. As a result, HHS will continue to employ this methodology and expects to report an estimate of the national TANF error rate in the FY 2008 PAR, which will be finalized and reported in the FY 2009 PAR. Congressional support for the Department's funding requests to carry out IPIA activities in the TANF program is critical to the sustainability of this initiative.

Head Start

The Head Start Program provides grants to local public, for profit and non-profit agencies to provide comprehensive child development services to children and families, primarily preschoolers from low-income families. In the period covered by this testimony, Head Start regulations allowed Head Start programs to serve up to 10 percent of their enrolled children (up to 49 percent in certain situations for tribal Head Start programs) from families who do not meet Head Start income requirements. Under Head Start legislation, grantees are required to be monitored at least once every three years. In FY 2004, HHS developed a methodology for estimating a national Head Start payment error rate building on the required review process. In the FY 2007 PAR, Head Start reported an

error rate of 1.3 percent, which is one-third of the 3.9 percent error rate reported in FY 2004.

Foster Care

The Foster Care Program is designed to help States provide safe, appropriate, 24-hour, substitute care for children who are under the jurisdiction of the administering State agency and who need temporary placement and care outside their homes. Child and Family Services Reviews (CFSRs) are conducted in each State at least once every three years by teams who review cases selected from the State's Title IV-E foster care population. These reviews are intended to recover Title IV-E funds claimed by States for ineligible cases and, in conjunction with the required program improvement plan (PIP) for those States determined to be non-compliant, to help change their behavior so that subsequent reviews will result in lower error rates.

HHS developed a methodology for estimating a national payment error rate for the Title IV-E Foster Care Program using data gathered in the eligibility reviews. In FY 2007, Foster Care also began systemically measuring underpayments as well as overpayments, as required by OMB Circular A-123, Appendix C. The absolute value of the overpayments added to the underpayments was used in the improper payment calculation. For 2007, Foster Care reported an error rate of 3.3 percent, significantly down from the 10.33 percent first reported in FY 2004.

HHS is also in the process of developing a measurement methodology to measure Foster Care administrative cost payment errors. Congressional support of the Department's funding request to implement this methodology is critical to its success.

Child Care

The Child Care and Development Fund (CCDF) is a block grant composed of three distinct funding elements (mandatory, discretionary and matching) authorized in two different statutes. In FY 2007, the Child Care program completed pilot projects measuring improper payments based on state eligibility criteria. The payment error rates for these pilots ranged from 2 percent to 18 percent.

Also, in FY 2007, HHS issued a final regulation requiring States to measure improper payments in the CCDF program, based on eligibility, once every three years. As a result, in the FY 2008 PAR, HHS expects to report a national CCDF error rate.

HHS Prevention and Recovery Efforts

The Department's efforts to safeguard Federal funds are not limited to the error measurement initiatives described in this testimony. HHS' fiscal integrity program provides for a multi-faceted approach to assessing the extent of improper payments through the error measurement process, analyzing the cause of improper payments, strengthening internal controls to prevent improper payments from occurring, and

identifying and recovering improper payments when they occur. These initiatives help strengthen program integrity as well as protect taxpayer dollars. We believe that a few of these initiatives warrant the Committee's attention.

Data Matching Programs

Data matching has proven to be an effective tool for verifying eligibility and preventing improper payments. We would like to highlight two of HHS' successful data matching programs that benefit HHS programs as well as programs administered by other federal agencies.

Public Assistance Reporting Information System (PARIS)

PARIS is a voluntary data matching system facilitated by HHS that enables participating States' public assistance data to be matched against several databases to maintain program integrity and detect and deter improper payments in several programs (TANF, Medicaid, and the U.S. Department of Agriculture's Food Stamp program) by validating client-reported information and identifying potential improper payments. Currently 44 jurisdictions participate in the PARIS project. PARIS includes a number of matches that the States can utilize.

