WASTE AND ABUSE IN SOCIAL SECURITY ACT PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC ASSISTANCE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

NOVEMBER 16, 1979

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

56-941 O WASHINGTON : 1980 HG 96-58

5361-27

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WASTE AND ABUSE IN SOCIAL SECURITY ACT PROGRAMS

FRIDAY, NOVEMBER 16, 1979

U.S. SENATE,
SUBCOMMITTEE ON PUBLIC ASSISTANCE,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 2221, Dirksen Senate Office Building, Hon. Daniel P. Moynihan (chairman of the subcommittee) presiding.

Present: Senators Moynihan, Byrd, and Chafee.

[The press release announcing this hearing and the opening statement of Senator Dole follow:]

Press Release # H-69

PRESS RELEASE

FOR IMMEDIATE RELEASE
October 22, 1979

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON PUBLIC ASSISTANCE
2227 Dirksen Senate Office Bldg.

FINANCE SUBCOMMITTEE ON PUBLIC ASSISTANCE
SETS HEARINGS ON WASTE AND ABUSE IN SOCIAL SECURITY ACT
PROGRAMS--THE EXTENT OF THE PROBLEM AND PROPOSALS TO DEAL WITH IT

Senator Daniel Patrick Moynihan (D.,NY.), Chairman of the Finance Subcommittee on Public Assistance today announced that the Subcommittee will hold hearings on the extent and causes of erroneous payments in Social Security Act programs and on existing and proposed measures for dealing with these problems. (The intention of the Subcommittee to hold these hearings was previously announced in press release # H-52 of August 8, 1979.)

The hearings will be held starting at 10:00 a.m. on Friday, November 16, 1979 in Room 2221 Dirksen Senate Office Building.

Senator Moynihan stated that "We have heard a great deal about 'waste, fraud and abuse' in programs operated by the Department of Health, Education, and Welfare, but we know rather less about these problems and their possible solutions than we might, and certainly less than is necessary to craft appropriate legislative remedies. In the course of recent Senate floor debate on a proposal to reduce H.E.W.'s fiscal 1980 appropriation, ostensibly to eliminate Federal participation in erroneous State payments to recipients of the Aid to Families with Dependent Children and Medicaid programs, I indicated my intention to hold oversight hearings on the issue of error, fraud, waste and abuse in these and other programs authorized by the Social Security Act. These hearings will continue and build upon the efforts of the Subcommittee on Social Security which held hearings on April 9, 1979 on the subject of the administrative integrity of the Social Security program. This will afford an opportunity for Secretary Harris and her associates, including the H.E.W. Inspector General, to describe the causes and dimensions of various forms of error, waste, fraud and abuse in these programs, to explain the steps the Department is taking and proposes to take to minimize such problems, and to suggest appropriate legislative remedies.

"We intend also to hear testimony from State and local officials who administer certain of these programs (and whose governments ordinarily bear some of the cost of erroneous payments) and from experts in social welfare and public administration. For it is all too easy to get caught up in the obvious appeal of opposing waste, and to overlook the fundamental fact that needy, often destitute human beings are entitled to the benefits of these programs under a concept of entitlement that dates back to the origins of the Social Security Act under Franklin D. Roosevelt. To be sure, no one is entitled to an erroneous payment, let alone a fraudulent one, and it is entirely proper for the Federal government to take appropriate action to confine its benefits to those who in fact are eligible to receive them under law. This is as necessary in federally-administered programs as in State-run programs, and Congress is responsible for writing the authorizing statutes so as to make it practicable. But we must be sensitive to the human needs that these programs are intended to meet; to the likely limits on administrative precision in anything as large and complex as the programs of the Social Security Act; and to the paradoxes created when, for example, efforts to eliminate payments to ineligible persons lead to more elaborate forms and documentation requirements whose very complexity gives rise to more error.

"We have much to learn, and the Department of H.E.W. seemingly has much to learn, too. Certainly it has much to

explain. These hearings give us an opportunity to begin this important process."

Requests to testify.--Chairman Moynihan stated that witnesses desiring to testify at the hearing must make their requests to testify to Michael Stern, Staff Director, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, not later than the close of business on Wednesday October 31, 1979. Witnesses who are scheduled to testify will be notified as soon as possible after this date as to when they will appear. If for some reason the witness is unable to appear at the time scheduled, he may file a written statement for the record in lieu of the personal appearance. Chairman Moynihan also stated that the Subcommittee strongly urges all witnesses who have a common position or the same general interest to consolidate their testimony and to designate a single spokesman to present their common viewpoint to the Subcommittee. This procedure will enable the Subcommittee to receive a wider expression of views than it might otherwise obtain.

Legislative Reorganization Act.--Chairman Moynihan stated that the Legislative Reorganization Act of 1946 requires all witnesses appearing before the Committees of Congress to "file in advance written statements of their proposed testimony and to limit their oral presentation to brief summaries of their argument." Senator Moynihan stated that, in light of this statute, the number of witnesses who desire to appear before the Subcommittee, and the limited time available for the hearings, all witnesses who are scheduled to testify must comply with the following rules:

(1) A copy of the statement must be delivered to Room 2227 Dirksen Senate Office Building, not later than 5:00 p.m. on Wednesday, November 14, 1979.

(2) All witnesses must include with their written statements a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 100 copies must be delivered to Room 2227, Dirksen Senate Office Building, not later than noon, Thursday November 15, 1979.

(4) Witnesses are not to read their written statements to the Subcommittee, but are to confine their oral presentations to a summary of the points included in the statement.

(5) All witnesses will be limited in the amount of time for their oral summary before the Subcommittee. Witnesses will be informed as to the time limitation before their appearance.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.--Persons not scheduled to make an oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearing. Written testimony for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with 5 copies to Michael Stern, Staff Director, Senate Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, not later than November 30, 1979.

P.R. # H-69

OPENING STATEMENT
OF SENATOR DOLE
BEFORE THE SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON PUBLIC ASSISTANCE
NOVEMBER 16, 1979

MR. CHAIRMAN, THE HEARINGS TODAY BEFORE THE SUBCOMMITTEE ON PUBLIC ASSISTANCE REPRESENT AN IMPORTANT EXERCISE OF THE FINANCE COMMITTEE'S OVERSIGHT FUNCTION WITH RESPECT TO THE VAST SOCIAL SECURITY ADMINISTRATION. IN MY VIEW, THIS COMMITTEE'S CONTINUING OVERSIGHT OF SOCIAL SECURITY ACT PROGRAMS PLAYS A VITAL ROLE IN ASSURING THAT THE TAXPAYER'S MONEY IS NOT BEING SQUANDERED AND IN ASSURING THAT THE RECIPIENTS OF PUBLIC ASSISTANCE ARE TREATED FAIRLY.

MR. CHAIRMAN, THE AMERICAN PEOPLE ARE KEENLY INTERESTED IN THE MANAGEMENT OF THEIR PUBLIC ASSISTANCE PROGRAMS. THEY ARE HAPPY TO HELP THOSE TRULY IN NEED, BUT THEY ARE NO LONGER WILLING TO CARRY THE BURDEN OF HEAVIER TAXES WHICH RESULT FROM MISSPENT PUBLIC FUNDS THROUGH ERROR, FRAUD, WASTE AND ABUSE.

PUBLIC CONFIDENCE IN WELFARE PROGRAMS IS PROFOUNDLY AFFECTED BY REPORTS OF WASTE AND MISMANAGEMENT IN THE SYSTEM. A NUMBER OF KANSANS HAVE WRITTEN ME TO CONVEY THEIR CONCERN ABOUT THE $6 BILLION OR MORE THAT MAY BE LOST BY THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE AS A RESULT OF WASTE, ADMINISTRATIVE ERRORS OR MISMANAGEMENT, IF NOT OUTRIGHT FRAUD. SUCH STORIES CERTAINLY CONTRIBUTE DIRECTLY TO THE POPULAR BUT ERRONEOUS VIEW THAT MOST PEOPLE RECEIVING PUBLIC ASSISTANCE

ARE CHISELERS AND WELFARE CHEATS.

IT IS PARTICULARLY DISTURBING TO ME THAT THE FINANCE COMMITTEE SAT IN THIS VERY ROOM NOT TWO WEEKS AGO AND VOTED TO CUT BENEFITS FOR DISABLED INDIVIDUALS WITH FAMILIES WHILE SEVERAL BILLION DOLLARS IS BEING UNNECESSARILY SQUANDERED ON OTHER PUBLIC PROGRAMS. IT WOULD SEEM FAR PREFERABLE TO ME TO ACHIEVE COST SAVINGS THROUGH BETTER MANAGEMENT THAN TO RELY ON CUTBACKS IN BENEFITS TO ACCOMPLISH BUDGETARY OBJECTIVES.

AS A COSPONSOR OF LEGISLATION TO BLOCK GRANT FUNDS TO STATES FOR THE AFDC PROGRAM, I WOULD ALSO NOTE THAT BETTER QUALITY CONTROL WOULD RESULT FROM SUCH A MOVE. IF THE STATES RECEIVED FEDERAL DOLLARS AS A FIXED BLOCK GRANT RATHER THAN AN OPEN-ENDED MATCHING GRANT, THEY WOULD DO A MUCH BETTER JOB OF MANAGING THE FUNDS THROUGH TIGHTER ADMINISTRATIVE PROCEDURES AND MORE CAREFUL SCREENING OF ELIGIBILITY.

WE HAVE A RESPONSIBILITY TO THE TAXPAYERS AND TO THE RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS TO ASSURE THAT FUNDS FOR THESE PROGRAMS ARE HANDLED IN THE MOST EFFICIENT, EFFECTIVE WAY. I COMMEND THE CHAIRMAN FOR CALLING THESE HEARINGS AND FOR BRINGING THESE PROBLEMS TO THE ATTENTION OF THE SENATE AND THE AMERICAN PEOPLE.

Senator MOYNIHAN. A very good morning to you all.

Let the Chair begin by apologizing for a conflict which, it was hoped, would not take place, but there is a law that says if such things can they will, and they did.

Here we are. We have almost the whole of the day ahead of us. A few votes, perhaps; nothing more.

I have an opening statement which, contrary to the normal practice of our hearings, I am going to read. I would like our distinguished witnesses who have been so helpful in arranging this inquiry, to understand more precisely our purposes. We are gathered this morning for a serious, even a solemn purpose, to inquire into the incidence of what has been known as fraud, abuse, and waste in the programs authorized by the Social Security Act and into the causes and possible remedies for such activities.

It would be hard to describe a more depressing outcome 50 years after the enactment of the Social Security Act, than to find that the program apparently has been corrupted. Indeed, it has been indicted by those responsible for carrying it out.

This hearing had its origin on July 20, 1979, when I found myself upon the Senate floor trying—successfully, as it happened, but only for the time being—to table an amendment which had been offered to the fiscal 1980 Labor-HEW appropriation that would have reduced the funds available to the Department of HEW by $500 million, the savings supposedly to be made by curbing waste, error, fraud, and abuse in certain of the programs run by that Department. This was the waste, error, fraud, and abuse the Department had identified as, in fact, taking place.

The specific issue was whether limiting the appropriations for programs authorized as entitlements under the Social Security Act was a suitable means of reducing the amounts of money wasted, or improperly spent, in those programs. I contended that it was not, and I felt that it was my task and minimum responsibility as chairman of the subcommittee to investigate alternative, to reducing fraud, abuse, and waste.

I pointed out the elemental fact that there was not before us any appropriation made for waste, fraud, and abuse. I said that there is no line in this appropriations bill that says the following amounts of money are appropriated for waste, the following amounts of money are appropriated for fraud and further, there is an appropriation for abuse.

I did not dispute the contention that some moneys were being improperly spent. I do not dispute that contention today.

As I said in July, there are mistakes, and there are certainly a great many mistakes. There are too many mistakes. Because there are mistakes, but because I did not feel, and do not feel, that reduced appropriations are the proper way of dealing with the situation. I promised to hold hearings, as many hearings as desired, before the Subcommittee on Public Assistance of the Finance Committee on what we should do about HEW's administration of these programs.

We are here today to keep that promise. If today's hearing yields insufficient information and guidance, we will be back another day.

The issues that will be addressed are of the most fundamental importance and must be dealt with in a serious, sustained, and conclusive manner.

As we commence, I would offer four propositions. First, we must be clear about the nature of entitlement programs. They are different from other programs. There are not many of them, and most of them are embodied in the Social Security Act.

What troubled me most in the recent enactments was that the Congress seemingly proposed to curb entitlements as a remedy for waste, fraud, and abuse.

Those of you who have, as your solemn trust, the management and administration of these programs, should know that you have jeopardized this most sacred of principles. The Congress was prepared to say an entitlement was not such, and based its theory on the indictment of the program's management and administration which was made by the program managers themselves.

And that would be a pretty thing to come after one-half century.

The entitlement principle states that a person who satisfies various objective criteria is entitled by law to certain benefits from the Government. The criteria are prescribed in law. The benefits are prescribed in law—sometimes in Federal law, sometimes in State law, sometimes in a combination of the two.

The provision of those benefits to that person is not a discretionary act on the part of the Government. No program administrator selects among competing applicants. No budget director decides whether the necessary funds are available. No appropriations subcommittee decides whether or not to provide the funds.

If the individual satisfies the criteria, he receives the benefits. It is a compact between the individual and his Government and has been a familiar part of American democracy at least since the passage of the Social Security Act in 1935.

It is that principle that we are jeopardizing.

Second, there is only one legitimate control on Federal spending for entitlement programs, and that is through the provisions of the authorizing legislation. If it is felt that the Treasury can no longer afford a certain rate of increase in a given set of benefits, then the statute which fixes the benefit levels must be modified.

If it is felt that a certain type of benefit ought no longer be provided, the authorizing legislation must be changed to eliminate it. If it is felt that too many persons are receiving a benefit, the statute prescribing eligibility criteria must be amended.

Likewise, if it is felt that a particular benefit is insufficient, that problem must be remedied by revising the authorizing legislation to increase the benefit. The amount of money spent by entitlement programs cannot be subjected to the customary controls of the budget and appropriations process.

That is why, among other things, there are so few entitlement programs. They are a very special and very different genre of Government activity. We can neither increase nor decrease benefits, neither expand nor contract the number of persons eligible for those benefits, by adding to or subtracting from the amount of money available.

Third, it is in the very nature of an entitlement program that an individual should receive only the benefits prescribed by law for someone in his or her situation: No more, and no less. It is illegal to provide that individual with more benefits than those to which he or she is entitled and illegal to deny that individual the benefits to which he or she is entitled.

It is hardly surprising that in endeavoring to apply that principle in a large, complex program involving millions of persons, and in trying to determine exactly what level of benefits—if any—each of those persons is entitled to, mistakes are made.

Most are what might be termed "honest mistakes;" but some entail improper actions by persons knowingly seeking to obtain benefits that they are not entitled to.

It is absolutely essential that we take appropriate steps to minimize the incidence of both types of error. But it is unreasonable to expect programs of this sort ever to be error-free.

This subcommittee is not error-free—fraud-free, yes, waste-free, yes. Indeed, the point can be reached where efforts to solve one problem give rise to another.

For example, the harder that we try to limit benefits to persons who are entitled to them, the more elaborate the application forms we devise, the more documentation we require, the greater becomes the opportunities for error. If people have to fill out a form with 400 entries, they are more likely to make mistakes than they are if the form is six lines long.

This committee understands that. But I submit that there is a certain disingenuousness, perhaps even a certain irresponsibility, associated with some of HEW's well-publicized efforts to measure the incidence of waste, fraud, and error in its programs.

To be sure, it is important to estimate how much money is being spent for purposes other than those prescribed by law, and it is useful to have an inspector general charged, among other things, with taking such measurements. But let us be clear that there is a vast difference between measuring error and doing something about it, and while simply announcing that you have discovered quite a lot of it may be a sure way to get headlines for the officials making the announcement, the discovery per se is no solution to the problem. Indeed, to the extent that the announcement is not accompanied by concrete evidence that the problem is being solved, its principal accomplishment is to illuminate the Department's ineffectiveness and to invite others to impose solutions which may be clumsy, and which may endanger the benefits of persons truly entitled to them.

There is probably an irreducible minimum amount of error in a large complex Government program—irreducible in the sense that reducing it would cost more than it would save. I do not know what that unavoidable minimum rate of error is.

Probably it varies from program to program, and from place to place. It is, for example, manifestly harder to reduce waste and error in a welfare program in a big city where hundreds of thousands of people are involved than in a rural community where the program administrator is apt to know the names of most of the recipients.

I do not know whether more error must be expected from programs such as AFDC and medicaid, which operate under the auspices of two levels of Government, than from programs administered entirely by Washington.

It is the responsibility of the Department of HEW to provide answers to such questions. It is the responsibility of the Department of HEW to take all appropriate steps to define tolerable—or at least unavoidable—levels of error and then to make its programs attain those levels.

It is the responsibility of the Department of HEW to ask the Congress for any additional legislative authority it may need to do this. It is the responsibility of the Department of HEW to require States and localities that share in the administration of Federal programs to do their part to reduce error.

It is the responsibility of the Department of HEW to be honest with the public and with the Congress both about the amount of error it estimates to exist and about the feasibility of reducing that amount to levels it would consider tolerable.

But above all, it is the responsibility of the Department of HEW to defend the principle of entitlements and to insure that every single person in the United States who is legally entitled to a Federal benefit from an HEW program receives that benefit: nothing more, nothing less.

The Department must obtain the funds necessary to keep that sacred trust. It must let nothing impede it.

Today we shall hear from senior representatives of the Secretary of HEW and shall see what they know, what they are doing, and what they propose to do. We shall also hear from representatives of State and local governments, which are HEW's partners in the administration of many of these programs. We—and HEW—must be attentive to their concerns, too, for they share the dual interests of the National Government: insuring that dependent persons and other recipients of public benefits receive their due, while minimizing the amount of money that is wastefully or inappropriately spent.

It is my impression that a wide gulf sometimes separates the HEW bureaucrats who devise ever more intricate regulations for these programs, and the local officials who struggle, day in and day out, to meet urgent human needs via these programs. It may well be that from the perspective of those actually administering the programs, HEW aggravates the problems of waste and error, even as it seeks to measure the incidence of those phenomena in ways that may be inappropriate or irrelevant.

We have much to learn and in time I believe we will probably have to legislate in this area. For as I stated at the outset, there is only one proper form of legislative intervention in the terms of entitlement programs authorized under the Social Security Act, and that is to amend the Social Security Act.

That is the responsibility of this committee, perhaps our most solemn responsibility. The purpose of today's hearing is to begin the process of determining the adequacy of current provisions in that act and the need, if any, for amendments to it.

We are here to learn, not to indict. Before concluding these remarks, lengthier than I would ordinarily trouble you with, let me say one last thing.

There has been not a great deal of cause to rejoice in the level of achievement of persons who have been responsible for the Department of Health, Education, and Welfare in the past 3 years. Announcing themselves as the most liberal and progressive and advanced administrators to take hold of that Department, either since its inception or at least in the decade, they proceeded in 3 years to produce a record barren of any achievement with one exception. They did contrive to discredit the most important responsibility that they have, which is the operation of the social security system.

The welfare programs of this country have had a long and not happy history. They did manage to leave the word "welfare" out of the new department, as if ashamed of their responsibility. Ashamed of it. But it has been a long and unhappy aspect of the welfare programs, the honorable enactment of the New Deal, that they have been attacked by persons who presumably oppose them.

Some of those attacks have been vulgar. Some have been mean-spirited. Some of them have been honest inquiries, but never have the attacks come from the persons who are supposed to be the defenders of the program. Never have the persons whose solemn stewardship this was, turned to undermine the very principles that they have aspired to protect.

I have found it disturbing in the extreme to have to stand on the floor of the Senate and explain why the persons to whom the President and Congress had entrusted these programs had now set out to indict them in a way which, had their credentials not been their self-announced progressivity, would have repeatedly produced outrage elsewhere; 3 years barren of any achievements, save that of undermining the programs you are responsible for tending—that is something that requires explanation.

And so to begin and to welcome to the committee, we will have first the Honorable Frederick M. Bohen, the Assistant Secretary of HEW. Am I mistaken—Secretary Bohen, are you still the Assistant Secretary of Health, Education, and Welfare?

Mr. BOHEN. I am, Mr. Chairman, until the Department of Education takes effect, which is 6 months after the Secretary is sworn in.

Senator MOYNIHAN. I guess there is that interval so there is still welfare. I would like to hear why you dropped welfare.

Are you ashamed of it?

Mr. BOHEN. I think that was the language put in the Senate bill creating the Department of Education. I do not think that started——

Senator MOYNIHAN. We never heard a word from the Department. You were not here, were you?

Mr. BOHEN. Not on that one.

Senator MOYNIHAN. Yes. We never heard a word about it until we learned we had done it, which may teach us to read legislation more carefully.

Hon. Stanford G. Ross, Commissioner of Social Security; Hon. Leonard D. Schaeffer, Administrator of the Health Care Financing

Administration; and Hon. Richard B. Lowe, Acting Inspector General of the Department of Health, Education, and Welfare.

Let me, before starting, ask you gentlemen, Mr. Bohen, how long have you been in your position?

Mr. BOHEN. Mr. Chairman, I have been in this position in the Department for slightly over 1 year. I came into the position on November 1, 1978.

Senator MOYNIHAN. Have you been in the Department before that?

Mr. BOHEN. Yes, sir. I was in the Department as Executive Secretary from the beginning of this administration.

Senator MOYNIHAN. Three years.

Mr. Schaeffer, how long have you been in your job?

Mr. SCHAEFFER. I have been with the Department 1 year and 10 months. I have been in this job for just about a year.

Senator MOYNIHAN. A year.

Mr. Ross, how long have you been in your job?

Mr. ROSS. I took office on October 1, 1978, coming from the Statutory Advisory Council on Social Security where I was chairman at the beginning of 1978.

Senator MOYNIHAN. You are leaving, of course?

Mr. ROSS. At the end of the year, sir.

Senator MOYNIHAN. Mr. Schaeffer, are you planning to stay?

Mr. SCHAEFFER. We have a program in place in the Health Care Financing Administration and we have to see it through.

Senator MOYNIHAN. The operative word is "hope"?

Mr. SCHAEFFER. The operative word is "put the program in place."

Senator MOYNIHAN. You will stay, if you can.

Mr. SCHAEFFER. Sir, I intend to see that program implemented, yes, sir.

Senator MOYNIHAN. Good for you.

Mr. Lowe, you are the Acting Inspector General. How long have you been in your job?

Mr. LOWE. I have been in the acting capacity for the past 3 months, Senator. Previous to that, as you know, when you introduced me to the committee, I was the Deputy Inspector General. I arrived in Washington in January of this year, and was confirmed.

Senator MOYNIHAN. Is there anybody in the Department of HEW who has been there more than 9 months? It is an incredible record of mismanagement by the White House, not you.

This administration which proclaims its capacity in management, has been struck with incapacity. It is trying to run one of the most complex administrations the world has, and this Nation has, with people who have an official half-life of 5½ months.

Chuckle as you will, it is not funny. It is a responsibility not carried out, and partly not carried out because the people carrying it out were so certain of their superior virtues in these matters.

All right, Secretary Bohen. Let us begin.

Let's hear what you have to say. How did that situation on the Senate floor arise?

STATEMENT OF HON. FREDERICK M. BOHEN, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY HON. LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; HON. STANFORD G. ROSS, COMMISSIONER OF SOCIAL SECURITY; HON. RICHARD B. LOWE, ACTING INSPECTOR GENERAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. BOHEN. Mr. Chairman, thank you very much.

I am pleased to appear before you on behalf of Secretary Patricia Roberts Harris. As you know, and as you have introduced, I am accompanied by three of the people in the Department directly responsible for programs and activities that are under the cognizance of your committee and are the focus of your inquiry into our Department's activities.

We are here this morning to discuss with you the question of quality control in the HEW public assistance programs, the centerpiece of the Department's efforts to deal with waste and unnecessary unjustified expenditures in HEW programs and how HEW and the States have been working over the years to improve these management systems to reduce errors.

With your permission, Mr. Chairman, I would like to submit the full statement that I have prepared for the record and concentrate my introductory remarks on the very important role played by quality control and our effort to improve management and the conclusions that we believe can be drawn from that experience.

Senator MOYNIHAN. Without objection, we will include that in the record. You go right ahead, as you wish.

Mr. BOHEN. Thank you.

Senator MOYNIHAN. Do not consider that there is any limit on your time. Take all the time you want.

Mr. BOHEN. Thank you, Mr. Chairman.

First, Mr. Chairman, I hope today to try to correct a public misconception—indeed, I think one you have alluded to extensively in your own opening remarks. That is, that the beneficiaries of Federal social programs administered by HEW are defrauding the Government on a grand scale. This is emphatically not the case. The Inspector General found that less than 0.2 of 1 percent of HEW's budget goes to beneficiaries who may have obtained the benefits fraudulently. Less than 3 percent of the Inspector General's $6.5 billion estimate of costs that could be avoided is the result of fraud by the people we serve. I will come back to this problem in a moment.

Our major problem is management inefficiencies, not fraud. The vast majority of unjustified expenditures are rooted in the complexity of the legislative design and administrative error in these programs and we can halt these expenditures and achieve savings only through new legislation and continuing improvement and redesign of management systems.

The Inspector General stated this reality clearly on page 3 of his March 1978 report in a sentence which I would like entered into the record—I do not have the book right in front of me but I will come back to that. It points out that fraud is a minor part of our problem and the problem is fundamentally management.

Second, Mr. Chairman, we believe HEW and the States have made steady, demonstratable progress in reducing error rates for AFDC and SSI in recent years. The excess payment rate for AFDC dropped from 16.5 percent in September 1973 to 7.1 percent in September 1978, as this chart indicates. There was a more than 50 percent reduction in those error rates over a 5-year period. Similarly, the SSI error rate has dropped from 11.5 percent in June 1975 to 5 percent in March 1979.

Senator MOYNIHAN. Would you put that chart back? The rate was going down nicely until you came into office. What happened?

Mr. BOHEN. Well, there was some leveling off.

Senator MOYNIHAN. No; there was a rise. That is not a leveling off. Maybe my chair is not in the right place.

Mr. BOHEN. The rate dropped to 8.6 percent, I believe, in June 1976. It then rose to 8.7 percent by June 1977, and now has dropped down to 7.1 percent.

Senator MOYNIHAN. What was that decline rate? Do you remember?

Mr. BOHEN. What?

Senator MOYNIHAN. A straight line there and a line here. This seems to be on a very different line.

Mr. BOHEN. We would concede that.

Senator MOYNIHAN. Starting right here when you took office, the line was doing well. It would be here today and this administration took office there today. Why?

Mr. BOHEN. I am going to defer to the Commissioners.

Senator MOYNIHAN. These are your charts, not mine. You could put a straight line curve here and this curve there on SSI. Those are SSI payments.

This is where the people whom you despise so much took over and there here you are. What about that?

Mr. BOHEN. I would make some general points, Mr. Chairman.

Senator MOYNIHAN. I am not trying to harass you. These curves suggest that something happened when you came in and you apparently are not lying.

Mr. BOHEN. Yes, sir.

First of all, we make the basic point in both areas that this administration has made progress over the rates that were in place when we took office.

Senator MOYNIHAN. But you have not——

Mr. Bohen. Yes, sir, we have.

Senator MOYNIHAN. Please, sir, explain that to me.

Mr. BOHEN. When we took office it was 8.6 percent.

Senator MOYNIHAN. I thought it was a rate of decline.

Mr. BOHEN. The rate of decline is lower, but as I indicated in my detailed testimony, the reason for that, is that we have eliminated in many respects the easiest areas and we are approaching that point where further progress that we can make in SSI, and we can make in AFDC in partnership with the States, is increasingly difficult.

We are getting to that point, but we do not know where that exact point for each program is. Indeed, we have a study in progress in response to concerns of this committee, among others, to determine that point of irreducible error. We do have a slowing

clearly in both programs in the rate of progress. But there has continued to be progress.

Senator MOYNIHAN. You are saying there is a floor effect, a comparable ceiling effect in these things?

Mr. BOHEN. That is right. To achieve these results——

Senator MOYNIHAN. In the SSI you seem to be bouncing off the boards. It is starting to rise.

Mr. BOHEN. Our goal is to continue to make progress in SSI. Indeed, our budget envisages an error rate of 3.9 percent in the current fiscal year as against the 5 percent. So we are continuing to work on that and I think we can explain what we are doing to cope with that uptake.

Senator MOYNIHAN. Go right ahead.

Mr. BOHEN. To both accomplish the results we have and to provide the basis for further progress in the future, we have mounted an aggressive technical assistance program with the States to save AFDC and medicaid dollars.

For AFDC we have already helped five States introduce retrospective accounting. We have worked with six States to systematically use error-prone profiles—a basis for establishing benefit levels on actual experience, rather than future speculation—which help States deploy their resources more efficiently on the biggest problems.

Similarly, with HEW assistance, medicaid management information systems, aimed at reducing claims processing errors, are operating in 28 States and being designed in another 18 States. We believe that these systems will improve the capacity of the States to correct claims processing problems, such as duplicate payments, payments for uncovered services, and overpayments.

New York City, for example, avoided costs of $163.7 million in the first year of operation of its medicaid management information system. Other States have experienced similar progress.

As you know, Mr. Chairman, with your endorsement, HEW has also proposed legislation to make structural changes that would reform many error-prone features of our cash assistance and health care financing programs. The Social Welfare Amendments of 1979 would mandate that States establish benefit levels based on retrospective accounting and monthly reporting by beneficiaries.

Finally, HEW opposed legislated error rate targets with fixed, inflexible timetables. HEW's authority to withhold Federal matching in cases of poor State performance should be clear and unambiguous, but the quality control system should stay flexible to accommodate special problems and adapt to new information and program experience.

Indeed, expectations on error rates should take into account the point that you were just illustrating, that at some point, the rate of progress will slow down as you get to the toughest problems in these systems. Overly specific and harsh legislation could harm legitimate beneficiaries and could cause State performance to deteriorate, rather than continue to improve.

I would like now to return briefly to the March 1978 report of the Inspector General of HEW to underscore his findings then and what the Department has done since to address them.

Senator MOYNIHAN. Sir, just for the purposes of being clear, the Inspector General was a person, not a machine. Who was that person?

Mr. BOHEN. The Inspector General was Thomas D. Morris.

Senator MOYNIHAN. Thomas D. Morris. What happened to Thomas D. Morris?

Mr. BOHEN. Mr. Morris served in the job of Inspector General in HEW from January 1977, until his resignation in September of this year.

Senator MOYNIHAN. We know that he came in with much fanfare. His resignation?

Mr. BOHEN. Yes, sir; September 30, 1979.

Senator MOYNIHAN. September 30. He resigned. Quite seriously, why did he resign?

Mr. BOHEN. I am not personally aware of his reasons. Maybe Mr. Lowe, who is his successor and worked closely with him, can respond to that.

Senator MOYNIHAN. You do not know why he resigned. Was he fired?

Mr. BOHEN. He was not fired.

Senator MOYNIHAN. Almost everybody else was fired, right?

Mr. BOHEN. I believe Mr. Morris left of his own volition, having put in nearly 3 years in a difficult job.

Senator MOYNIHAN. An enormous sacrifice. Three years in Government, coming in like you were going to change the world, and after 3 years he left.

Why did he leave, Mr. Lowe?

Mr. LOWE. I believe, Mr. Chairman, Mr. Morris intended to leave back in April, prior to the change in the HEW administration. As a matter of fact, his intention then—after that, he had set up the Office of Inspector General and put it in place and accomplished the goals that he had initially set out to——

Senator MOYNIHAN. He sure accomplished his goals all right. He wrecked the program.

Mr. LOWE. Well——

Senator MOYNIHAN. Where did he go?

Mr. LOWE. He is now with the Air Transport Association.

Senator MOYNIHAN. How much money is he making?

Mr. LOWE. I have no idea, sir.

Senator MOYNIHAN. Did he double his pay?

Mr. LOWE. I honestly have no idea, sir.

Senator MOYNIHAN. The Air Transport Association?

Mr. LOWE. Yes.

Senator MOYNIHAN. Where did he come from?

Mr. LOWE. Well——

Senator MOYNIHAN. A lobbying group, is that it?

Mr. LOWE. No; Mr. Morris——

Senator MOYNIHAN. The Air Transport Association, I assume that is a lobbying group.

Mr. LOWE. It is my understanding that the Air Transport Association is a group composed of members of all of the airlines. Mr. Morris, it is my understanding that his initial assignment is to study the energy consumption of all of the airlines with a view toward seeing if they cannot come up with ways to achieve——

Senator MOYNIHAN. He is a management man?

Mr. LOWE. Yes.

Senator MOYNIHAN. That is a reasonable management job. I assume he is making more money?

Mr. LOWE. He has had a rather long career in Government, also. He worked for Lyndon Johnson in the Department of Defense for several years.

Senator MOYNIHAN. This whole HEW was going to change the world. We bring back a combination of compassion and professionalism. All we got was an announcement that the programs were a wreck. The people who announced it immediately left.

All right, sir. I am sorry. But it was Thomas D. Morris?

Mr. BOHEN. Yes, sir.

The Inspector General's report brought together for the first time everything he knew or could guess about opportunities for savings in HEW's programs. The data on which the estimates were based ranged from statistically sound projections such as AFDC-SSI error rates based both on systems that were generating data then and had been developed over a period of time to much more highly speculative guesses such as the extent of provider fraud in medicaid.

I think a fair reading of Mr. Morris' report, Mr. Chairman, will indicate that he took pains in that report to categorize the various types of management problems he reviewed, both in order to facilitate understanding and to encourage appropriate solutions.

Let me read into the record the sentence I was groping for a few minutes ago, which is on page 3, right at the beginning of the report——

Senator MOYNIHAN. Where is that in your testimony?

Mr. BOHEN. I just made reference to the fact that I wanted to put it in the record. I did not have it right in front of me.

"It is clear that most of the loss reported below is attributable to errors in faulty management systems, i.e., waste, rather than to fraud and abuse." Then he goes on to spell that out. The careful distinctions made throughout the report were unfortunately largely ignored once it became public. One crucial distinction, which I want to emphasize today, is this distinction between fraud and abuse, on the one hand, and systems deficiencies, on the other, because, as you have suggested in your opening remarks, the public, and indeed the impression widespread in the Congress, is that the Department is full of fraud and is being taken to the cleaners by the people that it serves.

This chart tries to graphically present——

Senator MOYNIHAN. It sure does.

Mr. BOHEN. The chart displaying the major categories of problems that were identified in that report could have been put together at that time. There were more detailed tables and charts in the Inspector General's report. We have put it together, but it is faithful to the numbers provided by the Inspector General at that time.

You will see that fraud, as a proportion of the total, is in the area of 14 percent and recipient fraud predominantly in these public assistance programs is but a fraction of the total fraud discussed in the Inspector General's report.

Senator MOYNIHAN. If I read that, recipient fraud would come to about 12 percent?
Mr. BOHEN. It would come to less than that.
Senator MOYNIHAN. About 7 percent.
Mr. BOHEN. Even less than that of the total, Mr. Chairman.
Senator MOYNIHAN. Fraud and abuse is about 7 percent and this is scarcely——
Mr. BOHEN. Less than 3 percent of the total problem.
Senator MOYNIHAN. Three percent of the total problem.
Mr. BOHEN. Exactly right.
Senator MOYNIHAN. Why did not somebody say that?
Mr. BOHEN. I cannot answer that question, Mr. Chairman. I can verify that that point was not said clearly.
Secretary Califano, in his response to the Inspector General's report, pointed out that the total amount of fraud was 14 percent of the total problem identified in that report. He did that in the context of emphasizing the smallness of the fraction, but what has since dominated the public debate and the congressional debate is the responsibility, if you will, of beneficiaries and recipients for our problem. This was not stated clearly at that time. It is something we want to do now.
Secretary Harris feels very strongly that it needs to be brought into the public domain with great force.
It is one of the reasons I have given the emphasis I have to the small percent of recipient fraud and abuse in the report.
Senator MOYNIHAN. Before we go on, was the report leaked, is that it? Or was it announced?
How come it came to be published?
Mr. BOHEN. Under the statute that created the Office of the Inspector General in HEW, the Inspector General is required to report to the Congress annually, and this report came to be published in response to that mandate.
Senator MOYNIHAN. It was not leaked. It was just published.
Did it appear in the Washington Post 2 days ahead of time, as is normal for official documents?
Mr. BOHEN. I think that it appeared the day that it became generally available.
Senator MOYNIHAN. People responsible for this had so little sensitivity to the nature of their subject that they lumped in other management systems with welfare mothers.
Waste, fraud and abuse have one symbol—welfare recipients getting something they should not get. Now we find that the health care providers, who are not welfare recipients, get 70 percent of the fraud and abuse, and that, in turn, is about 15 percent of the total. The remainder of the fraud, abuse, and waste comes from inefficient practices, and other management systems. And I hope that you will help me to understand what inefficient means.
If ever there was fraud, sir, it was thought to be this large sum of $5.6 billion or $5.7 billion—fraud was considered to comprise the waste in the welfare system.
Mr. BOHEN. As I indicated, Mr. Chairman, it is my judgment—and I believe it would be yours—if you read the Inspector General's report word for word, that that was not his intention, that indeed

the report has the clarifications and distinctions that are appropriate.

It was not perceived, nor treated that way, by the audience that received it and has lead to the problems——

Senator MOYNIHAN. I have here Secretary Califano's statement. If I may, I would like to put this in the record.

[The material referred to follows:]

PREPARED STATEMENT OF SECRETARY JOSEPH A. CALIFANO, JR., DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Early last year I asked the Inspector General to review HEW programs and make the best estimate possible of funds unnecessarily or improperly spent.

Today, in response to my request, in his first annual report to me and to the Congress, the Inspector General estimates that of $148 billion in HEW fiscal 1977 outlays, between $6.3 and $7.4 billion were unnecessarily or improperly spent.

The largest proportion of these misued funds $4 billion—are unnecessary costs associated with health care. These funds were spent to finance unnecessary surgery, unnecessary hospital stays, the portion of hospital charges attributable to excessive hospital beds, unnecessary x-ray costs, erroneous payments and payments to ineligible recipients, and losses due to the failure to collect payments from other medical insurance available to Medicaid recipients.

The remaining $2.3 to $3.4 billion of the total loss is attributable to fraud and abuse in the Medicaid program (approximately $650 million), and errors, fraud, and abuse in the welfare, income security, education, and social services programs.

These total figures of $6.3 to $7.4 billion constitute about five percent of the $136 billion in program outlays examined for fiscal 1977. Total HEW outlays for that year were $148 billion.

This is the first attempt ever made to review comprehensively HEW's outlays during a fiscal year with the objective of identifying all potential areas of unnecessary and inappropriate expenditures. Thus, these figures are rough and incomplete. In some instances they may be too low; in other instances too high. Since I have asked the Inspector General to compile these figures annually, they will become more refined each year.

The high levels of waste and fraud and abuse combined in the Medicare and Medicaid programs—totaling an estimated $4.5 to $4.9 billion in fiscal year 1977—underscores the vital importance of the Administration's efforts to control the rise in hospital costs, to eliminate unnecessary surgery, to use the full breadth of the existing law in reducing other unnecessay costs associated with medical care, and to implement promptly the recently enacted Medicare-Medicaid Anti-Fraud and Abuse Amendments Act of 1977.

For example, if the Congress enacted the President's proposed Hospital Cost Containment bill by June 30, 1978, we could save, for the balance of fiscal year 1978, $140 million in total health care spending and $45 million in Federal costs. In fiscal year 1979 the savings would be $2 billion in total health care expenditures and $730 million in Federal costs.

The amount of lost funds in fiscal 1977 attributable to fraud and abuse is presently estimated at about 14 percent of the total—roughly $1 billion dollars—chiefly in Medicaid, AFDC and the student financial assistance programs.

We have been moving administratively, as aggressively as we can within existing law and resources, to deal with this problem. During calendar 1977 there were 265 convictions for criminal fraud involving HEW programs (136 Federal and 129 State). 227 of those cases involved Medicaid and Medicare programs.

Since taking office in January 1977, we have instituted eleven major initiatives aimed at protecting the taxpayers' dollars and dealing with the problems discussed in the Inspector General's report. The first three are specifically aimed at eliminating fraud and abuse.

We have inaugurated Project Integrity, which uses computer techniques to screen Medicaid claims of doctors and pharmacists for fraud, abuse, and error. To date, 535 Project Integrity cases have been selected for full field investigation as potential criminal cases; 554 cases have been identified as meriting administrative action.

We have begun Project Match, which matches payrolls and welfare rolls to identify individuals improperly receiving cash assistance. To date, 18,000 active civilian and military Federal employees and 11,373 former civilian employees have been identified as being on welfare rolls.

We have begun Operation Cross-Check, to use computer techniques to identify government employees who have defaulted on student loans.

The other actions are:

A reorganization that joined Medicare and Medicaid administration under the Health Care Financing Administration in order to manage more effectively the Federal health dollar and to reduce fraud, abuse, and error;

A reorganization and consolidation of the student assistance programs to put them on a sound financial footing;

Consolidation of all cash assistance programs under the Social Security Administration;

Timely development of criteria for the establishment of State fraud and abuse units in Medicare and Medicaid as required by Congress;

Tightened control over grants and procurements;

Development of major new accounting and quality control systems in Medicare and Medicaid, SSI and AFDC aimed at reducing error rates;

Institution of a major initiatives tracking system to monitor departmental progress of services in an effective fashion including error rate reduction;

Proposing major welfare reform legislation that would consolidate all cash assistance programs on a single computer system to reduce fraud, abuse, and error.

These pioneering initiatives are crucial tools in our efforts to eliminate fraud and abuse in the Department's programs: And we hope to expand their use in the future: for example, in Project Integrity, we will begin screening other types of providers, such as dentists and commercial laboratories, for possible fraud, abuse or error and, in Project Match, we hope to match the Federal military and civilian payrolls against Supplemental Security Income and Social Security (Title II) benefit programs.

I have asked the Assistant Secretary for Management and Budget and the Assistant Secretary for Planning and Evaluation to study the report of the Inspector General in depth and, in conjunction with the Inspector General and other Departmental officials, to recommend any further steps the Department should take in combating fraud, abuse, error, and waste.

The taxpayers of this nation cannot be—and will not be—asked to tolerate the continued drainage of billions of dollars of their money into improper hands. The steps we have already taken to reduce the leakage ar significant, and I am pleased to be able to point to concrete results.

But a still more vigorous and far-reaching attack is plainly needed if we are to bring down the waste of public funds to its irreducible minimum. I commit myself and this department to an effort that will achieve just that result

Senator MOYNIHAN. He does not make that distinction. He does not say "I would like people to understand that the amounts of money inappropriately going to recipients on welfare are large in their own right, but a miniscule portion of this amount."

My impression is of a Cabinet officer telling a constituency, "I have caught a bunch of cheaters, and let it be thought that the cheaters are welfare recipients who do not vote, and are not doctors who do."

That is not something I should ask you to comment on, sir, but I assure you his statement did not make that point.

Mr. BOHEN. It does not make that distinction.

Senator MOYNIHAN. He did not make that distinction. Even though this is the most progressive, forward-looking, innovative administration that HEW has known since its inception.

Go ahead, sir.

Mr. BOHEN. In contrast to his estimate of fraud, the Inspector General estimated that $5.6 billion could be saved through changes in efficient systems, management practices and program policies. He highlighted three distinct types of problems, Mr. Chairman.

First and most important, the Inspector General assigned by a dollar value of $2.4 billion to the inefficient and excessive practices of the Nation's health care industry, which cause unnecessary

expenditures in the medicare and medicaid programs for X-rays, surgery, and excess or underutilized hospital beds. Under current legislation, HEW and the States have insufficient authority to control this problem. Its solution requires the cooperative efforts of HEW, Congress and the health care industry. In this context, it is the source of terrific disappointment to those of us in the Department to see the results in the House of Representatives yesterday on hospital cost containment, the major piece of legislation developed by the administration to address these problems in hospitals.

Senator MOYNIHAN. Do not blame the House. They thought the only place you were getting waste, fraud and abuse was from welfare recipients.

I am just harassing you. Of course, we are disappointed. But let me ask you——

Mr. BOHEN. Let me just say in response to that point and, again, I think the Inspector General's identification of that problem in the spring of 1978 was very clear—and here is another confusion in the interpretation of this report—that the Department could not address that part of the problem on its own, that it needed the help of the Congress with an effective piece of legislation to provide the authority to control this part of the waste problem in HEW programs.

Senator MOYNIHAN. Could you tell me just a little bit about the methodology? I would like to know just how hard this kind of thing—how hard the data are. All the sampling data, I assume.

How big a team did the Inspector General assemble for this? Did he work from existing literature? Did he go out and do samplings himself this?

What was the criterion of inefficient? That is a highly judgmental thing. How did he do it?

Mr. BOHEN. Mr. Chairman, I cannot provide the detail on this. As I indicated in my testimony, part of that estimate was speculative. It did represent——

Senator MOYNIHAN. Part of the estimate was speculative?

Mr. BOHEN. In the sense of drawing inferences from previous studies. When he did this report.

Senator MOYNIHAN. I know. I have had a lot of friends in my university life draw inferences. They are not speculative at all. They are part of a very complex and rigorous discipline called logic.

Mr. BOHEN. I would like to distinguish between an inference——

Senator MOYNIHAN. As you know, all scientific knowledge—and any other knowledge—is a matter of statistical probabilities called inferences. Inference is not a soft term; it is a hard term. Speculative, on the other hand, is rather a soft term.

Mr. BOHEN. Maybe I will withdraw speculative.

Senator MOYNIHAN. Not while I am here.

Mr. BOHEN. I am informed that his sources were congressional reports, GAO reports, audit reports and outside studies. I think that his own language suggests that in this area the rigor of the dollar estimates was less than in the area where we had good quality control systems.

Senator MOYNIHAN. Hold right there. Did Mr. Lowe pass you a note with that information?

Mr. BOHEN. No.

Senator MOYNIHAN. His sources were—read that again.

Mr. BOHEN. Congressional reports, GAO reports, audit reports from our own audit agency which is under——

Senator MOYNIHAN. GAO audit reports?

Mr. BOHEN. And outside studies.

Senator MOYNIHAN. No studies of his own?

He did not undertake one?

Mr. BOHEN. I do not believe we undertook a systematic study. He was drawing, I think, on materials already available.

Dick, do you want to answer that?

Mr. LOWE. Mr. Chairman, I think we may be doing Mr. Morris a disservice. He himself feels that his report was distorted, the numbers were simply taken and run with. I believe that his effort was to pull together all of the available information that was possible and to have HEW's managers look at themselves and look at their agencies and see where improvements could be made, where management improvements could be made, and where the efforts could be utilized to reduce what appeared to be a prevailing amount of inefficiency in waste and money being lost through the cracks on the basis of examining the various reports that he compiled and the various data an documents, including congressional reports.

It was not intended to be a scientific study.

Senator MOYNIHAN. It was not intended to be a scientific study?

Mr. BOHEN. No; it was not. Mr. Morris so testified before Senator Muskie.

Senator MOYNIHAN. Why?

Mr. LOWE. I beg your pardon, sir?

Senator MOYNIHAN. What was it intended to be, an exercise in fantasy?

Mr. LOWE. It was an attempt to see where future economies seem to be possible and to see if those economies could be achieved.

Senator MOYNIHAN. Is it your view that, while Mr. Morris put out a report which emphasized the limits of his information, Mr. Califano dispensed with all of those reservations and simply announced that a new satellite of Saturn had been discovered in the Department of HEW?

You do not have to answer that, but there is nothing in the statement by the Secretary that says this is not a scientific study.

Mr. BOHEN. If you look at the second page of the statement, there is the second paragraph that makes it clear that Secretary Califano's April 3 statement——

Senator MOYNIHAN. He says these figures are rough and incomplete. In some instances they may be too low. In other instances, too high. That, I grant you.

But the general announcement is that:

> Today in response to my request, in his first annual report to me and to the Congress, the Inspector General estimates that of the $148 billion in HEW fiscal 1977 outlays, between $6.3 billion and $7.4 billion were unnecessarily or improperly spent.

That is not the way you introduce a document which is a rough compilation.

What is Mr. Morris' training?

Mr. BOHEN. I believe his background is in public administration. I do not know what his formal academic training is, but his career has been in public management.

Senator MOYNIHAN. Public administrators are supposed to be able to do these things. OK.

Mr. BOHEN. The second part of the Inspector General's management focus was on the need for improved monitoring and review of grantees by HEW. He estimated that HEW could save $600 million annually in that area.

Because this problem can be attacked by HEW management, we have moved aggressively to bring it under control. To date, we have documented savings of over $400 million in fiscal year 1979 from increased audits and program and financial reviews of HEW activities, which identify misspent funds for future recovery or redirect misallocated funds to their proper purposes.

This comprises a host of activities, Mr. Chairman, ranging from a computer-based review and edit of the applications under the basic educational opportunity grant program which has screened out nearly a half a million applications in the fiscal 1979 period, and a much more thorough effort to allocate indirect costs for Federal grantees.

Third, the Inspector General estimated that payment errors in HEW's four major assistance programs—AFDC, SSI, medicaid, and social security—totaled $2.7 billion.

Those estimates, particularly with respect to AFDC and SSI, were much more refined, because they were based on data that had been accumulated through more rigorous quality control data. It should be indicated that that $2.7 billion figure is the equivalent of a zero error rate. To save $2.7 billion you would literally have had to have gone to no error across these programs. That is the total statement of the error problem.

Prior to the Inspector General's report, HEW and the States were, in fact, making significant improvements in these programs. Over the last several years, error rates in AFDC and SSI have been cut in half, a new medicaid quality control system has been designed and implementation has begun, and a new Social Security system has been developed and will soon begin to measure payment error rates for the first time.

As suggested in my detailed written testimony, our experience with quality control systems now extends over a period of 15 years. It has been evolutionary in character. We have had some false starts along the way, but we believe we now have in place, in close partnership with the States, modern systems that provide both reliable measurement and the information required to take corrective action.

The Department believes further gains in management of these programs are essential and possible. Everything in our experience, however, Mr. Chairman, leads us to emphasize the indispensibility of working in partnership with the States through a system that recognizes the diversity of the States themselves and of the AFDC and medicaid programs and the population served in each State.

In March of this year, HEW published regulations that reflected this extended dialog with the States to develop mutually acceptable error rate goals and criteria for assessing financial penalties.

Under these regulations, every State must either be within the national average error rate or be making appropriate progress toward that goal in order to avoid a disallowance of Federal matching payments for the amount the State exceeds its targeted error rate. States above the national average must reduce their AFDC error rates by 6.4 percent and their medicaid rates 15.7 percent every 6 months until the required tolerance is achieved.

At the same time, HEW established a standard for itself of 4 percent in SSI for those case where HEW has agreed to administer supplemental payments made by the States.

The March regulations also indicated that HEW would set more specific error rate goals for AFDC and medicaid after 2 years, based on the results of a study to determine the point at which error rate reduction costs more than it saves in erroneous payments. That study, which is being conducted in close cooperation with State and local advisory groups, will consider the characteristics of State caseloads, program policies and administrative practices in respect to error tolerances. The first phase of the study for AFDC will be completed in September 1980, the medicaid phase in March 1981.

Unfortunately, before we could implement the March 7 regulations, which I have just described, Congress directed HEW to issue another set of quality control regulations by the end of this month.

The statement of managers in the conference report in the 1979 supplemental appropriation bill directed that each State achieve a 4 percent AFDC and medicare error rate by September 30, 1982. States above this target would have to achieve this tolerance level in equal increments by the end of fiscal years 1980, 1981, and 1982.

States above the intermediate and final tolerance levels would lose Federal matching for payments beyond the tolerance. This directive was subsequently confirmed by a statutory provision in the 1980 Labor-HEW appropriations bill. In compliance with the congressional directive, HEW issued a new notice of proposed rulemaking in September. We are currently receiving and analyzing comments from interested parties and the public in response to this notice and are making every effort to issue final regulations as quickly as possible.

While we intend to comply with this law—indeed, we have no choice other than to comply in the absence of an action by the Congress which would supersede this law—HEW strongly opposed, and continues to oppose, this initiative to mandate AFDC and medicaid error rate tolerances through the appropriations process. Although it does have the positive effect of providing clear statutory authority for assessment of fiscal penalties by HEW if the States fail to meet error rate tolerances, it has a number of critically disabling consequences. The penalties implicit in the appropriations provision are very likely to harm legitimate beneficiaries, a concern that you highlighted in your opening statement.

The mandate has locked the Department and the States in a rigid timetable which may not be appropriate to the conditions of many States or, indeed, to the conditions of the Nation in a period of volatility in our economy. It has legislated a national error rate goal that is not based on any systematic study or empirical data. There is no flexibility for changing it administratively without——

Senator MOYNIHAN. Your description, Mr. Secretary, of what Congress has done is very reminiscent of my description of what HEW has done.

Mr. BOHEN. This is what we think that we are forced to do.

Senator MOYNIHAN. You did not have any data, any standards. This is just a compilation, a library—the sort of thing we have sent over to the Congessional Research Service, to say, "Give us a report on all the GAO audits" and it comes back like this, and we put it in the record and say we have discovered something. We have not added anything to knowledge.

I know your difficulties with the 4 percent and I do not disagree with you. You brought it on yourselves.

I do not know what you are going to do about it, but I tell you what I want to ask you, because I know I have your testimony and we appreciate it.

I want to get to something much more fundamental, that an executive is supposed to think about.

What do you mean by waste? Let's examine these words. Let's be semanticists, all right?

You said different things. What you did for purposes of our defending your programs in the U.S. Congress was to take this word and this word and effectively combined them into this word.

Fraud is an act tinged with illegality. You can go to jail for fraud. It is a term of the criminal law, is it not?

Is "abuse" a term of criminal law?

Mr. BOHEN. I think it is not, but it is close to criminal behavior without being criminal.

Senator MOYNIHAN. And waste, is that a crime?

Mr. BOHEN. No; waste was not described that way by the Inspector General.

Senator MOYNIHAN. Yes, but when you put it all together and say that there is fraud, abuse, and waste, it comes out to something like $6.5 billion. The recipient programs ought to be $200 million.

If Ronald Reagan had done that, it would be a scandal to this day, but since the impeccably progressive new administration at HEW did it, it is all right.

Look, there has to be some conceptual clarity. Fraud is fraud. I am not what I am representing myself to be. Health care provider fraud—somebody lies to the Government.

Have you put anybody in jail?

Have you fined anybody?

Mr. BOHEN. We have taken———

Senator MOYNIHAN. Is there anybody in jail? Did any doctors go to jail?

Mr. BOHEN. I am going to defer to Mr. Lowe. The responsibility for the program is with him.

Senator MOYNIHAN. You worked in New York. You know about things like that.

Mr. LOWE. Yes.

Senator MOYNIHAN. Who? Name them. Put their names in the record. It will not do any harm.

Mr. LOWE. I do not have that information with me.

Senator MOYNIHAN. How many are there?

Mr. LOWE. I could provide that for you.

Senator MOYNIHAN. How many were fined or in jail? You can have $668 million, an annual figure, for provider fraud. Am I correct?

Mr. LOWE. Yes, sir.

Senator MOYNIHAN. That comes to about $10 million or $11 million of fraud. Put somebody in jail, or stop telling us about how smart you are about what is going on. If you know that much is going on, somebody is doing it; somebody has got to be. Have you found anybody?

How much fraud took place last week? $10 million worth?

Mr. LOWE. I cannot answer that, but I will tell you that as of October 1979 as a result of an initiative that was launched by the Inspector General, Mr. Morris, called Project Integrity——

Senator MOYNIHAN. Don't say: "Initiative that was launched by Inspector General Morris." Say something more astute. How do you launch an initiative? You launch ships, right?

Mr. LOWE. All right.

Senator MOYNIHAN. All this fraud ends up with this kind of disaster and I have to stand on the floor and say, "Don't cut off payments for children."

Mr. LOWE. I chose the word "initiative" because at the time it was new, Senator.

It was the first use of the computer to identify providers who were, in fact, defrauding the system. What he did was to use computer screens to measure the billing practices of physicians who billed medicare and medicaid, and he set standards so any aberrant billings by providers would be punched out by the computers. That has the result of giving us targets which we could then go and investigate. So that it was an initiative and it was launched by him, and as a result of that some 53 individuals and 3 firms had, as of October 1979, been indicted. Thirty-three individuals and two firms we convicted. I cannot tell you who is in jail at this time, but I will be glad to submit that information for the record.

[The following was subsequenty supplied for the record:]

PROJECT INTEGRITY INDICTMENTS[1]

Name and jurisdiction

1. Richard J. Kones, M.D., Bridgeport, CT
2. Bertola Pembaur, M.D., Cincinnati, OH
3. C. B. Harris, M.D., Pineville, LA
4. Carlos Warter, M.D., Denver, CO
5. Lawrence J. Delaney, M.D., North Smithfield, RI
6. Winston Hall Worthington, M.D., Memphis, TN
7. Portis Pharmacy, Inc., Fort Gray, WV
8. Arnold Faudman, Detroit, MI
9. Forte Pharmacy, Columbus, GA
10. Ralph Bruyette, Ludlow, VT
11. Saye Drug Co., Fountain Inn, SC
12. Richard G. Crandall, M.D., Pocatello, ID
13. Sonnie Hereford, Huntsville, AL
14. Ellis Pharmacy, Cedar Rapids, IA
15. John Wang, M.D., Lowell, MA

[1] Also includes cases where information was sufficient to proceed directly with prosecution, negating the necessity for a grand jury hearing.

PROJECT INTEGRITY CONVICTIONS

Name and jurisdiction

1. Allen H. Bunch, M.D., Seminole, OK
2. William J. Powers, Ovaville, CA
3. Claude Jinks, Olathe, KS
4. John T. Bellflower, Valdosta, GA
5. Mortimer Schaffer, D.O., Miami, FL
6. Jackson Raymond Goudeau, Jr., Plaquemine, LA
7. Joe Gann, Montgomery, AL
8. Jack Bellfuss, Gary, IN
9. Jeffrey Berk, Gary, IN
10. Jimmy Graves, Gary, IN
11. Robert Akin, M.D., Hazelhurst, MS
12. James Yu, M.D., Harrah, WA
13. Frank James, Indianapolis, IN
14. Richard A. Schmidt, Wailuku, Hawaii
15. William Moscotti, Wailuku, Hawaii
16. Jack C. Pawol, Wailuku, Hawaii
17. J. Robert Martin, Fort Kent, ME
18. Jack A. Braley, D.O., PA, Wichita, KS
19. Dione Braley, Wichita, KS
20. Arthur Karwacki, Kailua, Hawaii
21. Edward Karwacki, Kailua, Hawaii
22. Clifford Bryant, Anderson, SC
23. Larry Goldstein, Kansas City, KS
24. Richard Silberg, Kansas City, KS
25. Frank Jones, M.D., Kansas City, KS
26. El-Dorado Jones, M.D., Roanoke, VA
27. Luis A. Alvarez, M.D., Overland Park, KS
28. Paul M. Wilde, Overland Park, KS
29. Diane Wille, Overland Park, KS
30. Medical Practice, P.A., Kansas City, KS
31. Richard J. Turner, M.D., Clayton, GA
32. John M. Brown, M.D., Atlanta, GA
33. H. W. Brooks, D.O., Albuquerque, NM
34. Frank Saye, Fountain Inn, NM
35. Leo F. Kenneally, M.D., Los Angeles, CA

Senator MOYNIHAN. When did this start?

Mr. LOWE. Project Integrity started when Mr. Morris became Inspector General. These figures are as of October 22, 1979.

Senator MOYNIHAN. Roughly speaking, that is 2½ years. It took a little time to get started.

Mr. LOWE. Yes.

Senator MOYNIHAN. Two and a half years with roughly round figures, we could say, $1.5 billion, and you have 58 people indicted.

Mr. LOWE. That is correct, sir.

Senator MOYNIHAN. Let's get that list of 58—we will put it in the hearing part of this record. Fifty-eight people. How much did they account for of the $1.5 billion? Give us a feeling. Indictments representing this much money were many, and you get a feeling from looking at it we could at least have got hold of 10 percent of it and tried to get it back, or 2 percent, or 88 percent, I do not know. Touching reality.

Mr. LOWE. If I can interrupt you, you must realize that that is a criminal process, No. 1. No. 2, those are the results of 2,500 providers who were found as a result of this project, 2,500 providers who underwent criminal investigation and you are very much aware of the difficult process by which the law enforcement community attempts to prosecute and convict providers of health care.

First of all, it is such a tenuous situation because half of the judgment goes into the medical practice which they claim.

Senator MOYNIHAN. That is precisely my point. If it is damned tenuous, it ought not be explained in precise figures to the decimal point as something that we know about. That is the point. We are given a false concreteness here.

What I want from you, sir, is to give us a report on what Project Integrity did so that we can get a feeling; you go at it this way and you pick up this much and this is the kind of result you get, and you get a feeling about what you can, and get some concreteness.

Fraud is a specific abuse. Abuse is a soft word, a little harder than waste because it suggests a wantonness. But inefficient, inefficient—wow. Inefficient practices. This is other management—I do not know. Is this inefficient other management systems?

Mr. BOHEN. The other management is predominantly——

Senator MOYNIHAN. We distinguish fraud and abuse over here and this should be waste?

Mr. BOHEN. That is right.

Senator MOYNIHAN. Waste here.

All right, waste.

There are people who think HEW is a waste.

Mr. BOHEN. This is an attempt to distinguish only part of it, which really is unnecessary or inappropriate.

Senator MOYNIHAN. I know that. That is a pretty soft term. There are people who think foreign aid is a waste, all right? There is almost a majority view that foreign aid is a waste, but the amount of fraud in foreign aid is another subject altogether.

There are people who think high school is a waste—and a widely held view. A majority of farmers until 50 years ago thought this way. When my son gets 8 years of education he can come back on the farm.

A different view. A different category.

Do you see my point?

Mr. LOWE. I see your point, Senator, if I might comment on this, and there is no question that, frankly, if Mr. Morris himself could have pulled back that report, he would pull it back, because of its interpretations. But the fact that it has been misinterpreted by others and the fact that the press took it and just took numbers and waved the numbers in the face of the American people does not mean that the efforts were launched by him, the sincere attempt to foster economy and efficiency in HEW is to be, frankly—well—I will withdraw that.

I just think that his efforts are laudible.

Senator MOYNIHAN. Do not withdraw it. Say what you want to say.

Mr. LOWE. The man accomplished a great deal and I have learned a great deal from him. I think that his efforts were sincere, and I think it is suggested that what he has done has been a disservice rather than a service to the agency. And I do not think that is accurate.

Senator MOYNIHAN. I happen to think that you are wrong. As a person who had to stand on the floor of the U.S. Senate and say, "No, do not take away entitlement money under the social security programs going to recipients because of this report."

The U.S. Congress did not say take it away from health care providers. It did not say take it away from persons who are not in the profession and admit persons themselves into the profession—anybody can become somebody called a public administrator, alas. Only a doctor can make you a doctor. That is the way we have arranged things. It is an old tradition which goes back to the Egyptians.

But this is one set of things and this other little yellow bar is another. Do I make any sense to you?

Mr. BOHEN. Yes, sir. We have brought that chart up because that distinction——

Senator MOYNIHAN. There is my problem. Do you see that as our problem?

Mr. BOHEN. Yes, sir.

Senator MOYNIHAN. Mr. Lowe, you are the Inspector General now. Do you see this problem?

Mr. LOWE. Yes, I do, sir, and so did Mr. Morris.

Senator MOYNIHAN. That is why he left.

Well, the distinction was not made by the Secretary's announcement of the report.

I do not want to presume, but I will tell you that it seemed to be playing, to that body of opinion here which always is happy to hear that there is a lot of fraud and abuse. It suggests that you can count on us, gentlemen. We are tough down here. As I look through the waste in that report—we are talking about, other management systems or inefficient practices in the health industry or other sources of waste. The report said take it away from people who are poor and dependent.

Mr. LOWE. I agree, sir.

Senator MOYNIHAN. It is the responsibility of this Department to make distinctions such that this kind of legislation does not happen. It happened last year. As far as I know, it will happen this year unless you make a fundamental distinction between what is criminal behavior—illegal, if not criminal—and what is the result of the system itself.

For example, one doctor might say, a patient does not need two X-rays. Another doctor might say, "I think we should have three as a matter of fact, doctor."

This is a conflict in judgment of professional men and women. What one nurse will think is a fair enough number of times to call and look in at a patient, another nurse will say is not enough. Or, it is too many.

You can make judgments, and you make them around median numbers, and there is a conflict between administrative judgment and professional judgment. The point about health care is that you are dealing with a profession. Professionals profess to know better than persons who are not in the profession. They also have the responsibility of admitting persons into the profession.

Anybody can become something called a public administrator, alas. But only a doctor can make you a doctor. That is the way we have arranged things. It is an old tradition, going back to the Egyptians. Do I make any sense to you?

Mr. BOHEN. Yes, sir. We have brought that chart up because that distinction——

Senator MOYNIHAN. There is my problem. Do you see that as our problem?
Mr. BOHEN. Yes, sir.
Senator MOYNIHAN. Mr. Lowe, you are Inspector General now. Do you see this problem?
Mr. LOWE. Yes, I did, sir, and so did Mr. Morris.
Senator MOYNIHAN. That is why he left.
Well, the distinction was not made by the report, was not made by the Secretary's announcement of the report. I do not want to presume, but I will tell you that it was read up here to be a certain playing, you know, playing to that body of opinion which always is happy to hear that there is a lot of fraud and abuse and suggests that you can count on us, gentlemen, we are tough down here.
As I look through the waste in that report—we were talking about waste in the BOG program, were we not?
Mr. BOHEN. Yes.
Senator MOYNIHAN. We were outraged on educational grounds. There was a difference between those causing the problem, and those who got blamed; this was all mixed up. Because the educational grants program was inefficient who would feel the cuts? Take it out of welfare recipients.
Now, it was very significant that no one said take it out of the grants of college students. This invited ire directed against the most defenseless set of constituents. This was not very seemly. It will have to be corrected.
You are going to have to get out there and say, "Now look, when there are inefficient practices in the provision of educational aid, prosthetic braces, users of CAT scanners, then we can try to correct this. This is a different matter than dependent women and children getting money. That is what I mean.
Let me ask Commissioner Ross, what is your view on this subject?
Mr. ROSS. I think it is very important to make the distinction that you are talking about—I think that there is a serious public misunderstanding. I also think, as an administrator, that it is very important that we work as hard as we can to make improvements in all of these areas.
And I think that there are different kinds of programs needed to deal with the lefthand side of that chart as opposed to the right.
Senator MOYNIHAN. Do you accept that they are two different things?
Mr. ROSS. Absolutely, sir.
Senator MOYNIHAN. Then I have made some progress, sir. HEW ought to insist upon that.
Mr. ROSS. Absolutely.
Senator MOYNIHAN. I do not have anything else to say. If you can make that distinction, you have your constant problem in inefficient activity. If this were a board meeting at General Motors, there would be a chart up there illustrating inefficient practices in the truck assembly plant, and board members would be asking how to get rid of the inefficiency?
And it would represent a general managerial concept that you could do it, on a least cost principle. The assertion is that this is

not being done at these costs, and that you are always working on that margin.

But if you do not send anybody to jail for it, then there are no penalties. There is no bad faith. There may be poor performance, but this is a very different thing. Am I correct?

Mr. ROSS. Absolutely.

Senator MOYNIHAN. How much of the $5.6 billion, are inefficient practices within your administration?

Mr. ROSS. Well, the green bar as I understand the chart, is within Mr. Schaeffer's administration.

Senator MOYNIHAN. He comes next. You are the blue bar.

Mr. ROSS. I assume that SSA is responsibile for part of the blue bar. We administer the AFDC and SSI programs and we have a number of actions that we are taking to improve our systems. Also, there are a number of provisions in the pending welfare reform bill which would allow us to improve our systems.

It is some piece of the blue bar.

Maybe Mr. Lowe can tell you what portion is attributed to SSA.

Mr. BOHEN. I can provide it. The date on the Inspector General's report as I said that. $750 million of the blue bar was potentially recoverable error in AFDC and SSI and then it provided a range for error in the title II SSI program of $175 million to $800 million because of systems error were much more.

Senator MOYNIHAN. What is recoverable error? Who made this error? The State made the error?

Mr. ROSS. It is different, in different programs, if I may answer.

Senator MOYNIHAN. AFDC?

Mr. ROSS. Under the AFDC program we would have a plan with the States to prevent error.

Senator MOYNIHAN. In AFDC the State made the error.

Mr. ROSS. Or it could be beneficiary error, to some extent.

Senator MOYNIHAN. The beneficiary made the error?

Mr. ROSS. Again, there is education. Error does not necessarily mean fault. There are problems of educating people about the details of very complex programs.

There are problems of error in our payment systems under SSI. There we have more control because it is a Federal program. We have made great strides, I think, in collecting overpayments.

Senator MOYNIHAN. You got off to a very shaky start. The program started in 1973.

Mr. ROSS. Oh, yes. It started in 1974. It did begin with a very shaky start. Yet, because we put in a good quality assurance system, we were able to bring that error down very substantially and within a relatively short period of time.

There were long lead times in putting these corrective action programs in. Indeed, one of the things that must be said is that the start up of progams like SSI is particularly difficult with, as you have pointed out, the changeover in personnel in a department like HEW.

It is very important to build programs. Very often the payoff occurs for actions that really happened under another administrator or things that you get credit for, or blame, are things that started earlier.

Senator MOYNIHAN. Oh, sure.

Mr. Ross. It is very important that you try to build carefully so that the things that you do are sound in and of themselves and not based on personalities.

Senator MOYNIHAN. That is called public administration.

Mr. Schaeffer, what about that green bar?

Mr. SCHAEFFER. Well——

Senator MOYNIHAN. Mr. Ross, you do not seem to have thumbed through the Inspector General's report very deeply. Did you read it?

Mr. Ross. I have gone through it, sir, yes, sir.

Senator MOYNIHAN. Have you read it?

Mr. Ross. Well, I——

Senator MOYNIHAN. I have your answer. You get a lot of reports. It was not something honestly—it was something you went through?

Mr. Ross. Yes, sir.

Senator MOYNIHAN. Without really saying this is what I am going to have to do.

Mr. Ross. We gear up with the Inspector General and the staff in SSA's Office of Assessment, which I established, do follow through as the report is prepared.

Senator MOYNIHAN. To read through for you?

Mr. Ross. No. To put in corrective action programs so that we have the capacity to follow up as we try to identify these things and try to do better. I think that is a very important aspect of the problem.

Senator MOYNIHAN. Sure.

Mr. Schaeffer.

Mr. SCHAEFFER. The fundamental mission of the Health Care Financing Administration is to finance the delivery of health care services to eligible individuals on a timely basis—quality services and appropriate services.

We are not crime fighters. The responsibility for fraud, for criminal behavior, is with the Inspector General. We are responsible for the efficiency of our programs and we have attempted, in a variety of ways, to improve the effectiveness of the way our programs work.

We are financers. We are purchasers of care. If you read the Inspector General's report, I think you will note that many of the problems alluded to in that report are problems in the health care industry—that is, there are too many beds in America.

We pay a proportionate share of the overhead due to that fact, because we purchase services.

In addition, as you have alluded to, there are a variety of judgments that can and are made by the professions and by the administrators, and we pay a proportionate share of those judgments. If they are bad, we pay all of it. If they are good.

Many of the items alluded to in that report have to do with that delivery system and many of those solutions are found in legislation and in industrywide approaches. Hospital cost containment, the planning act, that sort of activity. It is appropriate to get the overhead cost down, but we currently pay a proportionate share.

However, there are things that we can and should do ourselves to improve the way in which the program is run. And we have, and

have submitted for the record, a fairly lengthy and technical paper on our quality control systems.

Senator MOYNIHAN. Yes.

Let me say to you you are not going to have any difficulty with this committee when you say you have a quality control system and you have to make quality control judgments and they are judgments and while they balance—the practitioners might say something was inefficient. You might have just as strongly a view opposite that of other practitioners who know that it is not inefficient in the least.

This is a different thing from fraud.

Mr. SCHAEFFER. Sir, if you would refer to the 1978 report of the Inspector General, you will note that we provided information to him, indicating where we disagreed with some of the judgments and indicated that in some of the kinds of things are a necessary testing, for example, and we rely on them.

It is a difficult thing to do.

Senator MOYNIHAN. Mr. Schaeffer, you are responsible for medicaid also?

Mr. SCHAEFFER. Yes, sir.

Senator MOYNIHAN. As you know, it was the medicaid payments that were included in the Michel amendment that we were to have to strike out?

Mr. SCHAEFFER. Yes, sir.

Senator MOYNIHAN. We were on the point of sick, poor people. They cannot be paid.

An entitlement is going to be withheld because of all of this, and that is why we are serious.

I want to ask one last question of the panel. You have been very patient with me and I will address it to you, Mr. Secretary, but anybody can speak.

Two years ago the committee—this committee and subsequently, I think, the Appropriations Committee, specified error rates. This committee said, if you get your AFDC error rate down to 4 percent or less, then you will be rewarded for having done well.

And the Secretary of HEW was directed to promulgate regulations in accordance with that section 1. Two years later, we have no standards. What is going on?

Mr. BOHEN. Mr. Chairman, I made reference earlier in my testimony to the fact that there is a study underway. It has been assigned to the Assistant Secretary for Planning and Evaluation. There is an elaborate process of involving the States in both the design of that study and the review, the findings, to ascertain those aspects that should help us define what is an appropriate goal for these programs.

It is my understanding that we expect the study with respect to AFDC to be complete in September of 1980.

Senator MOYNIHAN. Wow.

Mr. BOHEN. With respect to the incentives side of your request, I understand that there are draft regulations that have not been issued in final, but are soon to be issued. Commissioner Ross may be able to be more precise on that.

Senator MOYNIHAN. I am going to put into the record the quality control regulations and to say to you without ire that you are taking a long time to do it.

The 1977 amendments gave a rather complex schedule—not too complex but nonetheless detailed—of the rewards that would come about from reducing error rates.

I will read them. A State with an error rate of between 3.5 and 4 would receive 10 percent of the Federal share of the money saved. A State with a rate of between 3 and 3.5 would receive 20 percent of the Federal share of the money saved, and so forth.

A State with an error rate of below 2 percent would receive 50 percent of the money saved. You have a responsibility to get that underway.

Would you tell Secretary Harris that we would like to hear from her on when we can expect this, and would she take secretarial notice that it is now 2 years since this was written into law. This is meant to be an incentive and not to be a reward. Let's see that we get it.

All right.

I would like to leave you with one request. We have explored something quite important to my view here and the next time that we have to go on the floor we will—and we will be there next time, unless a new Inspector General starts issuing two sets of reports, one on fraud and the other on waste and abuse.

I have a series of questions I am going to put in the record and ask you to give some answers for, if I could do that. What I would like to ask of you is to go back and get from Secretary Harris, who did not wish to appear, this is a matter that arose in a previous administration. I am not sure what she thinks about it. I do not know whether she has been able to get to it.

[The following was subsequently supplied for the record. Oral testimony is continued on p. 61.]

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

DEC 16 1979

The Honorable Daniel P. Moynihan
Chairman, Subcommittee on Public
Assistance
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Moynihan:

Thank you for giving the Department of Health, Education and Welfare the opportunity to testify before your Subcommittee on the Department's efforts to improve its systems and management practices.

It is unfortunate that the Inspector General's report created the impression that there was extensive fraud by recipients of cash and medical assistance. Based on your remarks at the hearing, we are in complete agreement on the need to put this aspect of the Inspector General's report in proper perspective. I will do all that I can to correct this mistaken impression and I have instructed my key staff to do likewise.

I am enclosing the answers to the questions that you submitted with your letter of November 16.

Sincerely yours,

Patricia Roberts Harris

Enclosure

Question: What were you doing to avoid waste before the Inspector General released his report? Is this what caused you to make waste reduction a major priority?

Answer: In March 1978, when the Inspector General released his report, HEW had several management actions already underway to improve program operations and to save Federal and State funds:

-- In both the AFDC and SSI programs, HEW and the States had quality control systems which had driven down the error rates. AFDC had reduced the payment error rate from 16.5% in September 1973 to 8.1% in June 1978 and SSI had reduced the payment error rate from 11% in June 1975 to 4.6% in March 1978.

-- In 1975, HEW designed its first Medicaid quality control system which focused on errors in determining client eligibility. This system proved to be wholly inadequate. By April 1978, HEW developed and implemented a more comprehensive Medicaid quality control system designed to include errors caused by claims processing and third party liability. The Department expects to have the first error rate data from this new system within two months.

-- In March 1977, HEW went through a major reorganization to facilitate sound financial control, program accountability and increased management efficiency in HEW's health financing, cash assistance, and student aid programs. For example, the reorganization created a new Bureau of Student Financial Assistance in the Office of Education which integrated the management of all student assistance programs under one bureau. This reorganization resulted in savings of $393.5 million in Student Assistance programs.

The Inspector General's report brought together for the first time everything we knew or could guess about savings opportunities in HEW programs. In many instances, the estimates made by the Inspector General highlighted management problems which the Department had already begun to attack. HEW used the findings and recommendations of the report to strengthen and intensify its effort to reduce the losses due to inefficient management practices or program abuse, and established a specific plan of action to reduce losses by at least $1.3 billion in FY 1979. This plan included savings targets for on-going activities, such as public assistance quality control programs, and new initiatives implemented in FY 1978 and FY 1979 such as more strict reimbursement principles in the Medicare program.

Question: HEW has made many promises since the Inspector General submitted his first report to Congress. Have you made any real progress in cutting waste?

Answer: As of September 30, 1979, HEW has documented savings totalling $705 million in FY 1979. The majority of the savings, $538 million, are derived from improved systems and management practices. For example:

-- HEW instituted tighter editing procedures to identify cases of insufficient or questionable information in basic educational opportunity grants applications. Of 1.5 million applications initially rejected, 484,031 applicants have not reentered the system or established grant eligibility for an estimated cost avoidance of $221.6 million.

-- HEW staff have conducted program and financial reviews and audits in most major HEW programs which resulted in savings of $209 million. For example, HEW regional staff conducted reviews and negotiations of cost allocation proposals submitted by all HEW grantees. This activity identified an additional $69 million in costs contained in the allocation and indirect cost proposals which were unrelated to, or excessive for, the conduct of HEW programs.

This documented savings constitutes 54% of HEW's total goal of $1.3 billion for FY 1979. However, this measure understates the Department's accomplishments under its FY 1979 plan. The plan includes initiatives totalling $642 million for which it was not possible to acquire data during FY 1979. Of this amount, $395 million depends on FY 1979 error rate data from the Medicaid, SSI, and AFDC quality control systems which will not be available until mid-1980. The plan also includes initiatives totalling $663 million, supported by regular data reporting cycles. For these latter initiatives, HEW can currently report accomplished savings of $597 million, 90% of the assigned targets. In addition, we can report savings of $108 million from new initiatives which did not have targets in the March 5 plan submitted to Congress. The following table, which I am submitting for the record, summarizes the Inspector General's findings and compares those findings to the savings the Department had documented through September 30, 1979.

Status of Reported Savings from HEW's Major Initiatives To Reduce Fraud, Abuse, and Waste ($m)

	Inspector General's Estimate	HEW's FY 79 Reduction Plan	Reported Savings as of September 30, 1979
A. Health Care			
1. Medicaid/Medicare fraud and abuse	668	93	23.84 1/
2. Medicare audit and cost reviews	17	16	6.33
3. Financial management			
a. Medicaid	--	*	45.3
b. Utilization control penalties	--	*	11.6
4. Reimbursement limitations for renal dialysis	--	22	10.7
5. Medicaid erroneous payments	1,100	265	
6. Medicare--reimbursement limitations			
a. Routine hospital costs	--	35	
b. Purchased inhalation therapy	--	13	
c. Malpractice insurance	--	10	
7. Unnecessary hospital stays	124	86	
Subtotal	1,909	540	96.97
B. Income Security			
1. SSI			
a. SSI overpayment recoveries	--	26	23.2
b. Disability conversion review	--	*	1.13
c. SSI payment errors	292	105	
2. AFDC			
a. Child support collections	--	*	27.0
b. Financial management	25	10	
c. AFDC payment errors	206	25	
3. RSDI			
a. Duplicate payments to dependent children	--	8	1.38
b. Student benefit initiative	--	100	
Subtotal	523	274	52.71
C. Student Financial Assistance Program			
1. Increased collection of FISL defaulted loans	--	68	133.7
2. Program reviews	--	27	8.2
3. Validation and editing activities	--	300	221.6
4. Increased collection of NDSL defaulted loans	--	10	
5. Reduction in FISL claims	--	11	30.0
Subtotal	203	416	393.5
D. Elementary and Secondary Education	53	22	22.2
E. Inspector General Computer Matching Initiatives			
1. SSI project match	--	*	.65
2. AFDC project match	--	12	9.63
3. RSDI project match	--	*	.02
Subtotal		12	10.30
F. Cross-Cutting Management Initiatives			
1. Indirect cost negotiations	23	15	68.8
2. Project integrity systems	--	*	3.42
3. IG Audit and criminal investigations			
a. Criminal investigations	--	10	.7
b. Audits	30	16	37.1
4. Recoveries on outstanding FY 1977/78 audits	--	*	16.1
5. Improved ADP practices	--	*	3.23
Subtotal	53	41	129.35
TOTAL	$2,741	$1,305	$705.03

* These initiatives did not have targets in our March 5 plan.

1/This figure is a combination of savings from State fraud control units, Medicare, and Medicaid investigations.

Question: How much money is being spent by HEW on efforts to measure and reduce waste, error, fraud, and abuse? How much money is being saved by those efforts? In other words, what is the cost-benefit ratio of such efforts?

Answer: The Department has not developed specific cost estimates for each initiative contained in the FY 1979 plan. However, we do have data on the Federal costs for the AFDC and SSI quality control programs.

-- We estimate that Federal costs for the AFDC quality control program, including the Federal share of States' costs, will be approximately $12.6 million and potential savings from reduced payment errors will be approximately $60 million, a cost/benefit ratio of $1 to $4.70.

-- In SSI, we expect Federal costs for quality control will be approximately $19 millioon and savings from reduced payment errors will be at least $68 million, a cost/benefit ratio of $1 to $3.60.

Question: You say that the public and the Congress misperceived the Inspector General's report. Why did this happen? What is the report's real message?

Answer: Unfortunately, most readers of the Inspector General's first report focused on his summary table contained on page 2, which in eight lines distributed the estimated fraud, abuse, and waste of $6.5 billion among the major programs in HEW. Although distinctions among these categories were identified on page 9 of the report, what immediately struck the reader was the $6.5 billion overall picture. In any public discussion, HEW has found it difficult to make people recognize that the Inspector General made some important distinctions in his report:

-- First, this estimate was not based on indepth analysis by the Inspector General. His estimate was simply a compilation of data from many sources, such as Congressional and GAO reports, HEW audit reports and outside studies that discussed a number of areas in which future economies seemed possible.

-- The major portion of his estimate, $5.67 billion, was due to inefficient program practices or management systems. Of this amount, $2.4 billion resulted from inefficient practices of the health care industry -- much of which could only be reduced through changes in authorizing legislation, such as hospital cost containment. Less than $220 million of his estimate was based on potential fraud by HEW recipients.

We can only conclude that human nature led to the misperception, since it is easier for individuals not familiar with the details to talk about the bottom line --$6.5 billion -- than to try to understand and discuss the intricacies of that number.

The Inspector General never intended this compilation of data to be interpreted as a scientific basis for budget cuts. The Inspector General's objective was to have his report serve as a stimulus to program managers in the Department by providing them with a compilation of the potential for savings from program improvements and legislative reforms.

Question: What happens when the Inspector General finds anything out of line? Does anyone with operating responsibility do anything about it?

Answer: With respect to audit activity, heads of Principal Operating Components (POCs) are responsible for resolving matters raised in audit reports. The Inspector General's office monitors the timeliness and adequacy of such actions and prepares periodic status reports to the Secretary. Under legislation establishing the role of the Inspector General (P.L. 94-505), periodic reports are also sent to the Congress.

In November 1978, HEW instituted a Department-wide system to monitor POCs' collection of outstanding audit disallowances. The system tracks the status of audits from the time a decision is made to sustain an audit finding to the time final collection of funds is recorded.

Allegations of fraud and other related violations of law are investigated by the Office of the Inspector General, Investigations. Programmatic weakness or management deficiencies which permitted the violations to occur are reported to the POC for corrective action. The action of the POC is monitored by the Office of the Inspector General (OIG) and is reported to the Secretary and to the Congress in the OIG quarterly and annual reports.

In response to the findings and conclusions of the Inspector General's first annual report, which compiled an inventory of his estimates of losses in HEW programs, HEW established a specific plan of action, including management initiatives to reduce losses by $1.3 billion in FY 1979. During FY 1979, the Department made excellent progress in its savings plan. As of September 30, 1979, HEW had documented savings totalling $705 million.

Question: Please give me the Administration's definition of an "entitlement program" and describe for me the effects of provisions such as the so-called "Michel amendment" on the administration of entitlement programs. Is it possible that such constraints on approrpriations for entitlement programs will lead to situations in which individual recipients of Federal assistance will not receive the benefits to which they are entitled? What does the Department propose to do about those situations?

Answer: An "entitlement program" is one in which the authorizing legislation confers the right to a specified benefit on prsons who meet certain eligibility criteria. If the applicant satisfies the criteria, benefits must be provided. AFDC and Medicaid are examples of entitlement programs.

In AFDC and Medicaid, the States present claims for Federal financial participation to the Department. To the extent that these claims are judged valid, the Federal Government must provide the financial assistance. The budget for these programs presents an estimate of the valid claims that will be presented for payment during the fiscal year. If the estimate is too low, we are bound to request a supplemental appropriation or utilize the borrowing authority in the Appropriation Act. The Act authorizes HEW to borrow against the next year's appropriation to make payments in the final quarter of the current fiscal year.

The Michel amendments reduces the HEW appropriation by $500 million for FY 1980. It is HEW's responsibility to allocate that reduction according to the terms of the Michel amendment. In practice, this will mean reductions in the line item appropriations for AFDC and Medicaid. These will be shown on the apportionments presented to OMB for approval. Despite these reductions we will continue to honor claims submitted by the States. If the appropriation, as reduced by the Michel amendment, is insufficient to honor all State claims, we will exercise the authority in the Appropriation Act to borrow from the fiscal year 1981 appropriation in the fourth quarter of FY 1980.

The Comptroller General ruled that the Department could use its borrowing authority to offset the Michel amendment reduction when the question arose in connection with the FY 1979 appropriation. Becuase of this borrowing authority, we can assure you that no individual beneficiary will suffer due to the reduced appropriation caused by the Michel amendment.

In addition to reducing HEW's appropriation, the Michel amendment requires HEW to impose fiscal sanctions on States which do not meet the congressionally mandated error rate targets. Congress stipulated that cash and medical assistance to legitimate recipients shall not be curtailed or delayed on account of such fiscal sanctions. The Department is examining policies that will, through legislation, regulation or other means, assure that no individual beneficiary will suffer due to benefit reductions in States that face fiscal sanctions.

Question: Your testimony states that "HEW opposes legislated error rate targets with fixed, inflexible timetables." If I am not mistaken that is precisely what has been legislated on the FY 1979 Supplemental Appropriation and in the FY 1980 Labor-HEW appropriation. Indeed, the Department has begun the process of issuing regulations to carry out those provisions.

It will no longer suffice, therefore, simply to express opposition to such legislative provisions, because they are going to be enacted whether you like them or not. The relevant question would seem to be whether the Department is content to take its legislative direction in these matters in the form of appropriation riders, or whether it would be better served by incorporating reasonable standards and requirements in the Social Security Act itself.

If you agree that it would be preferable to deal with error rate concerns in entitlement programs in the context of the legislation establishing the entitlements themselves, are you prepared to suggest amendments to the Social Security Act that this Committee could consider? If not, why not?

Answer: Yes, we are prepared to suggest a legislative alternative to the 4% legislated error rate in the FY 1980 Labor-HEW appropriation. We support legislative provisions for establishing errorrate tolerance similar to those for AFDC error rates added by the Conable amendment to HR 4904, the Welfare Reform bill. This amendment mandates the approach taken in HEW's regulations, published March 7, 1979. Title I, Part G of the bill:

-- Sets as a goal a national AFDC payment error rate of 4% and specifies the method for achieving this goal to be the Department's March 1979 quality control regulations.

-- Requires HEW to study State's AFDC error rates and submit its findings and recommendations to the Congress by December 31, 1980. This study is under way

-- Keeps in effect the March 1979 regulations until the mandated study is complete and the Congress has had 30 days (excluding recesses of more than 3 days) to review and take appropriate action on regulatory revisions recommended in the study.

With regard to Welfare Reform, we ask the Senate to accept the Conable amendment with a technical modification to make it clear that for AFDC this legislation supercedes the language in the FY 1980 appropriation. In addition, we intend to either include similar provisions for Medicaid error rates in the President's FY 1981 legislative program or request Congressional committees to consider approparíate provisions for Medicaid error rates as they are considering other amendments to Title XIX of the Social Security Act.

Question: In expressing your opposition to the inflexible rules of the Labor-HEW Appropriations bill, you also mention a provision in the House Welfare Reform bill which would retain the March 7 regulations of HEW. Is it your opinion that this section of the Welfare Reform bill (H.R. 4904), would in fact supercede the language of the Appropriations bill.

Answer: With respect to Medicaid error rates, the directive in the Appropriations bill would not be superceded by Section 132 of H.R. 4904, as passed by the House of Representatives. The directive in the Appropriations bill requires the Secretary to issue error rate regulations covering both AFDC and Medicaid. Section 132 applies only to error rates in AFDC.

With respect to AFDC error rates, the intent of Congress was apparently to keep the March 7 regulations in effect until the study mandated by Section 131 is completed in order that Congress have the opportunity to review the findings and recommendations of the study before any changes are made in existing regulations. An ambiguity arises, however, from the language of Section 132 which keeps in effect the March 7 regulations "as in effect on the date of enactment of this Act (i.e., the Welfare Reform Act)". If a regulation is issued in compliance with the directive in the Appropriations bill before the Welfare Reform bill is enacted, that regulation -- rather than the regulation of March 7 -- might be regarded "as in effect" on the date of the enactment of the Welfare Reform bill.

To remove this ambiguity and to assure that the directive in the Appropriations bill is superceded, Section 132 should be revised to make it clear that the March 7 regulation, as issued, both with respect to AFDC and Medicaid error rates, must remain in effect for a specified period.

Question: Would you please explain the relationship, if any, between the error reduction regulations promulgated by HEW last March, and the recent "notice of rulemaking" which was intended to carry out the provisions of the FY '79 supplementalappropriation?

Am I correct that the latter supercedes the former, and that the "moving average" goals for error reduction that you settled on last spring after extended consultation with the States, has now been replaced by an absolute 4 percent standard?

As I recall, and as you recount in your testimony, HEW in 1973 promulgated absolute standards of 3 and 5 percent that were later thrown out by the courts as "arbitrary and capricious." Is the four percent standard that was established in the Appropriations bill any less arbitrary and capricious?

Answer: The Department published final regulations on March 7, 1979 establishing error rate standards for AFDC and Medicaid. These regulations resulted from extensive negotiations with State and local government representatives. States not achieving the required standards would lose Federal matching funds for the amount of expenditures exceeeding the tolerances. The regulations embody three principal features:

- o No absolute error rate standard is specified. Instead, the Department announced its intention to complete a study by October 1980 of reasonable error rate tolerance levels.
- o In the interim, standards will be set annually at the level of the national average payment error rate. The Department believes that actual performance best reflects States' administrative and managerial capability to lower error rates.
- o Finally, States with error rates well above the national average are not expected to reduce their error rates to the national averge instantly. Rather, States must reduce errors at the rate of reduction historically achieved by the States on a national basis, i.e., 6.4 percent for AFDC and 15.7 percent for Medicaid payment errors. Thus, States only are required to make continual steady progress until the standards are finally achieved.

States will be subject to penalties based on these regulations beginning with the period April to September 1979.

On September 25, 1979 the Department published for comment a proposed regulation to carry out the congressional directive contained in the FY 1979 and FY 1980 appropriations. Unlike the March 7 regulations, the congressional directive establishes an absolute goal and a fixed timetable for meeting that goal. The March 7 regulations set a relative goal while the feasibility and appropriate level of nationally uniform absolute goals is studied. The congressional directive requires all States to achieve an error rate of four percent. The March 7 regulations allow States to reduce error rates to the standard by making reasonable annual reductions at the historical improvement rate. The congressional directive requires all States to achieve the four percent standard by September 30, 1982 regardless of how high a State's error rate may be now.

The standards set by the March 7 regulations will be superceded by the congressional standards beginning October 1, 1980. States will be subject to penalties under the regulations implementing the congressional directive beginning with the period October 1980 to March 1981.

Like the Department's 1973 standards, the four percent error rate standard set by Congress is not based on an emperical study. However, a court would not apply the "arbitrary and capricious" test to the congressionally mandated error rate standard.

The Department is currently studying what level of error would be cost effective and whether this level is the same for all States. We expect that the study will provide the basis for recommendations on measurement of errors and future quality control policy including tolerance levels. The study also will help HEW provide appropriate technical assistance to the States in reducing errors. Because the study is on the frontier of research in this area, it may not provide a definitive guideline with respect to error rate targets nor resolve the differences of opinion over error rate policy that have existed.

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Question: In the regulations of March 7, HEW specified that only overpayments and payments to ineligibles would be included in error rates. Thus the other two categories of errors - underpayments and denials to eligible applicants - are excluded from the computation of error rates. Doesn't this have the tendency of creating a distortion in these rates? Aren't they weighted in favor of errors in excess payments?

Doesn't this also tend to create an imbalance within the error rates, with the result that there is no incentive for States to improve their rates of error for underpayments and negative case actions?

Isn't it also possible that this imbalance might hasten a State's decision to reject an application for benefits to an applicant who is actually eligible, rather than risk paying benefits to those who are not eligible and thereby adding to the State's rate of error?

Answer: The Department's current quality control system measures error rates for overpayments and payments to ineligibles as well as underpayments and improper denials and terminations of assistance. Regulations establishing error standards and fiscal penalty policies, however, have established standards only for overpayments and payments to ineligibles. Standards and fiscal penalties were not established for underpayments and improper denials and terminations. This omission is based on two factors. First, current measurement of the extent of these errors shows them to be very low. Underpayments run less than one percent compared to 8.7 percent for overpayments and payments to ineligibles. Similarly, less than 4 percent of all denials and terminations were found to be questionable.

Second, the fiscal penalty regulations are based on the principle of disallowing Federal matching for incorrect expenditures. Since an underpayment or improper denial does not result in an incorrect expenditure, we cannot use the improper expenditure principle to establish fiscal penalties for poor performance on these measures.

Although error rate standards and related fiscal penalties do not apply to underpayments and improper denials and terminations, final regulations promulgated November 26 establishing incentives for low error rates do include these errors. Under the regulation, States with error rates below 4 percent receive an incentive payment. To qualify for the incentive, the combined error rate for all types of error, including underpayments and improper denials and terminations, must be under 4 percent.

As part of the quality control study now underway, we will examine the question of what distortion is caused by establishing penalty standards only for overpayments and payments to ineligibles. Based on the findings of the study, we will consider what legislation may be needed.

Question: We have focused primarily on AFDC and Medicaid, the State administered programs. Why don't you tell us more about SSI, Medicare, and the basic Social Security retirement and disability programs, i.e., those run directly by the Federal government. How do you measure error rate in them? How much of it is there? What do you do about it? What fiscal sanctions do you impose on yourself?

There was quite a scandal when the SSI program began because of the high rate of error in it. What is that rate now? How did you achieve it? What are you doing to lower it further?

Answer: I would like to submit the following papers for the record which provide a summary of the department's responses to your inquiries about SSI, Medicare, and the basic Social Security retirement and disability programs.

QUALITY REVIEW SYSTEMS — Supplemental Security Income (SSI) and Retirement, Survivors' Insurance (RSI) Programs

Error Rate Measurement

The SSI and RSI Quality Review systems are basically the same as the AFDC Quality Control system. The SSI and RSI Quality Control systems are based on random samples of all cases receiving payments. A sample is selected for every 6-month period, October through March and April through September. The sample includes cases from the entire caseload to ensure that a representative number of all kinds of cases receiving a regular monthly payment is reviewed.

The RSI and SSI Quality Control reviewer is responsible for doing a thorough and completely independent redevelopment of all of the factors which determine a beneficiary's eligibility and payment amount. The reviewer conducts an indepth interview with the beneficiary at home, and requests that all necessary proofs be available as appropriate to each program. This includes birth certificates, pay stubs, social security and VA eligibility letters, bank books, insurance policies, rent receipts, and other evidence.

For example, in the SSI program the reviewer:

- o asks about the beneficiary's work history to establish leads for pensions, VA benefits, etc.;
- o examines the living expenses to establish that the available income is sufficient to pay these expenses;
- o determines where the beneficiary cashes checks and carries out other financial transactions to provide a lead for banks to check for accounts; and
- o asks about the beneficiary's living arrangement, such as whether the house is owned by another, and whether other people live there.

The interview generally takes an hour or more. Afterward, the reviewer verifies all the information provided by the beneficiary. He/She contacts employers, visits local banks to check for possible accounts, and reviews public records to determine property ownership. (The reviewer fully informs the beneficiary of all contacts going to be made.) The reviewer then uses this information to compute the proper benefit and compares it with the amount actually paid. If the benefit is incorrect, specific information about the error is identified and recorded for use in further analysis. Information is recorded on the type of error in the case, who caused the error (the agency or the beneficiary), how the error happened, how the Quality Control reviewer discovered the error, the amount of the error, the effect of the error on the benefit amount, and how long the error has existed. Through the collection and correlation of all this data corrective actions are planned and implemented. If the Quality Control reviewer discovers an error, case results are sent to the local servicing office so that this particular case can be corrected.

In addition to the payment accuracy reviews, SSA reviews on an ongoing basis a sample of disability determinations made by State Disability Determination Sections (DDS's) for the Title II and Title XVI disability programs. Determinations that do not meet Federal standards are returned to State DDS's for additional development and/or revision of the determination. Individual performance evaluations are produced for each DDS. Those DDS's performing below desired levels are subject to more intensive reviews.

SSA has also had a system of operational reviews for RSI claims adjudication in place for years.

Current Error Rates

SSI dollars paid in error were reduced from 11.0 percent in June 1975 to 5.0 percent in March 1979, a major drop and significant savings in incorrectly paid dollars.

The RSI QC system is new. We have nearly completed our first 6 month sample and error rates will be available shortly. The DI QC system is in a pilot test stage and it will be some time before valid error rates are available. However, we can provide results from our reviews of RSI and DI adjudications.

Less than 5 percent of RSI claims adjudicated in 1979 contain an incorrect payment.

For the last 6 months of 1978, incorrect State DDS decisions or decisions with insufficient documentation averaged 7 percent of determinations for Title II and 9.6 percent of determinations for the Title XVI program.

Error Rate Reduction

When the SSI program began in 1974, it suffered from many problems. The more obvious among these problems were the lack of sufficient trained staff (adequate staff was not brought on board before the program began), systems problems, and major changes in the law shortly before implementation of the program.

Beginning in 1975, major efforts were directed to stabilizing the SSI program and the system and to accreting additional staff who, with the passage of time, gained experience and understanding of the SSI program. Additionally, there was a concerted effort directed to systems and program training, culminating with the Operations Training effort of 1975 which was directed toward training all regional office and district office (DO) personnel. Continuing these efforts, regional personnel have engaged in intensified, ongoing training on new, and existing, SSI policies and procedures.

SSA continues to evaluate the program for simplification and error reduction potential, reviewing and analyzing feedback from field operators, SSA initiated studies and outside audits. For example, one error reduction procedure we instituted in 1975 was the review of large, retroactive payments in the DO's. In 1977, we added a central office review. This review was expanded in 1979 and we are now seeking to further expand the universe of cases in the review.

Within Quality Control, the information from each sample case is combined with that from all other sample cases and provides an overall picture of what is incorrect in the SSI program. Various analyses are done and information is accumulated on:

- o what is causing the incorrect payments, and how frequently they occur. For example, to what extent are incorrect living arrangements, earnings amount, and resources, causing errors ?
- o why the incorrect payments are occurring. Is it because the beneficiary failed to give the correct information at the application interview or failed to report a change in circumstances? Did the agency staff make an error in computing the benefit or fail to verify a beneficiary's statement adequately?
- o how long the incorrect payments have existed and at what point in the payment process were they created.

Using the tabulated data from the Quality Control system, agency staff analyze the information, identifying the causes of error, why they occurred and how to correct them.

In the SSI program, the most recent findings show that the beneficiary was responsible for 63 percent of the incorrect payments, by reporting incorrect information to SSA, or by failing to make a required report regarding a change in circumstances. The agency-caused errors generally were due to failure by the SSA field office to properly verify and process the claim. Of the specific eligibility factors causing errors, the most frequently occurring were:

-- the beneficiary had funds in undisclosed bank accounts which resulted in resources exceeding the resource limits of $1,500 per person, or $2,250 per couple.

-- the living arrangement classification which determines whether or not the beneficiary's payment is reduced due to receipt of food and shelter in someone else's household was not correct.

-- cash or in-kind contributions from private sources were not correctly shown in SSA's records, and

-- the correct amount of earned income was not considered in determining the payment amount.

Specific corrective actions have been designed to attack these specific problems. For example, if the agency staff is responsible for an unacceptable level of incorrect payments in a specific category, then special training is provided. If it becomes apparent that the procedures for handling certain cases are unclear, the procedures are clarified or simplified. If beneficiary nonreporting of certain changes is causing the incorrect payments, then reminders may be sent to beneficiaries periodically, or redeterminations may be scheduled more frequently.

As this description of what we do with Quality Control information indicates, the Quality Control systems serve two major purposes--the first is simply to provide a measure of how well we are running the programs; the second is to provide data on the numbers, types and causes of error which managers can use to develop ways for improving program administration.

Quality performance with respect to disability determinations and the RSI program have been considerably more stable than performance in the SSI program. Individual DDS and field office performance are continually monitored. Components and programmatic areas experiencing a reduction in quality are subject to increased reviews and special studies. Corrective action plans are developed and monitored, as needed.

Fiscal Sanctions

The only part of the RSI and SSI programs where a sanction procedure would be appropriate is in the SSI program where SSA administers State optional supplement payments. That portion of incorrectly spent State funds above preset tolerances (currently 4 percent for October 1979 on) is reimbursed to the State.

Management Initiatives to Reduce Error in the SSI Program

Although we are continually looking for ways to simplify and reduce error, the SSI program is such that making correct payments depends on having exact information about income, resources, and living arrangements on all cases. Legislative changes in eligibility and benefit computation provisions would be needed to reduce error beyond a certain point and it is recognized that program simplification can lead to increased program costs. In addition, there are inherent errors in the program such as those caused by recipients' due process rights or litigation, and communication problems as we are dealing with aged/disabled individuals who have difficulty understanding complex program concepts such as inkind income and support and maintenance. The program also has a built-in disincentive to reporting since it can have an adverse effect on payment. We recognize that we have at least partial responsibility to overcome the disincentive and we will be working with Inspector General on a reporting study and considering the feasibility of requiring more frequent reporting for certain recipients.

In order to improve agency performance, it is essential to have the appropriate assessment mechanisms in place to tell the manager what is required. Consequently, we are continuing to stress and strengthen the Quality Control systems. We are increasing our capacity for analyzing the Quality Control data and for translating the information into effective corrective actions.

Our initiatives in SSI are comprehensive and tailored to address the areas in this program which require attention. A major SSA-wide initiative is the launching of "Project Accuracy"—the purpose of which is to live up to the Social Security Administration's traditional goal of right amount to the right person on time. This is a particularly important initiative. The thrust of this effort is threefold, to:

— prevent payment errors where possible;
—detect mistakes quickly; and
—recover incorrect payments or settle payment errors swiftly.

The major emphasis of Project Accuracy is to prevent incorrect payments from occuring. An emphasis on prevention is critical because most of our payments are to economically vulnerable people who have difficulty returning overpaid funds or face undue hardship if benefit amounts are erroneously low. We believe the most important action we can take is to do everything possible to keep payment errors from happening in the first place. However, when they do occur, they must be detected as promptly as possible and corrected swiftly if we are to be responsible caretakers of public funds. Other major activities include:

- Use of Error Prone Profiles - direct use of QC data to implement specific development for cases that are more likely to be in error; this is a major agency initiative now being used by SSA in redetermining all SSI cases and by some States to better control AFDC errors.

- Specialization in the social security district offices. Until recently, social security claims representatives were responsible for handling all aspects of SSI, old-age, survivor and disability claims. The scope and complexity of these programs have expanded to the point where it is no longer possible for one person to know all four programs in sufficient depth to process the claims at the level of accuracy we are demanding. Therefore, we have separated the district office staffs in many of our larger offices so that part is devoted to SSI and part to old-age, survivor, and disability insurance. An in-depth study we did before deciding to specialize indicates that significant improvements in the accuracy of decisions and payments should result.

- Establishment of special procedures to prevent and recover overpayments.

  -- We have instituted a number of safeguards when large retroactive checks are to be paid. A review of checks of $3,000 or more is conducted in SSA's Central Office. District offices also double check smaller retroactive payments. We estimate that these preventive measures will save $2 million in fiscal year 1980.

  -- We have instituted special claims development procedures to reduce the number of incorrect payments due to unknown bank accounts and living arrangements. Over 50 percent of cases in error and half of the money misspent result from these two factors. To prevent bank account errors, social security claims representatives are interviewing claimants and beneficiaries more thoroughly and verifying accounts at local banks in many instances. To reduce living arrangement errors, we have issued a new interviewing guide to all field personnel which simplifies and standardizes the procedures used in determining the correct living arrangement.

Description of Quality Assurance Programs in Medicare

Brief History of Medicare Program

Health insurance for the elderly (Medicare) was authorized by Congress under Title XVIII of the Social Security Act in 1965. The Medicare program was extended to the disabled and persons with chronic renal disorders by social security legislation enacted in 1972. The Bureau of Health Insurance, a component of the Social Security Administration, managed the program until March 1977 when the Bureau was transferred to the Health Care Financing Administration.

Medicare is a program of health insurance that was established to help people pay the high cost of health care. It is a federally run program operated by the Health Care Financing Administration. Medicare has two parts, hospital insurance (Part A) and medical insurance (Part B). Medicare hospital insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility and for a patient at home receiving services from a home health agency. Medicare medical insurance pays for doctor's services, outpatient hospital services, outpatient physical therapy, outpatient speech therapy, outpatient speech pathology services and other health services and supplies not covered by hospital insurance.

Everyone 65 or older who is entitled to monthly social security benefits gets Part A hospital insurance automatically. Part B medical insurance is voluntary and beneficiaries are charged a monthly premium. Practically everyone in the United States 65 and older is eligible for Part B as are disabled people under 65 who have been getting social security benefits for 24 consecutive months and people suffering from chronic renal disorders.

Medicare payments are handled by private insurance organizations under contract with the Government. Organizations handling claims from hospitals, skilled nursing facilities, and home health agencies are called intermediaries. Organizations handling claims from doctors and other suppliers* of services under the medical insurance part of Medicare are called carriers.

*Suppliers are persons or organizations, other than doctors or health care facilities that furnish equipment or services. For example, ambulance firms, independent laboratories and organizations that rent or sell medical equipment are considered suppliers.

Development and Implementation of Quality Assurance Programs in Medicare

Because the Department relies on administrative agents, intermediaries and carriers to carry out the operational functions of the program, it became necessary to develop administrative mechanisms to insure compliance with Medicare policies. In 1973, a quality assurance program was implemented to evaluate Part B contractors' performance by determining the number and type of claims processing errors associated with claims and dollars related to those errors. In July 1978, a quality assurance program was implemented in the Part A hospital insurance program designed to evaluate intermediaries' performance by reviewing a sample of settled hospital cost reports from providers. There are two major informational outputs that emanate from these quality assurance systems. One is a national report which ranks carriers based on their performance. An intermediary report will be issued starting in December 1980 ranking carriers based on their performance. These rankings are then factored into the overall contractor evaluation process for assessing carriers and intermediaries. The second output is the identification and recovery of erroneously spent funds and a detailed report on the types and causes of errors in Part B. A brief description of both programs follows.

Medicare Part B End-of-Line Quality Assurance Program

The primary purpose of this program is to provide insight into the quality of each carrier's claims operation and to enable the Health Care Financing Administration to compare contractor's operations by reviewing a statistical sample of claims. At the present time, there are 44 carriers.

The Part B end of line system covers a review of claims for services provided by doctors and suppliers. The number of claims sampled is determined by the carriers' claims volume. Approximately 1 million claims are included in the total sample annually out of an estimated 130 million claims processed. HCFA regional staff then review approximately 100 thousand of these claims to validate findings by the carriers.

Carriers select a sampling of claims on a weekly basis using computerized routines provided by HCFA. Carrier staff analyze sample claims to determine if processing was in accordance with Medicare and carrier requirements. Carrier sample review

findings are refined and adjusted on the basis of regional office review findings. Two reports are produced: one quarterly and an annual report. Carriers are ranked in descending order of performance in the annual report according to processing and payment error rates.

There are approximately 35 regional office reviewers and three central office analysts assigned to the Part B end of line program. Contractors have approximately 200 person years devoted to this effort.

Part A Quality Assurance Program

The Part A Quality Assurance program which is also referred to as the Cost Report Evaluation Program (CREP) is designed to measure the quality of intermediaries' action in reviewing, adjusting and settling hospital cost reports. A settled cost report is defined as one where the provider has been sent a notice of the final program reimbursement cost. The measurement of quality covers:

1. Adherence to policy and procedures necessary for cost report review.

2. Discovery and appropriate adjustment of errors in the cost report.

CREP consists of a series of questions designed to provide uniform feedback to HCFA on findings made in reviewing cost reports. The answers to these questions enables HCFA to determine a grade which summarizes the performance of an intermediary on a particular cost report and on all the cost reports in the sample. In addition, total dollar adjustments to the cost report are recorded.

During each review cycle, which corresponds with the fiscal year, the nation's 82 intermediaries are examined by reviewing a sample of settled hospital cost reports. Approximately 600 cost reports are reviewed each year out of a total of 6,800. HCFA determines the sampling methodology which is designed to include a larger number of hospitals with higher bed sizes. RO personnel then review the cost report for each provider selected utilizing the CREP questionnaire as review criteria. Hospital cost reports are examined together with intermediary work papers, permanent files and other documentation supporting the propriety of the settlement.

At the conclusion of the review, a report of the findings, recommendations and the intermediary's score is tabulated. The purpose of the scoring mechanism is to encourage improvement in poor performing intermediaries and to ensure that intermediaries with satisfactory scores continue to maintain their quality. National scores ranking each intermediary will be published for the first time in December 1980. Scores from the October 1978 to September 1979 review cycle were not published to allow sufficient time for refinement and adjustment to the survey instrument.

There are approximately 30 regional office auditors and 11 central office auditors assigned to the Part A quality assurance program. Contractor staff are estimated to be 500 person years.

Under the existing law, contractors are reimbursed on a cost basis and, therefore, no fiscal sanctions could be imposed. Contracts could, however, be terminated or nonrenewed for poor performance. Under the experimental authority granted in Public Law 92-603, HCFA entered into three fixed price contracts for the processing of Part B claims. All three of these contracts contain provisions for cash penalties for poor Part B end of line performance.

HCFA released two RFPs, one for Part A operations only and the other for a combined Part A & B operation. Both RFPs contained provision for cash penalties if the winning contractor failed to meet specific CREP scores and failed to correct the situation within a specified time period.

New Initiatives

Future plans call for extension of the CREP into other institutions (home health agencies, skilled nursing facilities) and into the evaluation settlement reports by State Medicaid agencies. In addition, a national work group comprised of carrier representatives, State and Federal Medicaid quality control staff, is exploring the feasibility of merging the best features of the Part B end of line and the Medicaid quality control review into uniform procedures for claims processing.

In both quality assurance programs, we are intensifying our analytical efforts to re-emphasize the merits and benefits of corrective action. Ten carriers and ten intermediaries who have performed poorly in the past have been identified for concentrated corrective action attention.

Error Rate in Medicare Program

Due to the nature of the Medicare program which uses private contractors to process claims and review cost reports, the exact rate of error is not available. However, some estimates have been prepared by the quality assurance programs.

From a review of sample claims, the Medicare Part B program has determined that nationwide error rates are about 2% of claims processsed. The Part A quality assurance program, on the other hand, has only been in effect about a year and no data are currently available. A review of a sample of settled cost reports results in a performance ranking score for intermediaries participating in Part A.

Question: Two years ago this Committee accepted an amendment to the Social Security Act, creating fiscal incentives for states with AFDC error rates below 4%. The Secretary of HEW was directed to promulgate regulations in accordance with this section of the law.

Why is it that two years later, we still have no regulations? Why hasn't HEW hastened to implement a system of financial incentives that is already written into law?

Answer: On November 26, 1979 Final Regulations were published in the Federal Register, which contain the Department's rules for providing incentive payments to States with AFDC error rates below four percent. (The Notice of Proposed Rulemaking was published in the Federal Register on November 20, 1978.)

The final regulation specifies the rates for increased Federal financial participation and the four types of errors included in the calculations as required by the law. In addition, the regulation provides a formula for assigning a dollar value to denial and termination errors -- the only type of error for which a dollar value is not generated by the quality control system because no expenditure of funds is involved. (The law specifies that the calculation must be done using the dollar value of the errors.)

These final regulations were delayed, while the Department determined how to assign a dollar value to denial and termination errors. The formula contained in the final regulation will provide a dollar error rate for these errors without requiring costly revisions to the quality control system to generate a dollar error rate or requiring States to complete a full review of all improperly denied and terminated cases to determine the actual amount of incorrect payments. However, we have also proposed a technical amendment in the Welfare Reform Bill that would establish a separate (and more accurate) error rate tolerance for improper denials and terminations.

The eligibility for incentive payments is retroactive back to January 1, 1978, thus no states will lose an incentive payment due to the delay in publishing the final regulations.

Question: Am I correct in sensing a sort of paradox in our efforts simultaneously to eliminate fraud and to reduce error? My impression is that the sorts of means we usually devise to cut down on fraud -- demanding ever more complex verification of eligibility information from individual recipients -- are apt to foster increased error. The easiest way to eliminate fraud is to define it out of existence by granting benefits to everyone who wants them. Then there won't be any error either. But if instead we require applicants for Medicaid or AFDC to fill out a 15 page form and to submit 23 supporting documents, do we not increase the likelihood of error?

Answer: In general, efforts to reduce fraud will also reduce error. For example, increasing verification and documentation requirements tends to reduce both fraud and payment errors. Although procedures are not always followed properly, as your question suggests, this alone would not cause an error to be recorded. Quality control registers an error only when the payment is incorrect.

Because fraud contributes so little to the total of improper payments, overcommiting resources to its eradication could actually increase total improper payments through neglect of efforts to improve systems and management practices. For example, if a State established a large fraud detection and investigation team and abolished a team identifying error-prone cases and redetermining benefits, payment errors would probably rise at a much higher rate than fraud would fall.

Question: Is it possible to have a "zero defects" system in public assistance? Do we really have to learn to live with error permanently?

Answer: Most people recognize that it is impossible to run any system in a totally error-free manner, particularly a system as complex as the welfare system. The purpose of quality control in both the public and private sectors is to measure the extent of errors or defects and to keep them to a tolerable level. In the context of the public assistance programs, the major objective of quality control is to ensure that proper payments are made to eligible recipients, no more and no less.

In striving to reduce erroneous payments there are at least two constraining factors that we must consider. First, we must guard against an increase in underpayments and improper denials or terminations and against any other deterioration in the quality of client service. Second, a point will be reached where further efforts to reduce error cost more than would be realized by the additional savings. Quaity control standards should not require States to reduce errors beyond this cost effective point. We know very litle at the present time about what level of error is tolerable and the extent to which this tolerable level depends on State program policies, administrative methods, and caseload characteristics. For this reason we have agreed with the States to study the question of what level of error is cost-effective and how this might vary across States. This study is now underway within the Department.

Senator MOYNIHAN. I would like to hear from you that you are going to, in the future, make a distinction and not lump together specific actionable, illegal activities with questions of judgment, with questions that have to do with professional judgment about the correct action to take. At other times, it is just management judgment about the least cost process.

You should not give to the public and to the Congress the impression that there is a massive illegality in programs, when these are just simply large and new, and could be better run. You run them with leadership. You run them in a public system which, in the main, does not provide very high rewards for people who run things well.

It is remarkable how fine a civil service we have. In public administration, there is a classic story about the Second World War when a man from General Motors named Newson was testifying before a committee of the House of Representatives—not the Senate—and he was asked why he was not doing something about war production and he said, "It won't work."

The chairman of the committee said, "What do you mean it won't work?"

He said, "It won't work."

He said, "How do you know?"

He says, "The General Motors Corp. pays me $200,000 a year to know when something will work and when it won't work."

Well, at that time the top salary of the Federal Government probably was about $12,000 and they took his point.

But I would like to call the attention of the Secretary to three things.

First, a statement of the Secretary that she does, or does not, accept the distinction I have tried to make between fraud and these other inefficiencies of management which we can deal with, as two different categories of public concern.

Second, I would like to draw attention to this subcommittee chairman's concern that the turnover of top management is so rapid. Does the Secretary think this can be dealt with? If we cannot have persons who will stay for a longer period of time, ought these jobs to be in the area of Presidential appointment at all, if we cannot expect people to give 4 or 5 years of their time to a job?

It is a real question.

The Inspector General who made this report is not here to tell us why he did it and he has in his successor a very loyal and feisty young man who will defend with great vigor what the Inspector General did but obviously cannot do so with quite the same authenticity as if the man were still in his job. But he has left.

Last, I would make the point to you which is something of a mindset and which refers to Mr. Schaeffer's statement. If I am not mistaken, you have an organizational mindset in HEW which assumes the public sector is not large enough, and that your job is to make it larger.

Does that puzzle you? Well, I will explain it to you.

That is what you have been doing since the thing was started. The whole purpose of your organization is to increase public services. But you are suddenly finding yourself dealing with a problem

on the ground, a particular aspect of your public sector is too large. Isn't this the problem, Mr. Schaeffer?

Mr. SCHAEFFER. I am sorry, Senator, I am not following.

Senator MOYNIHAN. All right, think. Let's be a little Socratic here.

What did you tell me your problem was in medicaid?

Mr. SCHAEFFER. I said that our mission was to finance services for eligible individuals and that many of the problems that we face have to do with the nature of the health care delivery system as it exists, and as we purchase services from that system, we inherently spend money on things that may not be considered——

Senator MOYNIHAN. But you said you had a specific problem. Think back to what you said the problem you said you had.

I am wondering if you recognize what you said?

You said you had too many beds. Right?

Mr. SCHAEFFER. I said the country had too many beds.

Senator MOYNIHAN. Yes, the country had too many beds. Do you know what you mean? What that says?

It says you have too large a public sector.

Mr. SCHAEFFER. No, sir. The point I was trying to make is the health care system in America that serves both the public and the private, or that is financed both publicly and privately, has, under an estimate made by the Institute of Medicine, has an excessive number of beds in the sense of overhead, that we have overconstructed.

Senator MOYNIHAN. And you overconstructed with public moneys, Hill-Burton.

I just offer you a little friendly advice that the whole institutional mindset of the Department will be—Mr. Bohen, listen to this; I am telling you, it is insight—is that the public sector is not large enough and has to be built up.

As a matter of fact, in some respects, there are aspects of the public sector which are now, in fact, too large, and you have to deal with the fact of too much. That requires a change of perception that is very hard for an institution to do.

Institutions take about 10, 15, 20 years to change their minds.

Mr. SCHAEFFER. I apologize for my inability to grasp your point. I think your point is very accurate, but I hope that you are aware of the fact that we have, indeed in health care grasped that issue and we are trying to change our reimbursement structure so that we can, indeed, reward efficiency.

Senator MOYNIHAN. Well, that is what this whole hospital cost containment is about. You have too large a public sector. How you got it is absolutely amazing to you. You spent all your lives, people did it, spent all their lives saying there is not enough.

As a matter of fact, it has become not just a cost problem, it has become a health problem. Doctors diagnose as a source of certain kinds of pathology, staying in the hospital too long.

Why? Because people keep you there, they will not let you out because they get medicaid and so forth. It is altogether a new problem.

I can say with some confidence, never in the history—and you are interested in your jobs, you do not find them dreary—never in

the history of the world has a people had to deal with the fact that they have too many medical facilities.

Mr. SCHAEFFER. Exactly.

I think if you would take a look at our plans for the next several years, although we are very concerned about issues of quality and issues of access, the cost end of medical services has to do with utilization, primarily, and in many cases overutilization.

And some of the things in the inefficient practices in the health care industry have to do with overutilization, which is indeed a new problem.

Senator MOYNIHAN. That is all I am talking about, an energetic and effective coalition of the health care bureaucracy and congressional staff and congressional members in this country built too many hospitals. That is one thing.

Blaming it on welfare mothers is another. That is all I meant.

Also, it is an interesting question, you know, how you get this.

I see the committee is honored to have its most implacable foe of inefficiency, the senior Senator from Virginia. We welcome you, sir. I am sorry to have been launched on this lecture when you arrived. I immediately turn the floor over to you.

Senator BYRD. I enjoyed it very much.

Thank you, Mr. Chairman. I will just take a couple of moments, and I appreciate the opportunity.

The chairman made a statement a few moments ago to which I want to express full support and concurrence. Senator Moynihan said that we have a fine civil service. I think we do. I think the overwhelming majority of those individuals who work for our Government are splendid civil servants.

I came today just to make a few comments in regard to the Inspector General's report of March 3, 1978. I have not had the privilege of knowing—I understand he is now the former Inspector General—Tom Morris.

Now, could someone enlighten me as to when this change in Inspectors General took place?

Senator MOYNIHAN. If I may say, Senator, that Mr. Richard B. Lowe, who is the Acting Inspector General is on your left, and he could answer your question.

Mr. BOHEN. Senator Byrd, Mr. Morris resigned from his position as Inspector General of HEW as of September 30 of this year based on a decision that he had made earlier. He stayed on at Secretary Harris' request for a couple of months after she came in. And Mr. Lowe has been named Acting Inspector General to replace him.

Senator BYRD. I do not know if you are the proper person to ask. I do not know if anyone can answer this question. But did the report of the Inspector General on March 3, 1978, result in the Inspector General's no longer being with the Department?

Mr. BOHEN. Speaking as the head of this panel, I do not believe that was a factor. I think he acted on his own inclination after nearly 3 years of service in that job.

Mr. LOWE. I would say, Senator Byrd, that as far as I know, I could say categorically that that is not the case. As a matter of fact, I mentioned to the chairman that as of this past April when Secretary Califano was still at HEW, Mr. Morris was planning to leave as Inspector General and undertake a new project within

HEW for the Secretary, so the report and his leaving had nothing to do with each other.

Senator BYRD. Well, that is even more interesting to me, that Mr. Morris and the Secretary were working out an arrangement where by he would leave the position of Inspector General, which I think is one of the most important positions that can be held in any department of Government.

I have just expressed my strong support for Senator Moynihan's statement that we have a fine civil service. I say it again, but I also believe that there is a lot of waste, a lot of abuse, a lot of inefficiency throughout our Government. Certainly there is in the Senate. Certainly there is in the congressional branch, and I think there is throughout Government.

The only reason I came here today was to express support for those Inspectors General, in whatever department they may be who have the courage to bring out the facts, even though the facts may be detrimental to their own department.

I think in the long run such facts being developed and made public would not be detrimental to the department but would be helpful to the department.

I do not know if I sense accurately the feeling of the American people. Maybe I do not. But I have the feeling that the American people believe that there is waste and abuse in Government. I have the feeling that the American people want something done about it.

I do not see the Congress doing much about it. I do see, in isolated instances, where various Inspectors General are doing something about it, or trying to do something about it, by way of bringing out facts.

Now, many of us may not want to give credence to the information developed. That is something else. And maybe the case, in some instances, is overstated. But I do believe it is very important that our Government and each department have Inspectors General who will develop the facts, who will make public to the department head and to the Congress and to the American people what waste and abuses there are in the various programs.

I hope that you will do that in your capacity as Acting Inspector General and I want to offer the support of one Senator for all Inspectors General, wherever they may be, who are willing to stick their neck out—because that is what they are doing.

I am not at all surprised—I did not know it until today—but I am not at all surprised that the Inspector General who wrote that report on March 3, 1978, is no longer Inspector General of HEW.

I know nothing about the case. I do not know why he is not, but I am not at all surprised.

Frankly, I think HEW has gotten too big. I do not think it can be effectively administered without waste and abuse and that is all the more reason that there should be a strong Inspector General who is willing to do the necessary digging and then has the courage to make those facts known.

Thank you very much, Mr. Chairman.

Senator MOYNIHAN. Thank you, sir.

I would like very much to endorse what the Senator has said, and I would hope that Mr. Lowe, as a son of New York, we expect nothing less of you than accepting the charge of Senator Byrd.

Mr. Schaeffer, would you do me a personal favor and send me a note as to when you think the excess capacity began to appear in the hospital system and what you would associate with it?

[The following was subsequently supplied for the record:]

Question: When did excess capacity in the hospital system begin to be an issue and what is its current status?

Answer: The over-supply of hospital beds has been recognized as a problem since the early 1970s. The Department formally recognized this as it developed standards for State certificate of need programs--one of the activities mandated by the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). State certificate of need programs regulate the establishment and expansion of health care facilities, including increases in hospital beds.

In addition, the over-supply of hospital beds was documented in an Institute of Medicine report, entitled Controlling the Supply of Hospital Beds, which was issued in October, 1976. This report served as a basis for the National Health Planning Guidelines, which address the question of the proper supply of hospital beds; these guidelines were published in the Federal Register on March 28, 1978 (copy attached).

Others noting the over-supply of hospital beds include Dr. Milton Roemer and Dr. Walter McClure. Dr. Roemer's work addresses the over-supply issue by showing that increases in hospital capacity promote increases in hospital utilization ("Beds beget patients"). Dr. McClure's work considers whether a reduction in hospital capacity will induce a drop in utilization (reverse Roemer effect). Dr. McClure has found persuasive evidence that this is the case and that a reduction in hospital capacity, if organized appropriately, will do so without endangering the health status of the population served. A useful example of Dr. Roemer's work on this subject appears in the April, 1959, issue of Modern Hospital, entitled "Hospital Costs Relate to Supply of Beds"; Dr. McClure is well known for his 1976 study, Reducing Excess Hospital Capacity.

HEW has addressed the over-supply of hospital beds in several ways:

- Developing a proposal (now in Public Law 96-79) for a demonstration grant program for closure and discontinuance of excess hospital capacity.

- Considering a demonstration in which HCFA reimbursement is used to pay for some cost incurred in closing excess hospital capacity.

- Implementing the National Health Planning and Resources Development Act of 1974 which requires States to establish certificate of need programs and to conduct appropriateness reviews of existing institutional health services, including bed capacity.

- Administering the capital expenditures review program under Section 1122 of the Social Security Act. This program was authorized by the 1972 amendments to the Social Security Act (Public Law 92-603).

- Discontinuing grant awards for construction, modernization, and renovation of health care facilities under the Hill-Burton Program.

- Limiting the award of FHA 242 mortgage insuring pursuant to a Memorandum of Agreement between HEW and HUD. The standards for bed capacity in the National Health Planning Guidelines must be observed in awarding FHA 242 mortgage insurance.

- Monitoring a voluntary limit for capital expenditures as part of the Voluntary Effort for hospital cost containment.

- Including a mandatory national limit for hospital capital expenditures in the Administration's National Health Plan.

federal register

TUESDAY, MARCH 28, 1978
PART IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

■

HEALTH PLANNING

National Guidelines

[4110-83]

Title 42—Public Health

CHAPTER 1—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 121—NATIONAL GUIDELINES FOR HEALTH PLANNING

National Guidelines for Health Planning

AGENCY: Public Health Service, HEW.

ACTION: Final rules.

SUMMARY: These rules establish, pursuant to section 1501 of the Public Health Service Act, National Guidelines for Health Planning with respect to the following types of health services and facilities: General hospital beds, obstetrical inpatient services, neonatal special care units, pediatric inpatient services, open heart surgery, cardiac catheterization, radiation therapy, computed tomographic scanners, and end-stage renal disease.

A purpose of these guidelines is to assist Health Systems Agencies in developing Health Systems Plans and to help clarify and coordinate national health policy. These guidelines will be followed by other issuances setting forth national health planning goals and additional standards addressing such issues as improvement of health status, health promotion and disease prevention, access to care, and the availability and distribution of health resources.

EFFECTIVE DATE: March 28, 1978.

All Health Systems Plans developed after December 31, 1978 must be consistent with the National Guidelines for Health Planning set out below.

FOR FURTHER INFORMATION CONTACT:

Daniel I. Zwick, Associate Administrator for Planning, Evaluation and Legislation, Health Resources Administration, Room 10-22, 3700 East-West Highway, Hyattsville, Md. 20782, 301-436-7270.

SUPPLEMENTARY INFORMATION: The standards established here have twice been revised in response to public comment. A notice of proposed rulemaking was issued on September 23, 1977 (42 FR 48502 et seq.), revised in response to public comment and published as a second notice on January 20, 1978 (43 FR 3056 et seq.). In response to public comments on the second notice, the Guidelines have been revised and issued in final form.

A. OVERVIEW

Section 1501 of the Public Health Service Act, as amended by the National Health Planning and Resources Development Act of 1974 (Pub. L. 93-641), requires the Secretary of Health, Education, and Welfare to issue, by regulation, guidelines concerning national health planning policy. The guidelines are to include:

(1) Standards respecting the appropriate supply, distribution, and organization of health resources, and

(2) A statement of national health planning goals developed after consideration of the priorities set forth in section 1502, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

The purposes of the National Guidelines for Health Planning are to help clarify and coordinate national health policy and to assist Health Systems Agencies (HSAs) established pursuant to section 1512 of the Public Health Service Act in developing required Health Systems Plans.

On January 20, 1978, the Secretary of Health, Education, and Welfare published a Notice of proposed rulemaking (43 FR 3056 et seq.) proposing an initial set of National Guidelines for Health Planning. The proposal was a revised version of material published as a Notice of proposed rulemaking (42 FR 45802 et seq.) on September 23, 1977. Revisions had been made on the basis of the comments received in response to the first Notice. In view of the widespread interest in this material, the Secretary decided it would be desirable to provide an additional 30-day period for public review and comment.

Over a period of time, the Department will issue a complete set of National Guidelines which will include a wide range of goals and standards as required by the Act and subsequently will revise these guidelines from time to time as may be appropriate. This first issue consists of resource standards with respect to nine specific categories of health services and facilities. The Department will soon propose national health planning goals relating to health status, health promotion and prevention, and access to care. Additional goals and standards will be issued on a periodic basis.

The focus of this initial statement is on the short-term opportunities for cost containment and quality enhancement in the institutional sector. As Congress noted in section 2(a)(4) of Pub. L. 93-641, increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary. The increases in hospital costs are absorbing an exaggerated share of available resources. Planning and action to contain such increases are essential steps to preserve resources needed to achieve other health goals and to make possible the achievement of the statutory aim of the Act, viz. equal access to quality health care at a reasonable cost.

Cost savings may be achieved without sacrificing the quality of or access to care through more efficient utilization of existing resources and increased emphases on ambulatory and community services. Moreover, limitations of certain resources, such as open heart units, can lead to improvements in the quality of care while at the same time containing costs.

Section 1513(b)(2) of the Act calls upon HSA's, in the development of their Health Systems Plans, to give "appropriate consideration" to the National Guidelines for Health Planning. Health Systems Plans must also "take into account" and be "consistent with" the standards respecting the supply, distribution, and organization of health resources.

HSA's are to establish goals and set forth plans which, if implemented, will achieve the targets set within five years. All plans established by Health Systems Agencies after December 31, 1978 are to be consistent with the Guidelines as set forth below.

HSA's are expected to use the quantitative standards as benchmarks against which to assess local conditions and needs. In developing their plans, they should determine those cases where the Guidelines are appropriate planning ceilings and targets and those cases where adjustments may be necessary in light of local conditions and needs.

In some cases, the Agency may need to adjust a quantitative standard upward or downward to meet a specific local situation. The Guidelines contain a number of specific local conditions which may justify such adjustments to one or more of the standards such as the age of the local population, seasonal population fluctuations, or the rural nature of the area.

In addition, the Guidelines contain a general provision which recognizes that other special local conditions may exist which justify adjustment of a national standard. This provision permits the HSA, pursuant to its own detailed analyses, to include adjustments to take account of those local conditions that involve special needs concerning access to needed care and unreasonable costs. Adjustments and related analyses will be reviewed by the State Health Planning and Development Agencies (SHPDA's) and Statewide Health Coordinating Councils (SHCC's) and, if appropriate, accepted as part of the State Health Plan.

Thus, the Guidelines issued here reflect a careful balance between the needs of local and State agencies to take account of local health conditions and needs and the Federal role as outlined in the statute to provide national health planning leadership and guidance.

Some areas of the country have already achieved conditions or adopted

standards more favorable than those specified in the National Guidelines. In those circumstances, it is not intended that HSA's plan for a level of resources in excess of that needed to adequately serve the needs of the community. Nor is it intended that HSA's refrain from planning with respect to health services and facilities which are not addressed in the Guidelines.

Each State's Health Plan developed under Title XV of the Public Health Service Act must be made up of the Health Systems Plans for areas within the State, revised as necessary by the SHCC to achieve appropriate consideration or to deal more effectively with Statewide health needs. Since HSP's must give appropriate consideration to the Guidelines and take into account and be consistent with the resource standards, the State Health Plan will also reflect these Guidelines. Moreover, Health Systems Plans also provide one of the bases for the development of the State Medical Facilities Plan required under Section 1603. Thus, the National Guidelines will be reflected in the development of the State Medical Facilities Plans.

In addition, regulations issued concerning the certificate of need function (42 CFR Chapters 122 and 123) cite consistency with the Health Systems Plan for an area as one criterion for review of new institutional health service projects. Thus, the National Guidelines should also be addressed in the criteria adopted by HSA's and SHPDA's governing review activities under certificate of need, the review of new institutional health services, and other mandated reviews.

As noted in the Notice of January 20, 1978, Health Systems Agencies have no authority under Federal law to close existing hospitals or services nor is the Federal Government authorized to do so. The Department believes that Health Systems Plans can and should be important occasions and vehicles for advancing public understanding of these issues and other factors contributing to rises in health care costs and other pressing health problems. Health Systems Plans will be of little value if they do not seriously address these issues.

The standards set forth below will receive periodic review and revision as knowledge is increased concerning the most appropriate configuration of resources to provide services which meet the health needs of the population with a minimum of duplication. The Guidelines will be reviewed periodically, at least every two years, and revised as necessary based upon further analyses, experiences with their use, and review of local Health Systems Plans and State Health Plans.

B. PROCESS OF INITIAL STANDARD DEVELOPMENT

Each of the standards presented below relates to a health care resource which has been widely discussed and is based on and adapted from a recommendation, guideline, or standard previously developed by one or more medical groups, health planning organizations, or other professional bodies. Additionally, documentation of health standards was obtained through searches undertaken by the National Library of Medicine and the National Health Planning Information Center and systematically reviewed by Department staff.

Materials included in these analyses were reports of such organizations as the Institute of Medicine, the Office of Technology Assessment, the American College of Obstetrics and Gynecology, American Academy of Pediatrics, American College of Radiology, Committee on Perinatal Health, and the Inter-Society Commission on Heart Disease Resources.

Proposed guidelines concerning hospital bed supply were included in a draft of National Guidelines that was widely distributed after October 1976. Some 1,300 comments were received on that material.

C. PROCESS OF PUBLIC CONSULTATION

Section 1501(c) requires the Secretary, in the development of the Guidelines, to consult with and solicit recommendations and comments from Health Systems Agencies, State Health Planning and Development Agencies, Statewide Health Coordinating Councils, associations and specialty societies representing medical and other health care providers and the National Council on Health Planning and Development. This has been accomplished over a period of more than 2 years through consultations, public notices, public meetings, review by the National Council on Health Planning and Development and other activities.

In publishing its first Notice of Proposed Rulemaking on September 23, 1977, the Department allotted a period of 60 days for public comments and later (42 FR 59888) extended this period for an additional 17 days. During this period, more than 55,000 communications were received. Among those who wrote were more than 100 Health Systems Agencies, 30 State Health Planning and Development Agencies, 50 Hospital Associations, 80 Medical Societies, 35 medical schools, 60 national associations as well as thousands of individual hospitals, practioners, and consumers.

During this period, the Department sponsored five public meetings in which individuals from the fields of medicine, health administration, and consumer interest participated. Comments and recommendations were also received as the result of the Department's direct request for the views of all State and local health planning agencies and numerous professional and consumer groups. Many other suggestions were received in public hearings before the Subcommittee on Health and the Environment of the House Interstate and Foreign Commerce Committee, and from individual Members of Congress.

The National Council on Health Planning and Development began its consideration of the proposed guidelines at its first formal meeting on September 23, 1977. The Council devoted 3 days, December 9, 10, and 21, to the review of the proposed Guidelines. At the latter meeting, it passed 11 resolutions providing comments and recommendations to the Secretary concerning the Guidelines.

The second Notice, as the first, was disseminated widely. In addition to publication in the FEDERAL REGISTER, copies were sent directly to all local and State health planning agencies and other agencies that had submitted comments on the first Notice and to over 100 additional groups. Copies were also provided members of the National Council on Health Planning and Development which reviewed them at its meeting on February 10, 1978.