Every quarter, PARIS member States voluntarily choose whether, and in which match to participate (at no charge to them). The more States that join and conduct matches under PARIS, the wider the net of potential matches of information

becomes available to PARIS member States to validate public assistance program client-reported information and identify potential improper payments.

During the period April 2003 through March 2007, New York State closed or removed from active public assistance 26,047 individuals identified by the PARIS match. The cost savings for these individuals was in excess of $192 million dollars. Pennsylvania is also another PARIS success story. Pennsylvania has participated in the PARIS matches for the past 7 years. As of February 2007, Pennsylvania has closed 13,348 public assistance cases resulting in cost savings in excess of $73 million dollars. The PARIS savings cited in this section are self-reported estimates by the States.

National Directory of New Hires (NDNH)

HHS is continuing to expand State access to the National Directory of New Hires (NDNH). The NDNH offers solutions to the prevalent under-detection by States and reporting of employment of TANF recipients. The NDNH was authorized under the welfare reform legislation to provide a national database of employment information for the purpose of collecting child support payments. HHS completed a demonstration project to enable State TANF agencies to match their TANF caseloads against the database. This effort began with a pilot effort in the District of Columbia (DC). In 2005, 30 States, DC and Puerto Rico conducted matches. During FY 2006, 34 States conducted matches and during FY 2007 29 States conducted matches. HHS will continue working with the States. Together, these States and Territories account for 82 percent of the TANF caseload.

Recovery Actions

The following paragraphs describe key activities used by HHS to deter, identify and recover improper payments used in connection with our largest program, Medicare.

Recovery Auditing Contracting (RAC)

In addition to measuring error rates, HHS is also conducting a project to recover erroneous payments from Medicare providers. Beginning in 2005, HHS engaged in a Demonstration Project for Improving Program Integrity in Medicare. Under section 306 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), HHS was given the authority to conduct a demonstration project to demonstrate the use of Recovery Audit Contractors (RACs) in identifying underpayments and overpayments and recouping overpayments under the Medicare fee-for-service program.

HHS initiated this 3-year demonstration in the three states with the highest Medicare utilization rates. HHS provided the recovery audit contractors with over $239 billion worth of claims submitted between FY 2002 and FY 2007 that are potentially subject to review. The RACs perform data analysis on the claims data to identify potential improper payments. For the claims the RACs believe may have been paid improperly they request the medical documentation from the provider and perform a medical review to determine whether the claim was paid correctly. From the inception of the RAC program through September 30, 2007, HHS has collected $432 million in payments determined to be improper.

Although the RAC demonstration was scheduled to end in March 2008, Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC program permanent and requires the Secretary to expand the program to all 50 states no later than 2010. HHS has already begun expanding the RAC program and as of September 2007, the RAC demonstration has expanded into 2 additional states (Massachusetts and South Carolina).

Fraud, Waste and Abuse

HHS' efforts to combat fraud, waste and abuse through the Medicare and Health Care Fraud and Abuse Control (HCFAC) Programs have a proven record of returning money to the Trust Fund for each dollar spent. The return on investment (ROI) for the Medicare integrity program (MIP) is 13:1. From 1997 to 2007, these activities have returned over $10 billion to the Trust Fund.

HHS employs "Payment Safeguard Contractors" (PSCs) in the Medicare fee-for-service program to identify potential problem areas, investigate potential fraud, and develop fraud cases for referral to law enforcement. In addition, HHS has regional Satellite offices in Miami, Florida; Los Angeles, California; and New York City, New York, where fraud and abuse is more prevalent. The Satellite offices are focused on investigating allegations of fraud and abuse in their specific geographical areas. Due to HHS' targeted efforts in these areas, HHS has recovered $1.8 billion in improper payments from FY 2004 through mid-FY 2007.