Readers are referred to the Preamble of the Notice of Proposed Rulemaking issued on January 20, 1978 (43 FR 3056-3063) for a detailed review of the concerns expressed by the public regarding the original proposals. The principal major issues centered around local control of the health planning process, and the possible effect of the standards on health services in rural areas. A number of other general issues were raised as well as many comments addressed to proposed general provisions and individual standards.

About 900 letters were received in response to the January 20 Notice including over 1,700 individual comments. Most of the comments were of a general nature. Some focused on particular aspects of the proposed Guidelines. The following section discusses the more general points and this is followed by sections on the general provisions and individual standards set forth in the January 20 Notice.

D. GENERAL COMMENTS

Many of the comments indicated satisfaction with the revised Guidelines. Numerous writers expressed agreement with the added emphases on the roles and responsibilities of local Health Systems Agencies in analyzing and planning how the Guidelines apply to local conditions and needs.

On the other hand, some commentators questioned whether local Agencies have the capabilities to make the necessary analyses and to prepare adequate justifications for adjustments. The Department has confidence in the increasing capabilities of HSA's to

handle these responsibilities. Their resources will be further strengthened as a result of the increased funds likely to be made available to them in fiscal year 1979. Further, the Department is establishing a training program on the National Guidelines for all local and State health planning agencies through the 10 Centers for Health Planning.

Some comments expressed continuing concern that excess emphasis was placed on cost containment issues and too little attention was being given to goals concerning health status, access and quality. It should be noted that a number of the initial guidelines are concerned with the enhancement of quality of care. In addition, the Department intends to issue proposed guidelines concerning national health planning goals in the near future that will address these issues. As discussed in the Overview, the Secretary believes that additional actions must be taken to contain rapidly rising health care costs, especially hospital costs, so that resources are available to improve health status and access to necessary high quality services.

Further concern was expressed by some writers that many small, rural hospitals would be threatened. On the other hand, some commended the specific provisions in the Guidelines which address the special conditions and needs of rural areas. The Department has reviewed the provisions concerning the special condition and needs of rural areas and believes they provide appropriate flexibility. Additional attention will be devoted to communicating the intent to strengthen accessibility to needed health services in rural and other underserved areas.

The provision of adjustments of standards for particular Health Systems Plans (para. 121.6) received much attention. Some suggested that so many adjustments would be made that "exceptions would become the rule". The Department's emphasis is on the need to ensure that adjustments that are made be justified on the basis of sound data and careful analyses, not on their number.

The respective roles of the State Health Planning and Development Agencies and Statewide Health Coordinating Councils in approving adjustments included by HSA's in their Health Systems Plans (HSP) was questioned. The SHCC has the sole responsibility for approving the State health plan, which is made up of HSP's and may contain revisions (including revisions of adjustments) to achieve their appropriate coordination and to deal more effectively with Statewide health needs.

Some writers ask why the SHCC was required to report its comments on and disposition of proposed adjustments to the Secretary. Concern was expressed that this arrangement might result in actions by the Department to challenge individual adjustments. That is not the intent. The Department's review of adjustments will be aimed at identifying patterns of analyses and adjustments and also at developing potential changes in the National Guidelines.

Some comments expressed concern that the Secretary would be involved too much in the review of adjustments and plans. Others urged the Secretary to review each proposed adjustment to ensure that the aims of Pub. L. 93-641 were not undermined. The Department believes the adopted approach is an appropriate balance and is in accord with the Secretary's responsibility, under Section 1535, to assess the performance of planning functions.

Some writers pointed out that changes in knowledge and practices might soon make some of the standards inappropriate. Concern was expressed that the Guidelines might become a barrier to desirable innovations. That is not the intent. The appropriateness and use of standards will be monitored on a continuing basis and changes can be made at any time. As indicated in this Preamble, the Guidelines will be reviewed periodically, at least every two years, and revised as necessary based on further analyses and experiences with their use. Further, the National Council on Health Planning and development has indicated its commitment to encourage and contribute to periodic reviews and desirable revisions. Analyses of Health Systems Plans and State Health Plans will be an important source of information for these reviews and revisions. The Department solicits the submission of further analyses and recommendations for changes on a continuing basis from all interested parties.

Some letters noted that legislation is being considered by the Congress to authorize new grant programs and other measures to encourage the conversion and closure of unneeded hospital services. They questioned how the proposed Guidelines relate to the pending legislations. If new legislation along these lines is enacted, there will be further processes of considering related rules and regulations, including provisions for public participation and review.

A number of commentators urged that population-based standards be substituted for all utilization-based standards. The Department agrees that population-based standards are desirable whenever practical but has been constrained by limitations of existing knowledge. The Department intends to devote continuing efforts to the development of additional population-based standards and urges others to do so as well and to share their findings and conclusions.

E. COMMENTS ON GENERAL PROVISIONS

Some comments recommended that Par. 121.6 be modified to indicate HSA's must take into account the national health priorities set forth in section 1502 of the Public Health Service Act. Section 1513(b)(2) of the Act provides that HSA's shall give appropriate consideration to the section 1502 priorities in establishing and amending Health Systems Plans. Therefore, it is not considered necessary to repeat that requirement here.

In some States, State certificate of need programs or related programs have established higher minimum levels and lower maximum levels than those included in the National Guidelines. In such cases, the State targets should be applied rather than those set forth in the National Guidelines. Section 121.6 has been modified to this effect.

Some questions were raised about the effective date (§ 121.3(b)). It is not required that all Health System Plans be consistent with the guidelines by December 31, 1978. Rather, the provision applies to Plans as they are revised and newly established by the Health System Agency after that date. Thus, almost all HSA's will have more than a year to plan for these provisions.

F. COMMENTS ON SPECIFIC STANDARDS

While it is not possible to make individual reply to all the particular suggestions and comments which have been received and considered, the following discussion reviews major substantive issues on which a number of comments were received and some major points not discussed in earlier Preambles.

The established standards, along with the three related published Preambles, will be printed together in a future publication for ready reference.

1. COMMENTS ON STANDARD CONCERNING HOSPITAL BED SUPPLY

Some further concern was expressed about the definition of hospital beds. It was pointed out that, in addition to licensed beds, there are often data on other measures, such as bed capacity, available beds and staffed beds. In applying this standard, licensed beds should be counted. Data used in the implementation of this standard and those used in the State Medical Facilities Plan regarding licensed non-federal short-stay hospital beds are to be identical.

Some writers suggested this standard assumes that all hospitals and hospital beds are alike. That is not the case. While significant variations exist among institutions and services and

those conditions complicate planning, the Department believes it is still possible and desirable to develop standards and plans on an areawide basis that are sensitive to such differences within an established ceiling.

Some commentators suggested that the provisions concerning adjustment for referral hospitals serving a substantial number of out-of-area patients be modified to require compensating adjustments downward in the areas from which the patients come. While such an approach is desirable, in many cases where patients come from many locations at substantial distances, it is not administratively feasible. In other cases, local Agencies may find it practical to apply such an adjustment factor.

2. COMMENTS ON STANDARD CONCERNING HOSPITAL OCCUPANCY RATES

Further concern was expressed that this standard might encourage unnecessary hospital admissions and stays. As emphasized in the Discussion section regarding this standard, that is not the intent. In fact, such an interpretation would be entirely at odds with the purposes of Pub. L. 93-641 to achieve more rational allocation of expensive health resources. The use of this standard is to be intimately related to the application of the standard concerning hospital bed supply so that increases in occupancy rates result from decreases in bed utilization and supply to the maximum extent appropriate. The standard has been modified to address this concern.

3. COMMENTS ON STANDARD CONCERNING OBSTETRICAL SERVICES

Questions were raised about the definition of Levels I, II and III. A general definition is included in the Discussion section. Many States have programs that specifically classify services and institutions along these lines. The Department believes that individual determinations are best made at State and local levels.

The question was raised whether non-infectious gynecological cases are to be included in the calculation of occupancy rates. They may be included in line with local practices.

4. COMMENTS ON STANDARD CONCERNING NEONATAL SPECIAL CARE UNITS

Comments were received on situations where travel distance makes it necessary to establish smaller units. The standard recognizes such cases by indicating that smaller Level II units may be justified when travel time to an alternate unit is a serious hardship due to geographic remoteness. The Department does not consider smaller level III units desirable because of their more specialized services.

5. COMMENTS ON STANDARD CONCERNING PEDIATRIC SERVICES

A question was raised whether it is intended that all individuals under 18 be cared for in specialized pediatric units in urbanized areas. That in not the intent. It is recognized that arrangements for the appropriate care of children vary among areas. The intent of the guidelines is to encourage planning for regionalized systems of high quality care.

Some comments pointed out that in some areas, pediatric units are planned to serve persons under 15 years of age; in other areas, the practice is to serve persons under 18 years of age; and in still others, such units serve individuals up to 21 years of age. The definition has been modified to recognize these differences.

6. COMMENTS ON STANDARD CONCERNING OPEN HEART SURGERY

Recommendations were received which pointed out that in some circumstances the standard might be most appropriately applies to the combined number of open heart procedures performed by a single team working in a number of institutions. A paragraph on this issue has been added to the Discussion section, including an indication of relevant conditions. HSAs have the responsibility for analyzing whether these circumstances exist locally.

Suggestions were received that the standard concerning pediatric heart operations be modified to provide for a smaller number of open heart procedures. The Department recognizes that there are different professional views on this subject and will be carefully monitoring developments to determine whether future changes are indicated.

7. COMMENTS ON STANDARD CONCERNING CARDIAC CATHETERIZATION UNIT SERVICES

The Section on Cardiology of the American Academy of Pediatrics recommended that an additional provision concerning pediatric cardiac catheterization units be added. That has been done.

8. COMMENTS ON STANDARD CONCERNING RADIATION THERAPY

Some comments suggested that 300 courses of treatment be included in the standard instead of 300 cancer cases. They felt that it would be inequitable to exclude cases previously treated at an institution while counting similar cases previously treated at another institution. That is not the intent. The two terms are considered to be synonymous for this purpose.

Further concern was expressed that, in some cases, failure by a single institution to achieve the higher target level could prevent the development of an additional needed resource. Some suggested the 6,000 target be considered as an average for all units in the area. While such averaging can be a useful part of analysis, it is not adequate by itself. As indicated in the Preamble to the January 20 Notice, in special cases where each existing unit cannot reasonably be expected to reach the target level and a new unit is appropriate, the HSA may call for an adjustment in the standard as part of its plan, based on analyses of pertinent local conditions.

9. COMMENTS ON STANDARD CONCERNING COMPUTED TOMOGRAPHIC SCANNERS

The principal objections concerning this standard were directed at the proposed target level of 2,500 "patient procedures" per year and the Department's proposed definition of "patient procedure." Before addressing those objections, it is emphasized that the Department's purpose in developing the Computed Tomographic Scanner standard has been to encourage appropriate community-wide planning for and to minimize unnecessary proliferation of these expensive machines and thereby hold down health care costs. The Department is seeking to do so by assuring that those already in use, as well as those acquired in the future, will be utilized at reasonably full levels of efficiency. As the discussion portion of the standard points out, it has been concluded that an operating schedule that achieves at least 2,500 patient procedures per year for each scanner represents such a reasonable level of use.

Thus, objections to the standard based on its failure to consider the "cost-effectiveness" of individual CT scanners miss the point. In the Department's judgment not only is the data available on the cost savings achieved by scanners as against the diagnostic procedures which the machines replace inconclusive, but such an approach to resource allocation decisions on a community-wide basis is unsound. Rather, the test adopted is to measure the efficiency with which the machines themselves are used in order to assure that the cost to the community is as low as can reasonably be expected, given the high cost of acquiring and operating the machines.

Some objections to the 2,500 figure have focused on the fact that the Institute of Medicine statement on Computed Tomographic Scanning used that number for a purpose different from that of these guidelines. While it is true that the immediate purpose of the Institute's use of this figure was to recommend appropriate charges for CT scans, the Institute adopted the figure of 2,500 patient examinations as a basis for that computation because of its conclusion, based upon its review of available data, that a minimum

volume of 2,500 patient examinations is a conservative basis for estimating machine use on which to establish charges. The Department's analysis, using the indicated definition and mix of "patient procedures", concluded that a CT scanner which is operated efficiently can normally perform 2,500 such procedures in a year with a work schedule which is less than 50-55 hours per week.

While some objections to this proposed standard have argued for a target based on a 40 hour work week and have correctly pointed out that most scanners in operation operate at less than the 50-55 hour level, the Department believes that the 50-55 hour week is a reasonable schedule of operation, that most scanners may fairly be expected to attain that if necessary, and that the fact that most scanners now provide substantially less than that level of service indicates the need for the standard. It should be noted that latitude is given to HSA's, both within the standard itself (see the Discussion portion of § 121.210) and in § 121.6 ("Adjustment of standards for particular Health Systems Plans") to adjust the 2,500 level where special local circumstances warrant, after careful analysis and consideration of extraordinary conditions.

It was suggested that the proposed definition of "patient procedure" might be interpreted to mean that a number of studies of the same anatomical region (such as the stomach, kidney and colon) should be considered a single procedure. To clarify this point, the definition has been revised to substitute "the same anatomic area of diagnostic interest" for "the same anatomical region."

With regard to the definition of "patient procedure," commentators argued that a contrast scan and a non-contrast scan of the same anatomic area should be considered two procedures. The requested change has not been made. This change has not been accepted since it is considered reasonable to define as one procedure the scans necessary for resolving a particular question. Reports from the Blue Cross Association indicate that it is the usual practice for an initial scan and an additional scan to be billed as a single procedure, with the additional scan usually increasing the charge by no more than 20-25 percent. While this suggests that a "weighting" formula might be appropriate which would assign fractional units to each additional scan, the Department has concluded that such an approach needs further study. As indicated in the Preamble to the January 20 Notice, the Department will continue to study this possibility and welcomes specific suggestions along these lines. For the present standard, in evaluating the impact of the 2,500 target level, the Department took into account the relative number of multiple scans. (For example, 60-70 percent of head scans involve more than one scan.) As the Discussion section points out, the Department also took into account an estimate of the potential relative frequency of more time-consuming body scans.

Some commentators suggested that the estimate of relative proportion of body scans to total procedures was too low. It is noted that only limited coverage of body scans has been approved for the Medicare program. As discussed in the Preamble to the January 20 Notice, developments in this field will be carefully and continuously monitored and changes proposed and made periodically as indicated. The Department welcomes the submission of further information for its consideration from all interested parties.

Some writers emphasized that the discussion of the potential special uses of CT scanners in research situations was too limited, covering only collaborative clinical trials. The material has been modified to include other research projects that have a fixed protocol and have been institutionally approved.

It was also pointed out that a newly installed scanner does not immediately reach its normal operating level. The standard has been changed to recognize this fact, and now provides that a new machine should attain the target level of patient procedures during its second year of operation.

Some commentators stated that some new, less expensive scanners as well as some early models operate relatively slowly and may not be capable of attaining the 2,500 level. These machines are head scanners and should ordinarily have little difficulty in attaining the target level if utilized efficiently. In any case, the "general adjustment" provisions of § 121.6 are available to HSA's for application to such unusual situations.

Recommendations were received that additional effort be focused on the development of a population-based standard. The Department agrees that population-based approaches are preferable to utilization-based standards whenever practical and intends to continue to work towards that end for this service and for other services.

Finally, the Department wishes to make clear its awareness that many medium-sized and small community hospitals may not be able to meet the target level set in this standard. Indeed, there would be little purpose in adopting a standard at all if that were not so. It is expected that vigorous application of the standard by HSA's will result in additional sharing arrangements among hospitals as part of the process of assuring that existing and new scanners are more efficiently utilized. Where such arrangements are not feasible because of travel or other difficulties, HSA's have authority to adjust the standard to assure that medically necessary CT scanner services will not be denied patients in their areas.

Accordingly, a new Part 121 is hereby added to 42 CFR as set forth below.

NOTE.—The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an Inflationary Impact Statement under Executive Order 11821 and OMB Circular A-107.

Dated: March 15, 1978.

JULIUS B. RICHMOND,
Assistant Secretary of Health.

Approved: March 22, 1978.

JOSEPH A. CALIFANO, Jr.,
Secretary.

PART 121—NATIONAL GUIDELINES FOR HEALTH PLANNING

Subpart A—General Provisions

Sec.
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Subpart B—National Health Planning Goals

[Reserved]

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AUTHORITY: Sec. 1501 of the Public Health Service Act, 88 Stat. 2227 (42 U.S.C. 300k-1).

§ 121.1 Definitions.

Terms used herein shall have the meanings given them in 42 CFR 122.1.

§ 121.2 Purpose and scope.

Section 1501 of the Public Health Service Act requires the Secretary to issue, by regulation, national guidelines for health planning. The guidelines are to include national health planning goals (section 1501(b)(2)) and standards respecting the supply, distri-

bution, and organization of health resources (section 1501(b)(1)). This subpart includes general provisions applicable to such goals and standards; subpart B of this part sets forth specific national health planning goals; and subpart C sets forth specific standards respecting the supply, distribution, and organization of health resources.

§ 121.3 Applicability of national guidelines to Health Systems Plans.

Section 1513(b)(2) of the Act requires health systems agencies, in the development of their Health Systems Plans, to give "appropriate consideration" to the national guidelines for health planning. Health Systems Plans must also "take into account" and be "consistent with" the standards respecting the supply, distribution, and organization of health resources set forth in subpart C.

(a) *Meaning of "consistent with."* A Health Systems Plan will be considered "consistent with" a standard set forth in subpart C where it (1) establishes a target level which is not in excess of the level set forth in the standard where that level is stated as a maximum, or not less than the level set forth in the standard where that level is stated as a minimum, except where a specific adjustment is justified in accordance with subpart C or § 121.6 of this subpart, and (2) includes plans which, if implemented, are reasonably calculated to achieve that target level within five years.

(b) *Effective date.* Health Systems Plans established after December 31, 1978, must be "consistent with" each standard set forth in subpart C.

§ 121.4 Applicability of national guidelines to State health plans.

Each State's State health plan developed under Title XV of the act must be "made up of" the Health Systems Plans of the health systems agencies within the State, revised as found necessary by the Statewide Health Coordinating Council to achieve their appropriate coordination with each other or to deal more effectively with Statewide health needs. (Section 1524(c)(2)(A) of the Act.) Since Health Systems Plans must individually give appropriate consideration to the national guidelines for health planning and take into account and be consistent with the standards respecting the supply, distribution, and organisation of health resources, the State health plan will accordingly reflect the guidelines.

§ 121.5 Responsibility of health systems agencies.

Subject to the authority of the Statewide Health Coordinating Council to require the revision of Health Systems Plans under section 1524(c)(2)(A) of the Act, each health systems agency is responsible for analyzing the needs and conditions in its health service area and applying the national guidelines for health planning in the development of its Health Systems Plan, including the need for adjustments.

§ 121.6 Adjustments of standards for particular Health Systems Plans.

Subpart C of this part includes provisions for adjustment of individual standards. In addition:

(a) Health systems agencies must make such adjustments as may be necessary:

(1) To take into account special needs and circumstances of Health Maintenance Organizations;

(2) To take into account services available to local residents from Federal health care facilities; and

(3) To take into account higher minimum target levels and lower maximum levels that are established for State Certificate-of-Need and related programs.

(b) Whenever a health systems agency concludes, on the basis of a detailed analysis, that development of a Health Systems Plan consistent with one or more of the standards set forth in subpart C would result in:

(1) Residents of the health service area not having access to necessary health services;

(2) Significantly increased costs of care for a substantial number of patients in the area; or

(3) The denial of care to persons with special needs resulting from moral and ethical values; and that result cannot be avoided through use of the adjustments specifically provided for in the standard or in paragraph (a) of this section, the agency may include in the Health Systems Plan a special adjustment of the standard or standards which will avoid this result. Whenever a special adjustment is so included, the plan must also contain a detailed justification for the adjustment and documentation of the circumstances that are the basis of the justification. In the case of an adjustment included on the basis of (1) or (2) above, the plan must further include an analysis indicating whether the need for such an adjustment is permanent. If it is, the supporting rationale must be documented and it it is not, an estimate must be included of how long inclusion of the adjustment will be required along with a detailed justification for that length of time.

(c) Any proposed adjustment under this section and the analyses supporting it must be reviewed by the State health planning and development agency in its preparation or review of the preliminary State health plan under section 1523(a)(2) of the Act and by the Statewide Health Coordinating Council in its preparation or review of the State health plan under section 1524(c)(2) of the Act. On the basis of that review, and consistent with Statewide health needs and the need to coordinate Health Systems Plans as determined by the Statewide Health Coordinating Council, the adjustment may be made part of the State health plan. The Statewide Health Coordinating Council shall report its comments on and disposition of the proposed adjustments to the Secretary under section 1524(c)(1) of the Act.

Subpart C—Standards Respecting the Appropriate Supply, Distribution, and Organization of Health Resources

§ 121.201 General hospitals—bed supply.

(a) *Standard.* There should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area except under extraordinary circumstances. For purposes of this section, short-stay hospital beds include all non-federal short-stay hospital beds (including general medical/surgical, children's, obstetric, psychiatric, and other short-stay specialized beds). Conditions which may justify adjustments to this ratio for a health service area include:

(1) *Age.* Individuals 65 years of age and older have a higher hospital utilization rate—up to four time that of the general population—than any other age group. Bed-population ratios for health service areas in which the percentage of elderly people is significantly higher (more than 12 percent of the population) than the national average may be planned at a higher ratio, based on analyses by the HSA.

2. *Seasonal population fluctuations.* Large seasonal variations in hospital utilisation may justify higher ratios. Plans should reflect vacation and recreation patterns as well as the needs of migrant workers and other factors causing ususual seasonal variations.

(3) *Rural areas.* Hospital care should be accessible within a reasonable period of time. For example, in rural areas in which a majority of the residents would otherwise be more than 30 minutes travel time from a hospital, the HSA may determine, based on analyses, that a bed-population ratio of greater than 4 per 1,000 persons may be justified.

(4) *Urban areas.* Large numbers of beds in one part of a Standard Metropolitan Statistical Area (SMSA) may be compensated for by fewer beds in other parts of the SMSA. Health service areas which include a part of an SMSA may plan for bed-population ratios higher than 4 per 1,000 persons reflecting existing patterns if there is a joint plan among all HSAs serving the SMSA which provides for less

than 4 beds per 1,000 persons in the SMSA as a whole.

(5) *Areas with referral hospitals.* In the case of referral institutions which provide a substantial portion of specialty services to individuals not residing in the area, the HSA may exclude from its computation of bed-population ratio the beds utilized by referred patients who reside outside both the SMSA and the HSA in which the facility is located.

(b) *Discussion.* There is general agreement that the number of general hospital beds in the United States is significantly in excess of what is needed and that utilization of acute in-patient care resources is often higher than necessary. Excess bed capacity and use contribute to the high cost of hospital care with little or no health benefits. Empty beds are often filled by patients who could be cared for as well or better in less expensive ways, such as ambulatory care or home care.

The Institute of Medicine's Report on "Controlling the Supply of Hospital Beds" in 1976 recommended that the nation should achieve at least a 10 percent reduction in the bed population ratio in the next five years and further significant reductions thereafter. The Institute statement noted: "This would mean a reduction from the current national average of approximately 4.4 non-Federal short-term general hospitals beds per 1,000 population to a national average of approximately 4 in five years and well below that in the years to follow." Similarly a study reported by InterStudy of Minneapolis, Minn., the same year concluded that a 10 percent reduction in hospital bed supply would be a desirable and reasonable first step toward reducing excess hospital capacity. As part of the process for determining this standard, the Department reviewed projections in State health facilities planning plans. Such plans have set targets for future hospital bed supply that, on an aggregate nationwide basis, project just under 4 beds per thousand. Many States set lower targets. Health Maintenance Organizations and similar groups have shown that high quality care can be provided with less than 3 beds per 1,000 population. Thus, 4 beds per 1,000 population is a ceiling, not an ideal situation. HSAs are expected to identify the desirable local ratio, working closely with the State Health Planning and development Agency and the Statewide Health Coordinating Council. It is anticipated that in subsequent plans HSAs will be required to indicate how they will reach a bed-population ratio of less than 3.7 per 1,000 population except under extraordinary circumstances. HSAs whose areas are now below the 4 per 1,000 level are urged to attempt to decrease bed-population ratios below 3.7 per 1,000 population. In areas where Federal medical facilities and Health Maintenance Organizations provide substantial services to local residents, lower ratios should be readily achieveable. Population growth must be carefully analyzed; in many cases, this factor alone will bring the area below the target level if no unnecessary additional beds are built. Under some conditions, a higher target ceiling may be justified by the HSA. Travel distance to the nearest hospital is one of the most important factors to be analyzed, especially in rural areas. A planning criteria of 30 minutes has been set, in line with the policies of many local and State health planning agencies around the country. In analyzing ways of reducing bed supply, it should be recognized that greater savings will be achieved when entire facilities are considered. In developing such plans, priority consideration should be given to maintaining and strengthening resources that are emphasizing activities identified as national health priorities in section 1502 of the Act.

§ 121.202 General hospitals—Occupancy rate.

(a) *Standard.* There should be an average annual occupancy rate for medically necessary hospital care of at least 80 percent for all non-Federal, short-stay hospital beds considered together in a health service area, except under extraordinary circumstances. Conditions which may justify an adjustment to this standard for a health service area include:

(1) *Seasonal population fluctuations.* In some areas, the influx of people for vacation or other purposes may require a greater supply of hospital beds than would otherwise be needed. Large seasonal variations in hospital utilization which can be predicted through hospital and health insurance records may justify an average annual occupancy rate lower than 80 percent based on analyses by the HSA.

(2) *Rural areas.* Lower average annual occupancy rates are usually required by small hospitals to maintain empty beds to accommodate normal fluctuations of admissions. In rural areas with significant numbers of small (fewer than 4,000 admissions per year) hospitals, an average occupancy rate of less than 80 percent may be justified, based on analyses by the HSA.

(b) *Discussion.* There is substantial evidence that excess capacity and use contribute significantly to high hospital costs. The 1976 report by the Institute of Medicine, for example, found that "there is a growing concern that the surpluses of hospital beds are contributing significantly to the recent rise of health care costs at a rate well beyond that of general inflation. This concern has not only to do with the cost of maintaining unused hospital bed capacity, but also with the unnecessary and inappropriate uses of hospital beds, especially those in the short-term care category." Occupancy rates currently average about 75 percent nationwide. Many hospital capacity studies, including those by InterStudy and the Bureau of Hospital Administration of the University of Michigan, indicate that an average hospital occupancy rate exceeding 80 percent is a reasonable target. In addition, many State and local health planning agencies have established higher occupancy targets. For example, health planning agencies in Illinois, New Jersey, New York, Massachusetts, Michigan, and Wisconsin have recommended occupancy rates higher than 80 percent for larger hospitals. Higher averages have been advocated, especially for medical-surgical units. While past studies typically apply these rates to individual institutions, the Department, in line with the objectives of community-wide planning, has extended this concept to apply on an area-wide basis. Within local health service areas, hospitals of varying size and circumstances will have varying occupancy rates; a collective rate exceeding 80 percent on an area-wide basis is a reasonable, achievable goal except in rural areas and when situations present extraordinary circumstances. Increases are to be attained through constrained capacity growth and improved planning and management. It is not, of course, intended that increased rates be achieved through unnecessary hospital admissions or stays.

§ 121.203 Obstetrical services.

(a) *Standard.* (1) Obstetrical services should be planned on a regional basis with linkages among all obstetrical services and with neonatal services.

(2) Hospitals providing care for complicated obstetrical problems (Levels II and III) should have at least 1,500 births annually.

(3) There should be an average annual occupancy rate of at least 75 percent in each unit with more than 1,500 births per year.

(b) *Discussion.* The importance of developing regional systems of care for maternal and perinatal health services has been broadly recognized. The Committee on Perinatal Health, representing the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the American Medical Association issued a report in 1976, "Toward Improving the Outcome of Pregnancy." The report identified opportunities to reduce rates of maternal, fetal and neonatal mortality as well as to improve deployment of scarce resources, especially

those needed to provide comprehensive services for high-risk patients. The impact on quality of care of both under-utilization and over-utilization was emphasized.

The report states: "A systematized, cohesive regional network including a number of differentiated resources is the approach most likely to achieve the objective. Each component of the regional system must provide the highest quality care, but the degree of complexity of patient needs determines where, and by whom; the care should be provided." Level I hospitals provide services primarily for uncomplicated maternity and newborn cases. Level II hospitals provide services for uncomplicated cases and for the majority of complicated problems, and certain specialized neonatal services. Level III hospitals are able also to handle all the serious types of illness and abnormalities. Established arrangements should provide for early access of high-risk pregnant women and prompt referrals among levels of care as appropriate. Regional planning should include a cooperative, coordinated network of hospitals, physicians and other health care professionals, providing: (1) Expert consultation and referral (2) basic and continuing education for health professionals and consumers, (3) transport of selected patients to facilities possessing more specialized maternal and neonatal services, (4) a continuing evaluation of the effectiveness and costs of regionalized programs. In 1972 the American College of Obstetrics and Gynecology identified a minimal target of 1,500 births per year for facilities in communities of 100,000 population or more to provide a full range of obstetrical services in an efficient manner. In 1974, this figure was revised: "The experience of many obstetric departments indicate that the size, equipment, services and personnel adequate to maintain a consistently high standard of ordinary obstetrical care and a reasonably economic operation generally require more than 2,000 deliveries." (Standards for Obstetical and Gynecological Services, Committee on Professional Standards of the American College of Obstetricians and Gynecologists, 1974.) The Committee on Perinatal Health also identified the 2,000 minimum figure for facilities identified as Level II facilities. In deteminimg the 1,500 target, the Department took into consideration these reports as well as the comments received from the public and from members of the expert advisory panel, particularly the criticism that a 2,000 target was too high. The 1,500 level is in line with the policies of many local and State health planning agencies and can help assure more economic use of specialized resources while avoiding inappropriate utilization of such facilities.

The Department also recognizes that there are substantial differences among facilities which provide different ranges of services, and there are circumstances, such as those involving special moral and ethical preferences, which may necessitate the HSA providing an adjustment to this standard. In addition, in order to promote more economical use of resources the Department has established the 75 percent minimum occupancy rate in Level II and III facilities. The 75 percent figure was derived from an analysis of various occupancy rate figures in a number of source documents, whose recommendations range from 50 percent to over 80 percent. The Hill-Burton program recommended an occupancy level for obstetrical units of at least 75 percent. The Department anticipates that institutions operating at Levels II and III will usually be able to exceed this level.

In keeping with the national priority set forth in Section 1502 of the Act for the consolidation and coordination of institutional health services, the consolidation of multiple, small obstetrical units with low occupancy rates should be undertaken unless such action is undesirable because of needs to assure ready access and sensitive care.

§ 121.204 Neonatal special care units.

(a) *Standard.* (1) Neonatal services should be planned on a regional basis with linkages with obstetrical services.

(2) The total number of neonatal intensive and intermediate care beds should not exceed 4 per 1,000 live births per year in a defined neonatal service area. An adjustment upward may be justified when the rate of high-risk pregnancies is unusually high, based on analyses by the HSA.

(3) A single neonatal special care unit (Level II or III) should contain a minimum of 15 beds. An adjustment downward may be justified for a Level II unit when travel time to an alternate unit is a serious hardship due to geographic remoteness, based on analyses by the HSA.

(b) *Discussion.* For this standard, the Department has adopted the widely endorsed concept of regionalization, involving various levels of care. Under this concept, Level III units are staffed and equipped for the intensive care of new-borns as well as intermediate and recovery care. Level II units provide intermediate and recovery care as well as some specialized services. Level I units provide recovery care. Neonatal special care is a highly specialized service required by only a very small percentage of infants. The Department believes that four neonatal special care beds for intensive and intermediate care per 1,000 live births will usually be adequate to meet the needs, taking into account the incidence of high risk pregnancies, the percentage of live births requiring intensive care, and the average length of stay. ("Bed" includes incubators or other heated units for specialized care and bassinettes.) In addition, the Department has established a minimum of 15 beds per unit for Levels II and III as the minimum number necessary to support economical operation for these services. Both standards are supported and recommended by the American Academy of Pediatrics. The American Academy of Pediatrics has noted that "the best care will be given to high risk and seriously ill neonates if intensive care units are developed in a few adequately qualified institutions within a community rather than within many hospitals. Properly conducted, early transfer of these infants to a qualified unit provides better care than do attempts to maintain them in inadequate units." This regionalized approach is reflected in the minimum size standard which is designed to foster the location of specialized units in medical centers which have available special staff, equipment, and consultative services and facilities. Since perinatal centers, which include neonatal units will serve the patient load resulting from a representative population of more than one million, a defined neonatal service area should be identified by the relevant HSAs in conjunction with the State Agency. Special attention should also be given to ensure adequate communication and transportation systems, including joint transfers of mother and child and maintenance of family contact. Hospitals with such units should have agreements with other facilities to serve referred patients. The regional plan should include a structured ongoing system of review, including assessment of changes in health status indicators.

§ 121.205 Pediatric inpatient services—number of beds.

(a) *Standard.* There should be a minimum of 20 beds in a pediatric unit in urbanized areas. An adjustment downward may be justified when travel time to an alternate unit exceeds 30 minutes for 10 percent or more of the population, based on analyses by the HSA.

(b) *Discussion.* Pediatric services should be planned on a regionalized basis with linkages among hospitals and other health agencies to provide comprehensive care. The 1977 report of the Committee on Implications of Declining Pediatric Hospitalization Rates for the National Research Council states that "for a policy of housing children separately to be effective, certain minimum services and facilities are needed, thus requiring bed capacity utilization to make provision for these services and facilities

economically feasible." This standard was developed by the Department in this context.

A number of sources support a minimum unit size of 20 pediatric beds, including planning agencies in California, Massachusetts, Ohio, Pennsylvania, and Wisconsin. Consolidation of pediatric care in units of at least 20 beds in urbanized areas will promote the concentration of nursing and support staff with special pediatric knowledge and skills, the increased training of staff, and the provision of special treatment and other ancillary facilities which meet the special needs of children. (A pediatric inpatient unit is a specific section, ward, wing, hospital or unit devoted primarily to the care of medical and surgical patients usually less than 18 years old, not including special care for infants.)

The criteria of 30 minutes travel time reflects interest in ensuring that children remain close to their homes, family and friends. Frequent visits to hospitalized children are highly desirable and can be an aid to improvement and recovery. The American Academy of Pediatrics has recommended to its State Chapters that child health plans should provide that primary care for children should be available within 30 minutes. This access standard is consistent with those of many local and State planning agencies such as those in Massachusetts, New York, Pennsylvania, and Wisconsin.

§ 121.206 Pediatric inpatient services—occupancy rates.

(a) *Standard.* Pediatric units should maintain average annual occupancy rates related to the number of pediatric beds (exclusive of neonatal special care units) in the facility. For a facility with 20-39 pediatric beds, the average annual occupancy rate should be at least 65 percent; for a facility with 40-79 pediatric beds, the rate should be at least 70 percent; for facilities with 80 or more pediatric beds, the rate should be at least 75 percent.

(b) *Discussion.* Variable occupancy rates are designed to reflect the need for smaller units to maintain the capacity to accommodate normal day-to-day fluctuations in admissions and to set aside pediatric beds for particular ages and types of cases. Such scheduling problems are less severe in pediatric units of a greater capacity. Moreover, large units are able to sustain higher occupancy rates because they are frequently associated with regional centers which serve patients needing types of care that can be scheduled on a more flexible basis. It is not intended, of course, to encourage unnecessary admissions or stays to achieve these levels. This standard is identical to that recommended by the American Academy of Pediatrics.

§ 121.207 Open heart surgery.

(a) *Standard.* (1) There should be a minimum of 200 open heart procedures performed annually, within three years after initiation, in any institution in which open heart surgery is performed for adults.

(2) There should be a minimum of 100 pediatric heart operations annually, within three years after initiation, in any institution in which pediatric open heart surgery is performed, of which at least 75 should be open heart surgery.

(3) There should be no additional open heart units initiated unless each existing unit in the health service area(s) is operating and is expected to continue to operate at a minimum of 350 open heart surgery cases per year in adult services or 130 pediatric open heart cased in pediatric services.

(b) *Discussion.* Open heart surgery for congenital and acquired heart and coronary artery disease represents a marked advance in patient care. Highly specialized open heart procedures require very costly, highly specialized manpower and facility resources. Thus, every effort should be made to limit duplication and unnecessary resources related to the performance of open heart procedures, while maintaining high quality care. Minimum case loads are essential to maintain and strengthen skills. (Open heart surgery procedures are defined as procedures which use a heart-lung by-pass machine to perform the functions of circulation during surgery.) A minimum of 200 adult open heart surgery procedures should be performed annually within an institution to maintain quality of patient care and make most efficient use of resources. This standard is based on recommendations of the Inter-Society Commission on Heart Disease Resources. In order to prevent duplication of costly resources which are not fully utilized, the opening of new units should be contingent upon existing units operating, and continuing to operate, at a level of at least 350 procedures per year. The 350 level assumes an average of 7 operations a week, a schedule that in the Department's judgement is feasible in most institutions providing these services. In units that provide services to children, lower targets are indicated because of the special needs involved. The established level for pediatric units is consistent with the recommendation of the Pediatric Cardiology Section of the American Academy of Pediatrics. In determining the utilization target of 130 pediatric open heart cases, the Department used the same ratio as for adult units. In the case of units that provide services to both adults and children, at least 200 open heart procedures should be performed, including 75 for children. In some areas, open heart surgical teams, including surgeons and specialized technologists, are utilizing more than one institution. For these institutions, the guidelines may be applied to the combined number of open heart procedures performed by the surgical team where and adjustment is justifiable in line with Section 121.6(B) and promotes more cost effective use of available facilities and support personnel. In such cases, in order to maintain quality care a minimum of 75 open heart procedures in any institution is advisable, which is consistent with recommendations of the American College of Surgeons. Data collection and quality assessment and control activities should be part of all open heart surgery programs.

§ 121.208 Cardiac catheterization.

(a) *Standard.* (1) There should be a minimum of 300 cardiac catheterizations, of which at least 200 should be intracardiac or coronary artery catheterizations, performed annually in any adult cardiac catheterization unit within three years after initiation.

(2) There should be a minimum of 150 pediatric cardiac catheterizations performed annually in any unit performing pediatric cardiac catheterizations within three years after initiation.

(3) There should be no new cardiac catheterization unit opened in any facility not performing open heart surgery.

(4) There should be no additional adult cardiac catheterization unit opened unless the number of studies per year in each existing unit in the health service area(s) is greater than 500 and no additional pediatric unit opened unless the number of studies per year in each existing unit is greater than 250.

(b) *Discussion.* The modern cardiac catheterization unit requires a highly skilled staff and expensive equipment. Safety and efficacy of laboratory performance requires a case load of adequate size to maintain the skill and efficiency of the staff. In addition, the underutilized unit represents a less efficient use of an expensive resource and frequently reflects unnecessary duplication. Based on recommendations from the Inter-Society Commission on Heart Disease Resources, the Department believes that a minimum level of 300 catheterizations per year is indicated to achieve economic use of resources. Several State health planning agencies, such as New Jersey, suggested a higher minimum level and the Department will be considering whether a higher level should be established in the future. The Department has also determined the existing units should be performing more than 500 cardiac catheterizations or 250 pediatric cardiac catheterizations before a new unit is opened. The 500 level is

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based on an average of two catheterizations a day, a rate that is in the Department's judgement readily achievable in most institutions providing these services and that will foster more effective use of current resources prior to the development of additional resources. More than 600 procedures are performed annually in some institutions. Pediatric cardiac catheterizations require special facilities and support services. Lower target numbers are presented in these cases because of the special conditions and needs of children. The established levels are consistent with the recommendations of the Section on Cardiology of the American Academy of Pediatrics and the Inter-Society Commission on Heart Disease Resources. The patient studied in the cardiac catheterization unit is frequently recommended for open heart surgery. While acceptable inter-institutional referral patterns exist in some areas, cardiac catheterization units should optimally be located within a facility in which cardiac surgery is performed.

§ 121.209 Radiation therapy.

(a) *Standard.* (1) A megavoltage radiation therapy unit should serve a population of at least 150,000 persons and treat at least 300 cancer cases annually, within three years after initiation.

(2) There should be no additional megavoltage units opened unless each existing megavoltage unit in the health service area(s) is performing at least 6,000 treatments per year.

(3) Adjustments downward may be justified when travel time to an alternate unit is a serious hardship due to geographic remoteness, based on analyses by the HSA.

(b) *Discussion.* While various types of radiation are indicated and used for tumors with different characteristics, megavoltage equipment is accepted as the most efficacious for treatment of deep-seated tumors. Megavoltage equipment is expensive to purchase, install, and support on a continuing basis. Every effort should thus be made to avoid unnecessary duplication of this costly resource. Established standards should provide needed treatment capabilities while preventing unnecessary duplication of radiation therapy units and underutilization of existing capacity. A unit refers to a single megavoltage machine or energy source. The most common types of units to deliver megavoltage therapy are cobalt 60 and linear accelerators. Treatments are meant to be the same as patient visits. A treatment or visit averages 2.2 fields, according to reports from the American College of Radiology. It also reports that about half of new cancer patients require megavoltage radiation therapy, and that many require subsequent courses of treatment. The American College of Radiology has indicated that at least 300 cancer cases annually are a reasonable minimum load for a megavoltage radiation therapy unit in order to maintain an efficient high quality operation. Based on the information and recommendations of the College, as well as comments received from the public and from members of the expert advisory panel which reviewed the standard, the Department has set a minimum standard of at least 300 cancer cases per unit per year. In 1974, the Department commissioned a study of the use of radiation therapy units. A committee appointed by the American College of Radiology and the American Society of Therapeutic Radiology to review that study suggested that economical operation of radiation units would call for existing units to do 5,000–8,700 treatments per year. The 7,500 level was included in the September 23, 1977 NPRM. This target would have required units to treat an average of 30 patients per day. Based on comments received from the profession and the general public, the Department has adjusted the standard downwards to 6,000 treatments per year, an average of about 25 patients per day, to take into account variations in patient mix and work schedules. Since many institutions meet and exceed these targets, this standard in the Department's judgement represents an attainable, efficient level of operation. The indicated target levels are minimal and should generally be exceeded.

Dedicated special purpose and extra high energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the development of Health Systems Plans.

§ 121.210 Computed Tomographic Scanners.

(a) *Standard.* (1) A Computed Tomographic Scanner (head and body) should operate at a minimum of 2,500 medically necessary patient procedures per year, for the second year of its operation and thereafter.

(2) There should be no additional scanners approved unless each existing scanner in the health service area is performing at a rate greater than 2,500 medically necessary patient procedures per year.

(3) There should be no additional scanners approved unless the operators of the proposed equipment will set in place data collection and utilization review systems.

(b) *Discussion.* Because CT scanners are expensive to purchase, maintain and staff, every effort must be made to contain costs while providing an acceptable level of service. Intensive utilization of existing units, regardless of location, will prevent needless duplication and limit unnecessary health care costs. Estimates and surveys for efficient utilization of CT scanners range from 1,800 to over 4,000 patient procedures a year. (One patient procedure includes, during a single visit, the initial scan plus any necessary additional scans of the same anatomic area of diagnostic interest).

The Institute of Medicine, the Office of Technology Assessment and others have carefully reviewed these data and the capabilities of various available units. The Department has reviewed these analyses as well as the extensive literature that has been developed on CT scanners. In arriving at a standard for the use of these machines, the Department has considered a variety of factors, including the difference in time required for head scans and body scans, the need for multiple scans in some patient examinations, variations in patient mix, the special needs of children, time required for maintenance, and staffing requirements. Moreover, the Department considered the actual operating experience of hospitals and institutions reflected in reports on the use of CT scanners.

The standard set in the Department's guidelines is intended to assure effective utilization and reasonable cost for CT scanning. These machines are expensive, and therefore must be used at levels of high efficiency if excessive costs are to be limited. The Department recognizes that the cost of some machines is declining, particularly those that perform only head scans which require less time. For machines that do predominantly head scans, the standard represents an efficient but more easily attainable level of utilization. For scanners capable of performing both head and body scans, it is imperative that they be effectively used in order to spread the high capital expenditures over as much operating time as possible. As the Institute of Medicine report stated, "The high fixed costs of operating a scanner argue for as high a volume of use as the equipment allows without jeopardizing the quality of care."

The Department believes that a 50-55 hour operating week is both consistent with the actual operating experience of many hospitals and a reasonable target. Based on reported experience for the time required for both head scans and body scans, the Department estimated that a patient mix of about 60 percent head scans and about 40 percent body scans, making allowance for the other factors identified above, would allow a CT scanner to perform about 2,500 patient procedures per year if it is efficiently used about 50-55 hours per week. This estimate assumes a higher percent of body scans than is currently being per-

formed. If fewer than 40 percent body scans are performed, then 2,500 patient procedures would involve even less than 50-55 hours per week. Basing the standard on a higher percentage of body scans also takes account of current trends toward increased proportions of such scans.

The Department believes that sharing arrangements in the use of CT scanners is desirable, in line with the national health priorities of section 1502. Individual institutions or providers should not acquire new machines until existing capacity is being well utilized.

In planning for CT scanners, the HSA should take into consideration special circumstances such as: 1) an institution with more than one scanner where the combined average annual number of procedures is greater than 2,500 per scanner although the unit doing primarily body scans is operating at less than 2,500 patient procedures per year; 2) units which are, or will be, devoting a significant portion of time to fixed protocol institutionally approved research projects and 3) units which are, or will be, servicing predominantly seriously sick or pediatric patients. A summary of the data collected on CT scanners should be submitted by the operators to the appropriate HSA to enable it to adequately plan the distribution and use of CT scanners in the area. The data to be collected should include information on utilization and a description of the operations of a utilization review program.

§ 121.211 End-Stage Renal Disease (ESRD).

(a) *Standard.* The Health Systems Plans established by HSAs should be consistent with standards and procedures contained in the DHEW regulations governing conditions for coverage of suppliers of end-stage renal disease services, 20 CFR Part 405, Subpart U.

(b) *Discussion.* The ESRD Program was created pursuant to section 2991 of the Social Security Amendments of 1972 (Pub. L. 92-603), which extends Medicare benefits to any individual who has end-stage renal disease requiring dialysis or transplantation, provided that such individual: (1) is fully or currently insured or entitled to monthly benefits under Title II of the Social Security Act; or (2) is the spouse or dependent child of an individual so insured or entitled to such monthly benefits. In order for an ESRD facility to quality for reimbursement under the program, the facility must meet the conditions for coverage of suppliers of end-stage renal disease services as established by regulation. These conditions incorporate standards which relate to supply, distribution, and organization of ESRD facilities. The standards were developed by the Department of Health, Education, and Welfare and were based on extensive consultation with professionals and other persons knowledgeable in the areas of nephrology and transplant surgery. Because these standards are already published as regulations, they are not republished here. The regulations do not try to encourage any particular type of dialysis setting. It is widely recognized that self-care dialysis can significantly contain costs without impairing the quality of care of the suitably chosen patient. The organization of resources to support self-care dialysis is therefore encouraged to the maximum extent practicable.

[FR Doc. 78-8130 Filed 3-23-78; 4:34 pm]

Senator MOYNIHAN. It is the kind of thing that it will help us deal with the problem if we begin to recognize—you know, it is a new one, and people are not as good dealing with new problems as they are with old ones, and it requires a different mindset.

Gentlemen, thank you very much.

Do you want to say something, sir?

Mr. BOHEN. Mr. Chairman, I just would like to say that I will be accountable for taking your three concerns back to Secretary Harris. As her personal representative on this panel, I really want to emphasize to you that she was immediately sensitive upon becoming aware of this controversy in HEW, to the point that we have developed at greater length today.

I think she will be pleased to send you a written communication. My testimony, as you know, emphasized that distinction and certainly——

Senator MOYNIHAN. It did. It certainly did.

Mr. BOHEN. And I can say that that is in direct response to her leadership and guidance.

I would also like to say that, for the Department, we are concerned with making progress on both the left-hand side of that chart in and the right-hand side. I believe we have a record of progress that predates the Inspector General's reports, some of which we have made reference to here today.

We report to the Congress semiannually in great detail on project integrity which Mr. Lowe covered and many, other initiatives to do something about waste and fraud where we can do something about it, I would like to provide that for the record of this committee, too, because I think both Secretaries are committed to it and there is a record of progress there.

[The material referred to follows:]

Status of Reported Savings from HEW's Major Initiatives
To Reduce Fraud, Abuse, and Waste ($m)

	Inspector General's Estimate	HEW's FY 79 Reduction Plan	Reported Savings as of September 30, 1979
A. Health Care			
1. Medicaid/Medicare fraud and abuse	668	93	23.04 1/
2. Medicare audit and cost reviews	17	16	6.33
3. Financial management			
a. Medicaid	--	*	45.3
b. Utilization control penalties	--	*	11.6
4. Reimbursement limitations for renal dialysis	--	22	10.7
5. Medicaid erroneous payments	1,100	265	
6. Medicare--reimbursement limitations			
a. Routine hospital costs	--	35	
b. Purchased inhalation therapy	--	13	
c. Malpractice insurance	--	10	
7. Unnecessary hospital stays	124	86	
Subtotal	1,909	540	96.97
B. Income Security			
1. SSI			
a. SSI overpayment recoveries	--	16	23.2
b. Disability conversion review	--	*	1.13
c. SSI payment errors	292	105	
2. AFDC			
a. Child support collections	--	*	27.0
b. Financial management	25	10	
c. AFDC payment errors	206	25	
3. RSDI			
a. Duplicate payments to dependent children	--	8	1.38
b. Student benefit initiative	--	100	
Subtotal	523	274	52.71
C. Student Financial Assistance Program			
1. Increased collection of FISL defaulted loans	--	68	133.7
2. Program reviews	--	27	8.2
3. Validation and editing activities	--	300	221.6
4. Increased collection of NDSL defaulted loans	--	10	
5. Reduction in FISL claims	--	11	30.0
Subtotal	203	416	393.5
D. Elementary and Secondary Education	53	22	22.2
E. Inspector General Computer Matching Initiatives			
1. SSI project match	--	*	.65
2. AFDC project match	--	12	9.63
3. RSDI project match	--	*	.02
Subtotal		12	10.30
F. Cross-Cutting Management Initiatives			
1. Indirect cost negotiations	23	15	68.8
2. Project integrity systems	--	*	3.42
3. IG Audit and criminal investigations			
a. Criminal investigations	--	10	.7
b. Audits	30	16	37.1
4. Recoveries on outstanding FY 1977/78 audits	--	*	16.1
5. Improved ADP practices	--	*	3.23
Subtotal	53	41	129.35
TOTAL	$2,741	$1,305	$705.03

* These initiatives did not have targets in our March 5 plan.

1/ This figure is a combination of savings from State fraud control units, Medicare, and Medicaid investigations.

Senator MOYNIHAN. Good, good. Because we are going to be dealing with this again next year and we have got to protect the principle of entitlement. That is our sacred trust.

Commissioner Stanford G. Ross, this is the last time you are likely to appear before this subcommittee. I would like to thank you for coming, thank you for what you have done for Government and know that we expect to see you back in Government and wish you, as they used to say in the Navy, a good tour onshore.

Thank you gentlemen very much.

Mr. ROSS. Thank you, sir.

Mr. BOHEN. Thank you, sir.

[The prepared statements of the preceding panel and the quality control regulations follow. Oral testimony is continued on p. 171.]

STATEMENT OF
FREDERICK M. BOHEN
ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman, and Members of the Committee, I am Frederick M. Bohen, Assistant Secretary for Management and Budget in the Department of Health, Education, and Welfare, and I am pleased to appear before you on behalf of Secretary Patricia Roberts Harris.

Accompanying me this morning are Richard Lowe, Acting Inspector General; Stanford Ross, Commissioner of Social Security; and Leonard Schaeffer, Administrator of the Health Care Financing Administration. We are here this morning to discuss with you the question of quality control in HEW public assistance programs -- and how HEW and the States have been working to improve management systems to reduce payment errors.

At the outset, I want to emphasize several important points about HEW's commitment to spend the funds allocated to it for the purposes and beneficiaries intended by our authorizing legislation:

- I come here on behalf of Secretary Harris in part to try to correct a public misconception that beneficiaries of Federal social programs administered by HEW are defrauding the Government on a grand scale. This is emphatically not the case. The Inspector General found that less than two tenths of one percent of HEW's budget goes to beneficiaries who may have obtained the benefits fraudulently. Less than 3% of the Inspector General's $6.5 billion estimate of costs that could be avoided is the result of fraud by the

people we serve. The vast majority of unjustified expenditures are rooted in the complexity of legislative design and administrative error in these programs, and we can halt these expenditures and achieve savings only through new legislation and continuing improvement and redesign of management systems.

- HEW and the States have made excellent progress in reducing error rates for AFDC and SSI. The excess payment rate for AFDC dropped from 16.5% in September 1973, to 7.1% in September 1978; the SSI rate has dropped from 11.5% in June 1975 to 5.0% in March 1979.

- HEW has mounted an aggressive technical assistance program to help States save AFDC and Medicaid dollars.

  -- For AFDC, we have already helped five States introduce retrospective accounting and six States to systematically use error prone profiles. These techniques base benefit levels on actual experience rather than future speculation and help States deploy their resources most efficiently.

  -- With HEW assistance Medicaid management information systems, aimed at reducing claims processing errors are operating in 28 States and being designed in another 18 States.

- HEW has sponsored legislation to make structural changes that would reform many error prone features of our cash assistance and health care financing programs. For example, the Social Welfare Amendments of 1979 would mandate that States establish benefit levels based on retrospective accounting and monthly reporting by beneficiaries.

- HEW opposes legislated error rate targets with fixed, inflexible timetables. HEW's authority to withhold Federal matching in cases of poor State performance should be clear and unambiguous, but the quality control system should stay flexible to accommodate special problems and adapt to new information and program experience. Overly specific and harsh legislation could harm legitimate beneficiaries and could cause State performance to deteriorate rather than continue to improve.

The Inspector General's Report

Since HEW's Inspector General issued his first report in 1978, there has been much publicity about fraud, abuse, and waste in HEW programs. As we can all readily agree, there is substantial room for improvement in HEW and State management of our major entitlement programs: cash assistance, health care financing, and student aid. However, the headlines and stories resulting from the Inspector General's report have often obscured the important questions and made it more difficult to frame constructive solutions.

At the same time, we in HEW have been unsuccessful in clarifying the Inspector General's findings and conclusions, and what the Department could and has done to address them.

So I would like to spend a few minutes reviewing that report and putting into context the Inspector General's estimate of dollars that could be saved before turning to the issue of what we in the Department are doing to strengthen quality control, and how we and the States have been working to improve the administration of the three major public assistance programs -- AFDC, SSI, and Medicaid.

The unique thing about the Inspector General's report is that it brought together for the first time everything we knew or could guess about opportunities for savings in HEW's programs. The data on which the estimates were based ranged from statistically sound projections -- such as the AFDC and SSI error rates -- to highly speculative guesses -- such as the extent of provider fraud in Medicaid. Nevertheless, the estimates on the whole were a useful exercise which called attention to real management problems and encouraged us to come up with creative solutions.

The Inspector General took great pains to categorize the various types of management problems he reviewed, both in order to facilitate understanding and to encourage appropriate solutions. The careful distinctions made throughout the report were largely ignored once it became public. One crucial distinction which I want to emphasize today is the distinction between fraud and abuse, on the one hand, and systems deficiencies on the other.

Listening to the public debate about the Inspector General's report one got the impression that HEW was being defrauded of $6.5 billion annually. This is emphatically not the case and was made crystal clear in the Inspector General's report itself.

Most of his $6.5 billion estimate stems not from fraud and abuse, but from dollars that could be saved only through legislative reforms, clarified program policies, and improved management through administrative and delivery system reforms.

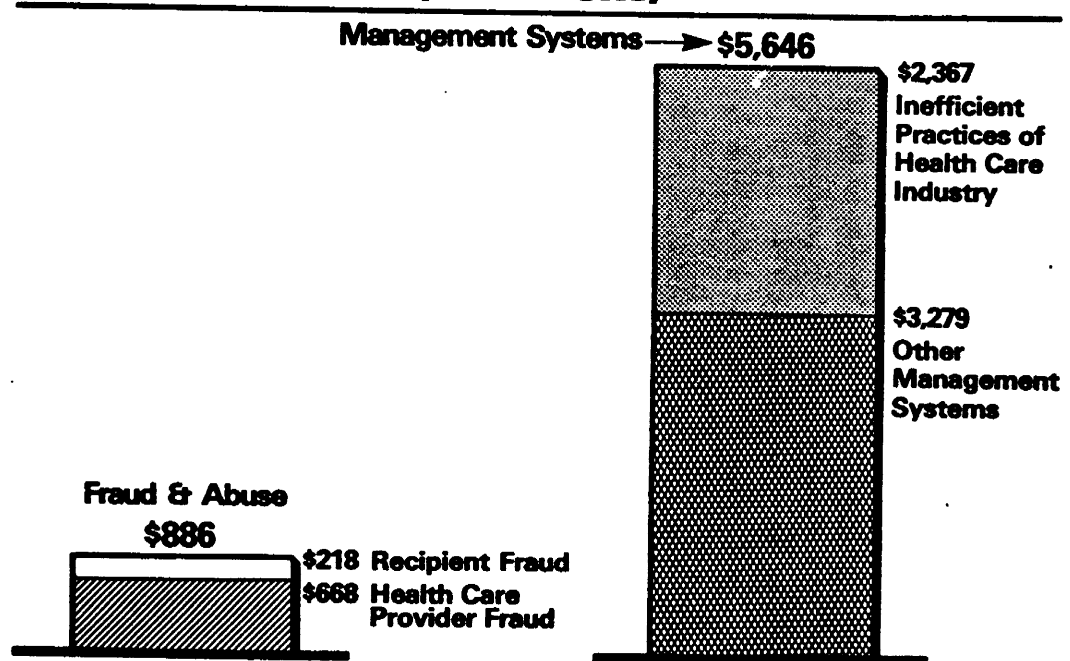
Fraud and Abuse

A relatively small proportion of the Inspector General's estimate, 14% or $886 million, is ascribed to fraud and abuse. The largest portion of this estimate, $668 million, was the Inspector General's ball park guess about the extent of health care provider fraud and abuse. Contrary to popular belief, fraud and abuse by recipients of the benefits under HEW programs was a relatively minor problem cited by the Inspector General. His estimate of fraud and abuse by students and AFDC recipients totalled $218 million, only three percent of his total estimate of $6.5 billion and less than two tenths of one percent of HEW's total budget.

Potential for Management Savings

In sharp contrast to his estimate of fraud, the Inspector General estimated $5.6 billion could be saved through changes in inef-

Elements of the Inspector General's $6.5 Billion Estimate of Fraud, Abuse, and Waste (in millions)



ficient systems, management practices and program policies. He highlighted three distinct types of problems:

- First, the Inspector General assigned a dollar value of $2.4 billion to the inefficient and excessive practices of the nation's health care industry, which cause unnecessary expenditures in the Medicare and Medicaid programs for x-rays, surgery, and excess or underutilized hospital beds. Under current legislation, HEW and the States have insufficient authority to control this problem. Its solution requires the cooperative efforts of HEW, Congress and the health care industry. It will take time, new legislation such as Hospital Cost Containment, and implementation of the new authorities in the Health Planning Act to accomplish the difficult task of changing the habits of health care providers. We remain hopeful that a substantial portion of our recommendations will be enacted by this Congress.

- Second, the Inspector General estimated that through improved monitoring and review of its grantees, HEW could save $600 million annually. Because this problem can be attacked by HEW management, we have moved aggressively to bring it under control. To date, we have documented savings of over $400 million in FY 1979 from increased audits and program and financial reviews of HEW activities, which identify misspent funds for future recovery or redirect misallocated funds to their proper purposes.

- Third, the Inspector General estimated that payment errors in HEW's four major assistance programs -- AFDC, SSI, Medicaid, and Social Security -- totalled $2.7 billion. Although it would be completely unreasonable and could not be cost effective to expect payment errors in these programs to be totally eliminated, HEW and the States have some legislative authority and management resources to cut error rates substantially.

  Prior to the Inspector General's report, HEW and the States were, in fact, making significant improvements in these programs. Over the last several years, error rates in AFDC and SSI have been cut in half, a new Medicaid quality control system has been designed and implementation has begun, and a new Social Security system has been developed and will soon begin to measure payment error rates for the first time.

  To recapitulate, fraud is not a major problem in HEW programs. Moreover, the vast majority of such fraud is not perpetrated by the recipients of Federally-supported cash assistance and medical services. This does not mean, however, that the problem should be ignored. Any fraud or abuse in these programs can undermine public confidence in them.

HEW's Quality Control Systems in Public Assistance Programs

I will now turn to the immediate concerns of this Committee -- the quality control systems in AFDC, SSI and Medicaid -- and their capacity to achieve tighter error tolerances in the future.

The fundamental responsibility of administrators of public assistance programs at all levels of government is to assure that:

- money and services are going to the people who are intended to be served, and
- those who are eligible receive what they are entitled to, no more and no less.

HEW and the States over the last one and a half decades have developed quality control systems to measure how well these basic responsibilities are being carried out in the AFDC, SSI, and Medicaid programs and what needs to be done to correct mistakes. These systems are the tools which HEW and the States use to administer their shared responsibilities for these programs more equitably and efficiently. They build on the experience of the private sector while introducing a number of innovative concepts necessary for quality control systems in the public sector.

Comparision with Private Sector

In many respects, the quality control systems by which we measure ourselves in APDC, SSI, and Medicaid are more rigorous than comparable systems in other public programs or in the private sector. Our systems determine error rates by reviewing a statistical sample of the entire caseload, not a sample of caseworker actions. The latter would restrict the review to cases recently examined and thus be less likely to have errors. Also, reviewers undertake extensive redevelopment of each case rather than merely conducting a few spot checks of bank accounts or employers.

On the other hand, quality control in other government agencies and in the banking and insurance industries tends to be process or transaction-oriented. That is, reviews focus on whether established procedures were followed, rather than whether the payment was correct. Also, the sample is often selected from recent transactions, not from all cases currently receiving payments. The insurance industry, for example, favors numerous reviews of new cases before initially awarding payments, with less attention to reexamining cases already approved and receiving regular payments. Those quality control systems designed to monitor transactions will tend to find lower error rates than systems reviewing a sample of the total caseload, as do the systems in AFDC, Medicaid and SSI. Indeed, this is the experience of the Department in comparing the caseworker action review system in effect in the 1960s with the total caseload review system initiated in the 1970s.

Structure of the Quality Control System

Quality control systems in the private and public sectors have two distinct functions: 1) measurement of errors and 2) corrective action to prevent recurring problems. Industry weighs the cost of correcting product flaws uncovered by quality control activities against the benefits to be gained, and may accept some continuing level of error, if the cost of a complete remedy is not matched by commensurate savings. We also believe the government needs to assess the resource costs as it sets goals for results under quality control activities.

The quality control systems which we will discuss today focus on the major types of errors in AFDC, SSI and Medicaid -- mistakes in determining whether or not a person is eligible for benefits, and mistakes in the amount of benefits paid to eligible persons.

The current quality control systems in public assistance have three major cycles:

- Cases are selected for examination based on statistically valid sampling techniques.

- The quality control reviewer does a new determination of the case eligibility and benefit amount, including verification of income, bank statements, employment status, and other relevant data. The reviewer also interviews the client. Based on these reviews, payment error rates are determined.

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In the AFDC and Medicaid quality control programs, Federal staff conduct a re-review of the States' quality control findings. The State's final error rate is based on the findings of both the Federal and State reviews.

- o The heart of the quality control program, however, is the corrective action process. Federal and State staff analyze the error rate data to determine how and why errors occur. States, often with Federal assistance, take action to resolve the problems and reduce future errors.

History of Quality Control in HEW

HEW made its first effort at quality control in the AFDC program in 1964. It focused only on the performance of welfare caseworkers in following predetermined procedures. Reviews were conducted as a sample of caseworker actions to see if those actions were performed correctly. The review system did not seek to determine if the overall payment was correct. Since the scope of the review was limited and since recently enrolled or adjusted cases tend to have fewer errors, the quality control systems of the 1960s generally found lower error rates than did the much more rigorous systems implemented in the 1970s.

This quality control system went through major modifications in the first few years, including increased sample sizes, the change from sampling caseworker actions to a sampling of all cases, and an increased focus on measuring errors in the determination of eligibility and payment levels. By the early 1970s, the early efforts

had been refined by the States and HEW to the current system which couples a device for obtaining information on where errors are occurring with a corrective action process to eliminate the cause of these errors.

HEW used the AFDC system as its model when designing the first Medicaid eligibility quality control system in 1975, and the SSI quality control system in 1974 -- the year the SSI program was federalized. The 1975 Medicaid system provided information only on beneficiary eligibility. In 1978, HEW implemented a more comprehensive quality control system which includes errors caused by claims processing -- for example, paying duplicate claims or paying for noncovered services -- and failure to determine liability of other parties for medical expenses of the beneficiary. We expect to have the first error rate data from this new system within two months.

Progress in Reducing Errors

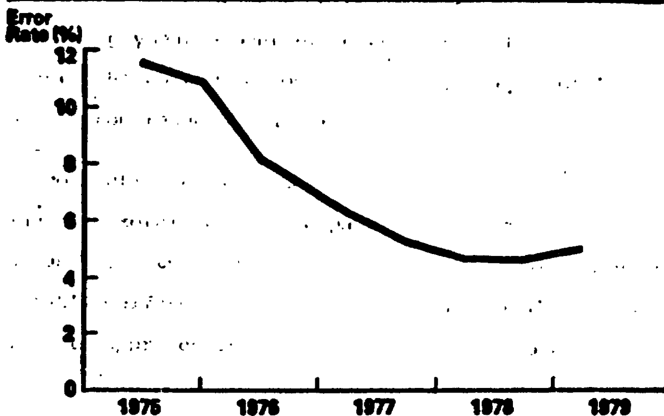
On the basis of the data from these quality control activities applied over time, we know that the AFDC and SSI programs have made and continue to make significant progress in reducing error rates. In AFDC and SSI, the most recent

error rate data show significant drops in excess payment errors, that is, payments to ineligible recipients or overpayments to eligible recipients for excessive amounts:

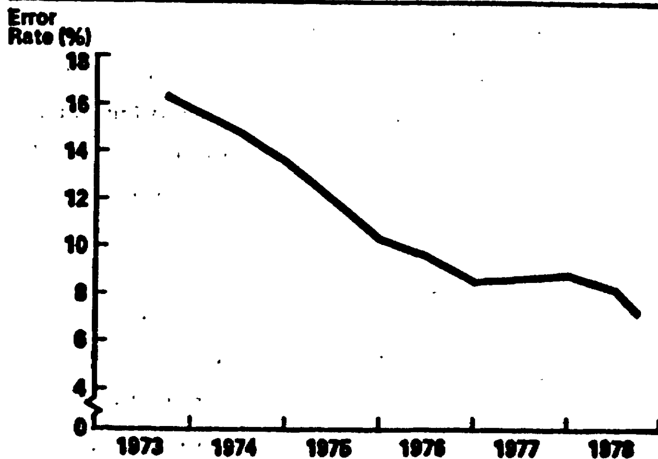
- o AFDC has brought excess payment errors from 16.5% in September, 1973 down to 7.1% in September, 1978.
- o SSI has brought excess payment errors from 11.5% in June, 1975 down to 5.0% in March, 1979.
- o These dramatic reductions in the AFDC and SSI error rates have also had a significant impact on Medicaid errors since persons eligible for AFDC and, in most instances, SSI are automatically considered eligible for Medicaid.

These significant reductions in error rates in the AFDC and SSI programs, illustrated by the following graphs, have been the result of States and HEW implementing many hundreds of corrective actions, such as reallocating staff to work in the determination of eligibility to decrease excessive caseloads per worker and allowing a better verification of information provided by the client, such as income. Although we will not have our first Federally-developed data from the expanded Medicaid quality control system for another two months, States have preliminary data and have already begun the corrective action process.

Progress in Reducing SSI Payment Error Rates



Progress in Reducing AFDC Payment Error Rates



Causes of Error

The causes of the errors identified by our quality control systems can be grouped into two broad categories: agency error or client error. The administering agency most commonly makes errors because of:

- o incorrect application of procedures by the caseworker when determining or adjusting the client's grant eligibility.
- o failure to follow-up on indications of changes to the beneficiary's eligibility, e.g., such as a change in address which could result in a possible change in living expenses.
- o simple errors by the eligibility worker in calculating the payment amount.

Beneficiary error generally results from failure to report information, such as change in income, or the information reported is incorrect or incomplete. In AFDC, based on data from the most recent sampling period -- April to September 1978 -- agency or administrative error accounted for 60% of all case error. More than half of these errors are due to the States' failure to take appropriate and timely action, e.g., following up on indications of changes to a client's eligibility status.

In the SSI program, agency error constitutes 40% of the overall payment error rate. About 60% of all agency error is due to incomplete documentation and verification of the data on the application.

In the Medicaid program, based on April - September 1976 error rate data, 63% of the payment errors are due to agency error.

The most common cause of client errors in AFDC and SSI is the recipient's failure to report in a timely fashion changes in circumstances, such as income and living arrangements.

In AFDC, our quality control sampling strongly suggests that the likelihood of an error increases substantially as the time elapses since a caseworker last did something on the case. For cases with caseworker attention within the last three months, 19.3 percent are in error, but for cases in which at least a year had lapsed since the last action, 33.9 percent are in error.

HEW's Technical Assistance for States

HEW is assisting States to address these problems and further reduce their error rates in a number of ways:

- We have established management institutes at the Federal level to identify and disseminate innovative State practices which result in improved program management and to help implement such improvements. For example, through our Medicaid -

Medicare Management Institute, we have assisted New York City to improve the process for determining initial eligibility of patients in nursing homes. Working with Pennsylvania, we are close to completing the development of a comprehensive program to identify and bill liable third parties such as insurance companies.

- We are assisting several other major States to improve the administration of their Medicaid programs and reduce payment errors: Federal staff assisted California to develop procedures to validate social security numbers routinely as client identifiers and analyzed the cost effectiveness of an error prone profile case management system. HEW provided assistance to Illinois in improving its Medicaid eligibility policy manual.

- HEW has prepared error prone profiles for AFDC cases for the six States (New York, Illinois, Ohio, Massachusetts, Pennsylvania, and Michigan) which make 61% of all AFDC payment errors. Such analyses of quality control data serve to identify the case characteristics most frequently associated with error. This information enables States to allocate administrative resources more effectively in monitoring both initial applications and redeterminations.

- We are currently helping five States (North Dakota, South Dakota, Wyoming, Illinois, and Kansas) install retrospective accounting and monthly reporting of income by recipients. Under this approach States will base assistance payments on income received in a prior period (i.e., actual income), rather than upon an estimate of income expected in the period for which the payment is made. At present, most States calculate their assistance payments on the basis of anticipated income. In any period when the income is greater or less than expected, the payment made will be in error. This is true even with a perfect income reporting system. We advocate retrospective accounting in our Welfare Reform proposal and encourage States to implement the procedure under the current system.

- Recently, we have made a special effort to assist the States' corrective action planning process. Specifically, the six AFDC States responsible for 61% of payment errors have received on-site technical assistance directed at error reduction through identification of causes of error and implementation of appropriate management improvements. We plan to provide similar technical assistance to States with exceptionally high Medicaid error rates.

- HCFA is already funding operational Medicaid management information systems in 28 States, and systems are under development

in another 18 States. These systems are helpful in improving the States' capacity to correct claims processing problems such as duplicate payments, payments for uncovered services and overpayments. For example, New York City avoided costs of $163.7 million in the first year of operation of its Medicaid management information system. Other States have experienced similar successes.

Future Prospects

Although past progress and current activities are impressive, further progress will be more costly. During the next few years, we may reach the point when the cost of further lowering error rates exceeds the savings in program dollars. For AFDC and SSI, many of the least complex and costly corrective actions have been implemented. For example in the early years of SSI, unreported income from Social Security and Veterans benefits contributed heavily to the error rate. SSA began matching SSI cases against Social Security and Veterans Administration files in 1975 and 1976 and during this period the error rate dropped from 12% to 8%.

Many of the remaining program deficiences will require major systems adjustments and structural reforms to correct. For example, policies of the current public assistance programs often require caseworkers at the local level to apply complex and frequently different eligibility criteria, e.g., treatment of work expenses and assets. Correcting this problem will require fundamental changes in legislation such as the proposal in the Administration's Welfare Reform bill to standardize the definition of income and assets in the AFDC and Food Stamp programs. Also,

States could reduce the errors caused by a caseworker's wrong calculation of the payment amount by computerizing this calculation. However, the cost of a computerized system could exceed the amount saved from reducing calculation errors.

Finally, some corrective actions would not be cost effective because they could increase total legitimate payments more than they would reduce erroneous payments. For example, many States individually determine client's welfare payments by budgeting for the client's actual rent. This approach is more error prone than one in which States pay a flat amount varying only for family size. To move to a flat payment, however, a State would have to either reduce a large number of recipients' benefit levels, or substantially increase total program costs.

Another major cause of AFDC errors is failure of the client to report income accurately. A State may be able to reduce these types of errors significantly, but only by an extensive and expensive search of banks and potential employers to verify the income status of all AFDC beneficiaries.

Role of Fiscal Penalties in Error Reduction

The history of fiscal penalties on States for high error rates begins in 1973. At that time several States still did not have fully operational quality control systems for the AFDC program even though HEW's regulations required such systems to be installed back in 1964. HEW resorted to fiscal penalties to ensure

that States fully implemented an effective quality control system for payment errors. In 1973, HEW published regulations to disallow Federal financial participation for AFDC case error rates in excess of 3% for ineligibility and 5% for overpayments. States which exceeded these tolerances were required to achieve them in one third increments over an 18-month period between July, 1974 and December, 1975.

When HEW was about to impose the first penalties, fourteen States mounted a court challenge against the disallowance regulations. In May 1976, the U.S. District Court for the District of Columbia issued an opinion that, although HEW had the authority to set goals and impose penalties, the tolerance levels of 3% and 5% were arbitrary and capricious because they were not based on an empirical study. The court enjoined HEW from taking any disallowances.

The March 7 Regulations

Following the court decision, HEW worked extensively with the States to develop mutually acceptable error rate goals and criteria for assessing financial penalties. The negotiations between HEW and the States culminated in March, 1979, when the Department published final regulations setting error rate standards for the AFDC and Medicaid programs. Under these regulations, each State must either be within the National average error rate or be making appropriate progress toward that goal in order to avoid a

disallowance of Federal matching payments equal to the amount the State exceeds its targeted error rate. States above the National average must reduce their AFDC error rates 6.4% and their Medicaid rates 15.7% every six months until the required tolerance is achieved. At the same time HEW established a standard for itself of 4% in SSI for those cases where HEW has agreed to administer supplemental payments made by States.

The March regulations also announce that HEW would set specific error rate goals for AFDC and Medicaid within two years based on the results of an HEW study to determine that point at which error rate reduction costs more than it saves in erroneous payments. This study, which is being conducted in close cooperation with State and local advisory groups, will consider the varying characteristics of States' caseloads, program policies, and administrative practices and their effect on error tolerances. The AFDC phase of the study will be completed in September 1980 and the Medicaid phase in March 1981.

Although there may be further court challenges ahead, these regulations represent a broad consensus among the States, as well as within HEW, about what the appropriate National policy on error rates should be. States would prefer to see no penalties at all, but reluctantly agree that HEW's approach to disallowances is reasonable and fair.

Appropriations Initiative

Before the March 7 regulations could be implemented, Congress directed HEW to issue another set of quality control regulations by the end of November. The Statement of the Managers in the Conference Report on the 1979 Supplemental Appropriation Bill directed that each State be required to achieve a 4% AFDC and Medicaid payment error rate by September 30, 1982. States above this target would have to achieve this tolerance level in equal increments by the end of fiscal years 1980, 1981, and 1982. States above the intermediate and final tolerance levels would lose Federal matching for payments beyond the tolerance. This directive was confirmed by a statutory provision in the 1980 Labor-HEW Appropriation Bill.

In compliance with this Congressional directive, HEW issued a Notice of Proposed Rulemaking in September. We are currently receiving and analyzing comments from interested parties and the public in response to this notice, and are making every effort to issue final regulations as quickly as possible.

While we intend to comply with the law, indeed have no choice other than to comply in the absence of an action by the Congress that would supercede existing law, HEW opposed and continues to oppose the initiative to mandate AFDC and Medicaid error rate tolerances through the appropriations process. Although it has a

positive effect of providing clear statutory basis for assessing fiscal penalties if States fail to meet error rate tolerances, it has a number of unfortunate consequences:

- The penalties implicit in the appropriations provision could very likely harm legitimate beneficiaries.
- It has locked the Department and the States into a rigid timetable which may not be appropriate to the conditions of many States.
- It has legislated a national error rate goal which is not based on any systematic study or empirical data. There is no flexibility for changing it without amending the law.
- It sharply limits the Department's future flexibility to revise quality control regulations based on new studies or accumulated experience.
- By setting aside the results of three years of negotiations between HEW and the States, it places an unnecessary strain on Federal-State relations. In the final analysis, the States are the units we most depend on to deliver services to the intended beneficiaries.

Legislative Recommendations

In the Social Welfare Amendments of 1979 (HR 4904), recently passed by the House, there are hopeful signs that Congress is reconsidering the statutory approach to error rate tolerances included in the

1979 and 1980 appropriations bills in the appropriate context of the authorizing process. Part G of this bill:

- Sets as a goal a National AFDC payment error rate of 4% and specifies the method for achieving this goal to be the Department's March 1979 quality control regulations.

- Requires HEW to conduct a study of States' AFDC error rates and make regulatory recommendations to Congress by December 31, 1980. The recommendations are to consider the effects of State's differences in program size, benefit levels, and program complexity.

- Keeps in effect the March 1979 regulations until the mandated study is complete and Congress has had 30 calendar days (excluding recesses of more than 3 days) to review and take appropriate action on regulatory revisions recommended in the study.

We strongly endorse the House action and stand ready to work with the Senate to complete Congressional action on a quality control provision pertaining to acceptable error rates which could be incorporated into the Social Security Act rather than being appended to an HEW appropriation. In our judgment, Part G of the Social Welfare Amendments includes the appropriate elements for legislative action on quality control.

- It provides a clear statutory basis for HEW to set standards and impose penalties for poor performance.

- It preserves HEW's regulatory flexibility to recognize special circumstances in carrying out a national quality control policy.

- It recognizes that much is yet to be learned about quality control policy in the future and provides a process for gathering information and implementing regulatory revisions.

Although the House action on the Social Welfare Amendments applies only to AFDC, we believe that a similar approach is appropriate for Medicaid. We suggest, however, that any new Medicaid error rate legislation recognize that since Medicaid quality control is a relatively new system, we need at least one more historical period of error rate data included in the study. Therefore, an error rate study for Medicaid could not be ready before the end of March 1981.

Conclusion

In sum, Mr. Chairman, HEW believes that a careful and fair reading of efforts by HEW and the States to improve administration of AFDC, SSI and Medicaid programs in recent years reveals substantial progress in tracking and reducing errors in these programs. This progress has been the result of a very active and close Federal-State partnership.

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As Congress moves into the area of error rate reduction with the objective of speeding up the rate of progress, we should all recognize the nature of the problem that we face. The most significant opportunities for lowering error rates lie in structural revisions in the eligibility determination process, and not in general statutory prescriptions for the States to lower rates according to a timetable prescribed by law. We welcome the affirmation by Congress of HEW's authority to withhold Federal matching for poor State performance in implementing quality control systems. However, we recommend against mandating universal goals on inflexible timetables, and against initiatives that would legislate the details of these systems. These are best left to the regulatory process, checked and reviewed by oversight hearings such as the one you are conducting today.

PREPARED STATEMENT OF STANFORD G. ROSS

The testimony given by Mr. Frederick Bohen, Assistant Secretary for Management and Budget, HEW, provides information on HEW's efforts to deal with problems of fraud, abuse and waste in its programs. I wish to submit the following statement for the record as supplementary background information on the integrity of the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs.

In this statement, we will discuss our current level of performance, the tools we use to measure our performance, and the actions we are taking to improve performance.

CURRENT LEVEL OF PERFORMANCE

There is no doubt that we can be proud of the achievements we have made in reducing error, fraud, and waste in the AFDC and SSI programs. We have been extremely successful over the past 6 years in dramatically reducing the number of incorrect payments in these programs. In AFDC, the error rate has dropped from 16.5 percent in 1973 to 7.1 percent in 1978. In SSI, the error rate has dropped from 11.5 percent in 1975 to 5.0 percent in 1978. To give some idea of what this decrease means in dollars, we can compare the amount of the incorrect payments at the higher and lower error rates.

For AFDC, the incorrect payments totalled $571 million for 6 months in 1973; this figure decreased significantly in 1978 and was only $361 million for 6 months. If the 1978 figures were adjusted for inflation, the decrease would be even more striking.

For SSI, incorrect payments totalled $321 million for 6 months in 1975, but were reduced to only $166 million for the 6 months ending March 1979.

Understanding the true measure of these achievements, however, requires an appreciation of the scope, complexity and administrative arrangements of the two programs:

The AFDC program provides over $10 billion a year in cash benefits to more than 3.5 million needy families with dependent children. We share both the administration and funding of the program with the States. The States operate the AFDC program within fairly broad programmatic and administrative guidelines and requirements defined in HEW regulations.

The SSI program provides over $6 billion a year in cash benefits to more than 4.2 million needy aged, blind and disabled beneficiaries. SSA administers the program nationally, with funding from general revenues. States may supplement the Federal benefit.

The complexity of these programs is due to the wide assortment of factors in the life of each beneficiary that must be known and verified before we can determine the correct payment amount.

We must know the amount of income a beneficiary receives from direct sources such as earnings, unemployment compensation, and social security benefits and from less obvious origins such as occasional support from relatives or interest on a small savings account.

We must account for all of an applicant's possessions to ensure that their value does not exceed the applicable resource limit. Depending on what resources are set for determining eligibility, we must calculate the total value of bank accounts, motor vehicles, a home, life insurance policies, savings bonds, and other assets. Some resources may be excluded under certain conditions. For example, in SSI, a car used for medical transportation is excluded regardless of its value. Resources can also increase in value and a person who was eligible for benefits at the time of application may become ineligible several years later even though he did not acquire more possessions.

Perhaps the most difficult element to consider in determining eligibility is the living arrangement of the beneficiary. To ensure that a correct benefit is paid, we must make an accurate determination of who lives in the home. In most cases, the assistant payment must be recalculated if someone leaves or moves into the household.

As these examples show, AFDC and SSI benefits are extremely difficult to keep correct. However, both of these programs are extremely important in ensuring that the most vulnerable in our society—children, the aged, and the disabled—receive a minimum level of income to provide for their basic needs. We who administer these programs must recognize the vulnerability of the beneficiaries we serve and administer the programs as humanely as possible.

At the same time, we have a responsibility, as administrators of public funds, to ensure that the monies go to the right people and in the right amount. We must be vigilant in our efforts to improve the integrity of both programs and to keep payment errors to an absolute minimum. If we are successful in this effort and can convince the American public that we are carefully and correctly administering the taxpayers' dollars, I believe that we will generate increased public support for our society's income maintenance programs.

HOW PERFORMANCE IS MEASURED

Both programs have established Quality Control systems designed to measure performance.

The present Quality Control system for the AFDC program was established in 1970 in response to congressional and public concern that there was no reliable measure of performance in the program. The States are responsible for operating the AFDC/Quality Control system, which is a national system that conforms to Federal specifications. The Federal Government is responsible for reviewing part of the sample the States have reviewed to ensure that the State review has been done accurately.

The SSI/Quality Control system was started as soon as the SSI program was implemented in 1974. This system was established both to provide a measure of our performance and to provide a basis for reimbursing the States for monies SSA misspent in administering State supplement programs. SSA operates the SSI Quality Control system, but the States have the option to review a sample of the cases we do in order to check the accuracy of our review.

Since the SSI Quality Control system was patterned after the AFDC Quality Control system, the two are basically the same. The Quality Control systems are based on random samples of all cases receiving assistance payments. A sample is selected for every 6-month period, October through March and April through September. The sample includes cases from the entire caseload to ensure that a representative number of all kinds of cases receiving a regular monthly payment is reviewed. In AFDC, the States review 44,000 Quality Control cases each 6 months, and in SSI, SSA staff review 24,000 cases every 6 months. The Quality Control staff both in the States and in SSA are specially trained to do Quality Control work. This staff is independent from those who regularly take applications and determine eligibility and payment amount.

The Quality Control reviewer is responsible for doing a thorough and completely independent redevelopment of all of the factors which determine a beneficiary's eligibility and payment amount. The reviewer conducts an indepth interview with the beneficiary at home, and requests that all necessary proofs be available. These include birth certificates, pay stubs, social security and VA eligibility letters, bank books, insurance policies, rent receipts, and other evidence.

The reviewer:

Asks about the beneficiary's work history to establish leads for pensions, VA benefits, etc.;

Examines the living expenses to establish that the available income is sufficient to pay these expenses;

Determines where the beneficiary cashes checks and carries out other financial transactions to provide a lead for banks to check for accounts; and

Asks about the beneficiary's living arrangement, such as whether the house is owned by another, and whether other people live there.

The interview generally takes an hour or more. Afterward, the reviewer verifies all the information provided by the beneficiary by contacting employers, visiting local banks to check for possible accounts, and reviewing public records to determine property ownership. The reviewer then uses this information to compute the proper benefit and compare it with the amount acutally paid.

If the benefit is incorrect, specific information about the error is identified and recorded for use in further analysis. Information is recorded on the type of error in the case, who caused the error (the agency or the beneficiary), how the error happened, how the Quality Control reviewer discovered the error, the amount of the error, the effect of the error on the benefit amount, and how long the error has existed. If the Quality Control reviewer discovers an error, case results are sent to the local servicing office so that this particular case can be corrected.

Within Quality Control, the information from this case is combined with that from all others and provides an overall picture of what is incorrect in the programs. Various analyses are done and information is accumulated on:

What is causing the incorrect payments, and how frequently they occur. For example, to what extent are incorrect living arrangements, earnings amount, and resources, causing errors.

Why the incorrect payments are occurring. Is it because the beneficiary failed to give the correct information at the application interview or failed to report a change in circumstances? Did the agency staff make an error in computing the benefit or fail to verify a beneficiary's statement adequately?

How long have the incorrect payments existed and at what point in the payment process were they created?

Using the tabulated data from the Quality Control system, agency staff analyze the information, identifying the causes of error, why they occurred and how to correct them.

For example, the most recent Quality Control data for the AFDC program indicates that responsibility for errors is shared fairly equally by the administering agency and the beneficiary. About two-thirds of the agency errors were caused by failure to take the correct action on reported information (e.g., reported information was disregarded, required verification was not undertaken). Of the errors caused by beneficiaries, about 80 percent were due to beneficiary failure to report changes in circumstances (i.e., the correct information was reported initially, but the agency was not informed of changes which affected the payment amount).

Errors in four eligibility factors accounted for more than half of the cases in error. These factors are:

Amount of earned income was not shown correctly in the record;

Failure to register for the WIN work and training programs;

Living expenses, on which the grant amount is based, were incorrectly calculated;

Eligibility was based on continued absence of a parent, however, the parent was not absent.

In the SSI program, the most recent findings show that the beneficiary was responsible for 63 percent of the incorrect payments, by reporting incorrect information to SSA, or by failing to make a required report regarding a change in circumstances. The agency-caused errors generally were due to failure by the SSA field office to properly verify and process the claim. Of the specific eligibility factors causing errors, the most frequently occurring were:

The beneficiary had funds in undisclosed bank accounts which resulted in resources exceeding the resource limits of $1,500 per person, or $2,250 per couple;

The living arrangement classification which determines whether or not the beneficiary's payment is reduced due to receipt of food and shelter in someone else's household was not correct;

Cash or in-kind contributions from private sources were not correctly shown in SSA's records; and

The correct amount of earned income was not considered in determining the payment amount.

Specific corrective actions have been designed to attack these specific problems. For example, if the agency staff is responsible for an unacceptable level of incorrect payments in a specific category, then special training is provided. If it becomes apparent that the procedures for handling certain cases are unclear, the procedures are clarified or simplified. If beneficiary nonreporting of certain changes is causing the incorrect payments, then reminders may be sent to beneficiaries periodically, or redeterminations may be scheduled more frequently.

In AFDC, the system for recording and analyzing the incorrect payment information is done at the State level and the degree of sophistication varies, however we are working with the States to improve this capability.

As this description of what we do with Quality Control information indicates, the Quality Control systems serve two major purposes—the first is simply to provide a measure of how well we are running the program; the second is to provide data on the numbers, types and causes of error which managers can use to develop ways for improving program administration. Our experience has convinced us that a Quality Control system is an essential tool for both measuring and improving the AFDC and SSI programs. The significant reduction in AFDC and SSI incorrect payments attests to this. Additionally, it is important to note that these systems are continually audited by GAO, the HEW Audit Agency and, on contract, by independent consulting firms, to ensure that they provide an objective and accurate measure of error in the AFDC and SSI programs.

ACTIONS TO IMPROVE PROGRAM PERFORMANCE

We cannot, however, rest on past achievements and both SSA and the States are continuing to take strong initiatives to reduce the number of incorrect payments. In the past year, we have intensified our efforts to bring greater efficiency and accuracy to the programs we administer. These efforts include improvements in the broad area of assessing agency performance, a full range of management initiatives and a series of legislative proposals contained in the Welfare Reform Amendments of 1979.

ASSESSING AGENCY PERFORMANCE

In order to improve agency performance, it is essential to have the appropriate assessment mechanisms in place to tell the manager what is required. Consequently, we are continuing to stress and strengthen the Quality Control systems for both AFDC and SSI. We are increasing our capacity for analyzing the Quality Control data and for translating the information into effective corrective actions. Some of the other more important activities we are engaging in jointly with the State AFDC administrators include:

A complete revision and updating of the Quality Control manual used by both State and Federal reviewers. The use of the new manual will result in expanded and tightened reviews as well as greater uniformity among the reviewers of all the State programs.

The initiation on a selective basis of a Federal/State management review of the State Quality Control systems and corrective action process. These reviews will strengthen both the Quality Control system in the State and the AFDC agency's ability to take the necessary steps to improve the accuracy of the payments.

Development of so-called error prone profiles for the States. The profiles are simply a description of the types of cases in which incorrect payments are most likely to occur. For example, a case in this category may be one where a widow has been receiving AFDC for less than one year. Quality Control data may indicate that such a family often receives income during this first year from insurance, friends, relatives etc. This, in turn, causes the payment to be incorrect. These error prone profiles, which we develop from analysis of the Quality Control data, provide administrators with the information to take specific corrective actions to reduce the possibility of error in this type of case. For example, we may contact the beneficiary more frequently to prevent an incorrect payment or provide the beneficiary with an explicit explanation of what types of income should be reported.

Establishment of a new SSA-wide Office of assessment which provides a new assessment capability with SSA's own Inspector General-type operation. This new, highly visible and focused assessment operation will be able to provide increased support to the State Quality Control and corrective action systems as well as ensure our own capabilities in these areas for SSI and the other programs SSA administers.

MANAGEMENT INITIATIVES

To complement and build on the work to improve our assessment capabilities, we, at the federal level, have undertaken some major management initiatives. These include:

Initiation of a joint Federal/State comprehensive program to reduce significantly and as quickly as possible the AFDC error rates in the six States with the greatest amount of incorrect payments. We refer to this as the "Six State Strategy." These States spend 44 percent of the monies nationwide in the AFDC program, but make 61 percent of all the incorrect payments. Therefore a substantial decrease in incorrect payments in these States will have a significant effect on the AFDC error rate overall. Through this initiative, we expect to be able to reduce the national error rate by 1.2 percent, from 7.1 to 5.9 by 1981. This will result in AFDC program savings totalling $145 million annually. To accomplish this reduction, we have worked with State officials to complete an indepth analysis of the causes of the incorrect payments in these states. We are also providing technical experts to the States and have developed corrective action plans for each of the States, which they are now in the process of implementing.

Creation of Welfare Management Institute which is a clearinghouse for sharing proven management and administrative techniques among States. This institute, directed from a separate organization in the Office of Family Assistance, assists States in developing technical expertise for resolving management problems and in sharing this knowledge among States. To encourage an exchange of ideas, two Urban Management Conferences have been held, and the Institute has arranged State-to-State personnel exchanges to aid States in implementing ideas which have proven successful elsewhere.

An increased use of computer matching of various Federal/State records at both the Federal and State levels to identify incorrect and duplicate payments. This is known as Project Match. This effort involves comparing AFDC records with other records like social security earnings histories and Civil Service and active duty military personnel rosters in order to verify information in the AFDC records which is used to determine the AFDC payment.

Our initiatives in SSI are also comprehensive and tailored to address the areas in this program which require attention. A major SSA-wide initiative is the launching of "Project Accuracy"—the purpose of which is to live up to social security's traditional goal of the right amount to the right person on time. This a particularly important initiative. The thrust of this effort is threefold, to:

Prevent payment errors where possible;
Detect mistakes quickly; and
Recover or settle payment errors swiftly.

The major emphasis of Project Accuracy is to prevent incorrect payments from occuring at all. An emphasis on prevention is critical because most of our payments are to economically vulnerable people who have difficulty returning overpaid funds or face undue hardship if benefit amounts are erroneously low. We believe the most important action we can take is to do everything possible to keep payment errors from happening in the first place. However, when they do occur, they must be detected as promptly as possible and corrected swiftly if we are to be responsible caretakers of public funds. Other major activities include:

Specialization in the social security district offices. Until recently, social security claims representatives were responsible for handling all aspects of SSI, old-age, survivor and disability claims. The scope and complexity of these programs have expanded to the point where it is no longer possible for one person to know all four programs in sufficient depth to process the claims at the level of accuracy we are demanding. Therefore, we have separated the district office staffs in many of our larger offices so that part is devoted to SSI and part to old-age, survivor, and disability insurance. An in-depth study we did before deciding to specialize indicates that significant improvements in the accuracy of decisions and payments should result.

Establishment of special procedures to prevent and recover overpayments. We have instituted a number of safeguards when large retroactive checks are paid. A review of checks of $3000 or more is conducted in SSA's Central Office. District offices also doublecheck smaller retroactive payments. We estimate that these preventive measures will save $2 million in fiscal year 1980. We have instituted special claims development procedures to reduce the number of incorrect payments due to unknown bank accounts and living arrangements. Over 50 percent of cases in error and half of the money misspent result from these two factors. To prevent bank account errors, social security claims representatives

are interviewing claimants and beneficiaries more thoroughly and verifying accounts at local banks in many more instances. To reduce living arrangement errors, we have issued a new interviewing guide to all field personnel which simplifies and standardizes the procedures used in determining the correct living arrangement.

Increased use of a Program Integrity Staff comprised of trained investigators responsible for reducing fraud in SSA administered programs. One of the staff's major projects is to recover more overpayments from SSI beneficiaries. Based on our success in the endeavor so far, we estimate we will recover $140 million in SSI overpayments for fiscal year 1979.

LEGISLATIVE INITIATIVES

In addition to the management initiatives just described, there are a number of provisions in the Administration's Welfare Reform bill designed to improve the accuracy of both eligibility determinations and payment amounts. These include:

Requiring AFDC beneficiaries in all states to report in writing each month their income and other information that would affect their eligibility and benefit amount. Currently, most States check this information only once every 6 months.

Requiring that the States base AFDC payments for each month on the income reported by the beneficiary for the prior month. This system, called retrospective budgeting, would use actual experience, rather than the beneficiary's estimates for a future period, to determine AFDC eligibility and payment amount. This system would also apply to SSI beneficiaries.

Simplifying the calculation of AFDC payments by substituting a flat 20-percent deduction of earned income for actual work expenses. Currently, the cost of each work expense like travel, clothing, and lunches must be itemized for each beneficiary and used to calculate the correct benefit.

Providing for increased Federal funds for State computer systems and other administrative improvements. An improved data maintenance capability and the ability to match AFDC records with those of other programs should result in better payment accuracy. Further, increased Federal funding should encourage States to make administrative improvements as well as experiment with more efficient methods for operating the program. These can then be transferred to other States.

Providing that like requirements for eligibility for AFDC be the same in all States and be consistent with food stamp eligibility rules. This will reduce substantially the complexity in some of the State programs—complexity which certainly contributes to incorrect payments. In addition, having the same program requirements in all States will make sharing of new and improved techniques for ensuring payment accuracy much easier. Finally, standardization among States will simplify the monitoring of State performance by the Federal Government.

FACTORS THAT AFFECT EFFORTS TO REDUCE INCORRECT PAYMENTS

The preceding discussion described at length some of the major efforts we are taking to improve the administration of the AFDC and SSI programs. We and the States are both committed to ensuring the highest level of program integrity possible, and it is important that the subcommittee know what activities we are pursuing in this effort. There are two other important points that should be made before outlining our incentive and sanction policies. First, the error rate figures we publish for both AFDC and SSI reflect the total amount in dollars misspent, but do not reflect the amount of the overpayments that we and the States have recovered from beneficiaries who have paid back part or all of the overpayment. This is a critical fact that must be understood in order to fully appreciate the meaning of any error rate figures we produce. The American public as a whole, as well as each of us individually, need to understand error rates in Government programs in a much more fundamental way. A simple citing of an error rate or the corresponding dollar figure can seriously misrepresent the state of affairs. For example, one way to reduce error is to simplify the criteria used to establish eligibility. However, this method may make more people eligible for the program and increase overall costs.

Second, we must be realistic in establishing our error rate goals. It will simply not be possible to reduce incorrect payments in AFDC and SSI beyond a certain point because of various factors and competing objectives which exist.

One of the most important of these factors is program complexity. Complexities of legislative provisions inevitably predetermine to some extent administrative error.

The more factors which must be considered in determining eligibility and payment amount, the more difficult the program is to administer. Also, some factors are inherently more difficult to evaluate than others and, therefore, more error prone. For example, in the SSI program we must reduce benefits by the value of any in-kind goods the beneficiary receives. First, it is difficult to make some beneficiaries understand what we mean by in-kind income, and second, it is difficult to place an accurate value on it.

Another example of program complexity is the number of factors involved in determining the correct living arrangement if the beneficiary is not living alone. These include the relationship of the household members, who owns the house, whether the beneficiary is paying toward the food and rent in the household, what, if any, others are paying, etc. A mistake in any one of these factors can result in an incorrect living arrangement determination and an incorrect payment.

The point is not that errors due to program complexity are tolerable, but that the complex nature of these programs makes the effort to prevent errors from occurring an enormous challenge.

Another factor which limits our ability to eliminate errors is that we often are balancing competing objectives. For example, in cash assistance programs we have two equally important goals, to pay benefits promptly and correctly. These goals often conflict. Particularly in assistance programs based on need, it is vital that we pay benefits promptly to those who are eligible. However, if we are to ensure that we are paying correctly and only to those eligible, we must thoroughly verify all statements the applicant makes. This can frequently require considerable amounts of time, particularly since we must depend upon banks and employers, some of whom do not respond quickly.

There is also a conflict between our commitment to due process and to correcting inaccurate payments as soon as possible. In the interest of due process, we give a beneficiary enough prior notice of the impending reductions or terminations in benefits for the person to appeal the action. In these instances, an overpayment occurs in at least 1 month. If the person requests a reconsideration or appeals higher to an Administrative Law Judge or the courts, additional months, and in some cases, years of overpayments will occur. However, the courts have ruled that we must continue to pay benefits until a final decision has been rendered.

Finally, a serious concern for the privacy of the beneficiaries limits the extent to which we will verify the statements about their circumstances. As indicated earlier, income assistance programs should serve the needy in a humane way which protects the beneficiary's dignity and self-respect. We must make every reasonable effort to keep payment errors at a minimum, but we must balance this goal against a beneficiary's right to a certain amount of privacy. Also, beyond a certain point, efforts to prevent error may exceed the savings possible—in other words, would not be cost effective. We certainly have not reached that point in SSA programs, but it is important that the American people not be misled into believing that zero error rates are attainable or always desirable. The point is to strive until we reach an acceptable level of performance for us all.

MOYNIHAN HEARINGS

MEDICAID QUALITY CONTROL

Background Paper on Medicaid Quality Control for Moynihan Hearings

I. Brief History of the Medicaid Program

Medicaid was authorized by Congress in 1965 under Title XIX of the Social Security Act. Medicaid's legislated purpose is to enable each State to furnish medical assistance to needy (poor) individuals whose income and resources are insufficient to meet the cost of necessary medical services and to provide rehabilitative and other services to help families and individuals attain or retain the capability for independence or self care.

The Medicaid program operates according to a Federal/State partnership. The Federal government matches expenditures of each participating State according to a formula based on the State's per capita income. Under this arrangement, States design and manage their own medical assistance programs within the parameters of Federal legislation, regulations and guidelines. States maintain broad discretion in deciding eligibility criteria, covered services, reimbursement rates, administrative resources and practices under Medicaid.

Since the inception of the Medicaid program, different administrations have attempted to find ways to curb the rising cost of health care services and reduce the cost of payment and other types of errors to help improve management of the Medicaid program. The Medicaid Quality Control (MQC) System is designed to help States achieve the latter objective of reducing payment and other types of errors and also to produce data which forms an information base for implementing corrective measures.

II. Complexities of the Medicaid Program

Medicaid eligibility is basically linked to the Federally assisted welfare programs of AFDC and SSI. In general, States must cover all cash assistance beneficiaries, with the exception that States have the option of limiting Medicaid coverage of SSI recipients by requiring that such recipients meet any more restrictive criteria which were in effect in the State on January 1, 1972, prior to the implementation of the SSI program. States which exercise this option are required to provide a "spend-down" for all aged, blind, and disabled persons (not just SSI recipients) by deducting any medical expenses incurred from income in determining Medicaid eligibility.

States may pay a cash supplement to the basic SSI payment. Some persons who have enough income so that they are not eligible for a Federal payment nonetheless receive a State supplement. States may provide Medicaid to persons whose only welfare payment is a State supplement.

Furthermore, States can provide coverage to the "medically needy" - those who would be eligible for cash assistance (i.e., they fall under one of the groups of aged, blind, disabled or a member of a family with dependent children) except for their level of income.

One of the difficulties in Medicaid administration is that when a Medicaid intake worker examines a case, he/she must be aware of all Medicaid eligibility rules and changing regulations which constantly affect different eligibility requirements.

All in all, there are at least 27 types of cases which a State can cover for Medicaid other than cash payment cases. Some of these are optional, some mandatory. The rules of eligibility may cover the following myriad combinations of cases:

1. Individuals who received Title II (RSDI) increases in August, 1972, and would otherwise be eligible for cash assistance and were either:

   a. Eligible for cash assistance under Titles I, IV - A, X, XIV, or XVI in August, 1972;

   b. Would have been eligible for cash assistance in August, 1972, except for institutionalization;

   c. Would have been eligible for cash assistance except for cost of living increases in RSDI benefits paid under Title II.

2. Persons who were eligible for Medicaid in December, 1973, as an "essential spouse" of a cash assistance beneficiary, and who continue to meet December, 1973 criteria.

3. Persons who were eligible for Medicaid in December 1973, who would have been eligible for cash assistance at that time except for institutionalization, and who continue to meet December, 1973 criteria.

4. Persons who were eligible for Medicaid in December, 1973, as blind or disabled, and who continue to meet the December, 1973 criteria.

5. Persons who would be eligible for SSI payments or a State supplemental payment only, but who have not applied for SSI.

6. SSI recipients who became ineligible for Title XVI cash assistance due solely to RSDI cost-of-living increases after April 1977.

7. Individuals for whom a notice of ineligibility for SSI benefits is received after the tenth of the previous month, and who are eligible for coverage through the end of the following month while the State is in the process of determining continued eligibility for Medicaid.

8. Individuals residing in medical institutions with income sufficient for personal needs while in the institution, but who would be eligible for SSI or a State supplemental payment if not living in the institution.

9. Individuals who would be eligible for any of the SSI categorically needy groups listed above, except for excess income and/or resources and whose income is insufficient to meet medical expenses.

10. Persons in a medical or intermediate care facility who, if they left the facility, would not be beneficiaries of optional State supplementary payments, but while in the facility are eligible under this plan.

11. Members of AFDC families who are eligible for four calendar months of medical service beginning with the month in which such families became ineligible for cash assistance due to increased hours of work or increased earned income.

12. Individuals under 21 who would be eligible for AFDC payments except for age or school attendance requirements.

13. Beneficiaries who are receiving AFDC foster care payments.

14. Beneficiaries who are receiving AFDC payments under special program provisions: AFDC Emergency Assistance.

15. Beneficiaries who are receiving AFDC payments under special program provisions which are not covered by the existing AFDC-QC System: Presumptive Eligibility.

16. Individuals who are a caretaker (or a spouse of a caretaker) who are caring for a child under 21 who would be eligible for AFDC except for age or school attendance requirements.

17. Persons who would be eligible for AFDC benefits but have not applied for them.

18. Individuals who would be eligible for AFDC payments if they did not receive child care services through the agency but had to pay for child care costs from earnings.

19. Persons who would be eligible for AFDC payments except that the State imposes eligibility conditions more stringent than or in addition to those in the Social Security Act.

20. Individuals residing in a medical institution with income sufficient for personal needs while in the institution but who would be eligible for AFDC if they were not living in the institution.

21. Individuals who would be eligible for any of the AFDC categorically needy groups listed above; except that excess income and/or resources are insufficient to meet medical expenses.

22. Individuals under 21 who meet the AFDC income and resource limits, but do not meet the definition of dependent child under the AFDC program, or reasonable groups thereof.

23. Individuals who would be eligible for Medicaid as a needy individual under 21 except for excess income and/or resources and whose income is insufficient to meet medical expenses.

24. Individuals whose eligibility for Medicaid has otherwise ceased, but who are still overcoming the effects of their eligibility condition.

25. Beneficiaries who receive mandatory State supplemental payments only, where the State determines Medicaid eligibility and administers the supplemental payment.

26. Individuals who receive State optional supplemental payments only, where the State determines Medicaid eligibility using SSI criteria and administers the supplemental payment.

27. Individuals who receive SSI optional supplemental payments only where the State determines Medicaid eligibility using criteria which are more stringent than SSI requirements and the State administers the supplemental payment.

Possibly the most complex feature of Medicaid eligibility and its determination of eligibility in Quality Control involves the application of "spend down liability."

Individuals or families with income in excess of the applicable medically needy income level incur a spend down liability. Coverage begins on the date on which incurred medical bills equal the spend down liability. Generally one in a series of medical bills will reduce income below the medically needy income level, and for this bill, known as a split claim, both the applicant and the State will be partially responsible for payment. Medicaid will then pay for any additional expenses incurred which are covered under the State Plan until the end of the period of consideration.

The medically needy income level represents a protected maintenance level, that is, an amount of income considered essential for an individual's or family's basic support and maintenance. Under the spend down provision, Medicaid coverage is available at that point when an individual or family would incur enough medical expenses to offset income.

As an example, assume a State uses a fixed quarterly period of consideration. A categorically-related individual with no incurred medical expenses applies for Medicaid and is determined to have a spend down liability of $150. This individual must incur medical expenses in excess of $150 to establish eligibility, and these expenses must be incurred within the quarter of consideration. If he applies on January 1 but does not incur medical expenses sufficient to meet his spend down liability until February 1, his period of eligibility will be only two months, i.e., February and March. At the end of March his entitlement under Medicaid ceases, and he must reapply for Medicaid if he continues to have medical expense for which he needs assistance in paying.

In the example above, the determination of eligibility was for a prospective period only, since the hypothetical applicant had incurred no medical expenses. However, generally people turn to Medicaid for assistance only after medical expenses have been incurred which they are unable to pay or for which they need some assistance in paying, and spend down

determinations are usually of chief importance in covering expenses prior to the date of application of Medicaid. Using a quarterly period of consideration, for example, an applicant may have had medical expenses in the quarter preceding the date of application which would have met his spend down liability, had he applied earlier. Assume an individual applies on January 1, with sufficient retroactive medical expenses to have met a spend down liability by November 1 for the retroactive quarter October 1 - December 31. The individual would be retroactively eligible for Medicaid from November 1 up to the date of his application. The individual would then request the hospital or physician to bill the Medicaid program for bills incurred after the spend down day of November 1. As of the date of application in this example, it is important to note that a new quarter of consideration begins. Thus, on the date of application in this example, the individual has a new spend down liability which must be offset by further medical expenses before eligibility and coverage under Medicaid will resume.

Although the spend down liability represents medical expenses for which the applicant is responsible, eligibility for Medicaid is not contingent on the applicant's actual payment but only on the incurring of the expenses for which he/she is liable in order to establish Medicaid eligibility.

Two other aspects of the spend down provision should also be noted. First, in computing initial spend down liability, Federal regulations require that incurred medical expenses be considered in a certain order based on whether the expenses are for services covered under the State's Medicaid program. Income is to be reduced first by incurred medical expenses which are not covered by the program, including expenses incurred for private health insurance and Medicare premiums. This procedure is designed to help insure that, should the spend down applicant have medical expenses greater than needed to establish eligibility at the time of application, the remaining medical expenses can be covered by the Medicaid program. However, should the applicant not establish immediate eligibility but have a remaining spend down liability to be offset by future medical expenses, further incurred expenses may be considered by date order, whether or not they are covered under the State's Medicaid program.

Secondly, any incurred expenses for medical care recognized under State law may be used in establishing eligibility under the spend down so long as it is a valid bill for which the individual is still liable for payment, whenever it was incurred. However, under the Medicaid requirements for retroactive coverage, a State Medicaid program cannot pay for any medical claim incurred more than three months in advance of the date of application.

In addition to the complexity of eligibility determinations, the type of services which may be covered, reimbursement levels and questions of provider eligibility exist. These are subject to QC review as well. Mandatory services which are matched for Title XIX are:

1. Inpatient hospital care;
2. Outpatient hospital services;
3. Other x-ray and laboratory services;

4. Physicians' services;
5. Skilled nursing facility services and home health care services for individuals 21 years of age or older;
6. Early Periodic Screening and Diagnostic Treatment for individuals under 21 years of age;
7. Family Planning services.

Moreover, States, at their option, may also include any of the following additional services in their plans and receive additional Federal Matching funds:

1. Clinic services;
2. Prescribed drugs;
3. Dental services;
4. Prosthetic devices;
5. Eyeglasses;
6. Private duty nursing;
7. Physical therapy and related services;
8. Other diagnostic, screening, preventive, and rehabilitative services;
9. Emergency hospital services;
10. Skilled nursing facility services for patients under 21 years of age;
11. Optometrist services;
12. Podiatrist services;
13. Chiropractor services;
14. Care for patients 65 years of age or older in institutions for mental diseases;
15. Care for patients 65 years of age or older in institutions for tuberculosis;
16. Care for patients under 21 years of age in psychiatric hospitals;
17. Institutional services in intermediate care facilities;
18. Any other health care services recognized under State law which are written into the State plan and approved by HCFA.

Participating States are also required to provide reimbursement for transportation of recipients to and from the facilities at which services are provided. A State's Medicaid program does not provide services, rather it is the means by which providers are reimbursed for the costs of services to Medicaid beneficiaries.

Third party liability recovery is also a complex area. Medicaid, by law, is the payor of last resort. The causes of this complexity are:

1. Many Medicaid beneficiaries are unaware of potential coverage which may be incorporated into union dues, etc.;

2. Different insurance plans cover different services; and

3. Services resulting from casualties, eg. auto accidents - beneficiaries may not realize other drivers are liable.

These causes make the identification and recovery of third party resources a major concern in both the eligibility determination and claims payment process.

All these complexities of the program present many opportunities for erroneous payment. Present data and data for past periods indicate significant erroneous payments have been made. Because the program is complex, checking its operation with quality control programs is also complex. Several efforts have been launched culminating with the current comprehensive and complex Medicaid Quality Control System.

III. Medicaid Quality Control Prior to 1970

In 1965, Medicaid quality control reviews were begun as part of the Aid to Families with Dependent Children quality control program (AFDC-QC) efforts. These reviews were primarily case action oriented which meant only eligible Medicaid cases where assistance was terminated, denied, started, or involved reverifying beneficiaries' eligibility who were already determined eligible. Initially, these reviews covered only 22 States with large caseloads involving substantial money payments. Medicaid case action type reviews were conducted until April 1973. These reviews were then temporarily suspended to allow States to concentrate on establishing the new AFDC-QC system.

IV. Medicaid Eligibility Quality Contrtol System (MEQC) 1975-1978

In July 1975, a new Medicaid Eligibility Quality Control (MEQC) system was implemented. MEQC was designed to measure the rate of erroneous medical claims and payments as a result of errors made at the time eligibility was determined. This system also provided some data for corrective action.

The primary focus of MEQC claims reviews was to determine if beneficiaries were eligible at the time services were received. Paid medical claims formed the sampling unit. Reviews of medical claims were conducted on a 6 month review period from October to March and April to September of each year. States sampled 17,500 claims semi-annually out of an estimated 9.6 million beneficiaries in the universe. AFDC and certain SSI beneficiaries were excluded from the sample. At the Federal level, 3,500 paid claims were re-reviewed to verify the accuracy of State findings.

MEQC implementation by States was slow with only three States completing required reviews during the July to September 1975 review period. During the October 1975 to March 1976 period, 44 States completed required reviews and 45 States completed reviews for the April to September 1976 period.

States began to question the effectiveness of the MEQC as a useful management tool because the sample of 17,500 claims did not provide an accurate estimate of dollars misspent and a review of claims could not be correlated with case reviews. State and Federal staff uncovered other

system deficiencies which raised further questions about MEQC as a management tool. As an example, some claims on beneficiaries were collected; however, the data were not used if those specific claims were not chosen in the sample.

In the fall of 1976 after a year and a half of operation, a private contractor was hired to evaluate a redesign of the system and to correct the deficiencies in MEQC. The MEQC system operated through February 1978 and was then replaced by the current Medicaid Quality Control (MQC) System in April 1978.

V. Medicaid Quality Control (MQC) System - April 1978 to Present - Overview

MQC is a comprehensive State operated management system for detecting errors in eligibility, third party liability and claims processing. It is aimed at assuring that public funds only go to the people who are eligible under Federal and State law. The MQC system was implemented in April 1978. This revised system shifted the review from paid claims to a case review and added two new review components for third party liability (TPL) and claims processing (CP). MQC covers the entire Medicaid population (estimated at 25 million beneficiaries). The claims processing reviews insure that claims are paid only for covered services to eligible providers in the correct amount. Under the law, Medicaid is payor of last resort. The TPL review is a check on beneficiary's bills to make certain that other entities like insurance companies and workmen's compensation pay their share of medical expenses before using Medicaid funds. The eligibility review from the MEQC system was retained but was changed to a case review of beneficiaries' eligibility during a given month.

MQC reviews are conducted on a 6 month cycle from October to March and April to September each year. The sampling unit is a Medicaid case on the States' Medicaid eligibility roles that is:

- Certified for medical assistance;
- Receiving an SSI check; or
- An AFDC case receiving payments.

States sample 78,000 cases semi-annually out of an estimated 9.3 million cases in the Medicaid program. The Federal government then re-reviews 16,000 of these cases to assure the accuracy of States' findings.

The initial 6 month review period runs from July to December 1978. The period from April to June 1978 was used as a start-up period to give States an opportunity to test the new procedures. Results from the initial period, July to December 1978, will be compared with results the from April to September 1979 period to determine if States have met required error rate reduction targets. Federal matching will be disallowed where performance targets are not met.

A. Legislative and Regulatory Authority

The legislative authority for MQC is Sections 1903 and 1102 of the Social Security Act. All States (except Arizona) and the U.S. territories of Guam, Puerto Rico and the Virgin Islands participate in the Medicaid program and are required to have MQC systems in operation. Regulations (45 CFR, 425.25) implementing the MEQC system were issued June 27, 1975, and became effective July 1, 1975, the MQC regulation (42 CFR 431.800) was issued March 27, 1978, and became effective April 1, 1978. The disallowance regulation (42 CFR 431.801) which requires States to reduce their eligibility payment error rates to the nationally weighted mean or by 15.7% was issued March 7, 1979, effective with the April 1, 1979, review period.

B. The MQC Process

The essential steps in the MQC process are as follows:

- A sample of Medicaid cases is selected monthly.
- The eligibility status of sampled cases for the review month is determined and potential third party liability and claims for medical services are identified by reviewing the sampled cases;
- Claims for services received during the review month by members of the sampled cases which are paid before, during and for four months after the review month, are collected and assembled at the beginning of the sixth month following the review month.
- Review of the paid claims for claims processing and third party liability errors is conducted;
- Payment error rates are calculated using claims paid for sampled case services received during the review month.

Review and sampling methods for MQC may differ depending upon how a State determines Medicaid eligibility for SSI recipients.

In this regard, the three different categories of States are as follows:

- 1634 Contract States - States in which Medicaid eligibility determinations for SSI recipients are made by the Federal government under a contract from the State using the same criteria as in SSI eligibility determination.
- 209(b)/1902(f) States - States in which Medicaid eligibility determinations for SSI recipients are made by the States and in which Medicaid benefits may not be afforded to all SSI recipients, because Medicaid eligibility requirements are more stringent than SSI eligibility requirements.

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- State Determination/SSI Criteria States - States in which Medicaid eligibility determinations for SSI recipients are made by the State, using the same criteria the Federal government uses in determining SSI eligibility.

These categories decide how Medicaid cases will be sampled. A Medicaid case is defined as:

1) for the AFDC population, the AFDC case which receives a payment for the month

2) for the SSI population, the SSI payees for the month determined eligible for Medicaid

3) for non-cash payment cases, a group of Medicaid beneficiaries (a) who are eligible for Federal Financial Participation in the cost of services, and (b) for whom Medicaid eligibility was determined based upon common financial circumstances.

MQC uses an integrated sampling approach which relies on quality control systems in AFDC-QC and SSI-QA to obtain information about Medicaid beneficiaries. This "integrated" sampling approach enables MQC to include the entire Medicaid population in the sampling universe and avoids the necessity of conducting duplicative reviews. AFDC and SSI cases determined to be ineligible are then reviewed by State MQC reviewers to determine their eligibility for Medicaid. After State reviewers complete their review of these ineligible cases, Federal reviewers conduct a review to validate State findings.

The attached chart, Tab A, provides a graphic flow chart of the MQC review process. At the State level, cases in Medicaid population are selected (systematic random sample) from the State's master eligibility files. These cases are reviewed by State MQC reviewers to determine if they are eligible to have received a Medicaid card during the month of review. Reviewers make a home visit to verify the eligibility of cases selected. Collateral contacts with banks and employers may also be required. A sample of cases completed by State reviews are then re-reviewed by Federal reviewers to verify the accuracy of State findings.

In order to assign dollar values to cases and errors, paid claims for rendered services must be attached to each sample case. The method HCFA uses is as follows:

Collection of Paid Claims - Paid claims are collected at the State level (for services delivered in the sample month) 4 months after the sample month. One additional month, referred to as an administrative period, is allowed to permit States an opportunity take corrective measures. (The 1 month administrative period has been allowed after payments in the 4th month to permit normal corrective action required to adjust incorrect payments and identify TPL prior to commencing TPL and CP quality control reviews.) States then initiate reviews for CP and TPL by reviewing claims to verify the appropriate payments for services,

that the provider is certified and the amount is for an approved service. The TPL review assures that the State initiated action to get other entities to pay their share of medical bills. Federal reviewers also review a subsample of CP and TPL claims to verify State findings.

In the last phase of the review process, State reviewers make a careful analysis of dollars found in error to make certain that misspent dollars are only counted once. The hierarchy for sorting misspent dollars is ineligibility, claims processing, and third party liability.

State and Federal management staff then meet to resolve differences between State and Federal findings prior to submitting the required statistical reports. A minimum of 10 months following each 6 month cycle is required to complete the reviews, submit the statistical reports and compute the final error rates.

C. Calculation of Final Error Rates

Federal re-review findings are incorporated in determining final error rates to ensure the validity and consistency of State and national error rates. Final error rates are calculated by taking the relationship between original State findings and final Federal findings in the subsample. Where State and Federal findings are in substantial agreement, final rates are similar to State rates. Where they substantially disagree, final rates are more similar to Federal subsample rates. Unresolved disagreement between final State and Federal findings are resolved in favor of the Federal findings and weighted in the error rate computation. The final State error rate may thus be significantly affected by the results of the Federal re-review.

D. Negative Case Action Reviews

In October 1977, States were required to implement a negative case action review as a part of the overall MQC system. The purpose of the negative case action review is to assure that applicants for Medicaid or current recipients are not being denied or terminated from assistance for which they are eligible. This system provides information on the total error rate in negative case actions, the reasons for these errors and the means for correcting them. One difference between the negative review component and the current MQC review is that the negative review component focuses only on the reasons given for terminating a recipient or denying the application rather than a full re-examination of all factors of eligibility.

A national sample of 11,000 cases is selected from a univers approximately 650,000 cases. Federal staff re-review approximately of the 11,000 reviewed by States.

E. State and Federal Resources Committed to MQC

Approximately 1000 State person- year equivalents comprised supervisors, reviewers, statisticians, clericals and others make up the MQC State work force. Over 600 of these State employees are reviewers. Staff turnover is high because of the extensive travel requirements. The

salaries range from a low of $10,000 for beginning reviewers to a high of $20,000 for more experienced reviewers.

Some States require as a minimum an undergraduate degree for a reviewer while other States accept a high school diploma with related experience. Presently, we lack sufficient evidence to determine if States requiring an undergraduate degree as a minimum have correspondingly low error rates.

At the Federal regional level, there are 147 staff working on the MQC program. Over 90 of these are directly involved in reviewing State cases. Reviewers are in the GS-5-7-9 grade level. The education background is mixture of college graduates and staff making the transition from clerical duties. Supervisors are at the GS-13 level and statisticians are GS-13s and GS-12s. The majority of supervisors are program analysts.

In central office there are 20 people working on MQC in grade levels from GS-4 through GS-15. The majority of the staff are program analysts with undergraduate degrees. The Federal and State annual operating cost of MQC is roughly estimated to be $25 million. The annual saving from this program is estimated at $235 million. These savings are reflected in reduced State budgets and State grant awards.

F. July-December 1978 Period

1. Technical Errors-Claims Processing

During the base period covering July to December 1978, errors were recorded in the claims processing review which may not have resulted in dollars being misspent. Some examples are missing provider codes, missing signature by a doctor or an incorrect procedure code. Effective with the April to September 1979 review period, these errors will be recorded for corrective action purposes but no dollars will be assigned as being spent erroneously without validating their existence.

2. MQC Implementation

Medicaid Quality Control is the first attempt by HEW to examine quantitatively, the effectiveness of State management performance across the entire spectrum of Medicaid cases in significant areas of mispayment, i.e. eligibility, third party liability and claims processing. In the past, Medicaid measurement systems only measured parts of the system, e.g. eligibility in non-AFDC, non-SSI cases, system errors but no overall error rate for claims processing, etc. Furthermore, the MQC system measures the interrelationships among these types of errors. Thus, States are compared and ranked relative to the total error regarding cases and payments. Also, the system measurement is based upon a methodology which easily lends itself to analysis for effective corrective actions. For example, correction of systemic eligibility problems is case based and the MQC system produces data by case.

This achievement has not come easily. The design and implementation of this system was fraught with problems.

- States were slow to hire and train staff in the new system. Traditionally, State Medicaid Quality Control staff measured eligibility, not claims processing and third party liability. Some States had difficulty getting State legislatures to authorize additional staff in enough time to train them in the new techniques.

- State computer systems, with help from HEW, had to be reprogrammed to produce the desired information.

- Numerous data systems problems at the Federal level including late computer hardware delivery and problems with the hardware, technical methodology redesigns, and software problems were compounded by the relatively short time to make such systems operational.

3. State Commitment to MQC

Six jurisdictions have failed to conduct required payment reviews in eligibility claims processing and third party liability for July-December 1978. Those jurisdictions are District of Columbia, Pennsylvania, Alaska, Kentucky, Guam and Virgin Islands. Meetings have been held with each jurisdiction to work out an arrangement to complete these reviews. A private auditing contractor has been engaged to help conduct these reviews.

G. Key Points

The key issues about Medicaid Quality Control are that:

1) The system for producing meaningful corrective action data is complex because the Medicaid program is complex. Further, the MQC system is complex because of the integration of Medicaid reviews with AFDC and SSI-QA programs, the system for tying paid claims with cases, and the review procedures to determine eligibility, third party and claims processing information. Each type of error has its own rules which are often complicated and are State specific; and

2) Quality Control focuses a spotlight on problems in different States. Sometimes policies have not been formalized. Other times, policy makers and policy implementers do not communicate. For example, in several States, the systems staff which pays claims was unaware of recent policy changes with respect to claims payment. MQC focused on these issues forcing communication between these two groups.

3) MQC produces data for meaningful corrective action. Data is produced which enables policy makers to analyze and correct sources of error in eligibility and claims payment.

H. Formation of Two Workgroups to Improve MQC Process

Two workgroups comprised of Federal and State staff and representatives from carrriers have been formed to evaluate review procedures in MQC.

The objective of the first group is to simplify and eliminate unnecessary paperwork in the review process. This group was formed in response to concerns raised by State and Federal regional staff. An initial meeting was held in September and a second meeting was held in late October.

The objective of the second group is to develop integrated claims processing procedures which merge the MQC and Medicare Part B end-of-line review. This project is consistent with the overall Agency thrust of making uniform Medicare and Medicaid functions and policy where feasible.

VI. New Program Initiatives

In addition to managing ongoing QC programs, HCFA is exploring the feasibility of developing additional QC programs. For example, institutional claims for reimbursement are submitted through cost reports to intermediaries in the case of Medicare and to State agencies in the case of Medicaid. A major function of the Medicare intermediaries is the audit and settlement of cost reports submitted by providers. During FY 1978, a national program to assure the quality of performance of these activities for medical expenditures in hospitals was developed. The program is entitled "Cost Report Evaluation Program (CREP)." States have a responsibility to review and audit Medicaid cost reports. The Bureau of Quality Control, HCFA, is presently undertaking a study to determine the feasibility of extending this program (CREP) to review the State settlement of provider cost reports.

The purpose of HCFA's present study is to determine whether the quality of cost report settlements made for the Medicaid program can be determined within the same framework of the Medicare CREP. In carrying out the study, HCFA is soliciting data from HCFA regional staff concerning their current activities in assuring the quality or effectiveness of Medicaid settlements. HCFA is also requesting current data concerning the operational aspect of Title XIX cost settlements. In addition, Bureau of Quality Control central office staff have visited regional offices and discussed the issues jointly with Medicare and Medicaid staff.

VII. HCFA Corrective Action Activities

The most essential output from the MQC system is the information produced for managers about the amount and causes of errors and incorrect payments associated with those errors which form an information base for developing and implementing corrective measures. Full July-December data is available to the States. This data has not, however, been adjusted by the Federal re-review. Many States have begun to correct major errors as results of information gathered during the review process. One State, for example, is revising its Medicaid policy to be consistent with its claims processing policy. Other States are initiating efforts to simplify the manual procedures for easier interpretation and understanding by reviewers. Another State is revising its State plan to make it consistent with the State's claims processing practices.

The Corrective Action Project (CAP) in HCFA has major responsibilities for developing an overall corrective action strategy. CAP's major activities for FY 80 are as follows:

(1) Analysis of State MQC Data and operations to pinpoint the most feasible and immediately effective corrective action;

(2) develop and enhance State capabilities for automated eligibility file data exchange to identify or verify client income and assets; and

(3) use of error-profiling system to identify characteristics of cases requiring more intensive processing and caseload allocation.

In the year since the availability of technical assistance through HCFA was publicly announced (August 9, 1978), HCFA has conducted or is conducting 17 technical assistance projects in 9 States. Moreover, projects are under negotiation or in the very early stages of research and analysis in 9 additional States.

Most projects have been conducted in the following areas:

- Design and development of comprehensive third party liability systems, including both cost avoidance and post-payment recovery
- Management of the Medicaid eligibility determination process, including caseworker training, redesign of procedures, and use of statistical techniques to identify error-prone cases for special attention.
- Implementation of various computerized data exchanges to verify or obtain additional information such as Social Security number, private health insurance coverage, earned income or unemployment compensation, etc.

Projects are beginning in the:

- Use of post-payment review mechanisms (such as the Surveillance/Utilizatior

Review Subsystem of MMIS) for fraud and abuse detection and prevention and for other management purposes.

- Conducting several Third-Party Liability (TPL) Workshops for States and preparation of a formal TPL "Guide for States," based on exemplary practices documented during a review of several States. The Guide outlines several possible approaches to developing TPL cost avoidance and recovery systems, depending on what resources the State has available.

- Development, under contract, of a model Eligibility Determination and Management System, based on a review of 5 excellent State Systems. This document can serve as a state-of-the-art guide to States desiring to upgrade their eligibility computer systems.

- Preparation of a journal article which gathers together numerous innovative and exemplary practices which States use to improve the efficiency and effectiveness of caseworkers who determine Medicaid eligibility. The article also presents a HCFA-developed, questionnaire-based methodology for assessing what factors are most critical to improving caseworkers' performance.

- Development of a computerized Medicaid Quality Control (MQC) Reporting System. This system, which is being made available to States, converts raw MQC data into the formal reports which are required. Savings result because States do not have to invest the necessary personnel and computer time to develop the software themselves.

- Preparation of a journal article intended to encourage use of data from the Surveillance/Utilization Review Subsystem (S/URS) of the MMIS. The article explores the program management uses, beyond fraud and abuse detection, which can be made of S/URS data.

Individual State Accomplishments

- New York City - HCFA provided NYC with information on the LA county internal QC system. This information is being used by NYC Medicaid to develop their own internal QC Unit.

  HCFA Staff are assisting NYC in improving the initial eligibility determination process in their Nursing Home Division.

- Pennsylvania - HCFA staff are close to completing a project which entails the development of a comprehensive benefit recovery program including computer programs to identify and bill liable third parties such as insurance companies and other government agencies.

  HCFA staff will soon begin a feasibility study which would determine what would be needed to automatically identify welfare recipients filing malpractice or accident suits. State Medicaid staff could then pursue recovery of expenditures made on behalf of these Medicaid recipients.

- Illinois - HCFA has completed a project which entailed the development of a comprehensive benefit recovery program for the State.

  HCFA has completed a project which called for assisting the State in improving its Medicaid eligibility policy manual.

- California - HCFA assisted the State in developing automated procedures for processing Medicare-Medicaid "cross-over" claims.

  HCFA is near completion in assisting the State to develop procedures for routinely validating Social Security account numbers as client identifiers to enhance the possibilities of State-wide data exchange.

  HCFA assisted the State in developing and analyzing the cost-effectiveness of installing an error-prone profile case management system.

  HCFA assisted the State in conducting a feasibility study of potential data exchange projects to verify client income and assets.

- Massachusetts - HCFA has completed a project which required analysis and improvement of the State claims processing system's capability to deal with client liability claims (spend-down).

  HCFA is in the process of developing a benefit recovery tracking system for the State.

- Virginia - HCFA has just begun an analysis of the State's MQC and AFDC data to determine what areas future technical assistance efforts should be dedicated to.

- Tennessee - HCFA is in the process of developing a Unform Case Management System to track cases and assure that eligibility determinations are processed timely and efficiently.

  HCFA is in the process of sending out questionnaires to casework supervisors to determine where caseworker training efforts should be concentrated.

- Arkansas - HCFA is in the process of developing the specifications for the automated cost avoidance section of the State's TPL operation.

  HCFA has analyzed existing pre-payment edits and recommended additional ones to assure that the State's claims processing system is rejecting claims whenever possible at the front end. Additional edits include: utilization edits, dental edits and lifetime procedures edits.

  HCFA is developing procedures to implement a tape data exchange between the State and its fiscal agent, Blue Cross/Blue Shield. The Blues have agreed that a match could be done between the Blues and Medicaid if a common link could be found.

- Utah - HCFA is assisting the State in the process of implementing the enhanced Minnesota SURS II system. CAP is setting up the test control file and determining system validation procedures.
- New Hampshire - HCFA recently made a presentation on the Minnesota SURS II system and assisted the State in obtaining information on the acquisition of a sole source contract.
- Louisiana - HCFA is assisting in the transfer of an automated eligibility system based on existing approaches in Wisconsin, Maryland, New Hampshire, Oklahoma and Texas to the State of Louisiana.
- Florida - HCFA analyzed the State's existing SURS system and recommended improvements on the format and uses of the SURS reports.

VIII. Summary

- The present MQC system measures eligibility, third party liability and claims processing errors across all Medicaid cases.
- The first data from this system will be released soon.
- While many problems arose during implementation, almost all jurisdictions have operable MQC systems.
- States are now ready to use MQC data in the corrective action process.

BACKGROUND PAPER - AFDC QUALITY CONTROL

History of AFDC Quality Control Measurement

Scope of Quality Control Monitoring Prior to 1973

The AFDC Quality Control system originated in response to concern over high ineligibility rates in the early 1960's. It has existed in one form of another since 1964. The quality control system used in AFDC is an adaptation of a technique used extensively in industry for maintaining control over the quality of production services.

As noted, quality control began in 1964 following the Eligibility Review study conducted nationally at the request of Congress. In reporting the findings to Congress, the Department made a commitment to the Congress that (a) we would never again be in a position where we did not have adequate and current information on error rates in the income maintenance program, and (b) a system would be implemented immediately, not only to provide this information, but more importantly, to assist States in identifying the cause of errors, in order that corrective action could be taken to improve the management of the program.

The quality control system which evolved initially focused on errors in performance. If workers failed to follow the procedures and methods set forth by the State agency, it was deemed to be an error regardless of whether the eligibility or payment status of the case was affected.

In this process, the actions of the agency were examined at the time they were made; the term "case action" sample was used to describe the type of cases being sampled (approved applications, redeterminations where assistance was to continued, denied applications and terminations). States were broken down into specific identifiable areas and assigned one or more "lots" or samples of 150 cases. If more than nine errors occurred in any lot (a 3 percent tolerance criteria at the 95 percent confidence level), it would mean that corrective action was necessary. The rates of ineligibility and incorrect payment produced by this sample were intended to be representative of that portion of the caseload requiring action, rather than the entire caseload.

The introduction of the "Simplified Method" for processing applications in the late 1960's greatly reduced the State's procedural requirements in the eligibility determination process. This led to a revised QC system which became effective in October 1970. The revised system focused on the eligibility status and correctness of payment of the recipient at a point in time representing a valid cross-section of the caseload. Sample sizes were substantially incresed; the review process called for a de novo review documenting all factors of eligibility in the reaching of a definitive conclusion; a National monthly subsample became an integral part of the on-going system; monthly control charts for "early warning" purposes were maintained by States. Schedules and reports were revised and when a State exceeded one or more of the established tolerances, a narrative report was required on the nature and causes of the problem, and the corrective actions planned or being taken by the State. Federal monitoring became much more structured and formalized requiring a yearly appraisal of the State's system, i.e., organization, staffing, sampling, corrective action, and adequcy of the full field review. This assessment included a full field review by Federal staff on a subsample of State QC cases.

Chronology of Regulations and Policies in the 1970's

Disallowance Regulations

April 6, 1973

To provide an incentive to States to fully implement a Quality Control (QC) system and to take corrective actions aimed at reducing erroneous payments, the Department published, for the first time, regulations to disallow Federal financial participation (FFP) in excess error rates based on AFDC-QC data. This regulation established a 3 percent ineligibility case error ratetolerance and a 5 percent overpayment case error rate tolerance. States were required to reduce their ineligibility and overpayment case error rates down to these tolerances in 1/3 increments by June 1975 or be subject to a disallowance of Federal matching funds.

October 18, 1974

The Department amended the regulations by waiving any disallowance for States that did not achieve the target 1/3 reduction. We took this action in recognition that implemented corrective actions required time to impact the entire caseload and thus the error rates. States were now required to achieve the prescribed tolerance levels in two steps, i.e., 2/3 reduction and tolerance levels.

August 5, 1975

The regulations were amended to provide States with an "administrative grace period" during which time changes in the recipient's circumstances affecting eligibility or payment status would not be counted as errors. States had complained that their payment systems could not respond immediately to changes in circumstances. The 3 and 5 percent case tolerances were retained but previous reduction targets were deleted. States were now required to achieve the 3 and 5 percent tolerance by the July-December 1975 sample period. The regulations included the provision that the error rates would be computed through the use of a "regression formula" which incorporated the finding of a Federal sub-sample to insure national consistency of QC data.

March 16, 1977

On May 14, 1976, the U.S. District Court for the District of Columbia issued an opinion in the case of State of Maryland v. Mathews in which 14 States challenged the validity of the existing AFDC-QC disallowance regulations. The court found the 3 and 5 percent tolerance levels to be arbitrary and capricious, and accordingly enjoined the Department from taking any disallowances based on these tolerance levels in the plaintiff States. We decided not to appeal the Maryland decision. The disallowance regulations were revoked while we undertook to develop revisions to the QC program through extensive discussions with a number of States and local government representatives.

March 7, 1979

The AFDC-QC disallowance regulations are reinstated. Under these regulations a national standard (weighted mean payment error rate) is established each April-September sample period beginning with April-September 1978 period. That standard applies to the second and third six-month sample periods after each April-September period. States are required to reduce their payment error rates to that national standard or a prescribed target error rate whichever is higher in order to avoid disallowance of FFP. The prescribed target improvement rate is a 6.4 percent reduction in a State payment error rate. The regulations provide that an ultimate error reduction goal will be established after a two year study. It also provides the Secretary with authority to waive all or part of any disallowance for States that did not meet the national standard or target error rate if the State can demonstrate that such failure was due to factors beyond its control.