Recoveries from IPIA Error Measurement

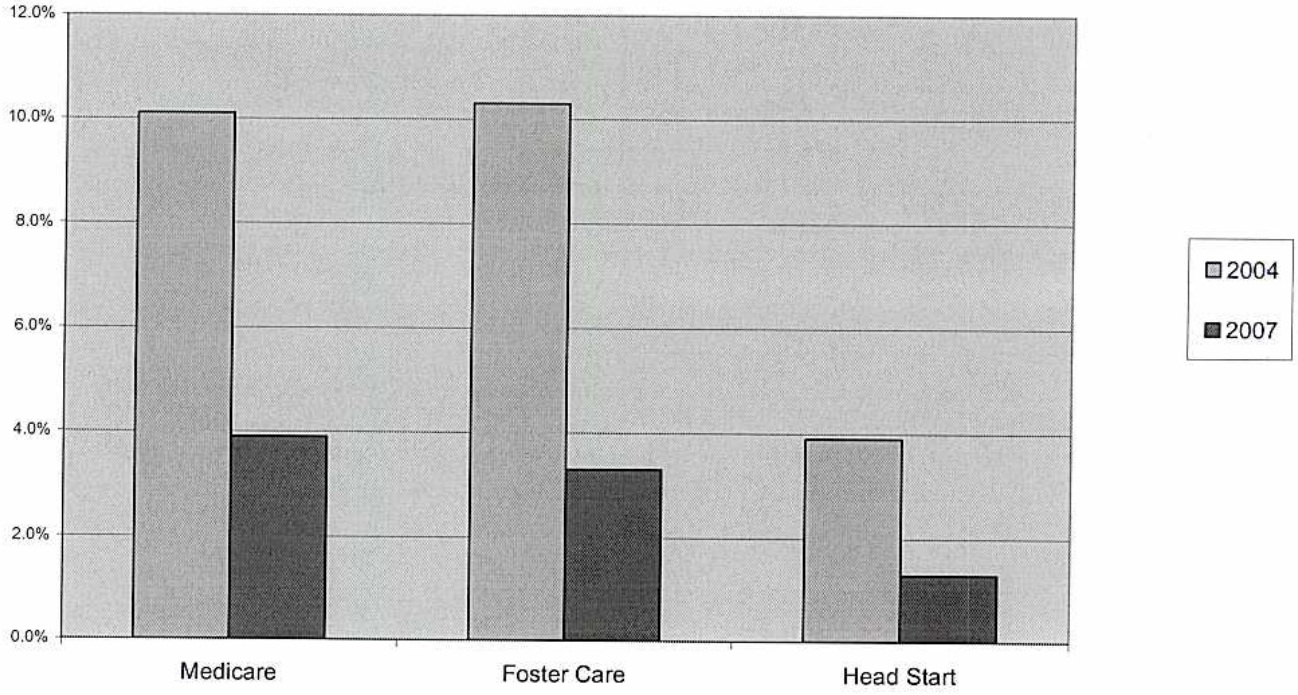
HHS has mechanisms in place to recover the overpayments identified in the Medicare FFS error rate measurement sample. Since FY 2004, the Medicare FFS measurement process collected almost 90 percent of the actual overpayments identified in the Medicare FFS measurement process.

Conclusion

In conclusion, HHS has had numerous accomplishments and successes in its improper payment activities. In our three programs that have produced comprehensive rates since FY 2004, we are seeing positive results from our corrective actions and the rates have dropped significantly as a result.

Exhibit 1

U.S. Department of Health and Human Services
Error Rates for Programs Measured
Since 2004



Medicare FFS Rate Reduction by Category

Exhibit 2

	2004	2007	Percent Change
Overall Rate	10.1	3.9	(61.4%)
No documentation	3.1	0.6	(80.6%)
Insufficient Documentation	4.1	0.4	(90.2%)
Coding Errors	1.2	1.5	25.0%
Medically Unnecessary	1.6	1.3	(18.8%)
Other	0.2	0.2	0.0%

Columns do not sum correctly due to rounding.

Comparison of Error Categories
First Year Reporting under IPIA
Medicaid 2007 vs. Medicare 2004

Exhibit 3