September 25, 1979

A Notice of Proposed Rule Making was published amending the current AFDC-QC disallowance regulations. The amendments are necessary to implement a directive of the Congress issued during action on the 1979 Supplemental Appropriations Bill. Under the new requirements, States must reduce their payment error rate to 4 percent by September 30, 1982 in equal steps beginning in fiscal year 1980. Federal matching will be denied for erroneous expenditures in excess of the standards. To meet the standards States must reduce their April-September 1978 base period error rates: by 1/3 for the annual QC reporting period of October 1980 - March 1981 and April-September 1981; by 2/3 for the reporting period October 1981 - March 1982 and April-September 1982; and the 4 percent standard for the reporting periods October 1982 - March 1983 and April-September 1983 and each succeeding year. This proposed regulation also modifies the basis on which the Secretary may grant a waiver to include the concept of a good faith effort.

Incentive Regulation

November 20, 1978 (NPRM)

The 1977 amendment to the Social Security Act (section 403(j)) provides that incentive payments will be provided States with low error rates in the AFDC program. The incentive payments are based on a State's payment error rate, as measured by Quality Control, of less than 4 percent calculated by including payments to ineligible families, overpayments to eligible families, underpayments to eligible families and nonpayments to eligible families due to erroneous terminations or denials. For each one-half percentage point below 4 percent in which a State's error rate falls, we will give the State 10 percent of the Federal share of money saved, up to a maximum of 50 percent for rates below 2 percent. The final regulations will be published shortly and will be retroactive to January 1978.

II. Current Status of Quality Control Systems

A. Sample Universe

Active Cases

The active AFDC-QC system is based on a monthly review of a statistically reliable sample of cases selected from all State agency AFDC cases paid in that month. Certain types of cases that may appear in the universe are not to be included in the QC sample. These are normally eliminated in the sampling process. Such cases include: (1) presumptive eligibility, (2) death of a payee or applicant, (3) cases in which a check was not received for the review month even though the name appeared on the payroll from which the sample was drawn (e.g., cancelled checks, withheld checks, returned checks), (4) AFDC foster care, and (5) emergency assistance.

The territories of Guam, Puerto Rico, and the Virgin Islands must also select a sample of all active adult money payment cases, i.e., OAA, AB, APTD and AABD cases.

Negative Case Actions

The universe for the AFDC-QC review of negative case actions is a list of all denied applications and terminations of assistance occurring in a given month. Certain types of negative case actions are to be excluded from the QC sample. These are normally eliminated in the sampling process. Such actions involve the following types of cases: (1) foster care, (2) emergency assistance, (3) transfers or moves to another county without interruption of assistance, and (4) actions to withhold checks. (These are generally released to the recipients at a later date and subject to sampling as an active case.)

As for active cases, the territories of Guam, Puerto Rico, and the Virgin Islands must also select a sample of all negative case actions in the adult programs, i.e., OAA, AB, APTD, and AABD cases.

B. Sample Size

Active Cases

The size of the AFDC-QC sample for a State is dependent on the size of the State's average AFDC caseload over the six-

month review period, Sample sizes currently required for the AFDC-QC active review for a six-month period are as follows: States with caseloads of less than 10,000--150 cases: States with caseloads of 60,000 and over--1,200 cases; States with caseloads between 10,000 and 60,000 are required to use a formula developed by the Department which provides increases in sample size as the caseload increases.

In order to accommodate the possibility of eliminating cases from the sample for proper reasons, sampling procedures require that States oversample in order that the required number of sample cases be reviewed. However, when a State oversamples, the cases actually selected become the new sample requirement of the State, i.e., if a State requiring a 1,200 sample selects 1,250 cases, it is required to account for 1,250 cases. If the State finds it does not have to drop any cases, it must review 1,250, not 1,200, and its percent of completion is based on 1,250 not 1,200.

The required sample size is to be completed over a six-month period. Each State, knowing what its sample requirement is, determines how many cases must be selected each month. A random start number and sample interval is determined by the State. Each month, the required number of sample cases are selected randomly from the payroll or other list of cases receiving money payment. For example, a State with a 1,200 sample over a six-month period will select 200 cases each month for review.

Negative Case Actions

The negative case action sample sizes also depend on each State's negative case action universe size for a six-month review period. Samples range from a low of 100 actions in States with less than 3,500 actions to 800 actions in States with 76,000 or more negative actions in a six-month period.

As with the AFDC-QC active case sample, States must oversample in order that the required number of negative case actions be reviewed. When a State oversamples, the negative case actions actually selected become the new sample requirement for the State.

The required sample size is to be completed over a six-month period. Each State, knowing what its sample requirement is, determines how many negative case actions must be selected each month. A random start number and sample interval is determined by the State. Each month, the required number of negative case actions are selected randomly from the universe listing of negative case actions.

Nature of Quality Control Review

Quality Control in the Aid to Families with Dependent Children Program (AFDC-QC) is a management system developed by the Department and operated by the States to ensure the proper and correct expenditure of public assistance funds, through locating unacceptable performance and ineffective policies and taking corrective action on them. We accomplish this goal by means of: (1) continuous review of statistically reliable, statewide samples of cases; (2) periodic assembly and analysis of case findings to determine incidence and amount of errors; and (3) application of corrective action to reduce error rates. The system is used by States and the Federal Government to maintain a continuous and systematic control over the AFDC caseload. It is carried out in all States in accordance with Federally established policies and procedures. At specific intervals State agencies assemble sample case findings for reporting to the Federal agency.

The AFDC-QC review encompasses monthly samples of AFDC active money payment cases as well as negative case actions (denials and terminations) in all States and the territories of Guam, Puerto Rico, and the Virgin Islands. The review is designed to provide information on the accuracy with which the local agency is applying State AFDC eligibility/payment policy. Case records are reviewed, face-to-face recipient interviews are conducted and collateral contacts are made to verify eligibility and payment related factors for all active cases and as necessary for negative case actions.

Data is collected on correctness and incorrectness of eligibility or payment decisions for reporting to the State agency and to the Federal AFDC-QC monitoring unit. In the event an error is found, it is reported for correction to the local office. This individual corrective action provides feedback to the eligibility worker. As data is received from AFDC-QC reviewers, it is assembled into reports, charts and tables for reporting to the State agency and to the Federal monitoring units. In addition to the tracking and processing of the data, data management, analytical studies are performed to determine whether the agency's error reduction goal was reached, to identify trends clusters and causes of errors and to estimate costs of types of errors. The results of these studies are summarized and distributed within the State agency.

Federal Re-Review Process

The Federal re-review of the State AFDC-QC sample is designed to: (1) validate the AFDC error rates established by the State AFDC Quality Control units; (2) evaluate the quality of the case review work performed by the State QC units and (3) identify training needs.

The re-review encompasses a complete review of a sample of completed State AFDC-QC active and negative sample cases. The re-review includes a recalculation of the budget, an in-depth review of the State QC casefile documentation, recipient interviews, collateral contacts and the preparation of data report documents. Where differences between the Federal re-review and State QC findings are identified, the State is notified and afforded an opportunity to present information to reverse the Federal finding. The final determination as to whether a difference stands is made by the Department.

The use of a re-review sub-sample and the incorporation of those findings in the "regression formula" ensures the validity and consistency of State and national error rates. Sub-sample cases for the Federal re-review are selected randomly and statisticaly relate to the size of the State sample. Thus, each Federal re-review case can represent a fixed number of cases in the total AFDC caseload. The regression formula methodology allows us to establish the relationship between the Federal findings and the State's original findings in the Federal sub-sample. This relationship determines the influence the Federal finding will have on the "official" error rate. In all cases where there are differences in Federal and State findings the regression formula adjusts the State original error rate up or down as appropriate.

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Review Concepts

Administrative Period

The focus for the AFDC-QC system is on the eligibility and correctness of payment of the case as of the review month from which the sample was selected. The review month means the specific calendar or fiscal month for which the assistance under review was received. The review is conducted in terms of the actual case situation as it existed on the first day of the pay period or review month covered by the payment under review. State payment systems vary widely in terms of technological sophistication and thus, in the time it takes to respond to changes in the eligibility or payment status of a case. QC procedures recognize the need for an administrative period for States to reflect changes in the assistance payment. This administrative period is the review month as well as the month immediately preceeding the review month. Changes in the assistance unit's circumstances which first occur in the administrative period and which are not reflected in the payment of the review month, are not considered to be errors (unless the assistance payment was, in fact, adjusted incorrectly as a result of such a change). It is to be noted that this administrative period is all encompassing and provides for reporting by the recipient, agency review, expiration of notice period, payroll processing, etc. It also encompasses unreported as well as reported changes. In reviewing a payment as of the review date, the QC reviewer will first determine whether or not eligibility exists and the payment is accurate. Where the individual was not eligible or the payment was inaccurate due to a change in circumstances, the reviewer will then determine when the change first occurred. If the unreflected change first occurred in the review month, or the month immediately preceeding the review month, a finding or no error will be made. If the unreflected change first occurred in the second prior month to the review month or before, a finding of error will be made based on the circumstances as of the second prior month.

Five Dollar Disregard

For purposes of the AFDC-QC process an overpayment means a financial assistance payment received by or for an assistance unit which exceeds by at least $5.00 the amount for which that unit was eligible under permissible State practice in effect on the first day of the review month. An underpayment means a payment received by an assistance unit for the review month which is at least $5.00 less than the amount the unit is due. This $5.00 tolerance is applied so as not to distort the analysis of case or payment error rates with insignificant error amounts and for administrative expediency.

C. Reported Error Findings

Active Cases

Error findings are reported in terms of the number of cases in error and the dollar amounts associated with these error cases. Errors may result in cases being ineligible for a money payment, in an overpayment to an eligible case, or in an underpayment to an eligible case. The payment error is the amount of dollars paid in error to these cases in the instance of ineligible and overpayment errors, and is the amount of dollars that should have been paid in the instance of an underpayment.

Responsibility for the errors is assigned to either the State agency or the client. The State agency is responsible for errors resulting from incorrect application of policy, failure to take an indicated action (e.g. reported information disregarded or not applied, failure to follow-up on impending changes, failure to follow-up on inconsistent or incomplete information, and failure to verify where required by agency policy), and arithmetic computation.

The client is responsible for errors resulting from his failure to report information (not reported) and for errors resulting from the information he reported being incorrect or incomplete.

Questions have been raised regarding the inclusion of errors attributed to the recipient. The Department believes these errors are subject to control by the State agencies. Not to include them would act as a disincentive for States to establish those systems designed to monitor client reporting, i.e., BENDIX, IDX, monthly reporting, selective verification, etc. It would also build in a potential bias as States would find it advantageous to report all errors as client errors.

Errors are also reported in relation to the primary element of eligibility and/or payment in error, that is, the program element in which the error occurred that contributed most to the total amount of error dollars, even though other elements in error exist. We are in the process of changing our reporting requirements to include all program elements in which an error is found.

Technical errors, which are included in the reported error findings, are those errors that result when a particular procedural requirement is not met by the State agency (for whatever reason). The only "technical errors" identified by the Quality Control program are those established in law as basic eligibility requirements, e.g., WIN registration requirements, and requirements associated with the IV-D Child Support Enforcement program. Congress has stated that recipients not meeting these requirements are not eligible for Federal financial participation (FFP).

Negative Case Actions

Error findings are reported in terms of the recorded reason(s) given for the agency's action to deny an application for assistance or to terminate assistance for a case currently receiving a money payment. The review process calls for two separate and distinct review findings--(a) adherence to notice and hearing requirements, and (b) adherence to eligibility requirements. Adherence to both of these requirements are necessary for the action to be correct. At lease 10 days advance (timely) notice must be provided before terminating assistance and/or continuing assistance where an appeal is filed within the advance notice period. A negative case action is in error when the recorded reason for the action is incorrect and/or the advance notice and hearing requirements were not met.

In addition to reporting error findings by type of action (denial of an application or termination of assistance), incorrect actions are reported by agency reason for action. These reasons are grouped into three major categories: (1) those exceeding standards for financial eligibility; (2) those not meeting eligibility requirements other than financial; and (3) those failing to comply with other program requirements or failing to furnish required information.

III. E. Most Recent Findings on Extent of Error

Active Cases

The April-September 1978 AFDC quality control period is the latest period for which payment error rates are available. This period's error rates provide our first "base period" bench marks against which States' performance in reducing payment error rates will be measured. The rates for the April-September 1979 period will determine whether the State is subject to penalty. These rates are also to be combined with underpayment error rates and those obtained for cases incorrectly denied assistance to determine eligibility for incentives.

Payment error rates in the Aid to Families with Dependent Children (AFDC) program decreased from 8.1 percent in the January-June 1978 reporting period to 7.1 percent in April-September 1978.* This one point reduction is equivalent to annual savings of more than $100 milion in this $11 billion program -- funds that otherwise would have been spent on welfare payments to persons who are not eligible to receive them or on overpayments to eligible recipients.

Quality control encompasses the review of all elements of eligibility and payment of the AFDC program. Starting with January 1978, new types of AFDC errors which were not addressed before are being tablulated. These errors include failure to obtain Social Security numbers for AFDC recipients and failure to properly apply child support eligibility requirements. When we include these new types of errors, the payment error rates also show a decrease from 10.5 percent in the January-June 1978 reporting period to 9.4 percent in April-September 1978. Eighteen States showed decreases over the previous period in these new type errors, five States showed no change, and six States had no such errors at all.

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* In order to coincide with the Federal fiscal years, reporting periods for determining error rates were changed from January-June and July-December to April-September and October-March.

Approximately one-fourth of the payment error rate (2.3 percentage points of the 9.4 percent) was due to the new AFDC eligibility requirements associated with agency failure to properly apply child support requirements and failure to obtain Social Security numbers for AFDC recipients.

The percentage of errors attributable to the agency increased during the April-September 1978 period -- about 60 percent were agency errors compared with the previous period where responsibility was equally shared between agency and client. Although more of the errors were agency errors, the cost of recipient errors were found to be twice as high as the cost of agency errors. The reason for this is that the most costly errors (ineligibility) are more frequently recipient errors.

Almost 63 pecent of the agency errors were due to agency failure to take indicated action. The remaining agency errors were primarily caused by workers incorrectly applying policy. More than 75% of the client errors were due to recipient failure to report changes in circumstances.

Program elements of eligibility and payment determination vary in cost and do not necessarily account for the same percentage of the case error rate that they do of the payment error rate. For example, errors in basic program requirements--deprivation of parental support, relationship and living with specific relative, age, etc.,--account for about 30 percent of the total erors but involve more than 40 percent of the misspent dollars.

Urban areas were generally found to be more error-prone than other geographic areas in the States. An analysis was made of data for cities (or counties) that have AFDC caseloads of 25,000 or more and which represented at least 20 percent of the State's caseload. Eleven cities (or counties) met this criteria--New York, New York, Los Angeles County, California; Cook County, Illinois; Wayne County, Michigan; Philadelphia, Pennsylvania; Baltimore City, Maryland; Cuyahoga county, Ohio; Essex county, New Jersey; Suffolk county, Massachusetts; St. Louis City, Missouri; and Milwaukee County, Wisconsin. The April-September 1978 State reported data for these urban areas indicated that except for Milwaukee County, the payment error rate was larger than in the remaining areas of the State. In each of three urban areas--Wayne County, Philadelphia and St. Louis--the combined payment error rate was more than double the rate for the rest of the State (Table 11). In Milwaukee, the rate was 21 percent smaller than that for the rest of the State--7.8 percent compared to 9.9 percent.

- Information on payment error rates by eligibility factors involved were first reported by States for the July-December 1977 review period. Highlights based only on State reported information for this period were:

ERROR RATES

- The official national AFDC payment error rate[1/] for the July-December 1977 reporting period computed by a statistical regression method was 8.7%. (The weighted national payment error rate based only on State reported information was 8.1%.)
- Of the $5.1 billion paid to assistance recipients during this reporting period, an estimated $294.4 million were paid to totally ineligible cases and $193.2 million were in the form of overpayments to eligible cases. Estimated underpayments amounted to $45,358,000.
- Seven States--California, Illinois, Massachusetts, Michigan, New York, Ohio and Pennsylvania--accounted for almost 70% of the total misspent dollars.
- The official national AFDC case error rate[2/] was 22.5%. (Based on State reports the rate was 21.4%.)
- From a national caseload of 3.4 million families, an estimated 610,000 were totally ineligible or, if eligible, overpaid and 162,000 were underpaid.

RESPONSIBILITY FOR ERROR

- Responsibility for errors was equally shared by the agency and the recipient.
- 7.5% of the caseload (or two-thirds of all agency errors) was in error due to agency failure to take indicated action.
- 7.9% of the caseload (or almost 80% of the recipient errors) was in error due to recipient failure to report changes in circumstances.

1/ "Payment error rate" is the sum of payments to ineligible cases and overpayments to eligible cases expressed as a percentage of the total payments made to all cases in the sample.

2/ "Case error rate" is the number with errors (i.e., ineligible, overpaid and underpaid) expressed as a percentage of the total cases in the sample.

TIME SINCE MOST RECENT ACTION

- 15% of the caseload were overdue for a redetermination of eligibility (i.e., 7 months or more had elapsed since the last determination).

- 7 out of every 8 error cases (18.5% out of the State reported case error rate of 21.4%) had a redetermination of eligibility as their most recent action; the errors for two-thirds of these cases existed at the time of the redetermination but were not detected by the State agency.

- Only 1 case out of 8 error cases had an approved application as their most recent action; errors for half of these cases existed at the time of approval.

- The probability of a case being in error increased as the length of time since the most recent action increased. One-fifth of the cases for which the most recent action occurred within 3 months of the QC review had errors compared to one-third of those for which one year or more had elapsed since the most recent action.

- Three months or less had elapsed since most recent action for almost half of the error cases.

TIME SINCE LAST OPENING

- 43% of all cases and half of the error cases received AFDC continuously for 3 years or more.

- The longer the case has been on the assistance rolls, the greater the probability of the case being in error. One out of every 6 cases on the rolls for 3 months or less had errors compared to 1 out of every 4 of the cases receiving assistance for 3 years or more.

DEPRIVATION FACTOR

- 9 out of every 10 cases received assistance because of the continued absence of a parent, usually the father.

- Cases with deprivation factors of "death" or "incapacity" were more error prone than cases with other deprivation factors; about 30% of the cases with either a deprivation factor of "death" or "incapacity" were in error compared to about 20% of the cases with other deprivation factors.

CHILDREN IN ASSISTANCE GROUP

- Two-thirds of the cases receiving AFDC had 1 or 2 children; only 7.5% of the cases had 5 or more children.

- The greater the number of children in the assistance group up through six children, the larger the error rate. One-child cases had an error rate of 18.7% whereas cases with six children had a 30.2% error rate. The error rate declined to 12% for cases with 7 or more children.

PROGRAM AREAS AND ELEMENTS IN ERROR

- Errors in four elements--earned income, WIN, basic budgetary allowances and continued absence--accounted for 11.6 percentage points, or more than half of the 21.4% case error rate.

- The agency was responsible for 7 out of every 8 WIN errors and about 3 out of every 5 basic budgetary allowance errors; the recipient was responsible for 7 out of every 8 continued absence errors and for slightly over half of the earned income errors.

- An estimated 170,000 cases, nationally, were either ineligible or overpaid and another 50,000 cases were underpaid because of errors in earned income. This element accounted for close to one-fourth of all misspent dollars, or over $100 million, and almost one-third of all underpaid dollars, or $14 million.

- Except for child care expenses, earned income disregard errors were primarily agency errors.

Negative Case Actions

Negative Case Action error rates are reported as case error rates. The January-June 1978 reporting case is the latest period for which we have information on the error rate for negative case actions. Based only on information reported by the States, the agency's action in denying or terminating assistance for the eligibility reason given was deficient in 3.3 percent of the actions compared to 3.8 percent for the July-December 1977 period. In another 3.7 percent of the actions, the agency's action was justified and would have been correct had the notice and hearing requirements been complied with, compared to 5.0 percent for the previous period. As had been noted earlier, at least 10 days advance (timely) notice must be provided before terminating assistance and/or continuing assistance where an appeal is filed within the advance notice period.

Althoguh the Department has initiated corrective action as problems were identified, these error rates should be viewed as being subject to inference limitations. The negative case action quality control system, which initially began July 1977 has had a number of implementation problems. The experience gained in these initial operations have provided the information needed to improve the Negative Case Action sampling and review procedures so that future results will be more valuable.

QUALITY CONTROL

Includes New Payment Errors

TABLE 1. AFDC - APRIL-SEPTEMBER 1978 PAYMENT ERROR RATES COMPARED WITH JANUARY-JUNE 1978 PAYMENT ERROR RATES a/

STATE	AMOUNT OF PAYMENT ERRORS AS A PERCENT OF TOTAL PAYMENTS: INELIGIBLE AND ELIGIBLE OVERPAID			INELIGIBLE			ELIGIBLE BUT OVERPAID			ELIGIBLE BUT UNDERPAID		
	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE
U. S. AVERAGE b/...	9.4	10.5	-10.5	5.1	5.8	-12.1	4.4	4.7	-6.4	0.9	0.8c/	12.5
ALABAMA..........	9.4	11.0	-14.1	6.2	8.1	-23.5	3.2	3.5	-8.6	0.0	0.0	0.0
ALASKA..........	31.7	20.6	51.5	27.7	15.9	76.0	3.9	4.2	-7.1	0.7	1.6	-56.2
ARIZONA..........	6.6	8.7	-2.4	4.4	4.0	10.0	3.7	4.3	-14.0	0.4	0.5	-20.0
ARKANSAS..........	9.1	9.	-2.2	5.7	5.5	3.6	3.4	3.8	-10.5	0.3	0.8	-62.5
CALIFORNIA..........	3.7	4.3	-14.0	1.0	1.2	-16.7	2.7	3.1	-12.9	1.1	0.7	57.1
COLORADO..........	4.3	6.5	-33.8	1.2	2.5	-52.0	3.1	3.9	-20.5	0.6	0.8	-25.0
CONNECTICUT.....	8.4	6.5	32.3	5.5	4.1	34.1	3.1	2.4	29.2	0.7	0.8	-12.5
DELAWARE..........	16.1	14.4	11.8	11.1	10.3	7.8	5.0	4.1	22.0	0.8	0.7	14.3
DIST. OF COLUMBIA	27.4	31.6	-20.2	15.1	22.7	-33.5	7.3	8.5	-14.1	0.5	0.4	25.0
FLORIDA..........	5.6	5.7	-1.8	2.4	2.9	-17.2	3.3	2.7	22.2	0.9	0.9	0.0
GEORGIA..........	7.8	8.7	-10.3	5.6	6.1	-8.2	2.2	2.7	-18.5	0.4	0.8	-50.0
GUAM..........	9.2	6.6	39.4	7.5	3.8	97.4	1.8	3.2	-43.8	0.6	0.8	-25.0
HAWAII..........	4.4	5.7	-16.3	1.2	3.4	-64.7	3.2	2.5	28.0	1.1	0.6	83.3
ILLINOIS..........	17.1	19.5	-12.3	7.3	9.2	-21.5	9.8	10.2	-3.9	0.5	0.6	-16.7
INDIANA..........	3.7	3.3	12.1	1.6	2.0	-20.0	1.9	1.4	35.7	0.2	0.5 c/	-60.0
IOWA..........	7.8	8.8	-11.4	4.1	5.3	-22.6	3.6	3.8	-5.3	0.9	0.7	28.6
KANSAS..........	4.1	4.2	-2.4	1.7	1.7	0.0	2.4	2.5	-4.0	0.3	0.3	0.0
KENTUCKY..........	10.2	10.5	-2.9	5.0	6.8	-1.7	4.3	4.6	-6.5	0.5	0.6	-16.7
LOUISIANA..........	11.1	13.3	-16.5	5.1	6.0	-15.0	5.9	7.3	-19.2	1.2	0.6	100.0
MAINE..........	9.2	8.8	4.5	4.8	4.9	-2.0	4.5	3.9	15.4	0.6	0.5	-20.0
MARYLAND..........	13.6	17.7	-23.2	8.0	11.1	-27.9	5.5	6.6	-16.7	0.4	0.4	50.0
MASSACHUSETTS...	15.9	14.0	-8.6	12.0	11.6	3.4	3.9	4.3	-9.3	0.3	0.5	-40.0
MICHIGAN..........	6.2	6.6	-7.1	4.0	4.7	-14.9	5.1	4.7	8.5	0.9	0.5	80.0
MINNESOTA..........	3.6	4.2	-14.8	1.3	2.2	-40.9	2.1	2.1	0.0	0.3	0.3	0.0
MISSISSIPPI.....	11.8	14.6	-24.3	6.1	11.3	-46.0	5.4	4.9	10.2	1.8	1.5	20.0
MISSOURI..........	10.1	12.3	-17.9	6.1	7.3	-16.4	4.0	5.0	-20.0	0.9	1.1	-18.2
MONTANA..........	9.7	8.4	15.5	5.0	3.6	38.9	4.7	4.7	0.0	0.9	0.7	28.6
NEBRASKA..........	4.6	3.5	31.4	1.8	0.9	0.0	2.9	2.0	45.0	1.6	1.5	6.7
NEVADA..........	0.6	1.9	-68.4	0.6	0.6	0.0	0.0	1.3	-100.0	0.0	0.0	0.0
NEW HAMPSHIRE...	11.8	7.5	44.7	3.6	3.5	2.9	7.3	3.7	97.3	1.0	0.9	11.1
NEW JERSEY......	9.5	9.6	-1.1	4.5	4.7	-4.3	4.9	4.7	4.3	0.8	0.4	50.0
NEW MEXICO......	6.4	8.1	-23.6	2.7	3.5	-22.9	2.8	2.6	-20.6	1.4	1.6	-12.5
NEW YORK..........	9.6	13.9	-32.3	4.5	7.8	-42.3	4.2	5.2	-19.2	1.9	1.5	26.7
NORTH CAROLINA..	7.9	8.8	-10.2	4.5	4.8	-6.2	3.5	4.0	-12.5	4.8	1.4	28.6
NORTH DAKOTA....	1.6	1.6	0.0	1.3	1.0	30.0	0.3	0.6	-50.0	0.0	0.4	-100.0
OHIO..........	9.6	10.5	-8.6	5.4	5.3	1.9	4.2	5.1	-17.6	0.3	0.3	0.0
OKLAHOMA..........	3.2	3.8	-15.8	0.5	1.4	-64.3	2.4	2.4	0.0	0.2	0.4	-50.0
OREGON..........	12.7	8.6	47.7	9.1	6.1	49.2	3.5	3.4	2.9	0.3	0.3	0.0
PENNSYLVANIA....	16.3	16.1	1.2	9.1	9.4	-3.2	7.2	6.8	5.9	0.6	0.4	0.0
PUERTO RICO.....	7.8	8.8	-11.4	3.5	3.9	-10.3	4.3	4.9	-12.2	1.6	1.9	-15.8
RHODE ISLAND....	12.7	12.7	0.0	7.6	7.0	-1.3	4.9	4.8	2.1	0.1	0.1	0.0
SOUTH CAROLINA..	7.1	7.8	-9.0	3.1	4.4	-29.5	4.2	3.4	23.5	0.8	1.1	-27.3
SOUTH DAKOTA....	4.8	4.4	9.1	1.5	2.4	-37.5	2.7	2.0	10.0	0.2	0.3	-33.3
TENNESSEE..........	7.6	7.8	-11.6	3.7	4.8	-22.9	3.3	3.1	6.5	0.5	0.6	-16.7
TEXAS..........	6.8	7.6	-9.2	3.0	2.6	15.4	3.9	4.8	-18.7	1.0	0.8	25.0
UTAH..........	2.8	2.0	40.0	1.3	0.9	44.4	1.5	1.2	25.0	1.6	1.5	6.7
VERMONT..........	4.6	7.0	-43.8	1.2	3.5	-65.7	3.3	4.2	-21.4	0.9	0.9	0.0
VIRGIN ISLANDS..	11.8	8.7	15.6	6.5	4.6	41.3	4.2	5.1	-17.6	1.5	0.3	400.0
VIRGINIA..........	11.7	10.1 c/	15.8	7.9	5.4 c/	46.3	3.5	4.7 c/	-25.5	1.8	1.3 c/	-23.1
WASHINGTON......	6.7	6.8	1.5	3.9	4.5	-13.3	2.8	2.4	20.8	0.4	0.1	300.0
WEST VIRGINIA...	11.3	9.3	21.5	8.6	6.1	37.7	3.1	3.4	-8.8	0.6	0.6	0.0
WISCONSIN........	11.1	10.1	9.9	8.6	7.6	13.2	2.4	2.6	-7.7	1.4	1.1	27.3
WYOMING..........	4.0	3.6	11.1	1.7	1.6	6.3	2.3	2.2	4.5	0.0	1.3	-30.8

* "New payment errors" encompass errors excluded from QC review prior to 1978. These include new AFDC eligibility requirements associated with State failure to properly apply child support requirements and failure to obtain Social Security numbers for AFDC recipients.

a/ Based on reviews of statistically reliable samples of approximately 44,000 cases in each reporting period from an average national caseload of 3.4 million families.
b/ Weighted average.
c/ Revised.

SQC/OFRQ/DAA — 7/9/79

QUALITY CONTROL

Excludes New Payment Errors

* TABLE 2. AFDC - APRIL-SEPTEMBER 1978 PAYMENT ERROR RATES COMPARED WITH JANUARY-JUNE 1978 PAYMENT ERROR RATES a/

	AMOUNT OF PAYMENT ERRORS AS A PERCENT OF TOTAL PAYMENTS											
	INELIGIBLE AND ELIGIBLE OVERPAID*			INELIGIBLE			ELIGIBLE BUT OVERPAID			ELIGIBLE BUT UNDERPAID		
STATE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE	APR-SEPT 1978	JAN-JUNE 1978	PER-CENT CHANGE
U. S. AVERAGE b/	7.1	8.1	- 12.3	3.6	4.4	- 18.2	3.5	3.8	- 7.9	0.9	0.7	28.6
ALABAMA	4.6	4.2	9.5	3.2	2.2	45.5	1.4	2.0	- 30.0	0.0	0.0	0.0
ALASKA	12.1	12.4	- 2.4	8.8	8.3	6.0	3.5	4.3	- 18.6	0.4	0.9	- 55.6
ARIZONA	7.7	8.1	- 4.9	4.4	4.0	10.0	3.4	4.1	- 17.1	0.4	0.5	- 20.0
ARKANSAS	7.9	8.0	- 1.3	4.9	4.5	8.9	3.0	3.6	- 16.7	0.3	0.8	- 62.5
CALIFORNIA	3.1	4.0	- 22.5	1.0	1.2	- 16.7	2.1	2.8	- 25.0	1.1	0.7	57.1
COLORADO	3.5	5.3	- 34.0	1.2	2.3	- 47.8	2.4	3.0	- 20.0	0.6	0.8	- 25.0
CONNECTICUT	5.2	5.6	- 7.1	3.0	3.6	- 16.7	2.3	2.0	15.0	0.7	0.8	- 12.5
DELAWARE	[illegible]	7.5	- [illegible]	[illegible]	[illegible]	- [illegible]	2.9	2.5	16.0	0.9	0.7	28.6
DIST. OF COLUMBIA	16.2	[illegible]	- [illegible]	[illegible]	6.2	- [illegible]	5.1	5.3	- 3.8	0.5	0.4	25.0
FLORIDA	5.0	5.5	- 9.1	2.1	2.9	- 27.6	3.1	2.6	19.2	0.9	0.9	0.0
GEORGIA	6.9	8.4	- 17.9	4.9	5.8	- 15.5	2.1	2.7	- 22.2	0.4	0.8	- 50.0
HAWAII	8.8	6.3	39.7	7.0	3.6	94.4	1.8	3.2	- 43.8	0.6	0.8	- 25.0
IDAHO	3.9	3.7	5.4	1.1	1.6	- 31.3	2.8	2.1	33.3	1.1	0.6	83.3
ILLINOIS	14.7	17.1	- 14.0	6.8	8.6	- 20.9	8.0	8.4	- 4.8	0.5	0.6	- 16.7
INDIANA	3.7	3.3	12.1	1.6	2.0 c/	- 20.0	1.9	1.4	35.7	0.2	0.5 c/	- 60.0
IOWA	5.6	6.8	- 17.6	2.8	4.0	- 30.0	2.8	2.9	- 3.4	0.9	0.7	28.6
KANSAS	3.5	3.5	0.0	1.2	1.1	9.1	2.3	2.4	- 4.2	0.3	0.3	0.0
KENTUCKY	9.8	10.1	- 3.0	5.6	5.5	1.8	4.2	4.6	- 8.7	0.5	0.6	- 16.7
LOUISIANA	5.3	5.5	- 3.6	2.3	2.5	- 8.0	3.0	3.1	- 3.2	1.2	0.6	100.0
MAINE	[illegible]	[illegible]	- [illegible]	4.2	[illegible]	- [illegible]	[illegible]	3.5	[illegible]	0.4	0.5	- [illegible]
MARYLAND	11.6	13.2	- [illegible]	6.6	7.8	- 15.4	5.0	5.6	- 10.7	0.6	0.4	50.0
MASSACHUSETTS	10.5	9.9	6.1	7.4	6.6	12.1	3.1	3.3	- 6.1	0.3	0.5	- 40.0
MICHIGAN	8.9	9.2	- 3.3	3.8	4.6	- 17.4	5.0	4.6	8.7	0.9	0.5	80.0
MINNESOTA	3.1	3.9	- 20.5	1.2	2.2	- 45.5	1.9	1.7	11.8	0.3	0.3	0.0
MISSISSIPPI	6.2	5.6	10.7	1.6	2.1	- 23.8	4.4	3.2	37.5	1.8	1.5	20.0
MISSOURI	9.8	11.3	- 13.3	6.0	6.9	- 13.0	3.8	4.4	- 13.6	0.9	1.1	- 18.2
MONTANA	5.7	6.2	- 8.1	2.7	2.4	12.5	3.0	3.8	- 21.1	0.9	0.7	28.6
NEBRASKA	4.6	3.5	31.4	1.8	1.8	0.0	2.9	2.0	45.0	1.6	1.5	6.7
NEVADA	0.6	1.9	- [illegible]	0.6	0.6	0.0	0.0	1.3	-100.0	0.0	0.0	0.0
NEW HAMPSHIRE	8.5	4.4	93.2	1.6	1.6	0.0	7.0	3.3	112.1	1.0	0.9	11.1
NEW JERSEY	5.9	6.0	- [illegible]	2.6	[illegible]	- [illegible]	3.5	2.8	25.0	0.6	0.4	50.0
NEW MEXICO	[illegible]	[illegible]	- [illegible]	2.5	3.2	- 21.8	1.6	2.2	- [illegible]	1.4	1.5	- 6.7
NEW YORK	[illegible]	[illegible]	- [illegible]	3.7	7.0	- 47.1	4.1	5.0	- 18.0	1.8	1.4	28.6
NORTH CAROLINA	5.9	6.0	- 1.7	2.7	2.4	12.5	3.2	3.6	- 11.1	1.8	1.4	28.6
NORTH DAKOTA	1.6	1.4	14.3	1.3	1.0	30.0	0.3	0.4	- 25.0	0.0	0.4	-100.0
OHIO	8.1	8.4	- 3.6	5.3	5.3	0.0	2.9	3.0	- 3.3	0.3	0.3	0.0
OKLAHOMA	3.0	3.5	- 14.3	0.5	1.0	- 50.0	2.4	2.3	4.3	0.2	0.4	- 50.0
OREGON	6.5	5.4	20.4	3.9	3.0	30.0	2.6	2.5	4.0	0.3	0.3	0.0
PENNSYLVANIA	8.9	8.5	4.7	[illegible]	[illegible]	[illegible]	4.1	4.0	2.5	0.3	0.4	- 25.0
PUERTO RICO	7.4	8.4	- 11.9	3.4	3.7	- 8.1	4.0	4.7	- 14.9	1.6	1.8	- 11.1
RHODE ISLAND	6.3	8.0	- [illegible]	4.1	6.0	- 31.7	2.3	3.0	- 23.3	0.1	0.1	0.0
SOUTH CAROLINA	5.0	6.6	- 24.2	2.6	3.9	- 33.3	2.6	2.7	- 3.7	0.8	1.1	- 27.3
SOUTH DAKOTA	4.4	4.1	7.3	[illegible]	2.6	- [illegible]	1.8	1.6	12.5	0.2	0.3	- 33.3
TENNESSEE	6.5	7.5	- 13.3	3.3	4.5	- 26.7	3.2	3.0	6.7	0.5	0.6	- 16.7
TEXAS	4.6	4.1	[illegible]	2.1	1.3	61.5	2.8	2.7	3.7	1.0	0.8	25.0
UTAH	2.8	2.0	40.0	1.3	0.9	44.4	1.5	1.2	25.0	1.6	1.5	6.7
VERMONT	3.6	7.2	- 50.0	1.2	3.5	- 65.7	2.4	3.5	- 31.4	0.9	0.9	0.0
VIRGIN ISLANDS	7.8	7.9	- 1.3	6.0	3.8	57.9	1.6	4.1	- 61.0	1.5	0.3	400.0
VIRGINIA	6.0	6.9 c/	- 13.0	3.2	3.2 c/	0.0	2.5	3.7 c/	- 32.4	1.0	1.3 c/	- 23.1
WASHINGTON	6.0	5.9	1.7	3.6	4.4	- 18.2	2.5	1.9	31.6	0.4	0.1	300.0
WEST VIRGINIA	5.3	5.0	6.0	3.2	2.5	28.0	2.2	2.5	- 12.0	0.6	0.6	0.0
WISCONSIN	4.0	3.9	2.6	2.3	2.3	[illegible]	1.7	1.9	- 10.5	1.5	1.1	36.4
WYOMING	3.1	2.7	14.8	0.8	0.7	14.3	2.3	2.2	4.5	0.8	1.3	- 38.5

* See footnote on Table 1 for explanation of "new payment errors".

a/ Based on reviews of statistically reliable samples of approximately 44,000 cases in each reporting period from an average national caseload of 3.4 million families.
b/ Weighted average.
c/ Revised.

SSA/OFPQ/DBA — 1/5/79

Includes New Payment Errors

QUALITY CONTROL

TABLE 5. AFDC - TOTAL MONEY PAYMENT EXPENDITURES AND ESTIMATED ERRONEOUS PAYMENTS TO ASSISTANCE RECIPIENTS, APRIL-SEPTEMBER 1978
(IN THOUSANDS OF DOLLARS)

STATE	TOTAL EXPENDITURES a/	TOTAL ERRONEOUS PAYMENTS: TOTAL b/	PAYMENTS TO INELIGIBLE CASES	OVERPAYMENTS TO ELIGIBLE CASES
U. S. TOTAL c/.....	$5,884,588	$479,119	$256,910	$221,356
ALABAMA..........	38,236	3,617	2,372	1,236
ALASKA..........	9,278	2,894	2,571	363
ARIZONA..........	15,546	1,244	677	568
ARKANSAS.........	24,738	2,261	1,411	850
CALIFORNIA.......	844,638	32,084	8,777	23,107
COLORADO.........	35,145	1,518	439	1,079
CONNECTICUT......	88,767	6,988	4,475	2,501
DELAWARE.........	13,693	2,201	1,514	688
DIST OF COLUMBIA	45,333	10,176	6,852	3,311
FLORIDA..........	71,559	4,021	1,701	2,330
GEORGIA..........	51,345	4,001	2,848	1,133
HAWAII...........	42,127	3,896	3,141	772
IDAHO............	10,170	451	124	326
ILLINOIS.........	331,390	56,844	24,243	32,397
INDIANA..........	56,698	2,101	927	1,069
IOWA.............	54,434	4,234	2,251	1,987
KANSAS...........	32,983	1,361	561	797
KENTUCKY.........	59,610	6,049	3,501	2,571
LOUISIANA........	47,884	5,205	2,381	2,783
MAINE............	25,197	2,318	1,204	1,124
MARYLAND.........	81,467	11,083	6,524	4,467
MASSACHUSETTS...	237,972	37,763	28,477	9,283
MICHIGAN.........	381,011	35,138	15,420	19,631
MINNESOTA........	88,493	2,987	1,111	1,881
MISSISSIPPI......	17,438	2,015	1,058	934
MISSOURI.........	73,966	7,470	4,513	2,956
MONTANA..........	6,898	672	345	327
NEBRASKA.........	18,827	875	332	543
NEVADA...........	3,732	23	23	0
NEW HAMPSHIRE...	10,611	1,167	378	775
NEW JERSEY.......	230,955	22,369	10,770	11,817
NEW MEXICO.......	16,627	791	456	336
NEW YORK.........	727,508	63,707	32,795	30,882
NORTH CAROLINA..	67,918	5,372	3,025	2,346
NORTH DAKOTA....	6,845	112	92	21
OHIO.............	217,519	20,738	11,693	9,172
OKLAHOMA.........	37,643	1,219	107	912
OREGON...........	71,857	9,138	6,568	2,512
PENNSYLVANIA....	357,476	58,370	32,436	25,570
PUERTO RICO.....	8,268	648	292	357
RHODE ISLAND....	27,358	3,464	2,133	1,333
SOUTH CAROLINA..	25,665	1,816	789	1,074
SOUTH DAKOTA....	8,799	421	131	194
TENNESSEE........	36,695	2,558	1,354	1,204
TEXAS............	56,689	3,893	1,682	2,214
UTAH.............	20,084	559	259	300
VERMONT..........	12,828	574	148	422
VIRGIN ISLANDS..	879	99	58	37
VIRGINIA.........	67,477	7,909	5,339	2,330
WASHINGTON.......	88,846	5,905	3,462	2,587
WEST VIRGINIA...	26,966	4,053	2,266	826
WISCONSIN........	174,792	13,805	10,738	3,057
WYOMING..........	3,211	127	54	73

* "New payment errors" encompass errors excluded from QC review prior to 1978. These include new AFDC eligibility requirements associated with State failure to properly apply child support requirements and failure to obtain Social Security numbers for AFDC recipients.

a/ Total Federal, State and local funds excluding emergency assistance, foster care and adjustments for prior periods as reported in State OA-41 reports submitted for the third and fourth quarter of FY 1978.

b/ Based on combined rates computed by regression formula; thus payment amounts to ineligible cases and overpayments to eligible cases may not add to total shown.

c/ Columns may not add to totals shown due to rounding.

DQC/OFRQ/DBA — 7/3/79

QUALITY CONTROL

Includes New Payment Errors

TABLE 6. AFDC - TOTAL MONEY PAYMENT EXPENDITURES AND ESTIMATED ERRONEOUS PAYMENTS TO ASSISTANCE RECIPIENTS, APRIL-SEPTEMBER 1978
(IN THOUSANDS OF DOLLARS)

STATE	TOTAL EXPENDITURES a/	TOTAL ERRONEOUS PAYMENTS: TOTAL b/	PAYMENTS TO INELIGIBLE CASES	OVERPAYMENTS TO ELIGIBLE CASES
U. S. TOTAL c/	$5,0[illegible],588	$361,631	$183,992	$178,394
ALABAMA	34,736	1,744	1,225	520
ALASKA	9,278	1,125	810	323
ARIZONA	15,566	1,204	677	529
ARKANSAS	24,738	1,966	1,222	744
CALIFORNIA	820,630	27,255	8,777	18,375
COLORADO	35,145	1,238	410	827
CONNECTICUT	80,767	4,212	2,392	1,820
DELAWARE	13,893	931	535	396
DIST OF COLUMBIA	45,333	4,620	2,342	2,299
FLORIDA	71,559	3,598	1,515	2,202
GEORGIA	51,364	3,567	2,507	1,063
HAWAII	42,127	3,701	2,963	765
IDAHO	10,178	397	114	281
ILLINOIS	331,398	48,872	22,398	26,477
INDIANA	56,696	2,865	927	1,869
IOWA	54,494	3,035	1,518	1,517
KANSAS	32,903	1,145	383	761
KENTUCKY	59,618	5,823	3,318	2,507
LOUISIANA	47,886	2,880	1,079	1,431
MAINE	25,197	1,966	1,058	911
MARYLAND	81,887	9,241	5,173	4,066
MASSACHUSETTS	237,972	24,911	17,491	7,412
MICHIGAN	381,811	33,889	14,605	19,278
MINNESOTA	88,493	2,746	1,093	1,654
MISSISSIPPI	17,430	1,078	276	766
MISSOURI	73,966	7,244	4,431	2,813
MONTANA	8,898	349	105	285
NEBRASKA	18,822	875	332	543
NEVADA	3,732	23	73	0
NEW HAMPSHIRE	10,611	898	146	741
NEW JERSEY	239,955	12,696	6,756	6,376
NEW MEXICO	18,827	587	425	162
NEW YORK	727,508	57,109	27,063	30,075
NORTH CAROLINA	87,918	3,946	1,829	2,155
NORTH DAKOTA	6,865	112	92	21
OHIO	217,519	17,517	11,432	6,310
OKLAHOMA	37,643	1,139	190	886
OREGON	71,857	4,898	2,797	1,862
PENNSYLVANIA	357,476	35,350	21,190	14,496
PUERTO RICO	8,268	614	285	329
RHODE ISLAND	27,454	1,730	1,114	616
SOUTH CAROLINA	25,665	1,292	675	667
SOUTH DAKOTA	8,799	386	131	197
TENNESSEE	36,695	2,376	1,204	1,170
TEXAS	56,649	2,779	1,213	1,568
UTAH	20,888	558	259	300
VERMONT	12,820	458	148	311
VIRGIN ISLANDS	879	68	53	14
VIRGINIA	67,477	4,038	2,187	1,670
WASHINGTON	88,860	5,332	3,192	2,105
WEST VIRGINIA	28,966	1,432	851	581
WISCONSIN	126,792	4,948	3,096	2,065
WYOMING	3,211	199	27	73

* See footnote on Table 5 for explanation of "new payment errors".

a/ Total Federal, State and local funds excluding emergency assistance, foster care and adjustments for prior periods as reported in State OA-41 reports submitted for the third and fourth quarter of FY 1978.
b/ Based on combined rates computed by regression formula; thus payment amounts to ineligible cases and overpayments to eligible cases may not add to total shown.
c/ Columns may not add to totals shown due to rounding.

DQC/OFRQ/SSA — 7/9/79

Includes New Payment Errors

QUALITY CONTROL

TABLE 7. AFDC - ESTIMATED APRIL-SEPTEMBER 1978 EXPENDITURES AND ERRONEOUS PAYMENTS TO ASSISTANCE RECIPIENTS
(IN THOUSANDS OF DOLLARS)

STATE	TOTAL EXPENDITURES a/	ERRONEOUS EXPENDITURES		
		TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
U. S. TOTAL b/.....	$5,084,508	$470,119	$250,134	$220,985
ALABAMA..........	38,236	3,617	2,625	992
ALASKA...........	9,278	2,906	1,480	1,426
ARIZONA..........	15,546	1,266	567	702
ARKANSAS.........	26,738	2,261	1,629	632
CALIFORNIA.......	866,636	32,084	16,042	16,042
COLORADO.........	35,145	1,518	815	703
CONNECTICUT......	80,767	6,980	3,490	3,490
DELAWARE.........	13,493	2,281	1,180	1,101
DIST OF COLUMBIA	45,333	10,176	5,088	5,088
FLORIDA..........	71,559	4,021	2,274	1,747
GEORGIA..........	51,345	4,001	2,634	1,367
HAWAII...........	42,127	3,896	1,948	1,948
IDAHO............	10,178	451	287	164
ILLINOIS.........	331,398	56,644	28,322	28,322
INDIANA..........	58,698	2,101	1,215	885
IOWA.............	54,436	4,238	2,202	2,036
KANSAS...........	32,903	1,361	712	648
KENTUCKY.........	50,618	6,069	4,230	1,838
LOUISIANA........	47,886	5,205	3,667	1,538
MAINE............	25,197	2,318	1,600	718
MARYLAND.........	81,067	11,003	5,501	5,501
MASSACHUSETTS....	237,972	37,763	19,493	18,270
MICHIGAN.........	381,811	35,138	17,569	17,569
MINNESOTA........	88,493	2,987	1,650	1,336
MISSISSIPPI......	17,430	2,015	1,671	345
MISSOURI.........	73,966	7,470	4,532	2,939
MONTANA..........	6,808	672	411	262
NEBRASKA.........	18,822	875	468	407
NEVADA...........	3,732	23	11	11
NEW HAMPSHIRE....	18,611	1,167	734	434
NEW JERSEY.......	239,955	22,369	11,184	11,184
NEW MEXICO.......	18,627	791	568	223
NEW YORK.........	727,594	63,707	31,853	31,853
NORTH CAROLINA...	67,914	5,372	3,643	1,729
NORTH DAKOTA.....	6,845	112	57	55
OHIO.............	217,519	20,738	11,501	9,237
OKLAHOMA.........	37,643	1,219	797	421
OREGON...........	71,857	9,138	5,235	3,903
PENNSYLVANIA.....	357,476	58,370	32,168	26,203
PUERTO RICO......	8,268	648	324	324
RHODE ISLAND.....	27,358	3,464	1,974	1,489
SOUTH CAROLINA...	75,465	1,816	1,381	435
SOUTH DAKOTA.....	8,799	421	269	152
TENNESSEE........	36,695	2,558	1,762	796
TEXAS............	56,680	3,893	2,746	1,147
UTAH.............	20,006	559	384	175
VERMONT..........	12,828	574	394	180
VIRGIN ISLANDS...	879	98	49	49
VIRGINIA.........	67,477	7,989	4,589	3,400
WASHINGTON.......	88,846	5,985	3,089	2,896
WEST VIRGINIA....	28,966	3,053	2,142	911
WISCONSIN........	174,797	13,805	8,080	5,725
WYOMING..........	3,211	127	68	59

* "New payment errors" encompass errors excluded from QC review prior to 1978. These include new AFDC eligibility requirements associated with State failure to properly apply child support requirements and failure to obtain Social Security numbers for AFDC recipients.

a/ Total Federal, State and local funds excluding emergency assistance, foster care and adjustments for prior periods as reported in State OA-41 reports submitted for the third and fourth quarter of FY 1978.

b/ Columns may not add to totals shown due to rounding.

DQC/OPRQ/RSA — 7/9/79

QUALITY CONTROL

Excludes New Payment Errors

TABLE 8. AFDC - ESTIMATED APRIL-SEPTEMBER 1978 EXPENDITURES AND ERRONEOUS PAYMENTS TO ASSISTANCE RECIPIENTS (IN THOUSANDS OF DOLLARS)

STATE	TOTAL EXPENDITURES a/	ERRONEOUS EXPENDITURES TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
U. S. TOTAL b/	$5,086,588	$362,431	$193,599	$168,832.
ALABAMA..........	38,236	1,749	1,270	480
ALASKA..........	9,278	1,125	571	554
ARIZONA..........	35,546	1,206	544	669
ARKANSAS..........	24,736	1,966	1,417	549
CALIFORNIA..........	886,830	27,255	13,627	13,627
COLORADO..........	35,145	1,238	665	573
CONNECTICUT..........	80,767	4,212	2,106	2,106
DELAWARE..........	13,693	931	466	466
DIST OF COLUMBIA	45,335	4,628	2,314	2,314
FLORIDA..........	71,550	3,599	2,039	1,560
GEORGIA..........	51,365	3,587	2,369	1,219
HAWAII..........	42,127	3,701	1,851	1,851
IDAHO..........	16,170	397	252	146
ILLINOIS..........	331,396	48,872	24,436	24,436
INDIANA..........	58,058	2,085	1,208	879
IOWA..........	56,036	3,035	1,577	1,458
KANSAS..........	37,903	1,165	599	566
KENTUCKY..........	55,618	5,823	4,059	1,764
LOUISIANA..........	47,086	2,668	1,888	780
MAINE..........	25,147	1,966	1,364	602
MARYLAND..........	81,087	9,251	4,628	4,623
MASSACHUSETTS...	237,972	24,911	12,459	12,452
MICHIGAN..........	381,811	33,850	16,925	16,925
MINNESOTA..........	88,693	2,768	1,518	1,249
MISSISSIPPI..........	17,438	1,078	894	184
MISSOURI..........	73,908	7,244	4,394	2,850
MONTANA..........	8,899	390	238	152
NEBRASKA..........	18,822	875	469	407
NEVADA..........	3,732	23	11	11
NEW HAMPSHIRE...	14,611	899	565	334
NEW JERSEY..........	236,954	12,609	6,303	6,303
NEW MEXICO..........	14,027	587	421	165
NEW YORK..........	727,508	57,109	28,554	28,554
NORTH CAROLINA..	47,918	3,966	2,762	1,203
NORTH DAKOTA....	6,865	112	57	55
OHIO..........	217,519	17,517	9,715	7,802
OKLAHOMA..........	37,843	1,138	745	394
OREGON..........	71,857	4,888	2,491	2,397
PENNSYLVANIA....	357,474	34,948	19,483	15,469
PUERTO RICO.....	8,286	414	307	307
RHODE ISLAND....	27,354	1,738	994	744
SOUTH CAROLINA..	25,885	1,242	902	316
SOUTH DAKOTA....	6,790	344	205	139
TENNESSEE..........	38,695	2,370	1,635	735
TEXAS..........	56,680	2,779	1,960	819
UTAH..........	26,008	659	344	175
VERMONT..........	17,024	480	313	167
VIRGIN ISLANDS..	419	66	36	34
VIRGINIA..........	67,477	4,038	2,298	1,733
WASHINGTON..........	88,808	5,312	2,752	2,560
WEST VIRGINIA....	26,986	1,432	1,005	427
WISCONSIN..........	174,792	4,988	2,919	2,069
WYOMING..........	9,211	100	53	47

* See footnote on Table 6 for explanation of "new payment errors".

a/ Total Federal, State and local funds excluding emergency assistance, foster care and adjustments for prior periods as reported in State (W-41) reports submitted for the third and fourth quarter of FY 1978.

b/ Columns may not add to totals shown due to rounding.

DQC/OFRQ/SSA -- 1/9/79

QUALITY CONTROL

Includes New Payment Errors*

TABLE 9. AFDC - ESTIMATED AVERAGE NUMBER OF CASES RECEIVING ASSISTANCE AND NUMBER PAID INCORRECTLY, APRIL-SEPTEMBER 1978

STATE	AVERAGE MONTHLY CASELOAD	CASES PAID INCORRECTLY		
		INELIGIBLE	ELIGIBLE BUT OVERPAID	ELIGIBLE BUT UNDERPAID
U. S. TOTAL a/	3,357,700	193,300	476,800	160,100
ALABAMA	55,800	4,100	6,100	1,500
ALASKA	4,900	1,500	600	300
ARIZONA	16,100	800	1,800	400
ARKANSAS	28,300	2,000	2,700	500
CALIFORNIA	444,900	4,800	43,400	29,000
COLORADO	27,200	500	2,100	700
CONNECTICUT	42,900	2,500	5,700	1,700
DELAWARE	10,500	1,400	1,800	900
DIST OF COLUMBIA	33,000	5,500	7,700	700
FLORIDA	76,100	2,400	7,500	2,500
GEORGIA	73,800	4,800	5,700	1,300
HAWAII	18,100	1,200	2,800	600
IDAHO	6,800	200	1,100	500
ILLINOIS	207,500	19,300	48,300	5,100
INDIANA	50,000	900	2,600	800
IOWA	31,400	1,500	5,200	2,100
KANSAS	23,700	700	1,800	600
KENTUCKY	59,500	3,800	6,400	1,400
LOUISIANA	60,400	3,900	9,300	2,100
MAINE	19,100	1,100	2,200	400
MARYLAND	70,000	6,300	10,800	2,100
MASSACHUSETTS	122,700	15,000	21,800	2,900
MICHIGAN	195,000	8,100	35,200	9,400
MINNESOTA	45,300	800	3,900	1,300
MISSISSIPPI	50,800	4,200	8,200	3,000
MISSOURI	67,000	4,800	7,800	2,800
MONTANA	6,000	400	600	200
NEBRASKA	11,400	200	1,000	700
NEVADA	3,200	b/	0	0
NEW HAMPSHIRE	7,000	400	1,400	500
NEW JERSEY	138,300	6,500	24,100	4,700
NEW MEXICO	15,900	600	1,400	900
NEW YORK	354,100	18,600	53,900	43,300
NORTH CAROLINA	72,400	3,800	8,900	4,400
NORTH DAKOTA	4,700	100	100	0
OHIO	162,100	9,500	22,000	2,800
OKLAHOMA	28,400	400	1,900	300
OREGON	42,000	4,300	5,900	1,300
PENNSYLVANIA	202,000	21,600	52,700	6,400
PUERTO RICO	41,700	1,700	4,500	1,700
RHODE ISLAND	17,100	1,500	2,900	300
SOUTH CAROLINA	48,900	1,600	5,600	1,600
SOUTH DAKOTA	7,300	200	700	100
TENNESSEE	56,600	2,500	4,800	1,200
TEXAS	88,900	3,400	7,800	2,800
UTAH	11,900	800	800	600
VERMONT	6,200	100	1,300	800
VIRGIN ISLANDS	1,100	100	100	b/
VIRGINIA	54,200	4,500	6,600	2,300
WASHINGTON	45,200	1,800	4,600	2,100
WEST VIRGINIA	22,800	1,700	2,800	600
WISCONSIN	67,100	6,000	7,900	5,300
WYOMING	2,300	b/	100	100

* "New payment errors" encompass errors excluded from QC review prior to 1978. These include new AFDC eligibility requirements associated with State failure to properly apply child support requirements and failure to obtain Social Security numbers for AFDC recipients.

a/ Columns may not add to totals shown due to rounding.
b/ Less than 50 cases.

DQC/OPBQ/BAA -- 7/9/79

QUALITY CONTROL

Excludes New Payment Errors

TABLE 10. AFDC - ESTIMATED AVERAGE NUMBER OF CASES RECEIVING ASSISTANCE AND NUMBER PAID INCORRECTLY, APRIL-SEPTEMBER 1978

STATE	AVERAGE MONTHLY CASELOAD	CASES PAID INCORRECTLY: INELIGIBLE	ELIGIBLE BUT OVERPAID	ELIGIBLE BUT UNDERPAID
U. S. TOTAL a/	3,357,700	141,000	377,900	159,700
ALABAMA	55,800	2,100	2,700	1,500
ALASKA	4,900	600	500	200
ARIZONA	26,100	800	1,700	400
ARKANSAS	28,300	1,700	2,300	500
CALIFORNIA	444,900	4,800	32,700	29,000
COLORADO	27,200	500	1,600	700
CONNECTICUT	42,900	1,400	4,100	1,700
DELAWARE	10,500	600	1,100	1,000
DIST OF COLUMBIA	31,000	2,100	5,200	700
FLORIDA	76,100	2,200	7,100	2,500
GEORGIA	73,800	4,200	5,200	1,300
HAWAII	18,100	1,100	2,700	800
IDAHO	6,800	200	1,000	500
ILLINOIS	207,500	18,100	39,500	5,100
INDIANA	50,000	900	2,600	800
IOWA	31,400	1,000	4,500	2,100
KANSAS	23,700	500	1,700	600
KENTUCKY	59,500	3,500	6,200	1,400
LOUISIANA	60,400	1,700	4,800	2,100
MAINE	19,100	1,000	1,900	400
MARYLAND	70,000	5,000	9,400	2,100
MASSACHUSETTS	122,700	8,800	17,300	2,900
MICHIGAN	195,000	7,500	34,300	9,300
MINNESOTA	45,300	700	3,600	1,300
MISSISSIPPI	50,800	1,400	6,700	3,000
MISSOURI	67,000	4,700	7,400	2,800
MONTANA	6,000	200	400	200
NEBRASKA	11,400	200	1,000	700
NEVADA	3,200	b/	0	0
NEW HAMPSHIRE	7,000	200	1,300	500
NEW JERSEY	138,300	3,400	17,400	4,700
NEW MEXICO	15,900	600	700	900
NEW YORK	354,100	15,500	52,300	43,200
NORTH CAROLINA	72,400	2,400	7,900	4,400
NORTH DAKOTA	4,700	100	100	0
OHIO	162,100	9,300	13,300	2,800
OKLAHOMA	28,400	300	1,800	300
OREGON	42,000	1,900	4,400	1,300
PENNSYLVANIA	202,000	14,800	31,800	6,100
PUERTO RICO	41,700	1,600	4,100	1,700
RHODE ISLAND	17,100	800	1,400	300
SOUTH CAROLINA	46,900	1,400	3,700	1,600
SOUTH DAKOTA	7,300	200	600	100
TENNESSEE	56,600	2,100	4,600	1,200
TEXAS	88,900	2,400	5,600	2,800
UTAH	11,900	200	800	600
VERMONT	6,200	100	1,000	800
VIRGIN ISLANDS	1,100	100	b/	b/
VIRGINIA	[illegible]	[illegible]	4,700	2,800
WASHINGTON	45,800	1,600	3,800	2,100
WEST VIRGINIA	22,800	800	1,800	600
WISCONSIN	67,100	1,700	5,400	5,700
WYOMING	2,300	b/	100	100

* See footnote on Table 7 for explanation of "new payment errors".

a/ Columns may not add to totals shown due to rounding.
b/ Less than 50 cases.

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Table 11. AFDC - Case and Payment Error Rates in 12 of the Largest Welfare Cities (or their counties) including State Case and Payment Error Rates -- April-September 1976*
(includes new payment errors — non-regression)

Case Error Rates

City or County**	% of State Sample Cases	Combined: City or Co.	Combined: State with City or Co.-- Excl.	Combined: State with City or Co.-- Incl.	Ineligibility: City or Co.	Ineligibility: State with City or Co.-- Excl.	Ineligibility: State with City or Co.-- Incl.	Overpayment: City or Co.	Overpayment: State with City or Co.-- Excl.	Overpayment: State with City or Co.-- Incl.	Underpayment: City or Co.	Underpayment: State with City or Co.-- Excl.	Underpayment: State with City or Co.-- Incl.
U.S. (weighted average).	--	--	19.4	22.4	--	4.5	5.3	--	11.2	13.0	--	3.7	4.0
New York City, N.Y.......	66.4	33.3	25.5	30.8	6.1	2.8	5.0	18.8	14.2	17.3	8.4	8.5	8.5
Los Angeles Co., Ca. a/.	40.7	10.9	12.7	12.0	1.9	0.9	1.3	7.0	6.3	6.6	1.9	5.6	4.1
Cook County, Ill. b/....	72.1	37.7	20.6	32.9	9.3	6.5	8.5	25.5	12.9	21.4	2.8	3.2	3.0
Wayne County, Mich. c/..	47.5	33.7	18.1	25.5	5.4	3.1	4.2	20.0	11.5	15.0	8.3	4.5	6.3
Philadelphia, Pa.........	40.7	51.6	31.5	35.7	17.1	7.4	11.3	31.5	20.6	25.0	3.1	3.6	3.4
Baltimore City, Md.......	61.6	29.3	22.2	26.6	9.0	7.8	6.5	17.3	11.2	15.0	3.0	3.2	3.1
Cuyahoga Co., Ohio d/...	21.2	21.6	19.6	15.6	5.9	5.5	5.6	13.0	12.3	12.5	1.6	1.8	1.8
Essex County, N.J. e/...	24.7	25.8	18.9	20.6	7.7	3.0	4.1	13.7	13.5	13.6	4.3	2.4	2.5
Washington, D.C..........	100.0	43.3	--	43.3	16.3	--	16.3	27.7	--	27.7	2.3	--	2.3
Suffolk Co., Mass. f/...	24.5	33.0	25.5	27.3	9.8	8.5	6.8	20.9	14.9	16.3	2.4	2.2	2.1
St. Louis City, Mo	33.8	31.7	18.6	23.1	12.1	4.6	7.2	15.2	5.7	11.6	4.4	4.3	4.3
Milwaukee Co., Wisc. g/.	38.6	19.0	26.7	23.7	5.4	7.6	6.7	8.4	12.3	10.8	5.2	6.8	6.2

Payment Error Rates

City or County**	% of State Sample Paymts	Combined***: City or Co.	Combined***: State with City or Co.-- Excl.	Combined***: State with City or Co.-- Incl.	Ineligibility: City or Co.	Ineligibility: State with City or Co.-- Excl.	Ineligibility: State with City or Co.-- Incl.	Overpayment: City or Co.	Overpayment: State with City or Co.-- Excl.	Overpayment: State with City or Co.-- Incl.	Underpayment: City or Co.	Underpayment: State with City or Co.-- Excl.	Underpayment: State with City or Co.-- Incl.
U.S. (weighted average).	--	--	7.0	8.5	--	3.9	4.6	--	3.0	3.9	--	0.7	0.7
New York City, N.Y.......	69.8	10.3	6.2	9.0	5.3	3.1	4.6	5.0	3.2	4.4	1.4	1.1	1.3
Los Angeles Co., Ca. a/.	43.3	3.5	2.3	2.8	1.4	0.8	1.1	2.1	1.5	1.7	0.2	0.6	0.4
Cook County, Ill. b/....	74.5	17.6	10.2	15.7	7.0	5.9	6.7	10.7	4.3	9.0	0.5	0.8	0.6
Wayne County, Mich. c/..	50.0	11.3	4.8	8.0	4.9	3.2	4.1	6.4	1.5	3.9	1.1	1.1	1.1
Philadelphia, Pa.........	42.6	24.1	11.1	16.6	14.7	6.1	9.8	9.4	5.0	6.9	0.4	0.4	0.4
Baltimore City, Md.......	63.5	13.6	11.7	12.9	7.7	7.4	7.6	5.9	4.4	5.3	0.5	0.7	0.6
Cuyahoga Co., Ohio d/...	21.1	10.1	9.0	9.2	5.9	5.2	5.3	4.2	3.8	3.9	0.5	0.3	0.3
Essex County, N.J. e/...	25.1	10.9	6.3	7.4	6.8	2.6	3.6	4.1	3.7	3.8	0.8	0.4	0.5
Washington, D.C..........	100.0	23.3	--	23.3	16.3	--	16.3	7.0	--	7.0	0.5	--	0.5
Suffolk Co., Mass. f/...	25.7	14.3	11.2	12.0	9.5	8.0	8.4	4.8	3.2	3.6	0.3	0.3	0.3
St. Louis City, Mo......	35.4	15.8	6.8	10.0	9.2	4.3	6.0	6.6	2.5	4.0	1.1	0.8	0.9
Milwaukee Co., Wisc. g/.	41.4	7.8	9.9	9.0	5.4	7.2	6.5	2.4	2.6	2.5	1.6	0.9	1.2

* Data are limited to cities (or counties) with AFDC caseloads of 25,000 or more which represent at least 20% of the State's total caseload. Error rates are derived from reports submitted by the State and are not computed by a statistical regression method. These rates, therefore, may differ from those above in other tables

** Cities (or counties) are listed according to size of caseload. These 12 largest welfare areas contain 28.8% of the total U.S. caseload

*** Underpayments are not included since they do not represent dollars expended.

Based on 1976 Census estimates:
a/ Los Angeles City - 39.2% of county population
b/ Chicago - 51.7% of county population
c/ Detroit - 53.0% of county population
d/ Cleveland - 39.1% of county population
e/ Newark - 38.0% of county population
f/ Boston - 87.8% of county population
g/ Milwaukee - 65.3% of county population

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AFDC QUALITY CONTROL

NEGATIVE CASE ACTIONS - Case Error Rates and Estimated Number of Incorrect Denials and Terminations of Assistance a/
January-June 1978

State	Case Error Rates: Eligibility Requirements	Case Error Rates: Advance Notice/ Hearing Requirements Only	Total Number of Incorrect Actions: Eligibility Requirements	Total Number of Incorrect Actions: Advance Notice/ Hearing Requirements Only
United States b/	3.3	3.7	38,280	47,860
Alabama...........	4.6	1.1	560	140
Alaska...........	7.0	1.0	170	20
Arizona...........	4.3	4.8	430	460
Arkansas..........	5.1	2.0	540	210
California........	--	5.1	0	12,120
Colorado..........	3.3	6.6	370	730
Connecticut.......	2.0	6.6	200	660
Delaware..........	1.4	4.9	50	180
Dist. of Col......	0.7	2.0	30	90
Florida...........	4.6	1.3	2,380	670
Georgia...........	2.5	1.6	830	530
Hawaii............	--	8.5	0	430
Idaho.............	1.3	1.3	80	80
Illinois..........	2.4	4.6	1,510	2,890
Indiana...........	2.3	3.9	320	550
Iowa..............	7.3	4.0	810	450
Kansas............	--	2.4	0	350
Kentucky..........	2.9	0.4	510	70
Louisiana.........	2.3	1.3	550	310
Maine.............	--	0.6	0	40
Maryland..........	2.1	2.1	490	490
Massachusetts.....	3.9	1.1	1,050	300
Michigan..........	2.9	6.0	1,760	3,630
Minnesota.........	0.9	4.1	120	550
Mississippi.......	0.5	0.9	50	90
Missouri..........	1.6	1.6	420	420
Montana...........	6.1	2.6	200	80
Nebraska..........	2.7	5.4	80	160
Nevada............	--	--	0	0
New Hampshire.....	0.8	--	20	0
New Jersey........	0.7	0.9	180	230
New Mexico........	3.1	0.5	180	30
New York..........	10.3	5.0	12,870	6,250
North Carolina....	12.6	2.6	2,410	500
North Dakota......	--	3.0	0	90
Ohio..............	2.0	4.5	1,050	2,360
Oklahoma..........	1.3	--	160	0
Oregon............	2.0	6.8	430	1,460
Pennsylvania......	2.4	6.1	1,790	4,550
Puerto Rico.......	2.0	10.2	180	900
Rhode Island......	--	19.4	0	750
South Carolina....	5.6	0.3	770	40
South Dakota......	3.8	2.9	120	90
Tennessee.........	2.4	0.3	490	60
Texas.............	1.9	0.8	1,020	430
Utah..............	7.8	7.5	700	670
Vermont...........	2.5	--	90	0
Virgin Islands....	2.3	14.8	10	40
Virginia..........	4.2	3.2	800	610
Washington........	1.9	3.7	430	830
West Virginia.....	1.8	3.6	220	450
Wisconsin.........	3.6	3.2	880	780
Wyoming...........	1.8	2.7	30	50

a/ Because of numerous problems associated with the implementation of this system in this period, the data for some of the States are subject to inference limitations.
b/ Percentages are weighted averages.

MANAGEMENT INITIATIVES TO REDUCE ERROR

II. AFDC Program Initiatives to Reduce Errors.

A. Project Match. Welfare case roles are matched against various cases of records (employment records) to determine unreported records which may effect the welfare payment.

B. Six State Strategy. The six state strategy is a concentrated error reduction effort in the six states which account for over 60% of the erroneous AFDC payments. SSA worked with the States in developing corrective action plans. The six states are: Massachusetts, Ohio, Michigan, Illinois, Pennsylvania, and New York.

C. The Welfare Management Institute in OFA is established to identify innovative State practices which result in improvement in program management. Also, the first issue of the quarterly newsletter designed to show successful techniques which were recently released.

D. The administrative proposal Welfare Reform bill includes several provisions designed to reduce error rates.

1. mandatory retrospective accounts
2. standardization of the work expense deduction
3. standardized income and asset definations
4. increased federal incomes for development of management information systems.

BACKGROUND PAPER - SSI QUALITY REVIEW

I. History of SSI Quality Review

The Congress enacted the SSI program in October 1972 and SSA began payments to over 3.2 million aged, blind, and disabled poor people in January 1974. (The rolls have increased by about a million since then.) There were many implementation problems which resulted in a significant amount of payment error. However, well before the program became operative, SSA had taken upon itself to set up a Quality Review (QR) system much like the AFDC system in that it would measure all payments. This decision proved to be of significant help in the first 2 years of the program, when many unfounded allegations were being made about all the benefits that were being paid in error. The QR system provided overall payment error data as well as detailed information regarding types and causes of error. The Commissioner was able to tell Congress precisely how big the problem was, what were the most frequently occurring types and causes of errors (by dollar magnitude), and delineate specific actions SSA was taking to get at each of the problems.

In the first 2 years, building of effective computer interfaces with regular social security payments and VA benefits were responsible for removing nearly a third of all the early errors. A high priority (and thus manpower resources) was given to building these interfaces because the QR data showed that these two types of errors (title II payments and VA benefits) were resulting in about 150 million error dollars annually. They could be controlled through administrative mechanisms which were comparatively inexpensive given the size of the payment errors; i.e., the controls were highly cost effective.

Operationally, QR data also were responsible for SSA being able to make early key decisions. For example, it was thought early on that the converted cases from the States were the most error prone even though SSA had already redetermined each of those cases once. SSA was going to redetermine the converted cases a second time to remove virtually all remaining errors from the rolls. But QR data showed that converted cases at that point contained about a 15 percent case error rate while new cases, taken by SSA in the first 18 months of the program, contained about a 30 percent case error rate. A decision was made to change the original plan. Instead, we redetermined the new cases before redetermining converted cases a second time. The result was that the error rate went down quickly and significantly.

The payment error rate was reduced from 11.5 percent early in the program to about 5 percent currently, a drop of nearly 60 percent.

Because the Department had issued regulations intended to disallow Federal matching of erroneous AFDC expenditures made by the States, HEW agreed to accept liability for erroneous payments above specified tolerance levels for federally misspent State dollars in the SSI program. The SSI Quality Review system was designed as the mechanism by which liability for erroneous payment of State funded supplementation is established.

The SSI Quality Review system was originally intended to become operative when the SSI program began in January 1974. However, the decision to use the system for fiscal liability measurement was made shortly before January 1974 and it was necessary to undertake a crash redesign of the QR system. This required that implementation of the QR system be deferred until July 1974.

To maintain the parallel between the AFDC and SSI QR systems, tolerance limits for incurring Federal liability under SSI were established. As in AFDC, these were set at three percent for ineligible cases and five percent for cases involving overpayments to eligible individuals. The July - December 1974 sampling period was designated as a base for individual States. In each of the next two six-month periods in 1975, SSA set interim stepdown goals, under which the tolerance limits were established for each State at two-thirds of the difference between the July - December 1974 base rate and the ultimate three and five percent limits for January - June 1975, and one-third of such difference for July - December 1975. (For example, if the base period overpayment rate was 11 percent in a particular State, the first stepdown goal would have been nine percent, and the goal for the second six months of 1975 would have been seven percent for that State.) Beginning in January 1976, SSA's tolerance limit for case errors was three percent for payments to ineligibles and five percent for overpayments to eligible individuals in all States.

SSA's contracts with the States provided that, for 1974 only, Federal fiscal liability (FFL) would be determined on a case by case basis. That is, for each case for which a payment error was identified—either by the State or by SSA—the State would be reimbursed for the full amount of the State supplemental payment to an ineligible individual or the amount of the State supplement included in an overpayment to an eligible individual unless there was State fault involved in a converted case. Unlike FFL settlements for periods after 1974, samples would not be used for projecting errors to the population.

When the U.S. District Court for the District of Columbia ruled, in Maryland v. Mathews (415 F. Supp. 1206, D.D.C., 1976), that the three percent and five percent AFDC error tolerance limits were "arbitrary" and "capricious," the AFDC Quality Control sanctions related to withholding of Federal matching funds were withdrawn.

But the comparable FFL provisions (which, as noted earlier, were modeled on the AFDC system) were not discontinued, for two reasons. First, HEW contracts with the States for Federal administration of State supplements expressly provided for determination of reimbursement for such liability. Second, the existence of an FFL provision maintained a strong incentive for SSA to monitor and improve the quality of its program management.

On July 8, 1978, a Notice of Proposed Rulemaking (NPRM) was published in the Federal Register (43 FR 29311) to reinitiate sanctions provisions under AFDC. To maintain the parallel with AFDC policies and procedures, the same NPRM included revised tolerance limits for SSA's determination of FFL. Final regulations were published in the Federal Register on March 7, 1979 (44 FR 12578). They were effective with the six-month SSI Quality Review sample period beginning April 1, 1979.

Previously, SSA had used case, rather than payment, error rates to determine FFL. In the new regulations, the payment error rate became the basis for assessing liability. The regulations provided that FFL would be calculated as the amount of misspent federally administered State funds that exceed the new tolerance limit, less the amount of such funds recovered from beneficiaries. The tolerance limit--or standard--was set at 4.85 percent for the April - September 1979 period, and four percent thereafter. The 4.85 percent figure was the midpoint between the prior case error rate tolerance limit (i.e., sum of the five percent overpayment and three percent payment to ineligibles rates), which was equivalent to a 5.7 percent payment error rate, and the ultimate four percent payment error standard.

Before the SSI Quality Review FFL regulations became effective, in April 1979, SSA took liability for erroneous payment of federally administered State supplements in States for which only mandatory supplementation was administered and for States for which both mandatory and optional supplementation was administered. Effective April 1979, SSA is not liable for erroneous supplementation in States for which only mandatory supplementation is administered. This change occurred because the number of recipients of such supplementation has declined continuously and sharply and the amount of liability is negligible. For the few States in which the potential for liability still existed, the Federal payment would have been a very small percentage of the cost of determining such liability. Thus, it became cost effective to discontinue FFL for such States.

II. SSI Quality Assurance System

Purpose

The SSI Quality Assurance (SSI-QA) system is designed to provide statistically reliable information about the accuracy of payments in the SSI program. Through a scientific sampling of selected SSI cases (about 4,000 each month), it provides information which reflects the relative "health" of the program, its operating effectiveness and the quality of its underlying policies. Sample review results are used to estimate payment errors for both Federal and federally administered State supplemental payments.

Sample Selection and Sample Size

The SSI-QA sample is defined over a 6-month period. There are two such periods in each fiscal year (October-March and April-September). The sample selection is performed monthly to obtain a random statistical sample of SSI beneficiaries and payments. Of the 4 million beneficiaries receiving SSI benefits, approximately 24,000 are sampled in each 6-month period.

The sample is a stratified disproportionate sample selected from each State's population. In those States where the Federal government administers State supplemental payments, the population is divided into two strata and two separate samples are selected: one from those cases receiving a State supplement, and one from those receiving only a Federal payment.

Review Process

The QA review process is most thorough in that both positive and negative allegations of all eligibility and payment criteria are verified with a third party. Each case review includes conducting an extensive interview with the beneficiary at his home during which time all of the aspects of his claim are extensively redeveloped. Collateral contacts are then performed to verify the statements made in the interview. In cases where payment errors are found, the beneficiary's SSI case file is then thoroughly reviewed to determine the exact reasons for the error.

Following each element of the QA review process, discrepancies in case information are identified and payment error determinations are made as required. The results of the review are then transmitted to the QA computer system to generate desired statistical data.

State Rereview Procedures

In connection with our contractual obligations to the States for errors in federally administered State supplements, we are liable for incorrectly paid State funds above the tolerance as determined by projecting SSI-QA results to total State supplement payments. Thus, the respective States have the right to rereview sample cases affecting our liability decisions. In those cases where the results of the State rereview document that the Federal finding was incorrect the case findings are adjusted.

Definition of an Administrative Period

As in the AFDC-QC program it was recognized that there was a need to differentiate payment errors from payments not changed because of a recent event. These payments cannot be avoided regardless of agency or beneficiary performance.

In the AFDC QC system the recent period is known as the administrative period and such cases falling with the period are considered correct. In SSI the period is termed the Payment Adjustment Lag period (PAL).

The Payment Adjustment Lag Concept is based on the relationship between the time a change in the beneficiary's circumstances occurs and the issue date of the sampled payment(s). A deficiency will be labeled Payment Adjustment Lag when the time factor precluded adjustment of the sample period's payment(s).

A Payment Adjustment Lag deficiency is defined as a deficiency that results from a change in the beneficary's circumstances which occurred during the following period:

(a) The calendar month preceding the calendar month in which the applicable check (i.e., retro check or first of the month check) was issued; or

(b) The sample month, or

(c) Any months after the sample month remaining in the sample quarter.

For purposes of defining a "change in circumstances," the date the deficiency causing event took place (rather than the date payment was first affected) is the reference point for determining whether the error is Payment Adjustment Lag or regular.

Small Error Disregard

For quality assurance purposes, an error is defined as a payment discrepancy existing between the amount of SSI benefit a beneficiary received in a sample period and the amount Quality Assurance determined he/she should have received.

The SSI case error rate is the projected number of SSI cases in error as a percentage of the number of total SSI cases in the universe. "In error" includes:

a. Overpayments of $5.00 or more

b. Payments to Ineligibles in any amount

c. Underpayments of $5.00 or more.

The SSI payment error rate is the projected number of SSI dollars paid in error as a percentage of the sum of all SSI dollars spent. "In error" includes:

a. Overpayments of $5.00 or more

b. Payments to Ineligibles in any amount

Underpayments are not included in the payment error rate since no dollars have been paid in error when an underpayment condition exists.

Reported Error Findings

SSI-QA findings are reported every 6 months for each region and the Nation. Inlcuded in the reports are case and payment error rates based on information collected during review of the individual QA sample cases. Both error rates are presented in three ways:

1. The overall error rates - the total payment and case error related to the total payments made and total cases paid respectively.

2. Agency and beneficiary error rates - the total payments and cases in error broken out according to whether they were due primarily to agency or beneficicary action or inaction, with each portion related separately to the total payments made and total cases paid.

3. Error rates by redetermination status - error rates figured separately for each of four groups of cases into which the population is divided based on their proportions in the SSI-QA sample:

   a. Cases recently redetermined using special procedures.

   b. Cases recently redetermined using regular procedures.

   c. Unredetermined cases.

   d. Cases redetermined more than 3 months prior to the 6-month sample period, and unredetermined converted cases.

SSI-QA data is also broken out to show the eligibility and payment factors most predominantly associated with payment error, the causes of payment error, where in the operational process it occurred or could have been corrected, and its effect on payment (i.e., overpayment, payment to ineligible, and underpayment).

III. Extent and Causes of Error in the Supplemental Security Income Program - April-September 1978

During the April-September 1978 sample period, $3.3 billion in Supplemental Security Income (SSI) payments were made, $151 million of which was projected to have been paid as overpayments or paid to ineligible recipients. This resulted in a payment error rate of 4.6 percent.

The payments were made in 24 million monthly SSI checks, of which 3.3 million had a payment error. The case error rate, which includes overpayments, payments to ineligibles, and underpayments, was estimated to be 13.3 percent.

These rates, along with their causes, have remained fairly constant over the past few sample periods and are expected to remain close to current levels.

Agency error was found to cause 1.7 percent of all SSI dollars to be overpaid or paid to ineligibles. About 60 percent of all agency caused dollars in error were due to incomplete development and verification at the field office level. This means that most of the agency caused errors could have been avoided if proper procedures for development and verification of data obtained during application or redetermination had been followed.

The beneficiary was found to be the cause of 63 percent of the overall payment error rate, or 2.9 percent of all SSI dollars paid. About half of all beneficiary caused error resulted from the beneficiary providing inaccurate or incomplete information during the last contact between the agency and the beneficiary. The remaining half resulted because the beneficiary failed to report changes in his circumstances that occurred since the beneficiary's last contact with the agency.

Nineteen point four (19.4) percent of the cases in payment status during the April-September 1978 sample period were recently redetermined using regular procedures. The case error rate for cases within this category was 13.3 percent, the same as the overall national rate. The cases in this category accounted for 20.3 percent of all SSI dollars paid and had a payment error rate of 4.2 percent.

Twenty one point nine (21.9) percent of all cases were recently redetermined using the abbreviated process,and cases within this category had a 10.4 percent case error rate. These cases involved 19.8 percent of all SSI dollars and had a payment error rate of 4.2 percent.

The category of unredetermined claims includes only cases that have not been redetermined since the beneficiary started receiving checks. Eight point two (8.2) percent of all cases fall into this category and were very error prone: 22.6 percent of the cases in this category had a payment error (including underpayments). The cases in this category accounted for 11.0 percent of SSI expenditures, with 5.8 percent of the dollars in this category in error.

The following eligibility and payment factors were related most predominantly to incorrect payments (for the discussion, "incorrect payments" includes underpayments, as well as overpayments and payments to ineligibles):

1) Bank Account Ownership

A bank account ownership error occurs when a beneficiary is found to have funds in savings accounts, checking accounts, or saving certificates totaling over the applicable resource limit ($1,500 for an individual; $2,250 for a couple). Nationally, this type of deficiency resulted in $44 million dollars in error during the April-September 1978 sample period. Virtually all bank account error is in the form of payments to beneficiaries who should get no benefits and results from faulty beneficiary reporting practices.

2) Household Living Arrangements

Deficiencies of this type result because the beneficiary's Federal Benefit Rate (FBR) did not reflect his correct household living arrangement (i.e., living in own household, living in the household of another). During the April-September 1978 sample period, SSA projected that $37 million were incorrect for this reason. A major problem involves determining that an individual can be considered to be living in his own household because he is paying his pro-rata share of expenses. This difficulty occurs primarily because of incomplete development and verification or because the beneficiary does not report changes in household composition or his contribution.

Of the $37 million in error, 69 percent was underpayments. This happened because the beneficiary's FBR was based on his being a member of someone else's household, while the SSI-QA review findings showed he actually met the criteria for living in his own household. The former situation requires a one-third reduction in the FBR; the latter is paid based on a full FBR.

3) Support and Maintenance

This deficiency type occurs when a beneficiary receives support and maintenance income either in cash or in-kind (in-kind includes free housing, low rents, free food, etc.), and this income was omitted, or an incorrect amount was used, in determining the SSI payment.

This type of error resulted in $35 million in incorrect payments. Fifty-six (56) percent of this was in the form of overpayments to entitled beneficiaries, while the single largest portion of it (41 percent) was caused by failure of the agency to develop and verify allegations made during the last contact with the beneficiary.

4) Wages

This type of error happens when earned or deemed wage income is not reflected on the SSI payment record, or an incorrect amount is used to compute the SSI payment. This situation caused $28 million in incorrect payments during the April-September 1978 sample period. Faulty beneficiary reporting plays a large part in the occurrence of wage deficiencies, with almost 46 percent of the dollar error resulting from beneficiary failure to report changes in employment status or amount of earnings.

MANAGEMENT INITIATIVES TO REDUCE ERROR

I. SSI Program Initiatives To Reduce Errors.

A. Prioritizing Determinations.
The redetermination process is being reviewed in an effort to keep administrative costs down. The use of quality assurance data error profiles have been developed to identify those cases likely to contain such payment errors. These cases will receive intensive reviews designed to identify the major error causes.

B. Prepayment review of large retroactive payments.
Large retroactive payments have been identified as frequently continuing errors. We have established a work group in Central Office to review retroactive payments of $3,000 or more. Additionally, we now require the district offices to a double review of retroactive payments of $2,000 or more. We estimated a $2.6 million savings for FY80 under this procedure.

C. Special bank account development procedures. In order to identify unreported or underreported bank accounts, we will, in certain cases, perform collateral contact development when that applicant does not alledge earning the bank account.

D. Special living arrangements and support maintenance development procedures. We have developed a national living arrangement and support maintenance state for district office use which will be permit us to standardize the development of these issues and reach more accurate and uniform determinations.

E. SSI Disability conversion review.
A study conducted in the State of Washington on the sample of SSI conversion cases which were subjective to a continuing disability investigation revealed that 20% of the sample recipients no longer meet the criteria for SSI eligibility. Based on these results all such cases in the State of Washington are now being reviewed. We plan to do a national review of such cases in FY 80 and 81.

Senator MOYNIHAN. We are now going to hear from a panel representing the National Council of State Public Welfare Administrators of the American Public Welfare Association, and once again, some old friends and some new friends.

Mr. John Affleck, who is the director of the Rhode Island Department of Social and Rehabilitative Services.

Ms. Barbara B. Blum, who is the commissioner of the New York State Department of Social Services.

Mr. John T. Dempsey of the Michigan Department of Social Services.

Mr. Marion J. Woods of the California Department of Social Services.

Mr. Alvin D. Roberts.

Is Mr. Roberts here? Thank you. We did not know that you had arrived, sir.

How shall we begin?

I see there is not even anybody in the middle.

Has the panel reached a decision?

Mr. AFFLECK. Yes, sir, Mr. Chairman, and it is very pleasant to be again with you.

As you indicated, I am John J. Affleck, director of the Rhode Island Department of Social and Rehabilitative Services and I speak as chairman of the National Council of State Public Welfare Administrators of the American Public Welfare Association.

It is my intention, Mr. Chairman, to give, if you will, an overview of this very critical area and then to ask my colleagues with me to speak to specific points.

We had submitted written statements——

Senator MOYNIHAN. Yes, you have, and we will put that in the record.

Mr. AFFLECK. If those could be incorporated into the record, we would most appreciate it, Mr. Chairman.

Senator MOYNIHAN. And a very thoughtful statement, too, if I can say, both the combined and the individual.

STATEMENT OF JOHN J. AFFLECK, CHAIRMAN, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

Mr. AFFLECK. I am privileged to be accompanied this morning by four very distinguished associates: Barbara Blum, commissioner of your own New York State Department of Social Services; Dr. John Dempsey, director of the Michigan Department; Mr. Marion Woods, director of the California Department; and Mr. Alvin Roberts, the assistant secretary of the Louisiana Department.

On my immediate right is Rikki Baum of the APWA staff.

I am very happy to advise also, Mr. Chairman, that our statements have been reviewed by the National Governors' Association. They support the positions that we will articulate. Indeed Governor Garrahy, my Governor in Rhode Island with whom it is a privilege to serve, as chairman of the Governors' Committee of Human Resources, has directed to you a personal letter expressing complete agreement with the testimony we will present this morning.

He does, in addition to sending personal regards, suggest in his letter the hope that hearings might be held at an early point on a related matter—the welfare reform issue.

Senator MOYNIHAN. Yes.

Mr. AFFLECK. And that letter is being submitted for the record, too, Mr. Chairman.

Mr. AFFLECK. State administrators are very firmly convinced that the issue of program quality control—QC—is vitally important, and it deserves dispassionate and thoughtful attention. We commend you, certainly, for convening this hearing so that that kind of discussion might ensue.

We also believe the current Federal policy concerning quality control, as manifested by Mr. Michel's amendment to the fiscal year 1980 Labor-HEW appropriations bill, is very bad policy and needs immediate revision.

Mr. Chairman, we in the council of State administrators have strenuously opposed the Michel amendment and we actively sought its deletion from H.R. 4389. We note that the appropriations bill has yet to win approval by both houses and hope this irresponsible language may yet be deleted, or superseded, by subsequent legislation.

Senator MOYNIHAN. We have taken it out on the Senate side. But it is back in conference, yes.

Mr. AFFLECK. I might note, too, that the House Ways and Means Committee and, indeed, the full House has moved to adopt H.R. 4904 which does away with the meat-axe approach of the Michel amendment. We hope that a similar approach could be considered at an early point by the Senate.

Mr. Chairman, this hearing, the Michel amendment, the HEW Secretary's conference on fraud, waste and abuse, all of these events grow out of an increasing public consternation with payment errors in public welfare programs. In turn, the public's demand for program integrity is fueled by several very exaggerated claims. I would like to briefly just mention three.

The first claim is that all poor people on welfare are out to cheat the taxpayers. In fact, poor people, in our judgment, are as honest as their more affluent counterparts, perhaps even more so. The myth of rampant welfare fraud ought to be permanently retired, and I think you made a very personal contribution toward that end this morning in your discussion with the HEW officials.

The second myth is that State governments and State administrators are cavalier in their attitude toward welfare program administration. We are told that only the threat of Federal fiscal sanctions will motivate us to do a better job. This is absolute, utter nonsense.

No one, certainly least of all State administrators, disputes the desirability of operating accurate and cost-effective programs.

We are deeply committed to compassionate, effective program administration. This stems from our professional ethics as much as our desire to minimize the loss of State and Federal dollars. Indeed, I need not remind you, Mr. Chairman, that the States' investment in public assistance programs has grown faster, in recent years, than the Federal Government's.

The third difficulty, which I think was sharply amended this morning, to our pleasure, has been the unbounded zeal with which the Federal Government, primarily HEW, has very loudly prom-

ised to crack down on fraud, waste, and abuse and to hold the States' proverbial feet to the fire.

We note, with much appreciation, what appears to be a very modified position, articulated by the HEW officials this morning. It is a most welcome development.

Mr. Chairman, basically the council has long opposed—and we have spoken to this before—the principle of using quality control data as a basis for imposing fiscal sanctions. Our reasoning is as follows:

We believe quality control efforts are of critical importance as a constructive, management tool. To corrupt this tool by using it as a basis for imposing destructive fiscal sanctions will very likely cause three things to happen—three very unhappy things.

First, many States might well try to manipulate their quality control data—in order to assure that their reported error rates will not make them subject to sanctions. This would be a real loss, because we are just reaching a point where, in the state of the art, we can reap some useful data from the sources of error and, consequently, develop the most cost-effective means of reducing program errors.

Second, States that continue to very honestly and vigorously utilize QC systems may become subject to Federal sanctions that will reduce the funds available to them for their program administration and operations.

In our eyes, this second point is preferred, relatively speaking, over the third and the most negative effect of fiscal sanctions. In order to compensate for the loss of Federal funds, a number of States will be forced to reduce program benefits, thus working a terrible and unreasonable hardship on poor recipients.

Mr. Chairman, we do appreciate and share the desire of the Congress to reduce payment errors in public assistance programs. We ask only that the cure for payment errors meet three conditions.

First, it should be no more costly than the disease itself. Second, the cure for erroneous payments in poverty programs should be applied no more or less zealously than the cure for other diseased areas of Federal spending.

And, third, the cure should be reasonable and equitable in its application.

The current congressional policy governing quality control and fiscal sanctions, as embodied in the Michel amendment, simply fails on all three tests.

First, Mr. Michel's provision assumes, without any empirical evidence whatever, that it is both feasible and cost-effective to reduce payment errors to an arbitrary tolerance level of 4 percent.

The cost of attempting to do so, both in real dollars and the intangible costs of crippling the quality control system and punishing recipients, will probably exceed the cost of current payment errors.

Second, the standards of the Michel amendment are not consistent with Federal efforts to improve spending accuracy in other federally subsidized programs.

Third, the system by which the States will be measured and sanctioned under the Michel amendment—or, for that matter, HEW's March 7 regulations, are not necessarily fair or reasonable.

Let me now mention what we believe can be done to improve our situation in terms of welfare administration and the issue of fiscal sanctions.

First, we must very carefully study the nature of program payment errors with the hope of discovering the marginal cost-benefit ratio of reducing these payment errors. Many complex factors must be discussed, including intrastate program differences, demographics, and so forth.

The results of such a comprehensive study should shed light on what, if any, reasonable error rate tolerance levels can be established for these programs. We are following very closely the development of HEW's proposed error rate study. We are disappointed that it has taken so long to get such important research underway.

Second, I would say that the administration of welfare programs clearly must be simplified and standardized. Current House-passed welfare reform legislation, H.R. 4904, seeks to accomplish these objectives and, indeed, we strongly support that measure.

Third, the Federal Government must provide technical assistance and fiscal incentives to hard-pressed States and localities in order that they may simplify their AFDC programs, increase the size and capability of their staff as may be necessary, expand automated data processing procedures and capabilities, and encourage innovative management techniques.

In addition, Mr. Chairman, there are a number of technical issues that Federal policymakers must grapple with and attempt to resolve before implementing any fiscal sanctions system. They include the following:

One, the complexity and interrelationship between various federally subsidized programs, notably the AFDC and food stamp programs, must be addressed. The more uniform and simpler these programs become, the lower the payment errors will be.

The variations in State poverty programs must be acknowledged, including populations covered, the benefit levels paid, and the administrative approaches utilized.

Third, the variations in the individual State's quality control efforts must be recognized and somehow made uniform. Similarly, the variance in Federal rereviews has to be considered and corrected.

Only the real dollar loss of an error should be counted for purposes of determining sanctions. For example, procedural or technical errors that, when corrected, do not actually result as mispayments should not be counted for purposes of determining a fiscal sanction. This point was made in a September 24 colloquy between Senators Magnuson and Javits on the Senate floor, Mr. Chairman.

Similarly, if a State is actively recovering overpayments by making forward adjustments to recipients' monthly grants, their fiscal sanctions should be offset by the sums recovered.

And finally, Mr. Chairman, before my colleagues speak, I would like to point out that there ought to be a consistent Federal policy

with respect to fiscal liability for errors in the AFDC, medicaid, and SSI program.

If States are to be liable for State administrative errors that result in the erroneous payment of Federal AFDC and medicaid dollars, so, too, must the Federal Government assume full fiscal liability for Federal administrative errors resulting in the erroneous payments of State SSI supplements and medicaid benefits.

This concludes my own prepared remarks, Mr. Chairman. My colleagues will address specific issues briefly, and then we would be very happy to respond to any questions you may have

Senator MOYNIHAN. Thank you, very much, Mr. Director.

Mr. DEMPSEY. Senator, I, too have a long statement and I would like to put it in the record.

Senator MOYNIHAN. All statements will be put into the record.

STATEMENT OF JOHN T. DEMPSEY, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, STATE OF MICHIGAN

Mr. DEMPSEY. First of all, may I commend you for your introductory remarks this morning. I think they are extremely helpful and important. I hope they are on the front page of the Washington Post tomorrow.

Senator MOYNIHAN. They will not be. They will not be reported anywhere.

Mr. DEMPSEY. I would doubt that they would.

But let me also add to your remarks that one of the reasons for the condition you lament, and that is the national tendency to assume fraud in AFDC programs, is the fact that the public assistance programs of this democracy are really the only ones that measure errors and report them consistently.

We do not know what the extent of mispaid funds, or misspent funds, is in Defense or in Agriculture or almost anyplace else, but we precisely measure it, and we publish it in AFDC and in medicaid and so on and so forth.

I have said before, and I think before your committee, Senator, that I think the administration of the AFDC program is as excellent as any other program, public or private, in America, and when people lament the fact that we have an 8 percent error rate in AFDC, I really am tempted frequently to ask them, what is the error rate in the automobile industry when they recalled in 1 year more cars than they produced, and so on and so forth, you know.

Also, I would like to add that I agree with some of your comments, all of your comments, about the fact that for the past several years there has been a tendency for the administrators of the system to discredit it, but I would have to go further and say that that also preceded this administration. Secretary Weinberger was at least as reticent about pointing out progress.

Senator MOYNIHAN. Yes, but Secretary Weinberger did not arrive in town announcing himself as the most liberal, the most compassionate, the most progressive——

Mr. DEMPSEY. Right.

Senator MOYNIHAN. He said, "I am a bit of a son-of-a-gun."

Mr. DEMPSEY. The basic point I want to make to you, sir, though, is that the quality control system of this country is not a system, it is a collection of systems.

Each State has a quality control program that measures its performance against its own State plan, and the more complicated a State plan is, and the more sensitive to client needs, the more errors that will be developed.

Although a quality control program is very useful as a management tool to see how we were doing in Michigan compared to how we did a year ago, I think it is extremely dangerous for anyone to suggest that quality control reports reflect comparative progress between Michigan, California, New York, Louisiana, or what have you.

The simple fact is that because Federal law allows our programs to vary, they do vary, and therefore the quality control reports on different programs.

Senator MOYNIHAN. Let me ask you, Mr. Dempsey, there is another aspect of all this which deals with the question of who are you trying to help. Describe to me the average person, applying for welfare in Michigan.

How old is he or she?

Mr. DEMPSEY. The average person?

Senator MOYNIHAN. Yes, at the time of applying.

Mr. DEMPSEY. My guess would be that the average person applying for ADC is someone in their middle or late twenties with two and a half children.

Senator MOYNIHAN. With two and a half children. So it is a person normally older. It is not a younger woman—it is normally a female—and it does not come very early in her life.

How do they get into this situation?

Mr. DEMPSEY. They get into this situation in one of several ways. The typical way is a woman is married and the husband dies, deserts, disappears, or moves out.

Senator MOYNIHAN. Are the largest number of welfare recipients in Detroit married persons?

Mr. DEMPSEY. They either were legally married, or they are products of a common-law marriage.

Senator MOYNIHAN. Well, that is a bit of a difference. How do you describe a common-law marriage?

Mr. DEMPSEY. Well, Michigan law says in effect if a man and woman live together for a given period of time—my impression is it is a year or so—that is common law. And most of these recipient families did start as a family, legally defined as, you know, legally married or——

Senator MOYNIHAN. You cannot start a common-law family. You become a common-law family.

Mr. DEMPSEY. What happens then is the children begin to come and after the children something happens and the man just goes.

So that is the average family.

Now, we do have cases obviously—as any State does—where a young woman——

Senator MOYNIHAN. Younger and older, but the median.

Mr. DEMPSEY. But the average family in Michigan is about 3.6 people. In most cases, it is a female-headed household.

We have the ADC-U program, also, where the man is the head of the house.

Senator MOYNIHAN. Not typically people much given to making out income tax returns?

Mr. DEMPSEY. They definitely are not, and one of the problems is that the average case, if you can describe an average, has very little work experience and very little formal educational achievement.

Senator MOYNIHAN. Not bank clerks?

Mr. DEMPSEY. Not bank clerks.

Senator MOYNIHAN. If you would define their position, it would be people who have difficulty producing the precise kinds of information and calculations which are required if you are going to have a zero-error rate.

Mr. DEMPSEY. Yes; there is a very tragic consequence of all this, too. As you know, public assistance is available based on the presence of children in the unit, so that if you take a female, let us say, who gets on welfare because of the abandonment by her husband, and what have you, and has a couple of children, she gets on it in her early twenties, she stays on public assistance and is technically and legally eligible until the youngest child becomes 18 or 21 varying from State to State.

So, suddenly, when she is in her midforties and has had no practical experience and so on, she loses eligibility for public assistance.

Unless you have a general assistance program, she has nothing, and that is the tragic part of the problem——

Senator MOYNIHAN. I am not sure I would call that tragedy. I would call that life.

Mr. DEMPSEY. Well, when you are in your midforties——

Senator MOYNIHAN. One is not expected to live on public assistance all one's life.

Mr. DEMPSEY. No, sir, I agree. But there are instances where that happens,

Senator MOYNIHAN. I am sure there are.

But in any event, you would agree that part of the dependency which AFDC is intended to, and must of necessity, address, is the relative inexpertness of the population involved in handling the technical details of a modern bureaucracy.

It is as if we were saying, these people are partially blind, and then blaming them for not having 20-20 vision. Not to assume this kind of difficulty is to deny the nature of the program.

Now, you know that there is a great deal of such denial. But that is another matter.

Mr. DEMPSEY. Yes, sir.

Going on in my point, then, the quality control system is useful and produces significant results State by State. It does not necessarily produce meaningful comparisons State to State.

Second, the quality control system distinguishes between several types of error. There is a technical error, as Mr. Affleck described it, and there is an actual error. The colloquy on the Senate floor between Senators Magnuson and Javits suggested it was not the intent of Congress to sanction States for technical errors.

The HEW proposed regs, that Mr. Bohen described, does not make that distinction.

A technical error is one where the client really is eligible but does not meet the technicalities of the law. An example would be a case where the youngest child is over 6 and under the law that person must register with WIN.

So my agency prepares the paperwork, sends it to the employment agency. The employment agency processes it, mails it back, but it never gets there. That is a technical error, and that case is ruled ineligible.

But if we straighten out the technical error and somehow get the piece of paper back and forth, we remove the ineligibility but we do not save any money.

So technical errors really are not waste, fraud, and abuse. They are simply deficiencies in the case record.

We think that distinction should be recognized.

Senator MOYNIHAN. Thank you.

Mr. Woods, are you next?

Mr. DEMPSEY. No; Ms. Blum is next.

Senator MOYNIHAN. Ms. Blum is next. All right.

Ms. BLUM. We are simply out of order.

STATEMENT OF BARBARA B. BLUM, COMMISSIONER, DEPARTMENT OF SOCIAL SERVICES, NEW YORK STATE

Ms. BLUM. It is a pleasure, Mr. Chairman, to be participating with my colleagues today. My remarks will be directed toward aspects of complexity which affect administration of our public assistance programs. Lengthier remarks have been submitted as well for the record.

In New York State, as in many other States, there are five major assistance programs to meet the needs of individuals and families. They are: Aid to families with dependent children, medical assistance, food stamps, general assistance, or home relief as we call it in New York State, and supplementary security income.

To a very large extent these programs have developed independently and over time. At both the State and Federal level, complex and often contradictory standards have been added which make worker accuracy and client understanding difficult to achieve.

In one household unit in New York State, for example, comprised of a grandparent over 65, a mother with two young children and one child over 18, the worker must understand the eligibility criteria for AFDC, SSI, and general assistance as well as those for food stamps and medicaid.

One need look no further than the standards for computing resource or income to identify the potential for confusion within these programs.

In New York, with five programs which can and do impact on AFDC and medicaid error rates, there are four distinct standards for resources and five completely different standards for allowable income.

In addition, both the Federal and State Government have added variations within certain assistance categories, for such factors as work expenses and other allowable deductions.

The complexity of these programs affects the ability of the eligibility worker to implement standards accurately, as well as the client's ability to comply with reporting requirements.

In addition, unique requirements and program complexities have created fragmentation and inefficiencies at the local level between units that gather data and make eligibility determinations. The scope and variety of forms needed to meet eligibility requirements and the variety of data that must be collected and stored become an additional deterrent to the design of procedures that will promote effective program management.

We must also recognize the important impact of scale on the potential for program error. In New York State, for instance, there are currently over 22,000 State and local workers who participate in the process of determining eligibility for 3 million AFDC and medicaid recipients. It has been estimated that these workers handle an excess of 100 million documents each year for these caseloads. In the midst of such a mammoth operation, procedural errors are bound to occur.

I strongly agree with my colleagues that quality control can be an effective management tool when accompanied by indepth management reviews and plans for corrective action.

We object strenuously, however, to its use as a basis for fiscal sanctions. In its present form quality control includes the measurement of errors which are technical in nature and do not, in fact, result in erroneous payments to clients.

The issue of technical errors illustrates the complexity of the quality control process. It becomes even more complicated when applied differently among States.

In New York State, a major cause of error is the failure to qualify for assistance because of the alleged presence of the absent parent in the home. While the presence of this parent must indicate an error in each State, the procedures used to determine his presence vary widely.

In New York's program, quality control auditors spend an average of 26 hours investigating an AFDC case, where other large States with lower error rates spend much less time.

The application of quality control is also affected by the structure of programs on the State level. States such as New York, with stringent resource requirements, are more likely to have resource-related errors. The presence of optional program components, such as assistance for intact families or unborn children, also increases the potential for error.

Dollar sanctions based on this system are clearly inappropriate and we welcome your intervention to prevent their use.

Thank you.

Senator MOYNIHAN. I thank you, Commissioner Blum, as always, but I would like to point out that, you are going to get these standards. They are in the appropriations bill. And you are going to get them thanks to the Carter administration. They did it.

It is outrageous to have put out a report from the Inspector General in which you combine the fact that Portland, Oreg., might have three CAT scanners when two would do, with fraud by welfare mothers, and then leave the impression it is all fraud by welfare mothers.

That is what this most liberal administration has done. It is an outrage, but they do not think so. Nobody else does either, and nothing is going to be done about it.

It is in the appropriations bill. I got it out. It is back in. It is just disgusting.

Senator Chafee is here and I know your fellow Rhode Islander is here——

Senator CHAFEE. Yes. Thank you.

First, I want to say what a pleasure it is to see my great friend Jack Affleck here in his capacity not only as director of the Department of Social and Rehabilitative Services at home, but also in his position as chairman of the National Council of State Public Welfare Administrators.

Welcome, Jack, and those who are with you.

Mr. AFFLECK. Thank you, Senator.

Senator CHAFEE. I would just like to say this is an oldtime problem. Admiral Rickover always rails against the situation where you have got more checkers than you have people who are providing the services. This can be misinterpreted, Mr. Chairman, but I think any system or any government has to really expect a bit of waste. The alternative to waste is, as you point out in your testimony, is a whole ream of redtape so that nothing can be accomplished.

Obviously we do not want any more waste than there has to be in any system. I suspect that a marvelously run organization like IBM has plenty of waste and I can testify, without looking very far, that the U.S. Senate has a good deal of waste, and if we had had any——

Senator MOYNIHAN. May I take the liberty of handing you the medicaid application for the State of New York and saying, if you had to fill it out that you would not want to swear that everything you said in there was true.

Everything that is here is 10 times more difficult, I suppose, if one only speaks Spanish. Or maybe you have forms in Spanish.

Ms. BLUM. We do, yes.

Senator MOYNIHAN. What about Haitian, which is the new immigrant group?

Ms. BLUM. We are working on all of those, Senator.

Senator CHAFEE. I am not sure where this Michel amendment stands, Mr. Chairman.

You said it is in the appropriations bill?

Senator MOYNIHAN. Yes, sir.

Senator CHAFEE. And this hearing today, as is pointed out—I just read Mr. Affleck's testimony—raises a lot of problems, but you are saying it is with us. Is there nothing we can do?

Senator MOYNIHAN. Yes, sir. This hearing came about when we struck out from the appropriations bill the reduction in overall moneys available for welfare programs, which Mr. Michel had proposed, and we said at the time that we would hold hearings on this subject of waste, fraud, and abuse.

That is what we are doing here—just keeping a promise to the Senate.

Senator CHAFEE. Fine, Mr. Chairman.

I am sorry that I was late. I had another appointment and he is still standing by, and I guess we are all going to vote in about 3 minutes, so I regret I will have to leave.

Mr. AFFLECK. It is good to see you, Senator.

I might observe, Mr. Chairman, that the council is very concerned, as you are, about the unnecessary damage done by the Inspector General's report. We did, indeed, communicate with the Department to that effect. We asked the Department to make the same distinctions, if you will, that you note should be drawn.

We have been very active and I believe our communication assisted in a further issuance by the Inspector General's office.

Ms. BAUM. There was a second report—a revision to the first one—that I think was, in part, a response to letters like ours that went forward pointing out that certain provider fraud ought not to be confused with possible waste or mismanagement that is controllable in the program.

Senator MOYNIHAN. Yes, but it was done. It will not be undone. Do not suppose this hearing is going to change anybody's mind about anything.

You had a great blow and it was done to you by people who you thought were your own. Right?

Mr. AFFLECK. Mr. Chairman, Mr. Woods and Mr. Roberts have brief comments.

Senator MOYNIHAN. Mr. Woods?

Mr. Woods.

Mr. WOODS. I am Marion Woods from the State of California, Mr. Chairman.

Senator MOYNIHAN. Welcome, Mr. Woods.

STATEMENT OF MARION WOODS, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, STATE OF CALIFORNIA

Mr. WOODS. I want to express my great appreciation for the opportunity to appear before this subcommittee.

I certainly endorse all of the testimony of my colleagues that has been presented before you. I have a very brief paper in my testimony, which I think you have.

Senator MOYNIHAN. Which we have, and we will put it into the record, as if read.

Mr. WOODS. Thank you.

I would just like to say I, too, applaud your opening comments this morning in terms of public communication as it relates to fraud, waste, and abuse. I think that the misexpenditures in the welfare program are often loosely referred to as fraud, abuse, and waste, and with the exception of fraud, which has a very narrow legal definition, these terms do not have a very clear or common definition and their use certainly leads to confusion and overgeneralization. So we appreciate your comments on that.

The California Department of Social Services is committed to an efficient, effective, and equitable administration of the welfare programs, including holding the misexpenditure of public money at a minimum level. In California, the California Legislature has given me, as the director, the authority to encourage the reduction of errors through the use of fiscal sanctions to be levied against county welfare departments with high error rates, and we are in the process, in California now, of developing a sanction policy. We do not have the kind of constraints and restraints that the Michel amendment gives to HEW.

We suggest that the need to develop a policy that would impose sanctions should be included in the final regulations of HEW based upon the current study which they referred to this morning by Commissioner Ross. Because although sanctions are based on an error rate standard, which are determined by quality control reviews, we feel that a single performance standard nationally is unrealistic.

It is unrealistic to assume, as Mr. Dempsey indicated and as Mr. Affleck indicated earlier, that a single performance standard based on a quality control management review, would be equitable, fair or efficient, and the House-Senate conference committee of the fiscal 1979 appropriations act directed HEW to set a single performance standard for all States.

This requirement does not allow HEW to adequately take into account the differences among States. A single standard for all States does not take into account possible differences in error-control difficulty, which often result from various caseload characteristics, program requirements, et cetera.

Although the HEW Secretary may waive or reduce sanctions based on extenuating circumstances, the single-performance standard unduly restricts the Secretary's ability to develop a reasonable sanction policy.

And we feel that if Congress has a partnership with the States and the Federal Government is to carry out its responsibility for the effective administration of welfare programs, we would hope some means could be found to modify the Federal policy in order to accommodate the differences in error-control difficulties.

In closing, I would just like to comment on the question you asked Mr. Dempsey. In California, we have the largest caseload in the country, 1.5 million persons.

Mr. DEMPSEY. Yes, you do; yes.

Mr. WOODS. The average age of persons on the AFDC caseload in California is 27 years old.

The average size of family is 2.3 children, and it is declining, and the primary reason for welfare in California is a man leaving the home.

There are 1 million children on welfare in California and 95 percent of the remaining 500,000 are women. Welfare is a women's issue, although we are having increasing problems with teenage pregnancy. We are finding that more and more mothers are coming onto the rolls who are not married and who are not living with a man.

And the chances are, a 95-percent chance, that a woman who is 22 years old, with less than a high school education, and with a child, will have experience in the welfare system.

Senator MOYNIHAN. Would you say that again?

Mr. WOODS. There is a 95-percent chance that a woman without a high school education, 22 years of age with a child——

Senator MOYNIHAN. This means that there is a probability of 0.05 that a woman 22 years old with less than a high school education in California will have had some experience with welfare.

Mr. WOODS. With a child.

Senator MOYNIHAN. With a child, yes.

Right. We know to a fair degree what the population at risk——

Mr. WOODS. I might add also, in addition to the failure of the Inspector General's report to make the distinction between fraud and abuse, the report also contains some very serious inaccuracies.

Senator MOYNIHAN. I wish you would let us have your judgment on that. We would appreciate it very much, and we will put it in the record.

Mr. WOODS. I shall send it to you.[1]

Senator MOYNIHAN. Thank you, Mr. Roberts.

There is a vote on and so I am going to have to run, when the three or five bells ring, I have to run to vote on Cambodian aid, which I am sure you would want me to do.

We welcome you, sir, from Louisiana.

Mr. AFFLECK. I might note, in terms of longevity, Mr. Chairman, Mr. Roberts is one of our most senior members of the council.

Mr. ROBERTS. Thank you, Mr. Affleck.

Mr. Chairman, I am deeply grateful for the opportunity of sharing with you some of my ideas on how to reduce abuse and waste in the welfare programs. I am Alvis D. Roberts, assistant secretary of the Office of Family Services in the Department of Health and Human Resources in the State of Louisiana.

I have had over 40 years of experience administering programs of assistance for the aged, disabled and needy children. It is through these years of experience at both the local and State level that I have formulated these ideas.

I heartily agree with my colleagues that penalties are not going to reduce abuse in the welfare programs. Again, I repeat: Penalties are not going to reduce waste and abuse in the welfare program. If penalties against the States will not accomplish the goals that we all strive for, then what will?

I submit to you that there are some things that I think we can do, working together, to point us in the right direction.

The first is to provide fiscal incentives, provide the needed manpower and resources to do an acceptable job. Provide technical assistance and training.

Fiscal incentives can be provided in States in a number of ways. One is to allow a bonus for reducing error rates below a given level that would be meaningful to an individual State. Another would be to provide greater Federal financial participation across-the-board for administrative purposes.

This additional monetary aid would go a long way toward assisting the States to provide the staff capabilities to provide services to their large caseloads.

For example, in Louisiana we have about a 10-percent shortage of eligibility staff there to handle the loads that we are responsible for handling.

We have not been able to get this additional staff from the State legislature because they also face grave fiscal problems.

At present, there is not any Federal financial participation provided for prosecuting fraud cases in the medicaid program. It would be very helpful if Federal matching could be provided to hire the staff that is needed to review the various reports that we get from our medical management information system which are used

[1] At presstime, Feb. 21, 1980, the committee had not received the material requested.

as a basis for determining fraud and abuse cases eventually referred to the Attorney General for prosecution.

In my opinion, incentives and technical assistance are positive ways to assist States in reducing errors and administering assistance programs in a more efficient and effective manner. Fiscal penalties will only hurt the people the programs are designed to help and render the States less capable of maintaining sound programs by corrupting the purpose of the quality control system.

Mr. Chairman, my staff prepared a lengthy report for your subcommittee which outlines the methods employed in Louisiana to uncover fraud, waste and abuse and how it is dealt with when found to exist.

Contrary to reports that may have been made in the past, I believe this information will convince your subcommittee that fraud, waste and abuse are not rampant in the welfare programs.

Again, I thank you, sir.

Senator MOYNIHAN. I thank you, Mr. Roberts, and I would like to thank you all.

I have a letter here from Governor Garrahy, which you referred to, Mr. Affleck.

Mr. AFFLECK. Yes.

Senator MOYNIHAN. It just arrived.

I cannot say I read it. It just arrived, and I have been listening.

But I will put it in the record, if I may, as part of the testimony of this panel.

Mr. AFFLECK. All right.

[The material referred to follows:]

National Governors' Association

Otis R. Bowen, M.D.
Governor of Indiana
Chairman

Stephen B. Farber
Executive Director

November 16, 1979

The Honorable Daniel Patrick Moynihan, Chairman
Subcommittee on Public Assistance
Senate Committee on Finance
Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

On behalf of my colleagues, I would like to express appreciation to you for bringing the complex and important subject of erroneous payments in Social Security Act programs before the Senate. It was our desire to testify before your hearing this morning; however at the time you will be taking testimony, all Governors able to be in Washington will be meeting with the President to discuss the troubling Iranian situation and its implications. Accordingly, I have requested Mr. John J. Affleck, Director of my state's Department of Social and Rehabilitative Services, and Chairman of the National Council of State Public Welfare Administrators, to read this letter into the hearing record.

Primarily, I would like to indicate that state governments speak on this issue with one voice: the Governors' Association wishes to express its agreement with the testimony to be presented by Mr. Affleck for the Public Welfare Administrators. We would emphasize the following points:

- The concern of Governors and state governments for operating sound, efficient, cost-effective programs is unexcelled by the concern of any other public official or private citizen. Attempts to paint state governments as being irresponsibly callous on this issue stem from only two sources: tragic ignorance or malicious falsehood.
- While in no way minimizing the imperative to reduce errors and fraud to the absolute cost-effective minimum, we as public officials must courageously state the truth that there is no more fraud and error in Social Security Act programs than in other government and private programs, and our impoverished citizens are just as honest and law-abiding as our affluent citizens.
- Operation of a carefully constructed quality control program is essential to effective management of these programs -- to be used as a management tool which will contribute substantially to reduction of fraud and errors. However, it is neither appropriate nor productive to impose fiscal sanctions based on quality control programs, since such sanctions:
  - -- may lead to manipulation of quality control data to avoid destructive fiscal penalties, reducing its usefulness as a management tool;
  - -- may lead to cuts in funding for the very data systems, training programs, and other management improvements which are necessary to make meaningful progress in attacking error and fraud; and
  - -- may lead to substantial reductions in program benefits, harming those very persons the programs are designed to serve, where

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The Honorable Daniel Patrick Moynihan, Chairman
November 16, 1979
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states are simply unable to absorb the amount of fiscal sanctions elsewhere in their tight budgets. This is the most tragic consequence of all.

- Any federal program designed to produce reductions in fraud and error should
  - -- provide for savings at least as great as the cost
  - -- focus on improving the capabilities of both the state and federal governments to prevent fraud and error in the beginning, and, where prevention efforts are not successful, to find and eliminate all manifestations -- rather than engaging in absolutely unproductive punishment and name-calling
- The so-called "Michel Amendment" is an ill-considered, poorly conceived, counterproductive impediment to productive efforts to reduce fraud and error. Its implementation may well set back those efforts by years, and very likely will result in irreparable harm to many recipients of programs to which it applies
- The entire subject of fraud and error prevention and reduction is so complex that the committees with legislative jurisdiction over the programs affected, which in the Senate is the Finance Committee, should not allow other bodies, including the Appropriations Committee, to establish the basic policies, but should themselves establish those policies firmly founded on the extensive program knowledge which they alone possess. We call on the Finance Committee to exert leadership in this respect.

The Governors' Association pledges itself to full participation in the efforts toward these ends, and to assistance to your committee in whatever ways will be beneficial. Please call on us and our staff for this purpose.

I would also like to use the opportunity of this letter to strongly urge you to convene public hearings on welfare reform legislation, including the measure just passed by the House, before the Senate adjourns this year. There is no more important a subject in the human resources field requiring Congressional action than this. The Finance Committee should be able to proceed quickly to markup on this legislation as soon as the Congress reconvenes next year, without the necessity of scheduling and holding hearings at that time. There is sufficient time this year to conduct the hearings, and we urge you to take this step at the earliest possible moment.

Please accept my best wishes as you receive testimony today and proceed to deliberate on its indications.

Sincerely yours,

Governor J. Joseph Garrahy, Chairman
Committee on Human Resources

Senator MOYNIHAN. I am going to have to run, as these bells start ringing in a minute.

Let me, in a very friendly way, be a bit admonishing of you. May I?

You have a responsibility, too. I have made it very clear that I have felt that the persons responsible for social welfare in HEW failed in their responsibility when they let this report come forward, proclaimed it, won themselves a certain pleasant 5 days of publicity to show how tough they are on welfare lovers. Let no one think they are liberals. My God.

And, in fact, they put out a report which combined in money terms a judgment of the inefficiency of taking too many X-rays in the Mayo Clinic with cheating on welfare in Spanish Harlem.

Now, there have to be some standards here.

I tried to explain to Mr. Schaeffer. It is something new. HEW is a large and fairly dim-witted organization, like all large organizations.

They are dealing with a new phenomenon, which is what do you do when you have too large a public sector and you have empty beds and you try to fill them up, and so forth. Well, that is a legitimate problem, but you know, it is a totally different problem from cheating on welfare. However, they put them together and we are stuck with the damn thing now.

I am sorry, sir. You are going to get these restrictions and it was because of these people, sir. You ought to make them pay a little bit in their reputation as members in good standing with the people who are always for the right thing and who suffer with great sorrow and fortitude for the meanness and hostility inflicted on the unfortunate by the U.S. Congress.

This is a self-inflicted wound of the community itself. I feel that very strongly.

Am I wrong?

Mr. AFFLECK. You are on-target, sir, and your comments earlier were very helpful and very appropriate, I believe.

Mr. DEMPSEY. But, Senator, one very critical point and you understand it, but I am not sure your colleagues do.

The statement of managers on that conference says there will be sanctions but clients will not be hurt. Part of our position is there is no way you can have sanctions without hurting clients, and Mr. Michel ought to be told that.

Senator MOYNIHAN. I will tell him, but he is not in my body. Find somebody in the other body and have him—perhaps the Secretary of HEW could tell him, or is that asking too much.

Mr. DEMPSEY. I think Mrs. Harris implied to us that she plans to.

Senator MOYNIHAN. Yes.

I thank you very much for your courtesy, from coming across the country. You could not be kinder.

Do not leave until you have passed this word to the various people on that conference committee, will you not? It is very important to do.

[The prepared statements of the preceding panel follow. Oral testimony is continued on p. 256.]

Statement on Waste and Abuse in Social Security Act Programs, by Alvis D. Roberts, Assistant Secretary, Office of Family Security, Louisiana Department of Health and Human Resources

The Extent And Causes of Erroneous Payments in AFDC and Medicaid Programs,- Existing And Proposed Measures For Dealing With The Problems

The state of Louisiana has and continues to attempt to minimize error, waste, fraud and abuse in the AFDC and Medicaid Program through the activity of the:

I. Quality Control Section which identifies and gives information on types of errors

II. Corrective Action Plans

A. AFDC
B. Medicaid

III. SURS - Surveillance and Utilization Review System

IV. Recovery Section

V. The Special Investigations Section - That section which handles hard core cases that cannot be handled through local office or recovery activity.

The activity and results of these Plans and systems are as follows:

I. Quality Control Section

The system of Quality Control is an administrative program for determining the extent to which persons receiving public assistance are (1) eligible for assistance and; (2) receiving assistance payments in the amount to which they are entitled.

Purpose of the Quality Control System is to hold the evidence of error below pre-established tolerance limits of error. This purpose is achieved by means of three processes:

(1) Continuous review of statistically reliable statewide samples of cases;

(2) Periodic assembly and analysis of case findings to determine incidence of error; and

(3) When tolerance limits are found to be exceeded, corrective action to bring the level of erroneous cases within the tolerance established. The findings of the Quality Control system are assembled at periodic intervals and reported to the Department of Health, Education, & Welfare.

Statistical Analysis of Quality Control Findings in AFDC for the two most recent periods for which complete information is available is as follows:

I. April, 1978 through September, 1978

A total of 1,253 cases from an AFDC caseload of 60,245 were selected in the sample for April 1, 1978 to September 30, 1979, and 1,227 reviews were completed. Eligible overpaid cases (16.3 percent of case reviews completed) represent the largest group of error cases, and overpayments account for 5.9 percent of payments in all case reviews completed.

Policy incorrectly applied (31.4 percent of the agency errors) is the largest group of agency errors, whereas information not reported (93.0 percent of the client errors) is the largest group of client errors.

There are major concentrations of case errors in basic program requirements (57.2 percent of the error cases) and need-income (38.3 percent of the error cases). In the basic program requirements, there are 146 agency errors and 18 client errors. In need-income, there are 45 agency errors and 65 client errors.

Social security enumeration (22.6 percent of the error cases) and assignment of child support (20.6 percent of the error cases) have the highest concentrations of errors within the basic program requirements. Earned income (17.1 percent of the error cases) and other cash income--contributions (14.6 percent of the error cases)-- within need-income have the highest concentrations of errors.

There are major concentrations of payment errors in basic program requirements ($8,762 in ineligible and overpaid payment errors) and in need-income ($5,934 in ineligible and overpaid payment errors).

Social security enumeration ($4,345 in ineligible and overpaid payment errors) and assignment of support ($2,449 in ineligible and overpaid payment errors) within basic program requirements have the highest concentrations of errors. Earned income ($2,913 in ineligible and overpaid payment errors) and other cash income--

contributions ($1,911 in ineligible and overpaid payment errors) within need-income requirements have the highest concentrations of errors.

II. October, 1978 through March, 1979

A total of 1,238 positive case reviews were completed for the October, 1978 - March, 1979, reporting period. Of this number, 59 cases (4.8%) were found to be ineligible, 87 (7.0%) eligible but overpaid, and 32 (2.6%) eligible but underpaid.

Quality Control Findings for the October, 1978 - March, 1979, reporting period revealed a total of 178 positive case errors. The agency was responsible for 115 (65%) and the client 63 (35%).

Within agency controlled errors, failure to take indicated action is predominant representing 72% of all agency errors. Client errors are primarily related to information not reported (57 of 63 errors or 90%). Of the 63 client errors, 39 errors resulted from willfull misrepresentation by the client representing 62% of all client errors and 22% of all case errors for this reporting period. Errors involving willfull misrepresentation by the client are difficult to address in corrective action planning though improved interviewing techniques and verification procedures might afford some relief in this area.

As discussed in the error categories analysis, eligibility errors are clustered in Earned Income, Social Security Number, and Living With Specified Relative; overpayments in the two former elements and Contributions; and underpayments in Income - primarily earnings - and Proper Persons in Budget.

The responsibility for Earned Income errors is shared with 28 errors attributed to the agency and 29 to the recipient. Social Security Number (enumeration) relates primarily to an agency procedure and 32 of the 33 errors are reflected as agency errors. Fifteen of the 17 errors in Proper Persons are attributed to the agency which primarily makes this determination. Eleven of the 16 errors in

Contributions are due to recipient error.

With respect to payment errors, $6,419 (4.1%) of the payment to all cases reviewed was received by ineligible clients whereas $4,683 (3.0%) was overpaid to eligible clients. Underpayments totalled $1,526 (1.0%) of the $156,929 paid to all cases reviewed. Ineligible case errors, though fewer in number, are significantly more costly to the agency. Average payment errors for this review period are ineligible - $108.80, overpayments - $53.83, and underpayments - $47.69.

II. AFDC and Medicaid Corrective Action Plans

There are separate committees established for developing and implementing corrective action plans for the AFDC and Medicaid Programs. Corrective Action plans developed are related to Quality Control findings for the period upon which the AFDC Quality Control sample was drawn.

A. AFDC Corrective Action Plan

The AFDC Corrective Action committee provides input from various levels and sections related to the administration of the program and includes representation from the following sections: Training, Quality Control, Appeals, Recovery, Planning, Regional and State Program staff and local office staff.

EVALUATION OF PLANNED CORRECTIVE ACTION PREVIOUSLY REPORTED

Planned corrective action previously reported related to the Quality Control findings through 12-31-77. These measures are outlined below:

1. Training

   a. Resume 3-4 weeks orientation for new eligibility workers
   b. "Income Maintenance Eligibility Workshop" - development and implementation of a statewide on-going training effort in error-prone policy areas

2. Policy

   Clarify and simplify the AFDC Operations Manual by 1-1-79

3. Monitoring

   Implement a local office monitoring system structured to identify program and staff training needs

4. Supplementing Quality Control Data in an effort to more precisely identify error causes

   a. Use of "Error Cause Identification Schedule"
   b. Use of "Error Identification Schedule-Worker Profile"

Training efforts were hindered by the limited staff available to plan and implement AFDC training sessions. The agency recognized the need for on-going training in areas of error-prone policy. Efforts were successful in the development of a comprehensive orientation for new eligibility workers. Nine days in each session were devoted to AFDC with 4 days to Food Stamps. This comprehensive training related to both AFDC and Food Stamps results in a more versatile staff and provides administrators with more flexibility for utilization of staff more effectively and efficiently. Because of the promulgation of the Food Stamp Act of 1977, these orientation sessions were temporarily suspended but have been resumed. Local offices have indicated that this effort has not only provided new staff equipped to readily assume workloads, but it has also relieved supervisors appreciably in the area of initial job training.

During 1978, efforts were intensified toward the simplification and clarification of policies and procedures. Revisions of primary significance include:

1) Income other than earnings - special types
2) Contributions
3) Income and Assistance Unit Defined
4) Child Support Enforcement Program
5) Who Is Included - (parent)

It is recognized that income errors are primarily attributed to the client. An effort to identify or establish an error-prone worker profile was abandoned as the utility of the information did not justify the effort and cost of securing the data.

PLANNED CORRECTIVE ACTION

An AFDC Corrective Action Committee provides input from various levels and sections related to the administration of the program and includes representation from Training, Quality Control, Appeals, Recovery, Planning, Regional & State Program staff and local office staff.

For the January-June, 1978 reporting period, 115 errors were attributed to Social Security Enumeration. Revised policy in this area was issued 4-1-78 and an automated means of obtaining numbers from the Social Security Administration was developed. Upon determining that an applicant or recipient does not have a social security number, the eligibility worker enumerates the client. Upon issuance of a number, the SSA provides the state agency with this number by computer tape at which point the agency Data Processing Section matches this number by identifying characteristics (name, race, sex, birthdate, I.D. and recipient numbers) with the certified recipient and so advises the local office eligibility worker. In addition, the Data Processing Section generates a listing at three month intervals advising local office eligibility workers of those recipients on which enumeration activity is needed. The success of this procedure is noted in the reduction of errors in this area between the findings for the January-June, 1978 period (115) and for the April-September, 1978 period (65).

Errors in Assignment of Support Totalled 63 for the January-June, 1978 period and 59 for the April-September, 1978 period. Effective 10-1-78, Act 84 of the 1978 Louisiana Legislature provided that by accepting AFDC assistance, the AFDC applicant or recipient is automatically and without need for his written consent deemed to have assigned any past, present and future rights to child support he or any child for whom he is applying for assistance may have. Therefore, effective with the October, 1978-March, 1979 review period, errors in this area were eliminated.

Recently the agency considered the feasibility of utilizing a computer generated error profile based on Quality Control findings for purposes of workload management and corrective action direction. Assistance was extended by H.E.W. and the state of West Virginia in this effort. On January 31, 1979 the magnetic tape of Louisiana's Quality Control findings for the April-September, 1978 period was forwarded to West Virginia for formulation of an error-profile. The agency will continue

to seek documentation to determine its operability within our system.

Training continues to be a recognized on-going need in Planned Corrective Action. In recognition of the limited training staff available to meet this need, efforts will be made to expand training to a regional basis where Assistance Payments Consultants might provide training in specific need areas. In implementing the local office monitoring system (regular case reading), Consultants provided specific training for readers in an effort to assure statewide uniformity in this activity.

Policies and procedures continue to be reviewed on an on-going basis in an effort to simplify and clarify wherever possible. The agency is currently developing a centralized eligibility system which would allow for the consolidation of needed forms and elimination of superfluous forms.

EVALUATION OF PLANNED CORRECTIVE ACTION PREVIOUSLY REPORTED

The effectiveness of planned corrective action for the April-September, 1978, reporting period was evaluated as follows:

1. Act 84 of the 1978 Louisiana Legislature: This state statute provides that by accepting AFDC payments, the AFDC applicant or recipient is automatically (without need for his written consent) deemed to have assigned any past, present, and future rights to child support he or any child for whom he is applying for assistance may have. This law became effective 10-1-78 and thereby eliminated all errors in assignment of support for the October, 1978 - March, 1979, reporting period. For the previous period (April-September, 1978), errors in this element totalled 59 (21% of all error cases) and 15% of all dollars paid in error. The elimination of these errors has been instrumental in reducing overpayment case error rates from 16.3% for the last review period to a current 7.0% for the October, 1978 - March, 1979 period. Dollars overpaid declined from 5.9% to 3.0%.

2. Mechanization of Enumeration and Automatic Follow-Up Controls: Although enumeration errors remain significant in current findings, progress was made in reducing these errors as follows:

Reporting Period	Number of Case Errors	% of Cases Reviewed	% of $ paid in error
01/78 - 06/78	115	9.4	39.2
04/78 - 09/78	65	5.3	27.0
10/78 - 03/79	33	2.7	17.2

These effective action measures continue with implementation of accountability controls for follow-up activities as well as revisions in policy related to follow-up requirements.

3. Program Monitoring: The case monitoring training of field staff was completed.

4. Policy Revisions: With high concentrations of errors chronically surfacing in the area of earned income, the agency began extensive revisions in this area of the policy manual. The revisions include the addition of case situation examples to assist staff in the proper application of policy. Many revisions have been formulated and approved to be released to field staff.

5. Centralized Eligibility System: A pilot project in a parish to manually test the use of the common application continues. The common application form is used to collect the information needed to determine eligibility and benefits for AFDC, Medical Assistance, and Food Stamps and to collect data for referral to IV-D. This phase of the test is to be followed with the test of the mechanized use of the form. The system is patterned closely after that in use in Wisconsin where error rates were reduced significantly subsequent to its implementation.

6. Error-Prone Profile: Study of the feasibility of using an automated error-prone profile based on Quality Control findings for caseload management purposes continues. The State Of West Virginia has continued to work cooperatively with Louisiana in this effort. However, due to our own limited staff available to research this project coupled with unavoidable delays in securing a current and applicable profile, progress was hindered.

7. Training-Comprehensive Orientation for New Eligibility Workers: Although the evaluation of cause and effect cannot be statistically detailed, we do not underestimate the value of resuming the comprehensive orientation sessions. These orientations are ongoing and we continue to receive positive feedback as a result of this effort.

8&9. Guidlines for Narrative Entries and Indexing of Executive Bulletins: Limited staff necessitated the postponement of these projects. Each is recognized as a valuable tool in the process of assuring proper application of policy and will be pursued as staff and time are available.

PLANNED CORRECTIVE ACTION

It is recognized that the corrective action process is an ongoing effort with continuity in addressing established deficiencies. The committee, therefore, endeavors to meet quarterly.

Planned corrective action measures to initiate and/or pursue, the deficiencies are addressed below:

1. Mechanization of Enumeration and Automatic Follow-Up Controls:
   a. The mechanized enumeration process proved effective with the number of enumeration errors reduced from 115 (January - June, 1978) to 33 (October, 1978 - March, 1979). This system remains operative.

b. Quarterly listings prepared by Data Processing of recipients without social security numbers will continue to be made available to local office staff to trigger needed enumeration activities. The January 11, 1979 listing reflected 8,008 recipients not enumerated whereas the most current listing (July 10, 1979) reflected a reduction to 5,962.

c. Enumeration errors are projected to decline further based on a recent analysis of state policy in relation to required follow-up activity for enumeration purposes.

2. Past Management Review at Certification and Redetermination: The past management review provides valuable leads to sources of unreported income. The committee recommended that management review as an interviewing tool should be revived in central orientation sessions as well as in the policy manual.

3. Indexing Executive Bulletins to Policy: Action was taken to implement this practice. Each Executive Bulletin will be referenced as to the policy (policies) affected in the policy manual. In this way, field staff can efficiently and effectively maintain a cross-reference system to assure application of current policy.

4. Guidelines for Narrative Entries at Certification and Redetermination: Some parishes and/or regions have implemented their own guidelines for narrative entries. A uniform guide would serve to assure uniformity in program delivery and facilitate second party review. This would facilitate the program monitoring system.

5. Policy Revisions: Revision and clarification of policy are ongoing efforts in program administration. Major revisions to the income policy have been formulated with the inclusion of examples to assist staff in proper application. These revisions are directed at income errors - particularly earnings.

6. Extend Indefinitely the Waiver for Locating and Interviewing the Absent Parent: The waiver for locating and interviewing the absent parent was extended indefinitely. Initially this was done in order to alleviate the Assistance Payments workers load during the Food Stamp Conversion effort. Close monitoring of the affect of this waiver indicate that statistics relative to errors which might be associated with the waiver have actually declined rather than increased. For the April - September, 1978 period, errors in Deprivation - Continued Absence totalled 10 and errors in Contributions totalled 42. For the October, 1978 - March, 1979 period, these errors totalled 8 and 16 respectively.
7. Extend Indefinitely the Waiver for Home Visits at Certification: The requirement that a home visit be made prior to certification was waived to facilitate Food Stamp Conversion and has been extended indefinitely. The scheduled home visit is seldom effective in reducing incidences in which the client intends to willfully misrepresent his situation. And even in cases not involving misrepresentation, verifications by home visit alone are less conclusive than alternate documentations available.
8. Automation of WIN Reporting: State Office staff began pursuit of the feasibility of mechanizing Welfare Savings Reporting for the WIN Program. The nine WIN parishes in Louisiana carry approximately 50% of the statewide caseload. Not only would this system relieve workers of time-consuming activity, it would further assure accuracy in savings on obtained employment. In addition, this system through coding of WIN/Work status would assure that the registrant pool indicated by the IV-A agency's records would be reflected similarly in Department of Labor records.

SUMMARY

The effective measures taken by the agency have been largely systems and procedural changes. Such measures have resulted in a reduction of over 50% of case error rate and 31% drop in payment error for the period from September, 1978, to September, 1979. Further procedural and systems refinements are not readily available to the agency and the dramatic improvements as seen in the past cannot be accomplished through this means. We have reached an error level which cannot be broadly attacked. Intense individual effort on multiple error causes will now result in minimal change in error rate but will come about at high cost.

Despite intense effort to reduce error, the measures taken have been effective only in reduction of agency error. There have been no actions which have been measurably effective in reducing client errors. Training workers to improve skills in interviewing clients has been implemented; however, the results are not measurable. Client fraud and abuse if willfull will not be detected without greater and more comprehensive investigation than the agency can afford to make. Interim contacts and reporting requirements have been ineffective in reducing the client error rate. This, therefore, raises high the question as to whether sanctions on client error against an agency are appropriate.

Although, as an agency, we have been able to reduce errors dramatically, we frankly doubt the goal of a 4% error rate is realistic. Even if leverage, disregard or special tolerance were allowed for client error, we doubt our ability to achieve and maintain a 4% level.

B. Medicaid Corrective Action Plan

The Medicaid Corrective Action Plan includes all Medical Assistance Only cases, except SSI cases. The state does not assume corrective action for Federally administered eligibility determinations; therefore, SSI cases are excluded from the Quality Control sample. (Payments to ineligibiles in the AFDC category are treated in the AFDC Corrective Action Plan.)

October, November, December, 1978

Total cases completed	156	
Ineligible cases	7	(% 4.5)
Cases with understated recipient liability	5	(% 3.2)

April, May, June, July, 1979

Total cases completed	222	
Ineligible cases	13	(% 5.9)
Cases with understated recipient liability	8	(% 3.6)

Error Analysis

Ineligible payments resulted from the following elements:

1. Excess resources

   The recipients and the agency were equally at fault. Recipients (or responsible parties) failed to declare ownership of resources such as bank accounts, non-home property, life insurance. The agency failed to explore or develop potential ownership of resources.
2. Administrative failure to take timely action to close cases, through oversight.
3. Administrative delay (such as printing) in issuing policy and procedure guidelines to staff.

Income errors resulting in understated recipient liability (in Long Term Care cases) were identified as follows:

1. Failure of recipient to report accurately or timely changes in income.
2. Failure of Bendex system to generate accurate and timely data.
3. Failure of recipient to report changes in living arrangements/household composition.

Planned Corrective Action

To reduce the errors in the area of excess resources, plans were specified for administrative level State and Regional meetings, identification of training needs, expansion of policy material, and refinements to the computer system.

Controls were devised at all administrative levels to ensure timely disposition of case actions to prevent ineligible payments. Procedures were established to provide for advance and/or impediate release of pertinent policy issuances.

For income errors resulting in unstated recipient liability, the plan included refinements to the Bendex system, error printouts generated by the computer, and more thorough verifications by eligibility staff.

Implementation and Results

The error rates for ineligible cases, and for cases with understated liability have increased. However, the long-range results of the technical and mechanical measures should become evident in the subsequent review period. Planning and recent implementation of the following elements should serve to reduce errors:

1. The income and resource policy sections have been expanded.
2. Coordination between administrative staff in state office, eligibility staff, and Quality Control staff has been improved, resulting in uniform definitions and identification of error causes.
3. Training sessions are now in progress, on a regional basis, for concentrated groups of Medically Needy and Long Term Care staff.

4. The master file has been expanded to meet the needs of Medicaid cases.
5. Modifications to the SDX and Bendex systems have been made.
6. Controls have been placed on certain cases to assure that Medicaid eligibility is terminated appropriately.

III. The Surveillance and Utilization Review (S/UR) System

Even though the Medicaid claims error rate is not used in the assessment of the fiscal sanctions on the Titles IV-A and XIX funds, Louisiana feels it is important that the committee be fully aware of what efforts are being made in this area. Louisiana has had a fully certified Medicaid Management Information System (MMIS) since 1977. Our expertise in controlling our program is improving with this sophisticated computerized system. The MMIS has six systems, two of which collect and store basic health delivery information. Those are:

- the Recipient Subsystem which contains data on the identity and services provided each recipient;
- the Provider Subsystem which contains the identity of providers and the services they provide.

The third subsystem is the Claims Processing Subsystem which enters, verifies, and makes claims payments to providers. The system also stored the record of all claims payments. The fourth, the Reference File Subsystem, holds data on such areas as providers' usual and customary charges and other standards data sets such as diagnosis codes. Taken together, those four subsystems hold all the data necessary for the maintaining two subsystems, Surveillance and Utilization Review (S/UR) and Management and Administrative Reporting (MARS). These two supply the data needed for efforts to control misutilization; they support the general management capabilities of a Medicaid program; and, with the Claims Processing Subsystem, they help identify fraud and abuse.

The Surveillance and Utilization Review (S/UR) subsystem is specifically designed to address the problems of inappropriate utilization of services. The basic function of the S/UR is to compute actual performance against generally accepted utilization consistent with local norms and patterns of care. For example, a hospital length-of-stay may be three days for a specific diagnosis. The S/UR would review the data and report exceptions such as lengths of stay in the hospital which are more than the average three days for that diagnosis. This in itself does not necessarily mean inappropriate utilization, but it helps point out deviations from the norm where further action may be necessary.

The S/UR subsystem has thus been designed to accomplish the following objectives:

- to develop, over time, a comprehensive statistical profile of local health care delivery and utilization patterns established by provider and recipient participants in the various categories of service authorized under the Medicaid program;
- to reveal and review potential misutilization and to promote correction of actual misutilization of the Medicaid program by its individual participants;
- to provide information which will reveal and facilitate investigation of potential defects in the level of care or quality of service provided under Medicaid;
- to accomplish the substantive objectives stated above with a minimum level of manual clerical effort and a maximum level of flexibility with respect to management objectives.

We are providing you with the attached information in an effort to provide you with summary information on our program since January, 1979 as a result of our S/UR's activity. These figures document that we in Louisiana are making an earnest endeavor to help curtail fraud and abuse.

In addition, Louisiana has the first federally funded Medicaid Fraud Control Unit. This unit, under the administrative control of the Attorney General of the State of Louisiana actively follows-up on suspected cases of medicaid provider fraud.

UTILIZATION PROBLEM ANALYSIS
FIRST QUARTER
1979

UTILIZATION PROBLEM	1978	JAN.	FEB.	MAR.	TOTAL BY PROBLEM	% OF PROBLEMS ON CASES CARRIED THIS QUARTER
Billing Recipient	26	1	4	0	31	29.0
Excessive Services	25	0	0	0	25	23.4
Medical Necessity	19	0	1	0	20	18.7
Improper Billing:						28.9
Fragmenting	4	0	0	1	5	4.7
Professional & Full Service Components	1	0	0	1	2	1.9
Consultations on Own Patients	1	0	0	1	2	1.9
Restricted Practice	2	0	0	0	2	1.9
Services Not Rendered	6	1	0	0	7	6.5
Card Swapping	1	2	0	0	3	2.8
Recipient Ineligible	1	0	0	0	1	.9
Drug Substitution	1	0	0	0	1	.9
Denied Free Choice	0	1	0	0	1	.9
Quality of LTC Care	0	1	0	0	1	.9
Duplicate Billing	1	0	2	2	5	4.7
Individual Physician Not Identified in Clinic	1	0	0	0	1	.9
Total Number of Cases By Reporting Period	89	6	7	5	107	

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RECOVERY STATUS REPORT
FIRST QUARTER
1979

Month	A Pending Previews Period	B Overpayments Established This Period	C Balance Before Discount(A+B)	D Overpayments Discounted This Period	E Balance After Discount (C-D)	F Overpayments Received This Period	G Balance End This Period (E-F)	H Percent Recovered This Period (F+E)
January	$34,399.94	$21,481.10	$55,881.04	$221.47	$55,659.57	$983.10	$54,676.47	1.76%
February	54,676.47	1,405.26	56,081.73	145.00	55,936.73	307.70	55,629.03	.55%
March	55,629.03	0.00	55,629.03	0.00	55,629.03	150.10	55,478.93	.26%
Summary This Quarter	$34,399.94	$22,886.36	$57,286.30	$366.47	$56,919.83	$1,440.90	$55,478.93	2.53%

RECOVERY PENDING STATUS REPORT
FIRST QUARTER
1979

Blue Cross EDSF Audits	UR Committee Review	Administrative Decision	EDSF Adjustment	Provider	Recovery Unit	Total
$27,224.02	$18,207.40	$3,090.00	$2,773.02	$2,301.63	$1,882.86	$55,478.93
49.07%	32.81%	5.56%	4.99%	4.14%	3.39%	

RECOVERY STATUS REPORT
SECOND QUARTER
1979

Month	A Pending Begin Period	B Overpayments Established This Period	C Balance Before Discount(A+B)	D Overpayment Discounted This Period	E Balance After Discount (C-D)	F Overpayments Recovered This Period	G Balance End This Period (E-F)	H Percent Recovered This Period (F÷E)
April	$55,478.93	$1,480.60	$56,959.53	$ 2.50	$56,957.03	$1,970.25	$54,986.78	3.46%
May	54,986.78	2,318.90	57,305.68	0	57,305.68	748.90	56,556.78	1.30%
June	56,556.78	182.60	56,739.38	28,581.72	28,157.66	3,018.54	25,139.12	10.72%
Summary This Quarter	$55,478.93	$3,982.10	$59,461.03	$28,584.22	$30,876.81	$5,737.69	$25,139.12	18.58%

DISCOUNT REASON REPORT
SECOND QUARTER
1979

Provider No Longer In Practice/Business	Calculation Error	Administrative Decision	Total
$27,224.02 95.24%	$ 8.20 .02%	$1,352.00 4.72%	$28,584.22

RECOVERY PENDING STATUS REPORT
SECOND QUARTER
1979

EDS Federal Adjustment	Fraud Investigation	Recovery Unit	Total
$5,048.86 20.08%	$18,207.40 72.42%	$1,882.86 7.48%	$25,139.12

IV. Recovery Section

The Recovery Section makes a decision concerning the feasibility of recoupment and recovery for all ineligible payments and overpayments whether they resulted from administrative error, misunderstanding of policy or laws by the client or willfull withholding or misstatement on his part of factual information. Recovery Section is also responsible for the decision on cases in which evidence of ineligible payments becomes available only after closure.

The action of the Recovery Section will include:

A. Review of all available information.

B. Making a decision on the feasibility of seeking repayment from the client. In non-fraud cases that might result in hardship the decision may be made not to recoup the overpayments. In evaluating the question of hardship, the following is considered:

(1) Amount of current income and management.

(2) Members of the household

(3) Health condition.

(4) Shelter and utility costs.

(5) Any extenuating circumstances that would involve unusual expenditures.

In cases where there is no intent to commit fraud concerning eligibility factors, recoupment shall be made only when the recipient has currently available income or resources, exclusive of his grant income in an amount equal to or exceeding the amount of recoupment reduction of the grant. Recoupment shall be limited to the 12 months preceding the month of discovery in non-fraud cases. In cases which indicate intent to defraud, recoupment may include the entire loss. Statistics regarding Fraud and the recovery and/or recoupment in AFDC, Title XIX Provider and Medicaid for the State Fiscal Year July 1, 1978 through June 30, 1979 are as follows:

RECOVERY SECTION

STATISTICS REGARDING FRAUD AND ABUSE

AFDC PROGRAM

STATE FISCAL YEAR July 1, 1978 thru June 30, 1979

2,273	AFDC cases referred to Recovery Section for review
2,023	Decisions made on AFDC cases referred to Recovery
1,672	AFDC cases involving Client Error
351	AFDC cases involving Administrative Error
$153,084.00	AFDC Recoupment Collections for fiscal year
$ 79,579.78	AFDC Recovery Collections for fiscal year
$232,663.78	TOTAL AFDC COLLECTIONS FOR FISCAL YEAR

OVERPAYMENTS TO RECIPIENTS IN MEDICAID PROGRAM

$59,404.41	Total Amount Collected for Fiscal Year

TITLE XIX PROVIDER OVERPAYMENTS DISCOVERED BY AUDITS

539	Number of Referrals received in Recovery Section
$1,857,254.23	Total Amounts Involved in Referrals
$1,076.603.20	Total Amount Collected for Fiscal Year

Recovery Activities

FISCAL YEAR July 1978 through June 1979
AFDC FRAUD CASES
REFERRED TO DISTRICT ATTORNEYS FOR PROSECUTION

Number of Cases referred for prosecution involving ADC 97

Amount Involved $221,912.00

Number of Cases referred for prosecution involving Medical Vendor. . . 49

Amount Involved $53,566.27

Number of Cases prosecuted & convicted involving ADC 81

Amount Involved $227,481.45

Number of Cases prosecuted & convicted involving Medical Vendor. . . . 51

Amount Involved $38,402.19

Court-ordered Restitution	$ 62,306.07 ADC
	12,119.52 Medical Vendor
	$ 74,425.59 Total

V. The Special Investigations Section

The Special Investigations Section of the Office of Family Security detects and investigates suspected fraudulent situations involving agency staff, providers (except medicaid) and recipients in any program administered by the agency.

The staff is in the process of being brought up to full strength of 17 investigators and a director.

The Section has primary responsibility of investigating:

1. Cases of probable fraud discovered by investigators of the unit through initiative or through special projects.
2. Reports of instances of probable fraud received by the Section from the general public, state office staff and other local, state, federal or out of state agencies.
3. Cases involving recipients suspected of fraudulently receiving assistance in two or more names.
4. Cases of recipients suspected of receiving assistance in more than one parish or state.
5. Cases involving complex situations too difficult for parish office staff or other investigative or audit units to resolve, and in which fraud is suspected.

The majority of cases investigated by the Section are complaints from the general public or referrals from parish offices. Most cases of fraud in the state are routine in nature and are locally handled by Eligibility Workers. When local office staff is confronted with cases they cannot resolve, and in which fraud is suspected, they refer them to the Special Investigations Section. Cases referred are evaluated to determine whether they will be accepted for further investigation by the Section, referral elsewhere or returned to the referring source with recommendations for resolution.

During the Fiscal Year 1978-79, three hundred sixty-nine (369) referrals were received from 43 parishes and 15 requests for investigative assistance were received from other states. Two hundred and eight (208) referrals were accepted for investigation, 86 were not accepted for various reasons, and 75 were pending evaluation or assignment. One hundred thirty-six (136) investigations were completed.

Thirty-five (35) recipient cases were referred to district attorneys for prosecution and one case (a day care center) was referred to the U. S. Attorney. Twenty-six (26) people were arrested. Fifteen (15) prosecutions were completed by prosecutors with 19 pending.

The following breakdown shows the losses uncovered in cases investigated by staff of the Section, and it shows the estimated savings resulting from closure or reduction of grants:

	LOSSES	COUNTABLE SAVINGS
Public Assistance	$183,128.77	$70,389.42
Food Stamps	203,228.75	87,711.57
Medicaid (Recipient)	37,302.39	15,211.05*
Day Care	---------	61,138.00
Other	---------	27,510.00
	$423,659.91	$261,960.04**

* Incomplete figure due to difficulty verifying medicaid payments.
** Incomplete figure. Grant reductions or closures are frequently taken on cases and action is not reported to SIS.

Although statistical information generated by the SIS may seem non-spectacular in comparison to the millions expended in the various programs annually, there are other immeasurable benefits. There is no accurate measure of loss prevented through deterrence and improved skills of employees.

The major benefits of active fraud investigation are deterrence and an increase in reported instances of possible fraud. Information from the field indicates that requested closures and reported changes in family circumstances increase in areas where cases are actively investigated.

TESTIMONY OF

BARBARA B. BLUM

COMMISSIONER

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

BEFORE THE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON PUBLIC ASSISTANCE

UNITED STATE SENATE

SUMMARY

- NEW YORK STATE AND OTHER MEMBERS OF THE COUNCIL HAVE A STRONG COMMITTMENT TO PROVIDING QUALITY SERVICES IN AN ACCOUNTABLE MANNER
- THIS COMMITMENT IS EVIDENCED BY THE REDUCTION IN ERRORS IN NEW YORK STATE TO ONE-FOURTH OF THEIR ORIGINAL LEVELS
- MAJOR MANAGEMENT IMPROVEMENTS HAVE OCCURRED THAT ARE STATE INITIATIVES FINANCED BY STATE RESOURCES
- THE PRIMARY CAUSE OF ERROR IS PROGRAM COMPLEXITY AND LACK OF STANDARDIZATION AMONG PROGRAMS RATHER THAN CLIENT MISREPRESENTATION OR WORKER INEFFICIENCY
- THE SCALE OF PROGRAMS ADMINISTERED COMPOUNDS THESE PROBLEMS
- FISCAL SANCTIONS ARE NEITHER NECESSARY NOR APPROPRIATE TO IMPROVE PROGRAM MANAGEMENT
- QUALITY CONTROL IS A MANAGEMENT TOOL WHICH IS NOT INTENDED TO MEASURE MISSPENT DOLLARS
  - THE INCLUSION OF "TECHNICAL ERRORS" IN THIS PROCESS EXAGGERATES THE EXTENT OF MISSPENT FUNDS
- TO IMPOSE SANCTIONS BASED ON A SINGLE NATIONAL GOAL IS INAPPROPRIATE SINCE QUALITY CONTROL STANDARDS DIFFER SIGNIFICANTLY AMONG STATES
- THE IMPOSITION OF SANCTIONS ON THE BASIS OF QUALITY CONTROL STANDARDS WILL UNDERMINE THE MANAGEMENT VALUE OF QUALITY CONTROL AND MAY JEOPARDIZE THE ABILITY OF PROGRAMS TO SERVE LOW INCOME PERSONS

I AM BARBARA B. BLUM, COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES. IT IS MY PRIVILEGE TO JOIN WITH COLLEAGUES FROM THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS IN PRESENTING FOR THE SUBCOMMITTEE'S CONSIDERATION THE CAUSES OF ERRORS IN SOCIAL SECURITY ACT PROGRAMS.

THE STATE OF NEW YORK, AND OTHER STATES REPRESENTED IN THE NATIONAL COUNCIL, HAVE A STRONG COMMITMENT TO PROVIDING QUALITY SERVICES TO OUR CLIENTS IN A MANNER THAN CAN BE MEASURED FOR ITS ACCOUNTABILITY. THE FEDERAL GOVERNMENT HAS SHARED AND ENCOURAGED THIS COMMITMENT.

STATE AND FEDERAL PROGRAMS, WHILE OFTEN CLEAR IN INTENT, ALMOST ALWAYS BECOME COMPLEX IN REALITY. UNFORTUNATELY THESE HAVE EVOLVED IN A MANNER WHICH CREATES BARRIERS TO THE CLIENT AND TO THE WORKER ALIKE.

WHILE THE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) AND MEDICAID PROGRAMS ARE, IN FACT, PRONE TO ERROR, WE NEED TO CLARIFY MISCONCEPTIONS AND OVER-SIMPLIFICATIONS ABOUT THE CAUSES FOR ERRORS AND ERRONEOUS PAYMENTS. FAILURE TO DO SO MAY JEOPARDIZE CONTINUED PUBLIC SUPPORT FOR THESE CRITICAL PROGRAMS.

FIRST, LET US BE CLEAR THAT A MARGINAL NUMBER OF MISTAKES CAN BE ATTRIBUTED CLEARLY TO CLIENT MISREPRESENTATION OR WORKER INEFFICIENCY. THE MAJOR CAUSES OF ERROR, HOWEVER, LIE ELSEWHERE. WE MUST LOOK FOR THE CAUSES OF ERRORS IN THE COMPLEXITIES AND LACK OF STANDARDIZATION AMONG PROGRAMS.

IN THE VOLUME OF CLIENTS SERVED AND IN THE CONSTANTLY CHANGING CIRCUMSTANCES OF THE CLIENT POPULATION ITSELF.

TO THESE CAUSES WE MUST ADD CHARACTERISTICS OF THE QUALITY CONTROL PROCESS WHICH HAVE COMPOUNDED THE ISSUES BEFORE US. AMONG THE MOST IMPORTANT OF THESE IS THE ADDITION OF TECHNICAL ERRORS TO A SYSTEM THAT WAS ORIGINALLY INTENDED TO MEASURE MISSPENT DOLLARS AS WELL AS THE LACK OF UNIFORMITY IN QUALITY CONTROL STANDARDS AMONG STATES.

THE EXPERIENCES AND PERCEPTIONS OF NEW YORK STATE MAY ASSIST THE SUBCOMMITTEE IN ITS EFFORT TO ADDRESS THESE ISSUES. .

NEW YORK STATE RECORD

DESPITE THE OBSTACLES AND COMPLICATED ISSUES BEFORE US, NEW YORK AND OTHER STATES HAVE ACHIEVED PROGRESS IN REDUCING THE EXTENT OF ERRONEOUS PAYMENTS IN THE MAJOR ASSISTANCE PROGRAMS. SINCE THE INCEPTION OF QUALITY CONTROL IN 1973, NEW YORK HAS REDUCED ITS COMBINED AFDC AND MEDICAID PAYMENT ERRORS TO ONE-FORTH OF THE ORIGINAL LEVELS. OVER THE LAST FIVE YEARS, CORRECTIVE ACTIONS APPLIED BY THE STATE AND ITS LOCALITIES HAVE ALLOWED US TO AVOID OVER $1 BILLION IN ERRONEOUS PAYMENTS. DRAMATIC CHANGES HAVE OCCURRED IN THE MANAGEMENT OF OUR ASSISTANCE PROGRAMS BECAUSE OF THE COMMITMENT OF STATE RESOURCES. IN THE FACE OF A GROWING FISCAL CRISIS WE HAVE SPENT OVER $150 MILLION TO IMPROVE OUR EFFICIENCY, AND THESE INVESTMENTS HAVE RETURNED EXCEPTIONAL DIVIDENDS.

THE MANY ASPECTS OF INITIAL AND CONTINUING ELIGIBILITY HAVE BEEN ANALYZED AND STRENGTHENED THROUGH A VARIETY OF PROGRAMS. AMONG THE MAJOR CHANGES WERE:

- THE ADDITION OF OVER 1,000 STATE AND LOCAL STAFF TO PERFORM MANAGEMENT REVIEWS AND TO RECOMMEND CORRECTIVE ACTION TO REDUCE ERRORS.
- A COMPLETE REDESIGN OF THE APPLICATION USED TO DETERMINE ELIGIBILITY ALONG WITH ADDITIONAL STAFF SUPPORT SO THAT MEANINGFUL INFORMATION CAN BE CAPTURED, DOCUMENTED, AND EASILY UNDERSTOOD BY WORKER AND CLIENT ALIKE.
- THE INTRODUCTION OF A COMPREHENSIVE RECERTIFICATION PROCESS THAT REQUIRES THE REVIEW AND VERIFICATION OF IMPORTANT INFORMATION AT REGULAR INTERVALS.
- IMPROVED STAFF TRAINING TO ENCOURAGE PROPER DECISIONS MAKING.
- CHANGES IN LOCAL AGENCY ORGANIZATION TO FACILITATE THE EFFICIENT INTERACTION OF BOTH PEOPLE AND PAPER.
- THE ADDITION OF THOUSANDS OF STAFF TO MAKE HOME VISITS AND TO MAKE INDEPENDENT CONTACTS WITH SOURCES THAT COULD CORROBORATE STATEMENTS MADE BY CLIENTS, AND
- THE INTRODUCTION OF COMPUTER TECHNOLOGY THAT IS CAPABLE OF COLLECTING BILLIONS OF PIECES OF INFORMATION, CALCULATING ASSISTANCE ENTITLEMENTS, AND MATCHING INFORMATION TO OTHER COMPUTERIZED DATA SOURCES TO VERIFY INCOME..

I WOULD LIKE TO EMPHASIZE THAT NEW YORK'S PROGRESS RESULTS FROM A SINCERE COMMITMENT TO REDUCE DOLLAR LOSSES AND TO ASSURE CONFIDENCE IN THESE SYSTEMS. THE STATE'S EFFORTS TO ASSURE THE INTEGRITY OF THE MEDICAID PROGRAM IS ANOTHER EXAMPLE OF THIS MOTIVATION. WITHOUT FEDERAL MANDATES, NEW YORK STATE ADDED ALMOST 1,500 STAFF WITH INVESTIGATIVE AND AUDITING BACKGROUND TO REDUCE THE INCIDENCE OF ABUSE AND WASTE BY ALL TYPES OF MEDICAID PROVIDERS. THE STATE HAS ALSO IMPLEMENTED A COMPUTERIZED MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) WHICH MAKES PROMPT, ACCURATE PAYMENTS AND ISOLATES IMPROPER BILLINGS. THESE COMBINED EFFORTS HAVE ALLOWED THE STATE TO RECOVER OR AVOID THE MISUSE OF MILLIONS OF DOLLARS.

IN SHORT, STATES DO NOT NEED THE THREAT OF FISCAL SANCTIONS TO BEHAVE IN A RESPONSIBLE MANNER. STATE AS WELL AS FEDERAL DOLLARS ARE AT STAKE AS IS THE CONTINUED VIABILITY OF ESSENTIAL SERVICES TO PEOPLE IN NEED.

WE BELIEVE THE FEDERAL GOVERNMENT SHOULD FOCUS ON PROGRAMMATIC REFORMS TO REDUCE ADMINISTRATIVE COMPLEXITY AND THE SOURCES OF ERRORS THEMSELVES.

PROGRAM COMPLEXITY

IN NEW YORK, AS IN MANY OTHER STATES, THERE ARE FIVE MAJOR ASSISTANCE PROGRAMS TO MEET THE NEEDS OF INDIVIDUALS AND FAMILIES:

- AID TO FAMILIES WITH DEPENDENT CHILDREN

- Medical Assistance
- Food Stamps
- General Assistance and
- Supplemental Security Income

To a very large extent, these programs have developed independently and over time. At both the State and Federal level, complex and often contradictory standards have been added which make worker accuracy and client understanding difficult to achieve.

In one household unit in New York, for example, comprised of a grandparent over 65, a mother with two young children and one child over 18, the worker must understand the eligibility criteria for AFDC, SSI and General Assistance as well as those for Food Stamps and Medicaid.

One need look no further than the standards for computing resource or income to identify the potential for confusion within these programs. In New York, for the five programs which can and do impact on AFDC and Medicaid error rates, there are four distinct standards for resources and five completely different standards for allowable income. In addition, both the Federal and State government have added variations within certain assistance categories for such factors as work expenses and other allowable deductions.

The complexity of these programs affects the ability of the eligibility worker to implement standards accurately as well as the client's ability to comply with reporting requirements.

IN ADDITION, UNIQUE REQUIREMENTS AND PROGRAM COMPLEXITIES HAVE CREATED FRAGMENTATION AND INEFFICIENCIES AT THE LOCAL LEVEL BETWEEN UNITS THAT GATHER DATA AND MAKE ELIGIBILITY DETERMINATIONS. THE SCOPE AND VARIETY OF FORMS NEEDED TO MEET ELIGIBILITY REQUIREMENTS AND THE VARIETY OF DATA THAT MUST BE COLLECTED AND STORED BECOMES AN ADDITIONAL DETERRENT TO THE DESIGN OF PROCEDURES THAT WILL PROMOTE EFFECTIVE PROGRAM MANAGEMENT.

WE MUST ALSO RECOGNIZE THE IMPORTANT IMPACT OF SCALE ON THE POTENTIAL FOR PROGRAM ERROR. IN NEW YORK STATE, THERE ARE CURRENTLY OVER 22,000 STATE AND LOCAL WORKERS WHO PARTICIPATE IN THE PROCESS OF DETERMINING ELIGIBILITY FOR THREE MILLION AFDC AND MEDICAID RECIPIENTS. IT HAS BEEN ESTIMATED THAT THESE WORKERS HANDLE IN EXCESS OF 100 MILLION DOCUMENTS EACH YEAR FOR THESE CASELOADS. IN THE MIDST OF SUCH A MAMMOTH OPERATION, PROCEDURAL ERRORS ARE BOUND TO OCCUR.

THE QUALITY CONTROL PROCESS

THE EXPERIENCE OF NEW YORK STATE INDICATES THAT QUALITY CONTROL CAN BE AN EFFECTIVE MANAGEMENT TOOL WHEN ACCOMPANIED BY IN DEPTH MANAGEMENT REVIEWS AND PLANS FOR CORRECTIVE ACTION. THE STATE STRONGLY SUPPORTS THE STRENGTHENING OF QUALITY CONTROL FOR THIS PURPOSE. WE OBJECT STRENUOUSLY, HOWEVER, TO ITS USE AS A BASIS FOR FISCAL SANCTIONS.

OUR OBJECTIONS ARE BASED ON TWO FUNDAMENTAL ISSUES:

- QUALITY CONTROL DOES NOT MEASURE TRUE PAYMENT LOSSES AND

- Quality control standards vary widely from state to state

- Technical Errors

In its present form, Quality Control includes the measurement of errors which are "technical" in nature and do not, in fact, result in erroneous payments to clients. In New York State, for example, over one-third of what is described as overpayments for the period ending March 31, 1979 were in fact technical errors relating to program compliance or claiming procedures. Technical errors fall into three major categories:

- Failure to register an eligible WIN recipient
- Failure to obtain a Social Security number for young children and
- Claiming of expenditures in the improper category

Usually, no erroneous payments are made for the first two of these categories. The issue in the third category is somewhat more complex.

When errors occur related to improper claiming categories, charges that should have been assessed to state programs are charged to federal programs. The federal Quality Control process, however, does NOT reflect charges to state programs which SHOULD be made in federal categories.

In such situations, the client receives no additional payment and the claiming of federal dollars in one instance

IS OFFSET BY THE ABSENCE OF CLAIMING IN THE OTHER.

THE ISSUE OF TECHNICAL ERRORS ILLUSTRATES THE COMPLEXITY OF THE QUALITY CONTROL PROCESS. IT BECOMES EVEN MORE COMPLICATED WHEN APPLIED DIFFERENTLY AMONG STATES.

IN NEW YORK STATE, FOR EXAMPLE, A MAJOR CAUSE OF ERROR IS THE FAILURE TO QUALIFY FOR ASSISTANCE BECAUSE OF THE ALLEGED PRESENCE OF THE ABSENT PARENT IN THE HOME. WHILE THE PRESENCE OF THIS PARENT MUST INDICATE AN ERROR IN EACH STATE, THE PROCEDURES USED TO DETERMINE HIS PRESENCE VARY WIDELY. IN NEW YORK'S PROGRAM QUALITY CONTROL AUDITORS SPEND AN AVERAGE OF 26 HOURS INVESTIGATING AN AFDC CASE WHILE OTHER LARGE STATES WITH LOWER ERROR RATES SPEND MUCH LESS TIME.

RATHER UNDERSTANDABLY, NEW YORK STATE TENDS TO FIND MORE PARENTS PRESENT. IN OTHER AREAS AS WELL, INVESTIGATIVE TECHNIQUES AND CRITERIA FOR CONCLUDING THAT AN ERROR HAS OCCURRED VARY WIDELY. THERE ARE, IN FACT, AS MANY QUALITY CONTROL PROGRAMS AS THERE ARE STATES.

THE APPLICATION OF QUALITY CONTROL IS ALSO AFFECTED BY THE STRUCTURE OF PROGRAMS ON THE STATE LEVEL. STATES, SUCH AS NEW YORK, WITH STRINGENT RESOURCE REQUIREMENTS ARE MORE LIKELY TO HAVE RESOURCE RELATED ERRORS. THE PRESENCE OF OPTIONAL PROGRAM COMPONENTS, SUCH AS ASSISTANCE FOR INTACT

FAMILIES OR UNBORN CHILDREN, ALSO INCREASES THE POTENTIAL FOR ERROR IN A STATE. DOLLAR SANCTIONS BASED ON THIS SYSTEM ARE CLEARLY INAPPROPRIATE.

CONCLUSION

IT IS OUR BELIEF THAT THE FUTURE OF QUALITY CONTROL AS A VIABLE MANAGEMENT TOOL RESTS ENTIRELY WITH SUBSTANTIVE REFORM OF THE POLICIES AND PROCEDURES GOVERNING ASSISTANCE PROGRAMS AS WELL AS WITH THE STANDARDIZATION OF THE QUALITY CONTROL PROCESS THROUGHOUT THE COUNTRY. THE USE OF QUALITY CONTROL FOR PURPOSES OF SANCTION CAN LEAD ONLY TO ITS REDUCED USEFULNESS FOR PURPOSES OF PROGRAM MANAGEMENT.

UNDER THREAT OF SANCTION, IT WOULD NOT BE SURPRISING IF STATES REDUCED THE RIGOR OF QUALITY CONTROL PROCEDURES OR DEVELOPED TWO SEPARATE STANDARDS - ONE FOR INTERNAL MANAGEMENT AND THE OTHER FOR REPORTING TO THE FEDERAL GOVERNMENT. WHILE THIS APPROACH COULD PROTECT US FROM PENALTIES, IT WOULD SUBVERT THE VERY PURPOSE OF THE QUALITY CONTROL PROGRAM.

IMPOSITION OF SANCTIONS FOR PAYMENT ERRORS ABOVE ARBITRARILY DEFINED STANDARDS COULD HAVE SERIOUS FINANCIAL CONSEQUENCES FOR NEW YORK STATE. OF EQUAL IMPORTANCE IS THE POTENTIAL DAMAGE TO PROGRAMS DESIGNED TO PROVIDE ESSENTIAL SERVICES TO LOW INCOME PERSONS.

CONGRESS MAY WISH TO ASSESS THE REASONABLENESS OF THIS APPROACH AND TURN ITS ATTENTION TO PROGRAMMATIC CHANGES DESIGNED TO REDUCE ERRORS. QUALITY CONTROL CAN THEN BE DEVELOPED TO FURTHER IMPROVE PROGRAM MANAGEMENT.

56-941 O - 80 - 15

Statement by John T. Dempsey
Director - MDSS
before the Subcommittee on
Public Assistance of the Senate
Finance Committee
November 16, 1979

Provision of assistance to persons genuinely in need is a primary goal of our national public assistance programs. A related goal is to provide such assistance accurately and efficiently. A nationwide system of quality control has been instituted to provide some measurement of the realization of these goals. The quality control system is a management tool developed with the expectation of assuring the proper and correct expenditure of public assistance funds, through locating unacceptable performance and ineffective policies and initiating corrective action to reduce and eliminate waste and error. Recently it has been suggested — in fact it has been legislated by Congress — that data from the quality control system be utilized to impose fiscal sanctions upon states which are not achieving certain performance standards, and that incentives, in the form of increased federal funding, be provided to states which are exceeding performance standards. Substantial discussion has ensued concerning the relative merits of various plans for implementing disallowances or incentives. For the most part however, this discussion has focused upon the concept of disallowances and incentives and/or various techniques for implementing such a concept. Little attention has been given to the ability of the present quality control system to provide proper data from which to administer a national system of disallowances and/or incentives.

I propose to explore several issues which relate to inherent characteristics of the quality control systems in public assistance, their ability to provide meaningful state by state comparisons, and appropriateness of various causes of action directly related to various levels of misspent funds. To facilitate this explanation, four basic questions must be considered: 1) What constitutes misspent funds?, 2) How is the amount of misspent funds determined?, 3) What causes misspent funds?, 4) What can be done about misspent funds? While this statement does not intend to provide comprehensive coverage of each question, I believe that sufficient insight can be provided to facilitate decision-making. At the very least, I believe a careful review of this statement will suggest that the subject is not as simple as some believe.

WHAT CONSTITUTES MISSPENT FUNDS?

If mispayment rates are to be compared among states (whether for purposes of disallowances and/or incentives, or any other purpose), it is imperative that the definition of misspent funds be clear and meaningful and produce similar results from state to state. Current quality control systems are designed to provide relatively precise, unbiased estimates of each state's performance in complying with its own approved state plan of operation. The system provides these estimates, as intended, and has proved to be quite valuable as a source of information for corrective action planning on a state by state basis. This is the case since data supplied by the system is relevant to each state because measurement is against its own individual state plan of operation. Since each state has a different state plan of operation, however, it is not certain that state by state comparisons will have any pertinent meaning. What are actually considered misspent funds then, may vary from state to state according to the features of each individual state's plan of operation.

Those who are not completely familiar with various case budgeting methods allowable under the Social Security Act may not fully appreciate how differences in state plans can effect mispayment rates. The following examples demonstrate how c s with identical circumstances are viewed differently from state to state. Although the examples are hypothetical, they are based upon actual approved practices in various states.

Examples One — The Cap, or Maximum Grant

In this example, we will examine identical cases in two states. Each case will represent an eligible family of four recipients. In each state total needs for the family is determined to be $400. In each case the grantee has $300 of earned income which has gone unreported for several months. The only difference between the two cases is that State A pays 100 percent of need and State B has a maximum grant of $240 for a family of four.

Status of This Case in States A and B

	State A (100% of Needs)	State B (240 Cap)
Needs (family of 4)	$400	$400
Grant	$400	$240

To determine the effect of the $300 unreported income, we must determine how much of this was budgetable. The income disregard provisions require that the first $30 plus 1/3 of the remaining income must be disregarded. In addition, we will assume each state allows work expenses of $30. The substraction would be:

$300	gross income
-$30	less first $30
$270	
-$90	less 1/3
$180	
-$30	less work expenses
$150	net income

In each case, therefore, $150 of net income should have been budgeted. In the case of State A, $150 should have been deducted from the grant, so that a mispayment amount of $150 exists. Notice the interesting result in State B, however, when the $150 net income is considered. State B may exercise its option to deduct net income from needs. In this case the $150 net income would be subtracted from the $400 needs to indicate a grant of $250 (exactly the same as State A). However, ice State B has a maximum grant of $240, the amount they should properly pay remains at $240, regardless of the $300 of unreported earned income. Thus, no error exists in State B. In this example, therefore, identical cases of unreported income result in a large mispayment (37.5% of total payments) in the state which is doing the most to meet clients' needs, and no mispayment at all in the state which is doing substantially less in meeting needs. If sanctions and/or incentive payments are applied to these two states with identical case situations, the incentive for State A to provide a smaller percentage of clients' needs (and the incentive for State B to continue providing a smaller percentage of needs) is tremendous. This in direct opposition to the basic program goal of providing assistance to those in need.

Example Two — The Rateable Reduction

Much the same phenomenon can occur when a rateable reduction is in effect. In this example, we will consider the same cases which were considered in the last example. This time we will look at three states, A which pays 100 percent of need, and C and D which have a 40 percent rateable reduction in force. Again, $300 of unreported earned income will exist in each case, work expenses will be $30 and needs for a family of four will be $400. The difference between States C and D are in the manner that the rateable reduction is taken. In State C, it is taken against the grant and in State D, against needs.*

Status of This Case in States A, C and D

	STATE A (100% of Needs)	STATE C (40% R.R. Grant)	STATE D (40% R.R., Needs)
Needs (family of four)	$400	$400	$400
40% Rateable Reduction	-	160	160
Grant	$400	$240	$240
Budgetable Income	$150	$150	$150
Mispayment Amount	$150	$90	$0
Mispayment Percentage	37.5%	37.5%	0

All calculations are identical to Example One. State A again has a mispayment of $150 due to the unreported income. State C would have had a grant of $150 if the income had been reported since their rateable reduction is applied to the grant. ($400 needs less $150 budgetable income equals $250; less 40% r.R. - $100 -equals $150 grant amount.) In the case of State C, a mispayment percentage of 37.5 percent exists (comparable to State A). This is not the case in State D. When the 40 percent rateable reduction is applied against needs, a grant of $240 is determined. Subtraction of the $150 net income from $400 needs would indicate a grant of $250. However, this exceeds the $240 rateable reduction amount and therefore $240 is the correct payment. In this case, as in Example One, $300 of unreported income has no effect upon the mispayment rate. The disincentives for meeting needs are identical as in Example One.

Other examples could be cited, many of a more programmatic nature. Notice in each case, however, the discrepancy in mispayment amounts from state to state is not the result of any deficiency or variation in the quality control system. In each case, the quality control system accurately compares results with the state plan of operations. The problem, of course, arises from the large number of options available under the Social Security Act, and its implementing regulations, which produce state programs which are sufficiently dissimilar so as to render mispayment comparisons meaningless.

*This represents a minor simplification in actual procedures, for ease of discussion, but will not alter the conclusions.

The lack of differentiation between technical (or procedural) errors and actual mispayments is an area of current quality control policy which brings the credibility of the system into question. Technical (procedural) errors involve cases where the correct benefit was awarded to the desired target population but, due to an agency oversight, the cases are technically ineligible until the proper paperwork has been processed. Areas where these oversights occur involve assisting the recipient in applying for a social security number, fulfilling child support requirements, or registering the recipient for the WIN program. In each instance, however, the same amount of benefits would have been paid to the same recipients had all procedural requirements been met. Only in a technical sense does a mispayment exist. The corrective action concept in quality control implies that waste can be eliminated or diminished by proper corrective action. Mispayment amounts are viewed as being synonymous with waste. This is obviously not true in the area of technical errors. Corrective action to eliminate the source of error associated with five million dollars of technical errors will not reduce spending by one penny, since the proper benefit was already being given to the proper recipient. The failure of the current system to differentiate between these procedural errors and actual mispayments seriously undermines the credibility of all quality control results. I noted that in a colloquy on the Senate floor on September 27, 1979 (Cong. Record, PS 13218) Senator Magnuson told Senator Javits that it was the intent of the Conference Managers that technical errors would not be included in the base leading to fiscal sanctions. HEW's proposed regulation ignores such advice and does include technical errors — a bad policy, in my judgment.

HOW IS THE AMOUNT OF MISSPENT FUNDS DETERMINED?

Comparison of state mispayment rates on a national basis implies that the same standards will be used nationally to measure performance. Two primary areas will determine the uniformity of review from state to state — detailed specification of how a review is to be conducted, and similarity of review intensity. Currently there is considerable diversity among states within these two areas. DHEW is in the process of rewriting the quality control handbook in an effort to more closely standardize review and verification procedures among states. When this is accomplished we expect much more uniformity in review methodology among the states in the AFDC program. As of today, however, this project is not yet completed. I do not know when it will be.

Complete uniformity is not possible because program requirements (state plan of operation) vary from state to state, and because the reliability of certain types of verification vary from location to location. Nevertheless, at least in the AFDC program, we expect more uniformity of review techniques in the future. We do not hold such expectations for the Medicaid program.

Intensity of review is another matter. States which conscientiously spend more time and money in the quality control review process will detect more of the errors which actually exist than will those states which expend significantly smaller amounts of time and money. Currently, some states spend (on the average) three times the amount of time on a review as other states spend. While the states with the more extensive review procedures do not generally find that many more cases in error than other states, the additional errors that are uncovered tend to be very large mispayment amounts since they involve ineligible cases whose circumstances were willfully misrepresented by the recipient. It is no accident that the states

hich conduct the most extensive reviews consistently report client error rates nispayment amounts) well above the national average. So long as the quality ontrol data is only utilized for corrective action purposes within a state, the more xter ·e review reflects responsible management since it produces the most ccurate data on which to base decisions. Once states are compared with each ther for purposes of withholding FFP, however, the more extensive review can no onger be justified because of the large relative disadvantage a state places itself ı by doing excellent quality control reviews. In fact, under a sanction nvironment, states will have every incentive to drop back to barely minimal uality control reviews. Should this happen — and it will, believe me — fiscal anctions will be less than is presently projected, but quality control will also be reakened as a management tool.

)HEW attempts to adjust for these differences by means of a federal re-review of subsample of state reviews. When different results are found between the federal nd state samples, state findings are statistically adjusted to take federal findings ıto account. The contention is that this process eliminates a large portion of the tate to state differences in review procedures and intensity of effort. If the ederal re-review staff utilize uniform re-review procedures from state to state, it s entirely possible that most differences in review procedures can be taken into ccount. (Discussions between state directors, and state quality control directors egarding federal re-review experiences lead us to believe that the federal re-eview procedures are greatly lacking in uniformity nationally.)

'he contention that differences in intensity of effort can be taken into account is nore difficult to understand. The number of federal re-reviewers required in any tate is governed by the subsample size. Nationally, federal re-reviewers are taffed so as to be able to spend about the same amount of time on a re-review. Suppose that amount of time is two hours. The state averaging 24 working hours er review would get re-review cases that averaged 26 hours of review after the ederal re-review was completed. States averaging 8 hours would average 10 hours ifter federal re-review. We do not understand how this procedure rectifies the ntensity issue in any respect, although we have been assured that it does. It does ıot, regardless of what anyone says.

WHAT CAUSES MISSPENT FUNDS?

:t would be impossible to detail all causes of misspent funds in public assistance. I believe, however, that three general problem areas are paramount. The first area of concern involves the tremendous complexity of the laws, rules, regulations, and court decisions which determine the administration of public assistance programs.

Although program complexity effects all jurisdictions in their administration of pub' assistance programs, it cannot be said to effect them equally. Jurisdictions which are characterized by recipient populations whose circumstances are more unstable than the average recipient population, are particularly disadvantaged. In general, this characterizes the situation found in the larger metropolitan areas where recipients are more transient, are continually in and out of the labor market, and whose family situations tend to be more unsettled. This is well documented by the April-September 1978 national mispayment rates where we see the following mispayment rates:

Large Metropolitan Area	Mispayment Rate	Mispayment Rate Rest of State
Wayne Co. (Detroit)	11.3	4.8 (Mich.)
New York City	10.3	6.2 (N.Y.)
Cook Co. (Chicago)	17.6	10.2 (Ill.)
Philadelphia	24.1	11.1 (Pa.)
Los Angeles Co.	3.5	2.3 (Cal.)
Washington, D.C.	23.3	-

Although most are willing to concede the accuracy of this charge, little has been done to address the problem. In fact, during an era when national expectations demand a continual decrease in mispayment rates, Federal law and regulation seem to become more and more complex and difficult to administer. There seems to be an increasing tendency in both Congress and DHEW to absolve themselves from any responsibility for public assistance mispayments. Current sanction regulations place the entire responsibility for mispayment upon the states. Once again the states have become the scapegoat and the true nature of the Federal/State partnership is revealed. We would hope that Congress would not allow this injustice to continue.

Secondly, as already noted, states do not have uniform programs nationwide. Programs differ among states in benefit levels and in scope of coverage. It has already been shown that states which achieve a lower benefit level by virtue of a maximum grant or rateable reduction, tend to gain a sizable advantage over states paying a higher proportion of need. This is true because of the handling of unreported earnings, as previously demonstrated. Many low benefit states, however, do not employ such devices but merely declare a very low standard of need. Thus, they do not gain the advantages from the maximum grant or rateable reduction. This is not to imply, however, that these low benefit states do not possess an inherent advantage over high benefit states in terms of mispayment rates.

Probably the most error prone group of cases nationally is the group of cases receiving earned income. Mispayment rates for those receiving income tend to be astronomical and few states are free from such errors. However, as the amount of earned income increases, a point is finally reached where the case is no longer eligible for assistance. At this point, assuming proper reporting occurs, the case leaves the roles and the size of the error prone earned income case group is reduced. If many such cases reach this point, a substantial reduction in the size of the error prone case group can be achieved and mispayment rates will drop accordingly. Of particular interest, therefore, is the amount of earned income required in a state for the case to become ineligible for assistance. If this value is quite low, the state could be expected to administer fewer of these error prone cases than most, and therefore to have a lower mispayment rate if all other things were equal. Conversely, the higher the amount of earned income necessary to become ineligible for assistance, the more error prone cases the state would expect to administer (with the expected accompanying increase in mispayment rates). The following table examines the approximate number of hours which a grantee of a family of four would have to work, earning the minimum wage, before becoming ineligible for assistance.

STANDARD OF NEED (Family of Four)	Approximate Number of Hours Worked Per Month at Minimum Wage Before Becoming Ineligible for Assistance*
$ 80	63
$100	76
$120	89
$140	101
$160	114
$180	126
$200	139

*Assumes standard income disregard, 6% FICA tax, no income taxes, and no work expenses. Figures should be revised slightly upward to reflect work expenses.

It can be seen from the table that cases with earned income will earn their way off the roles much more quickly in states with a low standard of need than they would in states with a higher standard of need. This offers a clear advantage to low benefit states since the size of the error prone earned income group is more likely to be smaller than in higher standard states.

Statistics generated by the national quality control system tend to indicate that the more generous the program in a state, in terms of scope of coverage, the higher the mispayment rates will tend to be. For example, a state may choose to extend coverage to the unemployed father segment, or to 18-21 year old children; they may choose to provide allowances for special needs or allow more generous resource requirements; they may pay actual work expenses, rather than standard allowances, and may choose to disregard income from some sources. In each instance, the state, by adopting these options, is doing more for people in need (clearly the goal of the program). In each instance, however, the state also picks up an error prone segment which will tend to force mispayment rates up. States are faced with an obvious choice — keep mispayment rates low by restricting program coverage (and benefit levels), or provide for people in need at the expense of higher mispayment rates.

Thirdly, the effect of willful client misrepresentation of circumstances should be noted. Although the distribution of agency to client error has historically been 50%/50%, client errors as a group tend to involve much larger amounts. When mispayment rates are examined, two-thirds of the mispayment is attributable to client error and only one-third to agency errors. This would suggest that during the April-September 1978 period, approximately 5% of total ADC funds were misspent due to client error. The picture of the "welfare chiseler" is a popular concept these days. Many tend to take a hard line on misspent funds in public assistance programs because of their conception of the "welfare chiseler." We would call your attention to a recent report of the Internal Revenue Service (Publication 1104 (9-79)) which estimates that between 8%-11% of funds which should be received from the individual income tax are not received due to willful underreporting, or nonreporting, by the general population. When this 8%-11% figure is compared to the estimated 5% in the AFDC program, a more proper perspective may be gained. Certainly, misspent funds due to willful misrepresentation in public assistance programs must be addressed. It should be recognized, however, that this

undesirable behavior is even less prevalent in the public assistance population than it is in the general population. National policy which focuses upon fraud and abuse in public assistance, while ignoring equal incidences of fraud and abuse in the general population, as evidenced by the income tax study, promotes an insidious type of discrimination which cannot be tolerated. Persons and families on public assistance are at least as honest as the population generally. Yet the public perception is much different.

WHAT CAN BE DONE ABOUT MISSPENT FUNDS?

Current national policy suggests that the most effective way to reduce misspent funds is through a policy of fiscal disallowances to the states. I believe that this policy is probably the most counterproductive approach which could be undertaken, especially when the various consequences of the policy are examined. It is often argued that a disallowance of federal matching funds is required to provide the negative incentive necessary to stimulate the states into taking corrective action. This suggestion presupposes that 1) the size of the negative incentive is large enough to stimulate action, and 2) misspent funds are caused (and are therefore controllable) by the states. The negative incentive argument is curious, to say the least, since in every disallowance scheme seriously considered to date, the states will lose more money in state funds misspent than they will in federal disallowances. Certainly every state has sufficient incentive to reduce misspent funds in their own limited state budgets, without the need of further "incentives" of a federal nature. Clearly, then, something more than a negative incentive is required to reduce misspent funds. The argument that misspent funds result from faulty state administration is also perplexing. No state would be so bold (or so naive) as to claim perfect program administration. Without a doubt, all states will readily admit that a portion of the misspent funds directly result from less than perfect administration of the public assistance programs at the state level. Such does not appear to be true for DHEW or Congress, however. I find nothing in current disallowance regulations, or discussion, to indicate that DHEW or Congress assume any responsibility for the problem even though they are the source of public assistance law and regulation, and to a great extent determine how programs will be administered nationally. Current disallowance regulations, for example, pass the entire sanction amount to the states. There is no incentive whatsoever for improved performance from DHEW.

In addition, I have shown previously, the disadvantage, in terms of misspent funds, which is incurred by states which choose to offer higher benefit levels or a broader scope of program coverage. A policy of national disallowance, based upon misspent funds, would obviously provide strong disincentives to those states which do more to provide for human need by providing higher benefit levels and broader program coverage. Given the fact that public assistance programs exist to address the problem of human need, any policy which provides strong disincentives to states which do the most to provide for human need would appear antithetical to the basic purpose of public assistance. I believe fiscal disallowance to be such a policy.

One more point must be made and stressed. The only possible consequences of a policy of fiscal disallowance are contrary to what Congress intends. Only two real alternatives exist. Either benefits to clients will be reduced, or kept low, or staff reductions will be ordered. Should staff reductions result, error rates will increase. Surely, these alternatives are not Congressionally intended.

There is one other alternative, and it probably is most likely. I fear that a national policy of fiscal disallowance will destroy the quality control system, rather than reduce misspent funds. I have no doubt that fiscal sanctions will force states to report a misspent funds rate consistent with desired national targets. The key word here is report. Since many states will find it difficult, or impossible, to achieve necessary reductions in misspent funds, they will be forced to curtail quality control review activity to the point that only the target level can be detected. Although everyone will then be able to celebrate the effectiveness of the sanction policy in reducing misspent funds, in fact all that will be achieved is that the national capability to detect misspent funds will be diminished. Little reduction in actual misspent funds will occur, and the data necessary to formulate effective corrective action will no longer exist. This will be the tragic, although inevitable, result of a national disallowance policy.

Solution to the misspent fund problem must begin in Washington. Public assistance laws and regulations must be simplified to the point where programs are easily administered — even to clients who experience frequent changes in circumstances. At the very least, this would entail considerable standardization among requirements and definitions in the various federal programs, plus uniformity in eligibility and budgeting procedures. DHEW must be much more involved in the technical aspects of administration, such as identifying the most effective case management techniques, specifying minimum worker qualifications, suggesting performance standards for first line workers, and assisting with training modules. Finally, financial incentives should be available to states who develop innovative techniques to more effectively administer public assistance programs.

In conclusion, I wish to reiterate my support for positive efforts to reduce current rates of misspent funds. My interest in accomplishing this worthy objective is every bit as keen as the federal interest. I would hope that such efforts would recognize the true nature of the Federal/State partnership and place the burden of achievement equally upon all shoulders, rather than pursuing a bankrupt policy of "passing the buck" to the states.

NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS
AMERICAN PUBLIC WELFARE ASSOCIATION

TESTIMONY OF JOHN J. AFFLECK
DIRECTOR
RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

AND

CHAIRMAN
NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

BEFORE
SUBCOMMITTEE ON FINANCE
UNITED STATES SENATE FINANCE COMMITTEE

UNITED STATES SENATE

NOVEMBER 16, 1979

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, MY NAME IS JOHN J. AFFLECK. I AM DIRECTOR OF THE RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES AND CHAIRMAN OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS. THE NATIONAL COUNCIL, ON WHOSE BEHALF I AM TESTIFYING, IS COMPOSED OF THE OFFICIALS IN EACH STATE, THE DISTRICT OF COLUMBIA, AND THE U. S. TERRITORIES WHO ARE RESPONSIBLE FOR ADMINISTERING INCOME MAINTENANCE, MEDICAL CARE, AND SOCIAL SERVICE PROGRAMS WHICH PROVIDE ASSISTANCE TO MILLIONS OF PEOPLE IN NEED. I AM ACCOMPANIED TODAY BY DR. JOHN T. DEMPSEY, DIRECTOR OF THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES, BARBARA B. BLUM, COMMISSIONER OF THE NEW YORK DEPARTMENT OF SOCIAL SERVICES, AND ALVIS D. ROBERTS, ASSISTANT SECRETARY FOR THE OFFICE OF FAMILY SECURITY OF THE LOUISIANA DEPARTMENT OF HEALTH AND HUMAN RESOURCES. WHILE I TESTIFY AS CHAIRMAN OF THE COUNCIL, REFLECTING ITS VIEWS, I BASICALLY TESTIFY FROM MY VANTAGE POINT AS DIRECTOR OF THE RHODE ISLAND PROGRAM. THOSE WITH ME TODAY WILL BE PROVIDING THE COMMITTEE WITH TESTIMONY CAST FROM THEIR RESPECTIVE VANTAGE POINTS. WE ARE VERY APPRECIATIVE OF THE FACT THAT YOU ARE HOLDING THIS

HEARING TODAY IN RECOGNITION OF THE SERIOUS NATURE OF THE ISSUE AND YOUR DEEP AND CONTINUING INTEREST IN THE PROBLEMS FACING STATES IN ADMINISTERING THE PRESENT WELFARE SYSTEM. WE ARE GRATEFUL FOR THE OPPORTUNITY TO TESTIFY IN RELATION TO QUALITY CONTROL AND FISCAL SANCTIONS WHICH ARE SO COMPELLING IN OUR ADMINISTRATIVE CONCERNS.

I AM SURE YOU ARE VERY AWARE THAT THE COMBINATION OF FEDERAL REGULATIONS AND STATE LAWS FREQUENTLY MAKE FOR A CUMBERSOME AND SOMETIMES CONTRADICTORY JOB FOR ADMINISTRATORS AND WORKERS IN THE WELFARE FIELD AND SEEM TO MAKE OUR PROGRAMS ALMOST TOTALLY UNINTELLIGIBLE FOR THOSE PEOPLE WHO ARE RECEIVING BENEFITS. LET ME FIRST SAY THAT THIS SITUATION IS IN NO WAY AMELIORATED BY THE QUALITY CONTROL SYSTEM.

WE IN THE STATES WHO ARE RESPONSIBLE FOR ADMINISTERING WELFARE ARE VERY SERIOUSLY IN FAVOR OF THOSE PRINCIPLES WHICH UNDERPIN THE CONCEPT OF QUALITY CONTROL. SINCE OUR PROGRAMS ARE CONTINUALLY OPEN TO PUBLIC SCRUTINY, AND FREQUENTLY PUBLIC SCORN, IT IS A VERY REASONABLE GOAL FOR WELFARE ADMINISTRATORS TO ENCOURAGE A CONTINUING REVIEW OF THE QUALITY OF ITS PROGRAM.

WELFARE ADMINISTRATORS MUST ESTABLISH CORRECTIVE ACTION WHEN SUCH REVIEW INDICATES THE NEED, AND MAKE PUBLIC THE FINDINGS OF SUCH REVIEWS WITH AN EYE TOWARDS CAPTURING THAT DEGREE OF PUBLIC CONFIDENCE THAT SUCH A SYSTEM MAY ENGENDER. WE, HOWEVER, ARE NOT AT ALL SURE THAT LOGIC WAS THE MOTIVATING FORCE BEHIND THE ORIGINAL FEDERAL REGULATIONS WITH RESPECT TO QUALITY CONTROL. THERE ARE SOME WHO FEEL THAT THE ORIGINAL INTENT OF QUALITY CONTROL WAS TO DEMONSTRATE TO THE PUBLIC THAT THE WELFARE SYSTEM IN PLACE COULD NOT BE ADMINISTERED. RECENT NATIONAL ADMINISTRATIONS SEEM TO HAVE ATTEMPTED TO ERODE PUBLIC CONFIDENCE THROUGH THE USE OF QUALITY CONTROL FINDINGS.

WE, OF COURSE, DO NOT WHOLLY FEEL THAT QUALITY CONTROL IN A WELFARE PROGRAM CAN BE ANALGOUS TO THOSE QUALITY CONTROL SYSTEMS USED ON PRODUCTION LINES AND MANUFACTURING CONCERNS, A POINT THAT I WOULD LIKE TO SPEAK TO LATER.

IN RECENT YEARS IT HAS BECOME FASHIONABLE FOR PUBLIC ADMINISTRATORS TO ADOPT MANAGEMENT TECHNIQUES ESTABLISHED IN PRIVATE INDUSTRY. THE ASSUMPTION, OF COURSE, IS THAT PRIVATE INDUSTRY IS THE SOURCE OF INNOVATION IN SUCH TECHNIQUES AND BECAUSE OF THE PROFIT MOTIVE, PRIVATE ORGANIZATIONS HAVE THE CAPACITY AND WILLINGNESS TO CONCEIVE OF SCHEMES WHICH RESULT IN EFFICIENT AND EFFECTIVE MANAGEMENT. QUALITY CONTROL IS ONE TANGIBLE MANIFESTATION OF THAT ASSUMPTION. I SUSPECT THAT RECENTLY CHRYSLER CORPORATION HAS GIVEN SOME DOUBT TO THE CONTINUED WISDOM OF GOVERNMENT BORROWING FROM INDUSTRY; INDEED, THAT CORPORATION HAS MADE APPLICATION FOR WELFARE, IN SPITE OF THEIR ADVANCED MANAGEMENT TECHNIQUES.

ONE OF THE MAJOR PROBLEMS WHICH FACE STATE AND LOCAL WELFARE ADMINISTRATORS IS THE APPLICATION OF QUALITY CONTROL TECHNIQUES THAT ARE UNTUTORED. AS AN EXAMPLE, EACH JURISDICTION USES A SERIES OF TECHNIQUES IN ORDER TO ESTABLISH ELIGIBILITY FOR AFDC OF APPLICANTS. THESE TECHNIQUES ARE BASED ON THE NUMBER OF STAFF THE AGENCY HAS AVAILABLE TO TAKE SUCH APPLICATIONS, ON THE VOLUME OF APPLICATIONS THAT A PARTICULAR OFFICE REVIEWS AND OF PREVIOUS EXPERIENCE WITH RESPECT TO THE QUALITY OF THE APPLICATION PROCEDURE AND FINALLY, HOPEFULLY, WITH A STRONG DEGREE OF COMMON SENSE. THESE TECHNIQUES ARE, IF NOTHING ELSE, PRACTICAL. THEY PROVIDE THE STATE AND FEDERAL GOVERNMENT WITH A VARIETY OF DATA WHICH IS REQUIRED ON EACH APPLICANT. THEY ATTEMPT TO PROVIDE A MODICUM OF DIGNITY TO WHAT IS OTHERWISE AN UNDIGNIFIED PROCESS AND FINALLY, THEY ATTEMPT TO ELICIT SUFFICIENT INFORMATION TO GIVE SOME ASSURANCE THAT THE PERSON WHO IS APPLYING IS ELIGIBLE FOR THE PROGRAM.

FEDERAL QUALITY CONTROL REGULATIONS ON THE OTHER HAND APPLY AN ENTIRELY DIFFERENT SET OF TECHNIQUES IN REVIEWING WHETHER THAT APPLICANT WAS FINALLY ELIGIBLE. A QUALITY CONTROL REVIEWER MUST MAKE COLLATERAL VISITS, TALK TO BANKERS, FOLLOW UP ON A WHOLE VARIETY OF "LEADS" WHICH A WELFARE WORKER UNDER PRESSURE OF REALITY MUST IGNORE. WHEREAS A WELFARE WORKER MAY TAKE SEVEN APPLICATIONS FOR AFDC IN A SINGLE DAY, THE QUALITY CONTROL REVIEWER MAY REVIEW TWO TO THREE SUCH SITUATIONS IN A WEEK. IF GENERAL MOTORS WERE TO SET THEIR MACHINES SO THAT THERE WAS A TOLERANCE OF 5 CENTIMETERS IN THE CLEARANCE OF ONE OF THEIR ENGINE PARTS AND SUBSEQUENTLY TEST THE VALUE OF THAT PART TO THE 0.5 CENTIMETER TOLERANCE LEVEL, WE MUST ASSUME THAT THERE WOULD BE VERY FEW PARTS WHICH WOULD PASS SCRUTINY. THIS IS EXACTLY WHAT IS OCCURRING IN THE AFDC QUALITY CONTROL SYSTEM. ONE OF THE ANSWERS TO THIS DIFFERENCE WOULD BE TO USE THE SAME TECHNIQUES AT POINT OF APPLICATION AS ARE USED IN THE QUALITY CONTROL REVIEW, A CHOICE WHICH WOULD REQUIRE A MONUMENTAL INCREASE IN STAFF, SPACE, RED TAPE AND COST, ALL OF WHICH WOULD HAVE A QUESTIONABLE RETURN ON INVESTMENT.

AS AN EXAMPLE, LET ME SUGGEST THAT OUR SISTER STATE, NEVADA, HAS THE BEST QUALITY CONTROL ERROR RATE IN THE COUNTRY. WHILE WE CONTINUE TO STRIVE TO IMPROVE OUR QUALITY CONTROL ERROR RATE IN RHODE ISLAND, HISTORY WOULD SHOW THAT OUR PERFORMANCE IS CREDITABLE. IN REVIEWING FEDERAL PUBLICATIONS I HAVE OBSERVED THAT THE ADMINISTRATIVE CASE COSTS PER MONTH IN NEVADA ARE OVER 200% HIGHER THAN OURS IN RHODE ISLAND. NOW WHILE THERE MAY BE MANY VARIABLES ACCOUNTING FOR THAT DIFFERENCE, I SUSPECT THAT THE MAJOR ISSUE IS THAT THE STATE OF NEVADA HAS AS ITS MAJOR GOAL TO HAVE THE LEAST AMOUNT OF ERROR IN THE COUNTRY. THEY APPARENTLY ARE WILLING TO PAY FOR THAT GOAL EVEN THOUGH IT MAY BE LESS EXPENSIVE TO TOLERATE A HIGHER PERCENTAGE OF ERROR. THE LATTER STATEMENT SOUNDS, I AM SURE, LIKE HERESY BUT IN FACT IF THE REASON FOR QUALITY CONTROL REVIEW IS TO MINIMIZE THE DOLLAR

LOSS CREATED THROUGH ERROR, THEN THE QUALITY CONTROL SYSTEM ITSELF HAS TO BE MEASURED IN COST BENEFIT TERMS. THERE IS CLEARLY A POINT BEYOND WHICH ADDITIONAL ADMINISTRATIVE EXPENDITURES WOULD CREATE LITTLE OR NO DOLLAR RETURN AS A RESULT OF ERROR REDUCTION.

WHICH BRINGS US TO THE NEXT MAJOR ISSUE, THAT IS - THE ELYSIAN FIELD OF 3% INELIGIBILITY AND 5% INCORRECT PAYMENT, A SET OF NUMBERS WHICH ALL AGREE ARE BASED UPON THE WHIM AND CAPRICE OF UNKNOWN BUREAUCRATS. NO ONE, LEAST OF ALL HEW, HAS THE LEAST NOTION AS TO WHAT THE MINIMAL TOLERANCE ON ERROR SHOULD BE AND INTERESTINGLY, HEW IS ONLY NOW TAKING STEPS TO INITIATE A STUDY RELATED TO APPROPRIATE TOLERANCE LEVELS. IT WILL BE SOMETIME AT BEST BEFORE THE STUDY RESULTS ARE AVAILABLE. IN THE MEANTIME, THE OLD 3 AND 5% FIGURES FLOAT ESSENTIALLY UNCHALLENGED AS WELL AS THE CONGRESSIONAL DIRECTIVE OF 4%.

LET ME JUST BRIEFLY INDICATE SOME OF THE OPERATIONAL PROBLEMS OF THE PRESENT QUALITY CONTROL REGULATIONS AS THEY RELATE TO THE PUBLIC UNDERSTANDING OF THE WELFARE PROGRAM. WHEN QUALITY CONTROL REGULATIONS ARE PUBLISHED PEOPLE HAVE A RIGHT TO ASSUME THAT THOSE FAMILIES WHO ARE DEFINED AS INELIGIBLE SHOULD NOT BE RECEIVING BENEFITS. INELIGIBLE IN THE MINDS OF THE GENERAL PUBLIC MEANS THAT PEOPLE SHOULD NOT BE ON THE ROLLS, MAY BE CHEATING, LYING, OR ON THE OTHER HAND THE WELFARE DEPARTMENT IS NEGLIGENT IN ITS DUTY TO POLICE THE ROLLS.

DURING THE LAST QUALITY CONTROL SAMPLE PERIOD IN RHODE ISLAND AN UNUSUAL NUMBER OF FAMILIES ON AFDC WITH ONE CHILD WERE FOUND TO BE INELIGIBLE OWING TO THE FACT THAT THIS CHILD DID NOT HAVE A SOCIAL SECURITY NUMBER. UNDER FEDERAL REGULATIONS SUCH A CASE IS INELIGIBLE. THE FAMILY IS JUST AS POOR, THEY HAVE NO OTHER INCOME AND THEIR NEED CONTINUES TO EXIST. MY STAFF SIMPLY MUST DEMAND THAT

A SOCIAL SECURITY NUMBER BE OBTAINED FOR THIS CHILD (WHO MAY BE TWO MONTHS OLD) IN ORDER FOR THE FAMILY TO CONTINUE TO RECEIVE AFDC. BE ASSURED THAT RHODE ISLAND WOULD CONTINUE TO SUPPORT THAT FAMILY BUT WE DEMAND A SOCIAL SECURITY NUMBER IN ORDER TO MAKE THE FAMILY ELIGIBLE FOR THE FEDERAL AFDC PROGRAM AND, THEREFORE, FEDERAL FINANCIAL PARTICIPATION IN COSTS. THIS KIND OF SITUATION IS NOT UNIQUE, THE PRINCIPLE BEING THAT THE APPLICATION OF TECHNICAL REQUIREMENTS IN THE AFDC PROGRAM FREQUENTLY IGNORES THE BASIC PREMISE FOR WELFARE RECEIPT, I.E. LACK OF INCOME. I AM SURE THAT A DISPROPORTIONATE SHARE OF THE ERROR RATES PUBLISHED THROUGHOUT THE COUNTRY ARE MISLEADING THE PUBLIC TO BELIEVE THAT THERE ARE CASES RECEIVING WELFARE WHO ARE NOT ELIGIBLE WHEN WE ALL KNOW THAT THEY TRULY ARE.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I WANT TO MAKE IT CLEAR TO YOU THAT I AM ONLY AGAINST THE PRESENT SYSTEM OF QUALITY CONTROL. I AM NOT AGAINST THE PRINCIPLE OF APPLYING QUALITY CONTROL TECHNIQUES TO WELFARE PROGRAMS. I AM ASKING THAT THIS COUNTRY CONSIDER DEVELOPING TECHNIQUES WHICH ARE CONSISTENT WITH THE REALITIES OF THE WELFARE PROGRAMS.

AS TO THE ISSUE OF FISCAL SANCTIONS, I MUST ADMIT AGAIN THAT WE ARE DEALING WITH A PARADOX. ONE HOUSE OF THE CONGRESS HAS RECENTLY ACTED ON WHAT HAS BEEN CALLED WELFARE REFORM. ONE OF THE GOALS OF THIS NEW LEGISLATION IS TO INSURE THAT ALL PEOPLE IN THIS COUNTRY RECEIVE A NATIONAL MINIMUM FLOOR OF INCOME. THIS GOAL IS BEING ACCOMPLISHED PRIMARILY THROUGH THE USE OF FEDERAL FUNDS AND FEDERAL INITIATIVE. SINCE MANY STATES EITHER CANNOT OR WILL NOT PROVIDE FROM ITS REVENUE A WELFARE GRANT EQUAL TO THAT WHICH IS CONSIDERED MINIMALLY ADEQUATE, THE FEDERAL GOVERNMENT HAS TAKEN THE INITIATIVE WITH THIS NEW LEGISLATION. IT IS ALSO THE CASE THAT HEW IS SUGGESTING THAT UNLESS CERTAIN LEVELS OF ACCURACY ARE MAINTAINED

THE FEDERAL GOVERNMENT SHOULD WITHHOLD MONEY. ON THE ONE HAND CONGRESS IS SAYING THAT PEOPLE WHO ARE POOR SHOULD RECEIVE AT LEAST A MINIMUM AMOUNT OF MONEY THROUGHOUT THE COUNTRY AND ON THE OTHER HAND HEW IS PROPOSING TO REMOVE SOME OF THAT MONEY. THE NET EFFECT OF FISCAL SANCTIONS, OF COURSE, WOULD BE TO TAKE THE BURDEN OF SUPPORT FOR POOR PEOPLE AWAY FROM THE FEDERAL GOVERNMENT. ONE OF TWO THINGS WOULD LOGICALLY FOLLOW:

(1) THAT THE STATE WILL ASSUME THE BURDEN REMOVED BY THE FEDERALS (AS WOULD HOPEFULLY BE THE CASE IN THE STATE OF RHODE ISLAND) OR

(2) THAT THE STATE WOULD REDUCE THE AMOUNT OF ITS WELFARE GRANT TO REFLECT THE LOSS OF FEDERAL INCOME.

THIS COULD WELL BE THE CASE IN A SIGNIFICANT NUMBER OF STATES. THERE IS, FURTHER, AN ASSUMPTION IN THE MATTER OF FISCAL SANCTION THAT STATES ARE NOT CONCERNED ABOUT THE QUALITY OF THE ADMINISTRATION OF THEIR PROGRAM. LET ME ASSURE YOU, MR. CHAIRMAN, THAT NOTHING IS FURTHER FROM THE TRUTH. WHILE I CAN SPEAK PRIMARILY FOR RHODE ISLAND, I FEEL SAFE TO SAY THAT EACH STATE'S WELFARE PROGRAM IS UNDER CONSTRAINT AND CONTINUOUS SCRUTINY FROM THE CHIEF EXECUTIVE, FROM ITS GENERAL ASSEMBLY, FROM NEWSPAPERS, FROM SO-CALLED CONCERNED TAXPAYER GROUPS, AND EVEN FROM WELFARE RECIPIENTS THEMSELVES. THERE IS NO SERVICE PROVIDED BY THE GOVERNMENT WHICH IS MORE CONTROVERSIAL THAN WELFARE. THERE IS NO SERVICE PROVIDED BY THE GOVERNMENT WHICH IS CRITICIZED MORE OFTEN THAN WELFARE. IN MY MIND, THERE IS NO SERVICE PROVIDED BY GOVERNMENT WHICH FACES MORE UNANSWERABLE QUESTIONS THAN WELFARE. FOR HEW TO ASSUME THE POSTURE THAT IT WILL BE THE GUARDIAN OF TAX DOLLARS BY PUNISHING STATES BY WITHHOLDING FEDERAL FUNDS WHEN THEIR ERROR RATE IS IN EXCESS OF THAT WHICH HEW HAS ESTABLISHED AS THEIR GOAL, OR WHICH HAS BEEN ESTABLISHED FOR THEM AS A GOAL, THEN HEW IS NOT ONLY BEING POMPOUS, BUT IS IGNORING

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THAT WHICH SHOULD BE PATENTLY CLEAR TO ANYONE WHO READS THEIR OWN LOCAL NEWS-PAPER.

I APPRECIATE THE OPPORTUNITY TO COME BEFORE THIS COMMITTEE TODAY AND WOULD BE PLEASED TO PROVIDE ANY ADDITIONAL INFORMATION WHICH THIS COMMITTEE WOULD FEEL NECESSARY AND HOPE THAT YOU TAKE TESTIMONY FROM MY COLLEAGUES AND MYSELF INTO SERIOUS CONSIDERATION WHEN YOU ARE MAKING JUDGMENTS ON THIS MOST IMPORTANT AREA OF QUALITY CONTROL AND FISCAL SANCTIONS.

I AM PLEASED NOW TO HAVE MY OBSERVATIONS COMPLEMENTED BY MY ASSOCIATES.

TESTIMONY OF JOHN J. AFFLECK

DIRECTOR

RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

- and -

CHAIRMAN

NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

Mr. Chairman, members of the Subcommittee, good morning. I am John J. Affleck, Director of the Rhode Island Department of Social and Rehabilitative Services and Chairman of the National Council of State Public Welfare Administrators (NCSPWA) of the American Public Welfare Association (APWA).

Accompanying me today are four of my distinguished colleagues: I am pleased to be able to introduce Ms. Barbara Blum, Commissioner of the New York State Department of Social Services, Dr. John T. Dempsey, Director of the Michigan Department of Social Services; Mr. Marion J. Woods, Director of the California Department of Social Services; and Mr. Alvis Roberts, the Assistant Secretary of the Louisiana Office of Family Security.

Mr. Chairman, all of us have written statements that we would like to submit for the record. In order to save time, each of us will comment, in turn, on particular aspects of erroneous payments in the public assistance programs--notably the AFDC, Medicaid, and SSI programs operating under the Social Security Act. Generally, we will examine: (1) the extent of misspent funds, (2) probable causes of erroneous payments, and (3) the methods of correcting payment errors. With respect to the third point, we will discuss the drawbacks of fiscal sanctions and how

they would be applied, as well as the preferred course of fiscal incentives combined with federal technical assistance.

As you know, Mr. Chairman, we are speaking not only for our own states but for all of the states and territories as represented by the National Council of State Public Welfare Administrators. In fact, many states would have liked to be represented here today and I expect they will be submitting their statements for the record.

State administrators firmly believe that the issue of program quality control (QC) is important, that it deserves dispassionate, thoughtful attention, and that the current federal policy governing quality control--as manifested by Mr. Michel's amendment to the FY 80 Labor-HEW appropriations bill--needs immediate revision.

As you know, the Council strenuously opposes the Michel Amendment and actively sought its deletion from H.R. 4389. We note that the FY 80 Labor-HEW bill has yet to win approval by both Houses and hope that this irresponsible language may yet be deleted or superceded by subsequent legislation. Toward that end, the Council unanimously adopted a resolution requesting that the substantive Congressional committees reassert their responsibility in this area--rather than permit the Appropriations Committees to address complex substantive issues like quality

control and fiscal sanctions by default. (A copy of that resolution is attached to my written statement.) The Council, therefore, commends you, Mr. Chairman, for initiating this hearing.

I might note that the House Ways and Means Committee and, on November 7, 1979, the full House of Representatives, moved to undo the meat-axe approach of the Michel Amendment by passing H.R. 4904. Sections 130, 131, and 132 of H.R. 4904, the Social Welfare Reform Amendments of 1979, would reaffirm that payment error rates be steadily reduced toward a goal of 4 percent; would require the Secretary to complete a major study of payment errors by December 31, 1980; and would retain HEW's March 7, 1979, fiscal sanction regulations until such time as the Congress has completed its review of the afore-mentioned study and made an informed decision on how best to proceed. We strongly support this House-passed legislation.

Mr. Chairman, this hearing, the Michel Amendment, the HEW Secretary's conference on fraud, waste, and abuse--all of these events grow out of increasing public consternation with payment errors in public welfare programs. In turn, the public's demand for program integrity is fueled by several exaggerated claims. I'd like to briefly mention the three most important:

The first is that all poor people on welfare are out to cheat the taxpayers. In fact, poor people are as honest as their more affluent counterparts--perhaps even more honest. The myth of rampant "welfare fraud" ought to be permanently retired. There are, of course, a few criminals who will blatantly defraud and abuse the welfare system--just as there are a minority of Americans who will embezzle from their employers, cheat the Internal Revenue Service, and commit white-collar computer fraud. By and large, the vast majority of our clients are legitimately entitled to their benefits. As Dr. Dempsey will discuss shortly, the amount of malicious recipient fraud in the AFDC and Medicaid programs--while it needs to be vigorously prosecuted--appears to be significantly less than taxpayer fraud.

The second myth is that state governments and state administrators are cavalier in their attitude toward welfare program administration. We are told that only the threat of federal fiscal sanctions will motivate us to do a better job. This is utter nonsense. No one--least of all state administrators--disputes the desirability of operating accurate and cost-effective programs. In fact, we are deeply committed to compassionate, efficient program administration. Our conviction stems from our professional ethics as much as from our desire to minimize the loss of state and federal dollars. I need not remind the Chairman that the states' invest-

ment in public assistance programs has grown faster in recent years than has the federal government's.

sharply amended this morning,

The third difficulty, is the unbounded zeal with which the federal government--chiefly the Department of Health, Education, and Welfare--has loudly promised to "crack down" on fraud, waste, and abuse and to hold the states' proverbial "feet to the fire". Amidst all this promised violence, the Department has conspicuously failed to note the significant progress in error reduction that states have made--without the threat or imposition of sanctions.

These melodramatic, sensational claims of widespread recipient fraud, lazy states, and a crusading federal white knight have resulted in the current federal policy embodied in the Michel Amendment. By reciting this littany, I do not mean to excuse current payment errors in public assistance programs--but rather to put them into a more rational perspective.

We are here today to tell you why the current federal approach makes no sense and to examine the issues that must be equitably resolved before federal fiscal sanctions can begin to make sense.

The Council has long opposed the principle of using QC data

as a basis for imposing fiscal sanctions. Our reasoning is as follows:

In order to manage effectively, state administrators have come to rely heavily on our respective quality control systems. As a management tool, the QC system enables us to discover and track program errors, as well as develop and measure the effects of our corrective action plans. We believe that quality control efforts are of critical importance as a constructive management tool. To corrupt this tool by using it as the basis for imposing destructive fiscal sanctions will likely cause three unhappy consequences:

First, many states will manipulate their QC data--assuring that their reported error rates will not make them subject to sanctions. This would be a real loss because we are just reaching the point where the state of the art can reap useful data on the sources of error and, consequently, lead us to develop the most cost-effective means of reducing program errors.

Second, states that continue to honestly and vigorously utilize QC systems may become subject to federal sanctions that will reduce the funds available to them for their programs. At best, this will cause a state to cut back administrative funds

for necessary personnel, training, automated data processing, and so on. The message inherent in such an action is illogical. We are being told to: "Do better with less." It is our conviction that if our administrative funds were reduced because of a fiscal sanction, our services would worsen and our error rates would increase.

In our eyes, however, this second consequence is to be preferred over the third and final effect of fiscal sanctions. In order to compensate for the loss of federal funds, a number of states would be forced to reduce program benefits--thus working a terrible hardship on poor recipients. The scenario of a state cutting benefits intended for indigent, dependent children because of federal fiscal sanctions which are, in turn, based on the state's own quality control data is, indeed, a most painful irony.

Mr. Chairman, we appreciate and share the desire of the Congress to reduce payment errors in public assistance programs. We ask only that the "cure" meet three conditions:

- First, let it be no more costly than the disease.
- Second, let the "cure" for erroneous payments in poverty programs be applied no more or less zealously than the "cure" for other diseased areas of federal spending.

o Third, let the "cure" be reasonable and equitable in its application.

The current Congressional policy governing quality control and fiscal sanctions--as embodied in the Michel Amendment--fails all three tests.

First, Mr. Michel's provision assumes, without any empirical evidence whatsoever, that it is both feasible and cost-effective to reduce payment errors to an arbitrary tolerance level of four percent. The cost of attempting to do so--both in real dollars and the intangible costs of crippling the QC system and punishing recipients--will probably exceed the cost of current payment errors.

Second, the standards of the Michel Amendment are not consistent with federal efforts to improve spending accuracy in other federally subsidized programs.

Third, the system by which states will be measured and sanctioned under the Michel Amendment--or for that matter HEW's March 7 regulations--are not necessarily fair and reasonable.

Having described why we believe the current federal approach to fiscal sanctions to be totally inadequate, let me mention what can be done to improve upon it:

Collective federal-state knowledge of program payment errors is still relatively primitive. In recent years, our QC systems have grown more sophisticated. As a result, we can better detect errors, trace them, develop error prone profiles, develop corrective actions, and measure our success in reducing errors. However, we do not know the best, most cost-effective ways of reducing certain types of errors that seem to be characteristic of complex programs. Arithmetical computation errors are easy to understand and correct. Worker verification and client reporting errors are not so easy to understand or correct. We are of the mind that three basic things must be done to further the cause of program integrity.

o First, we must carefully study the nature of program payment errors with the hope of discovering the marginal cost/benefit ratio of reducing those payment errors. Many complex factors must be considered, including inter-state program differences, demographics, and so on. The results of such a comprehensive study should shed light on what, if any, reasonable error rate tolerance levels can be established for these programs.

o Second, the administration of welfare programs must be simplified and standardized. Welfare reform legislation (H.R. 4904), which we strongly support, seeks to accomplish these objectives.

o Third, the federal government must provide technical assistance and fiscal incentives to hard pressed states and localities in order that they may simplify their AFDC programs, increase the size and capability of their staff, expand automated data processing, and encourage innovative management techniques.

In addition, Mr. Chairman, there are a number of technical issues that federal policy makers must grapple with and attempt to resolve before implementing any fiscal sanction system. They include the following:

o The complexity and interrelationship between various federally subsidized programs--notably AFDC and Food Stamps--must be addressed. The more uniform and simpler these programs become--the lower the payment error rates will drop.

o The variations in state poverty programs must be acknowledged--including the populations covered, the benefit levels paid, and the administrative approaches utilized.

o The variations in individual state quality control efforts must be recognized and somehow made uniform. Similarly the variance in federal re-reviews has to be considered and corrected.

o Only the real dollar-loss of an error should be counted for purposes of determining sanctions. For example, procedural or technical errors (such as WIN registration, enumeration of Social Security numbers, or Title IV-D referals), that, when corrected,

don't actually result in mispayments, should <u>not</u> be counted for purposes of determining a fiscal sanction. Similarly, if a state is actively recovering overpayments by making forward adjustments to recipients' monthly grants, their fiscal sanctions should be offset by the sums recovered. And finally, when a recipient is found to have actual resources in excess of allowable limits, rather than counting the entire grant in error (as is the present practice), only the dollar value of the excess resources should be counted in error.

Finally, Mr. Chairman, I want to point out that there ought to be a consistent federal policy with respect to fiscal liability for errors in the AFDC, Medicaid, <u>and</u> SSI programs. If states are to be fiscally liable for state administrative errors that result in the erroneous payment of federal AFDC and Medicaid dollars, so too must the federal government assume full fiscal liability for federal administrative errors resulting in the erroneous payment of state SSI supplements <u>and</u> Medicaid benefits.

Under Section 1634 of the Social Security Act states may elect to have HEW's Social Security Administration (SSA) determine medicaid eligibility for persons receiving federal SSI payments or federally administered supplementary payments. At present, SSA determines medicaid eligibility for SSI recipients in 29 states

and for the recipients of mandatory state payments in 27 states. Under HEW's rules,erroneous federal eligibility determinations will not be included in calculating a state's error rate. However, HEW refuses to assume any financial responsibility for state dollars misspent as a result of federal errors.

I would like to emphasize that we are now talking about very large sums of state funds which are unprotected. According to the most recent published data on the Medicaid program, the 29 states with 1634 agreements account for nearly 75% of total medicaid payments. Nationwide, approximately 62% of all medicaid payments are made to recipients in the aged, blind and disabled categories. If this figure is applied to the 1634 states, we find that fully 45% of all Title XIX expenditures are being paid on behalf of recipients whose eligibility for medicaid benefits is determined by SSA. The state portion of Medicaid expenditures for SSI recipients in the 29 states with 1634 agreements in FY 80 is estimated to be $4.2 billion.

Errors in SSA eligibility determinations can thus have a very significant impact on states' medicaid expenditures. For example, during the period October 1978 through March 1979, the SSA caused error rate for ineligibles (as determined from SSI Quality Assurance data) was 6.5%. If we assume a similar error rate for medicaid

eligibility determinations in 1634 states, SSA errors could result in over $280 million in misspent state medicaid funds. However, even this considerable sum may be underestimated, since a number of states dispute the accuracy of SSI audit procedures. A GAO report released in May of last year substantiated this view by finding serious underreporting in the SSI Quality Assurance system error rate statistics. Last spring, in order to help rectify this inequitable situation, the Council developed and submitted to HEW a model agreement to be used by states wishing to contract with SSA pursuant to the provisions of Section 1634 of the Social Security Act.

To date, HEW has not responded to our proposed model agreement. In previous discussions, the Department has rejected the notion of federal liability for misspent state medicaid dollars--citing a lack of legislation authorizing restitution to states of such misspent funds. Moreover, the scope of the error rate study which HEW has recently undertaken has been defined so as to exclude examination of federally caused medicaid errors.

Mr. Chairman, should the federal government persist in imposing fiscal sanctions on states, we would strongly urge, for the sake of equity, that HEW be held responsible for misspent state funds attributable to erroneous federal SSI and Medicaid eligibility determinations.

This concludes my prepared remarks, Mr. Chairman. My colleagues will elaborate on these points and then we will all be happy to respond to any questions you may have.

Attachments.

ATTACHMENT I

AMERICAN PUBLIC WELFARE ASSOCIATION

1125 FIFTEENTH STREET, N.W., WASHINGTON, D.C. 20005

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Executive Director

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THE FY 80 Labor-HEW Appropriations Act

WHEREAS, the Congress has passed FY 80 appropriations legislation (H.R. 4389) which goes far beyond the traditional appropriations process by addressing substantive legislative issues ordinarily reserved for the standing committees of jurisdiction; and

WHEREAS, legislating in this fashion bypasses the hearing process, thereby denying opportunity for public comment; and

WHEREAS, substantive issues addressed in H.R. 4389 will have significant fiscal and programmatic impact on state and local agencies administering public welfare programs, as well as the recipients served by such programs; and

WHEREAS, these substantive issues include: the imposition of a one-year statute of limitations on claims for federal reimbursement under Titles IV-A, XIX, and XX of the Social Security Act; establishing arbitrary national quality control error rate tolerance level(s) and imposing fiscal sanctions upon states with error rates in excess of the stipulated level(s) in the AFDC and Medicaid programs; and setting a ceiling on Title XX training funds;

THEREFORE BE IT RESOLVED THAT: the National Council of State Public Welfare Administrators respectfully requests the appropriate substantive committees to reassert their responsibility for legislating these complex issues.

Adopted by the Income Maintenance Committee, August 30, 1979.
Adopted by the National Council of State Public Welfare Administrators on October 24, 1979

ATTACHMENT II

The Positions of the
National Council of State Public Welfare Administrators
on Quality Control-Fiscal Sanctions

- The Council opposes placing AFDC quality control procedures into law. In our judgement, quality control is an inappropriate topic for legislation. Framing quality control policies in statutory language would only undermine the flexibility required by federal and state administrators for effective program management.

- We wish to stress that successfully identifying and reducing errors does not require the imposition of fiscal sanctions. Indeed, the Council opposes any automatic sanctions that would be applied without opportunities for adequate state/federal interaction--including review and negotiation.

- We oppose utilization of a 4 percent payment error rate or any other inflexible and arbitrary national standard as the threshold for determining a state's eligibility for an incentive payment or for purposes of imposing fiscal sanctions. Each state is unique in the nature and scope of the programs it administers and the populations it serves. It is our firm conviction, therefore, that the only fair and accurate measure of error reduction is one which compares each state's performance to its own prior record.

- The Council supports any project or study that would help develop rational and valid error rate tolerance levels. In addition, we urge that, in conjunction with such a study, funds be made available to States for demonstration projects to test alternative quality control methodologies.

- Until such a study is completed, we take the position that any quality control standards be arrived at through negotiations with HEW; that if fiscal sanctions must be imposed, they be based on a state's failure to improve according to

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its own record; that any standard(s) developed for imposing fiscal sanctions be based solely on agency-caused errors; and that any sanctions be imposed solely against administrative costs and not against program dollars intended to benefit recipients.

- Finally, the Council believes that for purposes of quality control, the SSI program can be differentiated from the AFDC/Medicaid program. Compared to AFDC/Medicaid, the SSI program is less complicated--in the scope of benefits offered, eligibility determinations, etc.--and thus is easier to administer. Moreover, SSI involves a different set of funding and authority relationships which substantially diminish state discretion in the policy and administration of the program. For these reasons, the Council asserts that the SSI program warrants a lower error rate tolerance level than that established for the more complex AFDC/Medicaid programs. For example, SSI could be set at one half the level established for AFDC/Medicaid.

TESTIMONY

State of California - Department of Social Services

For Presentation To

Senate Finance Subcommittee on Public Assistance
November 16, 1979

I am Marion J. Woods, Director, California State Department of Social Services.

I want to express my appreciation for the opportunity to appear before this committee.

The California Department of Social Services is committed to an efficient, effective and equitable administration of the welfare programs, including holding the misexpenditure of public money at a minimum level.

We are all concerned about the loss of public money through fraud, abuse and waste in the welfare programs. It is clearly contrary to the public interest and cannot be justified.

But, there is another aspect of this problem I find of equal concern. The occurrence of fraud and abuse in the welfare system results in the loss of public confidence in the system. This loss of public confidence in turn undermines the very programs upon which the vast majority of needy persons depend for their survival.

For these reasons California is staunchly committed to minimizing fraud and abuse. We believe that the most accurate expenditure of the welfare dollar will occur through a strong partnership of state and local governments, HEW and the Congress. Each partner's efforts should complement the work of the others.

The states and HEW have cooperated in the development of techniques to discover and eradicate the causes of aid payment misexpenditure. Examples include: Computer matches of welfare records with Social Security, Veterans Benefit, Federal Employee Wage, and State Unemployment Insurance files. Various duplicate aid detection systems at the national, regional and state levels also help reduce fraud.

In California, the State Legislature has given me the authority to encourage the reduction of errors through the use of fiscal sanctions to be levied against county welfare departments with high error rates. Although sanctions are based on an error rate standard determined by quality control reviews, I have the authority to consider individual county problems and waive sanctions based on factors outside the counties' control.

Similarly, HEW, with input from the states has encouraged the reduction of errors by [illegible] toward the establishment of reasonable [illegible] and sanctions for poor state performance. However, the House-Senate Conference Committee on the Fiscal 1979 Supplemental Appropriations Act directed HEW to set a single performance standard for all states. This requirement does not allow HEW to adequately take into account differences among states. A single standard for all states does not take into account possible differences in error control difficulty resulting from varying caseload characteristics, program requirements, etc. Although the HEW Secretary may waive or reduce sanctions based on extenuating circumstances, the single performance standard unduly restricts HEW's ability to develop reasonable sanction policy.

If Congress is to carry-out its responsibility as a partner in the effective administration of welfare programs, it should modify its policy to accommodate differences in error control difficulty.

Senator MOYNIHAN. I have to recess, as I must run and vote for the Cambodians.

[A brief recess was taken.]

Senator MOYNIHAN. Mr. Vernez, we welcome you, sir.

Mr. VERNEZ. Thank you, Mr. Chairman.

Senator MOYNIHAN. You are accompanied by?

Mr. VERNEZ. I am George Vernez, deputy administrator for policy of the New York City Human Resources Administration.

To my right is Mr. Herb Rosenswei, deputy administrator for income maintenance.

Senator MOYNIHAN. We welcome you to the committee.

STATEMENT OF GEORGE VERNEZ, DEPUTY ADMINISTRATOR FOR POLICY, HUMAN RESOURCES ADMINISTRATION, NEW YORK CITY

Mr. VERNEZ. Mr. Chairman, it is a pleasure for us to appear before you to testify on the extent and causes of erroneous State payments to AFDC and medicaid recipients, on behalf of Mr. Stanley Brezenoff, administrator of the Human Resources Administration in the city of New York.

I would like to address briefly three major questions.

First, can State and local administrators of public assistance programs be trusted to implement effective quality control mechanisms?

Second, should a specific payment error rate goal be established and, if so, should this goal be the same for all States and how rapidly should it be met?

Third, if the specified goal is not met, should penalties be imposed?

The steady decline in AFDC payment error rates suggests that State and local administrators can generally be trusted to implement effective quality control mechanisms. Since 1973, the national average payment error rate, including ineligibility and overpayments, has declined by an impressive 71 percent from 16.5 percent in 1973 to 9.4 percent in 1978.

In New York City, the average payment error rate declined by an even larger amount of 171 percent.

In New York, this impressive achievement is due to a number of quality control programs which have been aggressively implemented. For instance, we increased the frequency of face-to-face recertification interviews from two to three times a year, have instituted a mail recertification program three times a year and have implemented an independent and thorough audit and investigation of all newly-accepted cases.

Through these, and other programs, New York City rejects assistance to some 77,000 ineligible applicants per year, closes cases of some 67,000 ineligibles, and reduces the budgets for another 12,000 recipients. Yet we hope to do better.

On a demonstration basis, we are now experimenting with a monthly reporting system at one income maintenance center. If the demonstration proves successful, we intend to implement monthly reporting citywide.

We strongly believe that establishing sanctions to States that do not meet a specific error rate goal, such as a 4-percent error rate as

recently set by the appropriation committee, are neither necessary nor desirable.

If Congress, however, desired to establish such a goal and specify the time period within which it is to be met, we suggest that both requirements be set only after giving full consideration to a number of factors that affect a State's and locality's ability to meet a specified goal.

First, it should be recognized that the lowering of the error rates by a given percentage becomes increasingly more difficult as the error rates get lower. A look at changes in payments error rates between 1973 and 1978 indicates that States with the highest error rates in 1973 had achieved a proportionately higher reduction in error rates than States with lower initial error rates.

These data are in table I attached to the testimony.

Second, if a minimal goal is established, a distinction should be made between actual errors which affect the ineligibility or payment received by the client, and technical errors which do not affect either the client's program eligibility or the payment received.

By excluding technical errors, New York City's payment error rate would be at 6.1 percent instead of the current 10.3 percent.

Third, there is no uniform measurement of error ratès among States so that an equal error rate between two States does not necessarily mean equal performance. For instance, in Michigan the quality control auditors are not allowed to use any source in their investigation that is not routinely available to welfare workers; in New York, there are no such restraints on investigators.

We believe that the establishment of an error rate goal should be preceded by the establishment of uniform requirements for quality control reviews by the States.

Also, substantial differences among States' error rates can be attribute to variations in local circumstances, not under the direct control of program administrators and to differences in State plans.

Error rates are typically higher in large urban areas and in areas with a relatively high percentage of its residents on welfare.

Similarly, States with ADC-U or emergency assistance programs and with low asset limitations typically have higher error rates. Again, these data are attached to the testimony in table II.

This suggests not only that numerical goals for error rates should vary from State to State, but also that establishing a goal at all may have an adverse effect on the population in need.

It would provide disincentives for States to implement optional programs, for instance.

The quality control program has its greatest value as a management tool aimed at discovering the extent and types of errors and providing a basis for corrective action. Were quality control results to be used as a basis for levying sanctions, States would have little reason for performing thorough investigations, defeating its primary purpose.

We would suggest that States be required to use quality control to identify the causes of errors and to submit corrective action plans to HEW for approval. HEW would be responsible for analyzing and monitoring those plans to assure that they are fully implemented.

If sanctions must be applied, they should be applied only if States fail to make a good faith effort in implementing the plans. States should not be penalized, though, if the plan does not produce the effect intended. If not effective, the plan should be modified and new techniques tried out.

The Federal Government can play an active and positive role in providing technical assistance and in the development of more effective quality control techniques.

Thank you.

Senator MOYNIHAN. I thank you, Mr. Vernez. May I say we are sorry to have troubled to bring you down as we did. We were given to understand that Mr. Brezenoff very much wanted to testify and if it turned out he was not able to do so, he could have simply sent his testimony, which I think probably you wrote for him.

In any event this is very helpful and we thank you both.

Mr. VERNEZ. Thank you.

[The prepared statement of Mr. Vernez follows:]

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STANLEY BREZENOFF
Administrator/Commissioner

GEORGES VERNEZ
Deputy Administrator

Summary

The Quality Control Program has its greatest value as a management tool aimed at discovering the extent and types of errors and providing a basis for corrective action. Were Quality Control results to be used as as basis for levying sanctions, states would have little reason for performing thorough investigations, defeating its primary purpose.

At present the significant share of welfare costs paid out of state/local tax revenues is an adequate incentive for local administrators to make every effort to reduce error rates. Since 1973, the national average payment error rate has declined by an impressive 71 percent; in New York City it declined by 171 percent in the same period.

If Congress desired to establish a numerical maximum goal for AFDC Medicaid payment error rate and specify the time period during which it is to be met, it should do so in full recognition that:

- The reduction of the payment error rate by a given percentage is increasingly more difficult as the error rate gets lower.
- Technical errors that do not effect either the actual client's eligibility for financial assistance or the amount they should receive constitute a major portion of the payments error rate as presently measured. These errors should not be excluded from the payments error rates.
- Because Quality Control investigations are not uniform among states, an equal error rate between states does not necessarily means equal performance. Establishment of a goal for error rate should be accompanied by uniform requirements for quality control reviews by the states.
- Significant differentials in error rates are attributable to variation in local circumstances not under the direct control of program administrators and to differences in state plans. Error rates are typically higher in:
  - Large urban areas
  - Areas with a large AFDC caseload
  - Areas with a high percentage of its population on public assistance
  - Areas providing a AFDC-U program
  - Areas providing an Emergency Assistance program
  - Areas with lower limit on assets
- If sanctions must be applied, they should be applied only if state/local governments do not make a good faith effort in implementing HEW approved corrective action plans. However, states should not be penalized, if the plan does not produce the effect intended. An ineffective plan is not necessarily a demonstration of administrative failure. It is only a signal that the plan should be modified and new more effective techniques implemented. The federal government can play an active and positive role in providing technical assistance and in the development of effective Quality Control techniques.

STATEMENT OF GEORGES VERNEZ

BEFORE THE U.S. SENATE,

COMMITTEE ON FINANCE

SUBCOMMITTEE ON PUBLIC ASSISTANCE

I am Georges Vernez, Deputy Administrator for Policy at the New York City's Human Resources Administration. Mr. Chairman, Members of the Subcommittee, it is a pleasure for me to appear before you to testify on the extent and causes of erroneous state payments to AFDC and medicaid recipients, on behalf of Mr. Stanley Brezenoff, Administrator of the Human Resources Administration and the City of New York.

New York City fully endorses every effort made to reduce error rates that will not adversely affect the quality of services to our public assistance clients. While there is full consensus regarding the general goal, a reduction in error rates, there is little consensus about the specific objectives that ought to be established and the means by which they ought to be achieved.

In this regard, I would like to address three major questions:

- Can state and local administrators of public assistance programs be trusted to implement effective quality control mechanisms?

- o Should a specific payment error rate goal be established? And if so, should this goal be the same for all states and how rapidly should it be met?

- o If the specified goal is not met, should penalties be imposed?

The steady decline in AFDC payment error rates indicates that state/local administrators can generally be trusted to implement effective quality control mechanisms. Since 1973, the national average payment error rate including ineligibility and over payments has declined by an impressive 71 percent from 16.5 in 1973 to 9.4 percent in 1978. In New York City, it declined by an even larger 171 percent from 27.4 percent to 10.3 percent. Whereas in 1973, the City's error rate was 10.9 percentage point above the national average, it is now less than 1 percentage point above the national average. The New York State's rate, at 8.8 percent, is already below the national average.

In New York City, this impressive achievement was due to a number of quality control programs which have been agressively implemented. We increased the frequency of face-to-face recertification interviews from two to three times a year and have instituted a mail recertification three times a year. These frequent reporting requirements approach the monthly reporting system proposed in the House Welfare Reform bill, HR 4904. We also implemented an independent and thorough audit and investigation of all newly accepted cases.

Computer matchings of public assistance rolls against payrolls of public agencies, bank tapes, other governmental benefit programs, marriage records, Department of Corrections records, and the State Wage Reporting System are

other means we use to find unreported income. These matchings have resulted in yearly closing of some 12,000 cases and a reduction in the amount of assistance to another 12,500.

Through these programs, New York City rejects assistance to some 77,000 ineligible applicants a year, closes cases of some 67,000 ineligibles, and reduces the budgets for another 12,500 recipients. Yet we hope to do better. On a demonstration basis, we are now experimenting with a monthly reporting system at one Income Maintenance Center. If the demonstration proves successful, we intend to implement monthly reporting City-wide.

We strongly believe, that establishing sanctions to states that do not meet a specific error rate goal, such as a 4 percent error rate as recently set by the appropriation committee, are neither necessary nor desirable.

If Congress, however, desired to establish such a goal and specify the time period within which it is to be met, we suggest that both requirements be set only after giving full consideration to a number of factors that affect a state's and locality's ability to meet a specified goal.

First, it should be recognized that the lowering of the error rates by a given percentage becomes increasingly more difficult as the error rates get lower. As the overall error rate becomes smaller client induced errors which stem from clients concealing of a father residing in the household, failing to report income or resources, or overstating the number of children actually living in the household, represent an increasing proportion of total errors. A look at changes in payments error rates between 1973 and 1978 further sub-

stantiate this point. By 1978 states with the highest error rates in 1973 had achieved a proportionately higher reduction in error rates than states with lower initial error rates (Table 1).

Second, if a minimal goal is established, a distinction should be made between actual errors which affect the eligibility or payment received by the client, and technical errors that do not affect either the client's program eligibility or the payment received. In FY '78, HRA estimated that 45 percent of the case eligibility error rates and 35 percent of the case overpayments rates were due to technical errors. By excluding this type of error, New York City's payment error rate would be 6.1 percent instead of the current 10.3 percent.

Third, there is no uniform measurement of error rates among states, so that an equal error rate between two states does not necessarily mean equal performance. For instance, in Illinois, Quality Control Investigators are required to obtain four independent pieces of evidence before a case may be found ineligible if the purportedly absent-parent is in the home. In Massachussetts three pieces of evidence are required and in New York only two. In another instance, in Michigan, the Quality Control auditors are not allowed to use any source in their investigation that is not routinely available to welfare workers; in New York there are no such restraints on investigators. The quality control auditors in New York State spend over 25 person-hours on each case investigated. Other states devote less than half of this manpower to the investigations. Clearly, the establishment of an error rate goal must be accompanied by uniform requirements for quality control reviews by the states.

Also, substantial differences among states' error rates can be attributable to variations in local circumstances not under the direct control of program administrators and to differences in state plans. Error rates are typically higher in large urban areas and in areas with a relatively high percentage of its residents on welfare. Similarly states with ADC-U or Emergency Assistance programs, and with low asset limitations typically have higher error rates (see Table 2). This suggests not only that numerical goals for error rates should vary from state to state, but also that establishing a goal at all may have an adverse effect on the population in need. It would provide disincentives for states to implement optional programs, such as AFDC-U and emergency assistance programs.

The Quality Control Program has its greatest value as a management tool aimed at discovering the extent and types of errors and providing a basis for corrective action. Were Quality Control results to be used as a basis for levying sanctions, states would have little reason for performing thorough investigations, defeating its primary purpose.

Congress and HEW can and should support states and localities in their efforts to reduce error rates. We would suggest that it be required that states use quality control to identify the causes of errors and to submit corrective action plans to HEW for approval. HEW would be responsible for analyzing and monitoring those plans to assure that they are fully implemented. If sanctions must be applied, they should be applied only if states fail to make a good faith effort in implementing the plans. States

should not be penalized, though, if the plan does not produce the effect intended. If not effective, the plans should be modified, and new techniques tried out. The federal government can play an active and positive role in providing technical assistance and in the development of more effective quality control techniques.

TABLE 1

1973 - 1978 Changes in State AFDC Payments Error Rates and Initial 1973 Payments Error Rates

States by Percent Change in Payment Error Rate 1973-78	Initial 1973 Average Error Rate	Change in Average Error Rate 1973-78
1st (highest) Quartile	13.6	- 68.4
2nd Quartile	16.0	- 49.0
3rd Quartile	13.3	- 31.2
4th Quartile	10.6	+ 12.3

NOTE: Payments error rates include payments to ineligible and overpayments to recipients.

TABLE 2

States AFDC Payment Error Rates Levels and Changes

Compared to Selected State Characteristics

State Characteristics	1978 Average Payment Error Rate	Change in Average Error Rate 1973-78
. States with one or more cities of 500,000 or more		
YES	10.1	-37.8
NO	7.6	-33.9
. Size of AFDC Caseload		
1st (highest) Quartile	10.0	-41.5
2nd Quartile	9.3	-34.4
3rd Quartile	8.8	-17.2
4th Quartile	6.4	-44.3
. Percent of Total Population on AFDC		
1st Quartile	12.1	-16.8
2nd Quartile	10.1	-36.7
3rd Quartile	7.4	-31.3
4th Quartile	5.1	-57.6
. Provision of AFDC-U Program		
YES	9.9	-31.7
NO	7.1	-40.3
. Provision of EEA Program		
YES	10.1	-32.2
NO	7.4	-38.2
. Asset Limit:		
Below $1,000	8.7	-35.1
Over $1,000	7.7	-40.3

NOTE: The payments error rates included payments to ineligible and over-payment to recipients.

Senator MOYNIHAN. And now, Dr. Norman Jacknis, who is the welfare inspector general for New York State.

Mr. Jacknis, we welcome you, sir. It is very nice of you to come down. I am sorry that we are running late, but that is an endemic condition.

You are the inspector general? Do we have testimony from you?

Mr. JACKNIS. Yes, you do, I believe.

Senator MOYNIHAN. I am sorry. Forgive me.

We will put this in the record as if read, and you go right ahead and take whatever time that you need.

STATEMENT OF NORMAN JACKNIS, WELFARE INSPECTOR GENERAL, NEW YORK STATE

Mr. JACKNIS. Thank you very much for the opportunity to be here.

I am Norman Jacknis and I am New York State's welfare inspector general.

The office of welfare inspector general is part of State Comptroller Edward V. Regan's department.

As you may know, my office was the first such office anywhere in the country and as such, it has made important contributions to the fiscal integrity of welfare programs in New York State.

We receive and investigate complaints from the public about abuses, fraud, and other violations of the welfare system. We also audit the operations of welfare agencies at the State and local level to assure that the programs are being properly administered and that the public is getting the most cost-effective use of its expenditures.

My thrust here today, is that an increasingly large share of the errors in the welfare system can be traced to their source in judicial decisions, in administrative systems of local and State governments, and in the regulations and policies established by the Federal Government.

For example, one of the most disconcerting of recent judicial trends has eroded the legal basis for recoupment programs.

In New York, the courts essentially have stated that if recipients are caught cheeting, there is very little that local agencies——

Senator MOYNIHAN. Wait, wait. Where are you?

Mr. JACKNIS. I am not reading the whole thing.

Senator MOYNIHAN. Help me where you are. I want to catch up with this.

Mr. JACKNIS. All right.

I am on the bottom of page 2, going into page 3. The detailed testimony cites some of the court decisions that I am referring to.

Now, the problem here is when the courts are left to interpret terms like "undue hardship" which are in Federal recoupment law, they can interpret them in a variety of ways. It is my feeling that Federal law must, for the benefit of both the localities and the recipients involved, clarify the guidelines to be used for recouping such moneys and help revive the recoupment program.

When we find individual welfare cheaters and providers of welfare services who are abusing the system, we have a statutory responsibility to follow up. Unfortunately, this is the equivalent of closing the barn door after the horses have escaped. And now, with

the recent judicial precedents that I mentioned, one is not even allowed to put the horses back into the barn when they are found.

Thus, the States and the Federal Government must develop systems which catch the errors up front and which prevent errors from occurring in the first place. There are some forthcoming changes which will certainly help in preventing errors before they occur.

Among the most important of these is the expected implementation of monthly reporting retrospective accounting systems. However, in States the size of New York, you cannot just mandate administrative improvements, like monthly reporting. The Federal Government, with its expertise and financial resources, must provide technical assistance, understanding and support, particularly financial support to large States like New York.

One of the major contributing factors to welfare errors throughout the country, and especially in New York State, are the regulations and policies themselves. In New York, the regulations are unnecessarily complex, contradictory, confusing, and ever changing. I will give you an interesting example.

A short time ago, my office completed a review of freestanding psychiatric clinics in New York City which were funded, in large part, by medicaid.

Senator MOYNIHAN. Would you say that again, please? Freestanding?

Mr. JACKNIS. Freestanding. They are not associated with hospitals.

We discovered that clinics were allowed to receive a full $28 per visit reimbursement fee for counseling sessions which were as brief as 30 seconds, were conducted by students without professional supervision, or were for general social services that were never authorized.

What is more discouraging, was that most of the abuses were the result of inadequate or nonexistent Federal and State regulations governing medicaid reimbursement and a lack of coordination among the various agencies responsible for implementing the program.

In this lax, regulatory environment, there is an invitation to fraud and to abuse.

This brings me to the concerns engendered by Mr. Michel's amendment. I must point out that this amendment is based on the false assumption that quality control measures are consistent across the States and are scientifically accurate. The fact is that the current quality control system is a rubber yardstick. This means that while a case may be judged ineligible in New York, the same case may not be judged ineligible in California or in Illinois.

Insofar as the errors in the welfare system today are in part the result of Federal policy and regulations, Federal officials cannot stand aloof and point their fingers at State and local government.

The Federal Government must make a positive contribution to reducing errors rather than the essentially negative approach embodied in Michel's amendment. We must not isolate our error reduction activities. Instead, we must incorporate the goal of reducing waste in welfare in the heart of the law's regulations and administrative systems that we use in public assistance.

Senator MOYNIHAN. Well, thank you, sir. That was very explicit and precise.

Let me ask you a couple of questions. First of all, you are quite right. The Michel amendment is as bad legislation as one can imagine on one level, but on the other hand, it is legislation and we do not seem to get any other kind of legislation. You know, one must give it credit for its existence. It survived a certain kind of biological improbability, the death rate of all such enterprises being very high.

I want to ask you a little bit about the New York State error rate. You've heard me on the subject of mixing up CAT scanners with boyfriends as a phenomena, and HEW is to blame for this. They brought it on themselves and they have avoided with the most energy I have seen out of HEW in 3 years, any responsibility for this problem. They will not do anything about it.

It is just a scandal.

If this happened under any poor Republican administration, would the howls not be coming up?

How do you account for the decline in the error rate in New York State which cannot all be the responsibility of Barbara Blum? It has gone down from a very high rate, well above the national average, to just about the national average.

What changed? Anything you know of?

Mr. JACKNIS. I think different kinds of people were brought in to administer welfare. I think Commissioner Blum in New York City, Blanche Bernstein and Stan Brezenoff deserve credit for trying to reduce what is, after all, a fairly mammoth problem.

There was a general trend in that direction and our office—I was not there—our office, however, did play a role in helping to prod things along. But I think in general people in the State realized there was a problem.

Senator MOYNIHAN. There is a rule of Maximus that says that which is not inspected deteriorates.

There was an unwillingness to accept the limits of the State's resources.

As you know, we had one of the consequences of a pretty prodigal attitude, so we have not been able to increase the basic allowance for welfare families since 1974. Any other State that did that, that was not known as a liberal State, would be thought to be shocking. If we heard Mississippi did it, we would understand. They are supposed to be bad people somehow. Mississippi last year boosted its welfare allowance. We have not been able to increase ours since 1974. In fact, I think we are saying, are we not, that a mother and children here today should eat half as much as they did 5 years ago.

Mr. JACKNIS. I am not familiar with the exact figures, but clearly there has been inflation.

Senator MOYNIHAN. Down about 57 percent. That is what comes of—well, I do not know what it comes under.

When you came into office, did you find that you were reasonably impressed at the way that the Inspector General's operation was working?

Obviously you could not be wholly impressed, otherwise there would be no opportunity for you to improve it, which is not a very nice thing to do with a young man with a career ahead of him.

Mr. JACKNIS. In fact, before I even came there, the Comptroller had expressed an interest in expanding the activities of the office and having it expand upon the traditional auditor's role of providing positive recommendations to improve things, not merely to complain.

I certainly took on that challenge and I think, as I am trying to point out in my testimony here, while there is obviously still a need to do something about individuals who cheat the system, you really have to look at the source of the problem. The thrust of my time in the welfare inspector general's position will be spent going to the source of the problem and looking at the regulations. I guess, to a certain extent, I am following up on the high expectations that I have of the administrators of the program, expectations which certainly ought to be at least as high as that which we expect from the recipients.

Senator MOYNIHAN. I remember around 1969 that the welfare problem was supposed to begin to diminish around 1981. But we are getting there, are we not?

Mr. JACKNIS. There has been reduction in caseload, yes.

Senator MOYNIHAN. But in New York—is there getting to be a more defined, dependent population, with about a third of the live births in the city of New York being now illegitimate? Probably there has not been anything like that since 1840 if that.

Do you have any sense of those things? Do you get into that kind of work?

Mr. JACKNIS. Actually, I thought what you were driving at is that the public assistance problem, per se, has been stabilizing. What has been happening in New York is that the medical assistance program has been expanding greatly and, in fact, there has to be an indirect cost of people who are not covered by assistance—for example, the cost of illegal aliens' care that gets channeled back into the medical assistance programs.

Senator MOYNIHAN. Yes.

Mr. JACKNIS. That part of it is not stabilizing.

Senator MOYHNIHAN. That is not stabilizing. That is your part, too.

Mr. JACKNIS. That is right. We worry about that.

Senator MOYNIHAN. What do you know about illegal aliens? Give us an estimate for which you will not be held responsible for, of the number of illegal aliens in the city.

Mr. JACKNIS. I would not care to guess. I have no basis for estimating that, and what I cannot say, I will not say.

Senator MOYNIHAN. You will never make it in Washington. You will never make it to the big time if you do not believe in just lumping in—why do you not say, in round figures, a million? That will give you a reputation. Joe Califano would have hired you.

I want to ask you another question.

Should we begin to address ourselves to the judiciary in terms of just how much the judiciary has the right to impose higher expenditures on Government? I have been wondering about this.

Mr. JACKNIS. Well, of course, we do have separation of powers and I am not sure that——

Senator Moynihan. Yes, that is it. We have separation of powers and that implies that Congress shall make the laws.

Mr. JACKNIS. Well, I think that when Congress creates a vacuum, someone else will make the laws, in effect, for it.

Senator MOYNIHAN. I do not know that Congress creates vacuums. I keep watching the Federal judiciary and the State judiciary saying you are not spending enough money here. And I wonder if there is not the time to raise the constitutional question, the decision of how much money to spend is a legislative decision and not a judicial decision.

Mr. JACKNIS. I agree with you. What I am trying to add, however, is that in the laws—and not only in the laws, but in the regulations that HEW promulgates, I think it would be worthwhile to be more precise so there is not that much leeway that the courts have to begin with.

Senator MOYNIHAN. It was you who raised the question of courts saying what you could and could not do.

Mr. JACKNIS. That's right.

Senator MOYNIHAN. Do they pay it out of their own pockets? Do they have a fund with which they pay the extra costs they impose?

Mr. JACKNIS. Eventually it all comes to the same source anyway.

Senator MOYNIHAN. This is why New York State is devastatingly overtaxed.

Mr. JACKNIS. I think that is true. I think the court in New York does not understand the real problems that exist and frankly I am not sure they have a realistic understanding of the needs of the recipients and citizens.

If you read some of the decisions, the words "eligibility worker" and "recipient" seem lost in a lot of the legal concepts.

There is the firing line out there where the day-to-day decisions are made, and I think it is important for us to focus in on that.

Senator MOYNIHAN. The State of New York has a social system with a curious combination. We have a legal system which is always on the side of the recipient. We have the bureaucracy always on the side of the recipient. We have a legislature always on the side of the recipient. And the recipients have not had an increase in their basic allowances in 5 years and they are presumably expected to eat half as much, because of the fact that bankruptcy has come about from those other attitudes.

If I found one person in the Department of Social Services who has had his or her allowances cut in half in the last 5 years, or if we were all starving together, I think this might be a useful collective experience, in the manner of the Iranian revolution.

But when we abandon the children and the mothers and maintain the tone of compassion, it is a little suspicious.

Mr. Jacknis, thank you very much. I would like you to think more than perhaps you have about the degree to which the courts invade the legislative prerogative when they impose additional costs.

Mr. JACKNIS. I certainly will.

Senator MOYNIHAN. It is not a small question. It is a large question in American Government right now.

It is not going to be an easy one. It is the sort of thing that is going to take a generation to figure out, but you have a generation of work ahead of you and I have a few years at most.

Thank you very much.

Mr. JACKNIS. Thank you.

[The prepared statement of Mr Jacknis follows:]

PREPARED TESTIMONY OF DR. NORMAN J. JACKNIS, NEW YORK STATE WELFARE INSPECTOR GENERAL

SUMMARY

The following is a summary of issues highlighted by Dr. Norman J. Jacknis, New York State Welfare Inspector General, in his testimony of November 16, 1979, before the United States Senate Finance Committee, Subcommittee on Public Assistance:

1. Recent court interpretations of federal law relating to "undue hardship" have severely limited local social service districts' ability to recover misspent welfare monies through recoupment procedures. The Federal government, in order to aid in the timely and effective recovery of these monies, should clearly define "undue hardship" and other such concepts as used in the regulations.

2. The limitation on recouping money, after it has mistakenly been spent, demonstrates the need for new computer and administrative systems to prevent welfare fraud and abuse from occurring in the first place. Technical assistance and financial support are needed by the states and localities in order to implement such systems.

3. A major contributing factor to welfare errors is the unnecessarily complex, contradictory and ever-changing nature of regulations and policies as promulgated by the state and federal governments. Simpler and more cost-effective regulations should be designed in order to ease administration and prevent error.

4. Proposals designed to penalize states on the basis of quality control results are inappropriate due to inconsistencies in the quality control system itself. The Federal government must establish uniform national quality control standards as a basis for judging state administration and comparing state performance on a nationwide basis.

FULL STATEMENT

Good morning, Senator Moynihan and Honorable Members of the Committee. I am Norman Jacknis and I serve as New York State's Welfare Inspector General. The Office of Welfare Inspector General is a part of State Comptroller Edward V. Regan's department.

I have been asked by the Chairman of the Subcommittee to discuss the factors contributing to waste and abuse in New York State's welfare programs.

As you may know, the Office of Welfare Inspector General was the first such office anywhere in the country and as such, it has made important contributions to the fiscal integrity of welfare programs in New York State. We receive and investigate complaints from the public about abuses, frauds and other violations of the welfare system. We also audit the operations of welfare agencies at the State and local level to assure that the programs are being properly administered and that the public is getting the most cost effective use of its expenditures. The Office of Welfare Inspector General has introduced and assisted in the development of new computer matching programs by the State and New York City.

Presumably because of that background, I should spend my time today talking about the relative share of errors which can be attributed to recipients and agencies involved in the administration of welfare. That is after all the traditional concern of anti-fraud agencies.

Instead, from my office's rather unique perspective, I would like to point out a slightly different way of looking at the causes of the errors.

From what I and my staff have been able to observe over the last several years, an increasingly large share of the errors in the welfare system can be traced to their source in judicial decisions, in the administrative systems of local and state governments, and in the regulations and policies established by the federal government.

One of the most disconcerting of recent judicial trends has severly eroded the legal basis for recoupment programs. In New York, the courts essentially have stated that recipients are invited to cheat and if they are caught, there is very little that the local agencies can do.

Existing federal law[1] provides that recoupment procedures of procedures used to recover misspent welfare monies from recipients are limited to a deduction that will not cause "undue hardship" to the recipient and family. New York State Law in interpreting this restriction has limited such recoupments to 10 percent of a recipients' household needs grants, or 15 percent if two recoupments are being made simultaneously.

Three recent New York State Appellate Court cases highlight the need for the federal government to clarify the term "undue hardship" as applied in recoupment cases so as to preclude differing judicial interpretations and to allow local social districts to actively pursue and recover monies that are owed them, thus relieving the taxpayer from subsidizing welfare cheats and the like.

On May 10, 1979, the New York State Court of Appeals in *the Matter of Lajara v. Rivera* held that any recoupment of public assistance grants requires a case-by-case determination, and that, in effect, the state's limiting recoupment to 10 percent of a welfare grant does not per se preclude undue hardship.

In *the Matter of Thompson v. Blum* decided by the Appellate Division, 2nd Dept., in June of 1979, an AFDC recipient was threatened with eviction for non-payment of rent. Following New York Law, the New York State Department of Social Services advanced the recipient $1,100 to pay back rents in order to avoid eviction and recouped this amount from the recipient's future grants. Although the recipient conceded that he had gambled away his original shelter allowances, the court ordered NYSDSS to return the $1,100 recouped because there existed no evidence that his children did not suffer undue hardship during the period in which the money was being subtracted from his grant.

Most recently, in *the Matter of Carlin v. Blum*, decided October 18, 1979, the same Appellate Court dealt with the case of a mother who admitted concealing the fact that she was receiving money from her boyfriend while receiving public assistance grants. The court stated that prior to reducing the woman's grant to recover the overpayment involved, the social services department must ensure that her children do not require the level of assistance being presently received, in other words that they will not suffer "undue hardship."

As is apparent, the courts, when left to interpret "undue hardship" as cited in federal recoupment law, are severely restricting the amounts of money which may be recovered in a timely fashion from public assistance recipients who have received welfare funds to which they are not entitled. Federal law, must, for the benefit of both the localities and the recipients involved, clarify the guidelines to be used for recouping such monies and help revive the recoupment program.

The end of recoupment, or at least its mortal wounding, is part of a fundamental shift. It used to be you could say "Let's hand the money out front and then cover up any mistakes we might find later on." This philosophy was part of the recent Food Stamp Regulations, where the eligibility standards for receiving Food Stamps were liberalized, but supposedly strong recoupment measures were put at the back end to deal with anyone cheating.

Of course, when we do find individual welfare cheats and providers of welfare services who are abusing the system, we have a statutory responsibility to follow up. Unfortunately, this is the equivalent of closing the barn door after the horses have escaped. And now, with the recent judicial precedents regarding recoupment, one is not even allowed to put the horses back into the barn when they are found.

Thus, the states and the federal government must develop systems which catch the errors up front and which prevent errors from occuring in the first place. This is one of the most important projects that my office and the Comptroller have been working on.

There are some forthcoming changes which will certainly help in preventing errors before they occur. Among the most important of these is the expected implementation of monthly reporting retrospective accounting systems. Before I assumed my current position a few months ago, I was at Mathematica Policy Research, managing a multistate project to develop a model welfare administration system. This was an outgrowth of the monthly reporting experiment in Colorado. Clearly, there is both the demand and the need for the kind of precise and timely estimation of recipient finances and administrative improvements that were part of and followed from the monthly reporting experiment.

However, in states the size of New York, with the immense problems of shifting populations, large caseloads, and less educated recipients, you can not just mandate administrative improvements like monthly reporting. The federal government, with its expertise and financial resources, must provide technical assistance, understanding and support, particularly financial support to large states like New York. I

[1] 45 CFR 233-20 (a) (12)(i)(a); 45 CFR 233.20 (f)

would suspect that if the Federal government plays a significant technical assistance role in implementing new computer and administrative systems in welfare, they too will learn quite a lot. They will for the first time become sensitive to the real issues of whether their regulations are operationally feasible. They will learn what is possible and worthwhile and what is possible but not worthwhile. They will learn what is not possible to expect. This is bound to improve the policies and regulations which HEW promulgates.

Indeed, one of the major contributing factors to welfare errors throughout the country, and especially in New York State, are the regulations and policies themselves. In New York, the regulations are unnecessarily complex, contradictory, confusing and ever-changing. And, while part of this is a result of state policy, a significant part of it is the result of federal policy.

I will give you an interesting example: A short time ago my office completed a review of "Free Standing Psychiatric Clinics" in New York City which were funded in large part by Medicaid. We found many abuses in these clinics. We discovered that the clinics were allowed to receive a full $28.00 per visit reimbursement fee for counseling sessions which were as brief as 30 seconds, or were conducted by students without professional supervision or were for general social services that were never authorized. What is more discouraging is that most of the abuses were the result of inadequate or non-existent Federal and state regulations governing Medicaid reimbursement and a lack of coordination among the various agencies responsible for implementing the program. In this lax regulatory atmosphere, there is an invitation to fraud and to abuse. Whenever government puts out such invitations you can bet people will respond.

I must emphasize that the Federal government has contributed to this particular problem because it has significantly broadened the uses of Medicaid to cover all kinds of non-medical services, but at the same time has not precisely defined what it expects of providers of those services.

There are similar examples in the AFDC program. If you review the application process for AFDC over the past few years, you will find an increasing complexity. While this complexity was often introduced in the name of fraud control, it had the effect of increasing errors and waste.

This brings me to the concerns engendered by the Michel Amendment and HEW regulations to implement that amendment. When the Michel Amendment was originally passed, I found it somewhat curious that, unlike other welfare reform proposals, this major policy initiative did not receive full analysis by the substantive committees of the House and the Senate. As you know, one result was that HEW was confused as to the intent and meaning of the amendment.

I must point out that this amendment is based on the false assumption that Quality Control (QC) measures are consistent across the states and are scientifically accurate. The fact is that the current quality control system is a rubber yardstick. It does not provide the kind of information which the Federal government believes it provides.

One example that is quite well known is the different treatment of the man in the house rule. The investigative methods used for quality control determinations differ from state to state as does the type and amount of evidence required to qualify a case as an error. This means that while a case may be judged ineligible in New York, the same case may not be judged ineligible in California or Illinois. Each state, working with regional HEW offices, is responsible for its QC standards. This decentralization clearly fosters great differences among the states.

In so far as the errors in the welfare system today are, in part, the result of Federal policy and regulations Federal officials can not stand aloof and point their fingers at state and local governments. The Federal government must bear responsibility for what are, after all, national welfare programs. Most of all, the Federal government must make a positive contribution to reducing errors rather than the essentially negative approach embodied in the Michel Amendment.

In my testimony above, I have suggested some ways in which this can occur. First, there need to be better definitions of key concepts such as hardships so that New York may recover from paralysis of the recoupment program. Second, there must be technical assistance and financial support to put into place modern error prevention systems. Third, simpler and more cost effective federal administration and preventing errors. Finally, so that each state really knows where it stands, the Federal government itself must establish uniform national quality control standards.

I would hope that when this committee takes up the House proposed welfare reform legislation, it will consider the issues that I have discussed here today. In a short time, I have only been able to outline some of the issues. I stand ready to offer

my assistance to you and your staff to provide greater details and information about areas that I have not been able to even touch upon today.

As you know, there exists an atmosphere and reality of severe financial constraint. There is great pressure from taxpayers to hold down the Federal budget. In New York State, we are not only under this same pressure, but the reality of New York State's weakened economy and the prospect of another hard recession make it nearly impossible for New York to raise any additional money for public assistance. In other words, there is essentially a finite amount wasted, which is abused, which is given to people who do not deserve it, is being taken out of the pockets of those who most desperately need it. All of us, at all levels of government and from all different perspectives, must join together to eliminate waste. We must not isolate our error reduction activities. Instead we must incorporate the goal of reducing waste in welfare in the heart of the laws, regulations and administrative systems that we use in public assistance if we are to succeed.

Thank you very much for your time.

Senator MOYNIHAN. And now, to close, we have Mrs. Dorothy Forney, who is the executive director, well known to this committee of the Eastern Regional Council on Welfare Fraud.

Mrs. Forney, we welcome you.

Ms. FORNEY. Thank you, Senator. It is nice to be here again before you.

Senator MOYNIHAN. You are always our cleanup hitter.

Ms. FORNEY. I know. I do not know how I get in this anchor position, but it is fun.

Senator MOYNIHAN. Next time you come early on, after the officials. It is not fair.

Ms. FORNEY. It is kind of fun to hear everybody else anyhow. I have a few remarks which will pertain to some of the things the other people said, if you will permit me at the end of my condensed testimony. You have the full statement.

Senator MOYNIHAN. I do have it.

STATEMENT OF DOROTHY M. FORNEY, EXECUTIVE DIRECTOR, EASTERN REGIONAL COUNCIL ON WELFARE FRAUD

Ms. FORNEY. The Eastern Regional Council on Welfare Fraud very much appreciates the opportunity to testify before the committee and it is very heartening to know that at least one Federal body is interested in controlling error, fraud, waste, and abuse in our Nation's ever-expanding welfare and income redistribution programs, and I would like to tell you that the Eastern Regional Council represents 911 members mostly on the east coast, but in 28 States and the District of Columbia, 16 percent of which are in your own State, Senator.

So I thought you might be interested in hearing that.

Senator MOYNIHAN. You know how to get to a fellow.

Ms. FORNEY. When several bills were before the Congress in the last session, some measures of correction to the problems in the system were proposed and they appeared to be well on their way to implementation through legislation. However, although the initial proposals failed passage, some slight reform was achieved in the Social Security Amendments of 1977 as a result of a promise that you made to me when I testified on H.R. 7200 and I thought that was very fine, and they have been very helpful.

There is still much work to be done. Several bills now before your committee will serve as the means to achieve the true welfare reform that the public seems to be demanding.

The full text of the testimony you have as instructed by the committee, I will summarize these points that are in my full testimony and then attempt to answer your questions.

One, a strong quality control system with fully mechanized equipment to provide the necessary information should be supported with adequate funds by HEW and required as a part of the system. It should be capable of providing management information which would include an exchange of information with other jurisdictions, number of fraud cases filed, number of investigations underway, plea bargains obtained, restitution figures, cases settled in other ways and, most importantly, all prosecutions and convictions.

This information would point up the weaknesses in administration of the system throughout the Nation and then should be circulated broadly to assist HEW in closing the loopholes that now exist.

Two, we should have a photoidentification system to be considered as a means of controlling ineligibles from cashing checks to which they are not entitled.

Senator MOYNIHAN. Could you tell me, you mentioned that you have it in Pennsylvania. Where else is it?

Ms. FORNEY. I am not sure what other States have it right now. Several other States have come to our State asking for advice on it, and in the first year of operation, in Philadelphia alone they were issuing 22,000 duplicate checks a month at an average value of $105 per check and that has been startlingly reduced to 2,000 per month.

Senator MOYNIHAN. I am just told that the District of Columbia has it also and it is having some effect.

Ms. FORNEY. Very good.

Having more than one social security number should be made illegal. Congress did consider this step in the last session but it failed to act on it, and it is true that the new social security issuances have been tightened up somewhat, but it is still not illegal to have more than one and as Senator Long suggested 18 months ago—it was on March 1, 1978, when he had a joint meeting with child support—perhaps every birth certificate should be stamped with a social security number, one that each individual would have for life. It is a suggestion I believe warrants serious consideration.

Despite the report of the Privacy Protection Study Commission, next to one's name, the social security number is the most important identification each of us has, because it is—or should be—unique.

It is the means for our proper due at the end of our working lives and proper credit should be contained in the record for appropriate payment.

Training: While the last point, it is the most important in the entire welfare system. As important as the Secretary herself is the eligibility worker, yet in many jurisdictions this is the least-trained person, often a high school graduate who has never had to handle money, and this person is entrusted with the judgment of eligibility, distribution of taxpayer's money, and a host of other responsibilities when an applicant for assistance comes before her or him.

The voluminous tomes of regulations, both Federal and State, are overwhelming, even to those who are familiar with the system.

Complex and confusing to say the least.

Our recommendation is that adequate funds be appropriated for intensive training of new eligibility workers, as well as those now employed in the art of fiscal management. We suggest funding of 90-10 matching by the States or local jurisdictions.

All of these suggestions would provide a more efficient system of control of the runaway monster called welfare until confidence in the system is restored in the eyes of the public through methods to eliminate those who are ineligibly collecting funds and therefore, providing additional funds to those who are truly needy.

I think this is something to which you alluded yourself several times today.

Congress and the administration are going to have to bear the brunt of strong public criticism and I thoroughly agree with your remarks this morning in tying into HEW with not being properly alert to the things that are going on.

More money is not needed, as proposed in several bills before the Congress now which are purported to reform welfare. Poverty, by most standards, has been reduced greatly since the beginning of the Great Society. Concentration should now be placed on providing jobs for those who are able to work, training for those with no skills, and more income for those who are unable to work because of infirmity.

We commend Senator Talmadge for his bill in strengthening quality control in the last session and we do hope for success for his excellent efforts in this particular Congress.

And as the Comptroller General said in his report to the Congress just about a year ago with respect to fraud and economic assistance programs, "No one knows the extent of fraud against the Government, but the Department of Justice officials believe"—and this goes back to the chart that you were talking about this morning—"believe it ranges from 1 to 10 percent of expenditures."

Senator, there are no true figures anywhere.

Let me say to you that the Inspector General, Mr. Morris, had called my office several times and said, "Does anyone have figures? Do you have figures?"

Sir, there are none. No one has ever taken the time, the money, the effort, the people involved to go after the true fraud that exists. Nobody can tell you whether it is 1 or it is 50 percent. We do not count anything but total convictions obtained and this usually results in the basis for our figures.

I know in Pennsylvania alone that we have nearly 200,000 cases which have never been brought to prosecution. They are just sitting there, and most of them have been adjudged to have fraud, or some kind of abuse, in them.

If that is true in one State, I am sure we are not unique. There have got to be cases elsewhere the same way.

The above recommendations we offer to the present system. However, there is another proposal which I think deserves the Senate and Congress study and consideration.

The States have established diverse programs, as you have heard today, which contribute to the complexity of regulations and their

interpretations and this diversity has been with the blessing of HEW, but it compounds the administrative problems with 55 separate programs in operation.

I think the block grant is an idea whose time has come. In legislation now before you, Senate 1382—and a companion bill, H.R. 4460—sponsored by the chairman of the Senate Finance Committee, Senator Long, and others including Pennsylvania's Senator Schweiker, the most acceptable and least costly welfare reform has been proposed.

The bill would provide a finite amount of money instead of the open-ended funding now available and would provide fiscal relief for the States to adjust. It would place an incentive on the States to put their houses in order since they would have to operate within the grants accorded them.

There would then be no need for the Federal Government to provide the strong quality control system proposed in the first part of my testimony.

The States would have to carefully monitor themselves because they would know their fiscal limitations and the carrot in this offer is that any money saved would then accrue to the States.

Many States have already instituted cost savings procedures in spite of existing regulations. Handling their own money totally would spark innovation not yet thought of, and result in savings.

Further, the proposed experiment of permitting two States to operate their programs without imposition of any Federal regulations is exciting. Release from restrictive Federal regulations such as the so-called 30⅓ would obviously remove a number of persons from the rolls who qualify only because of the inequitable incentive set up years ago.

As you yourself said, Senator Moynihan, in the lead article for the Journal of the Institute for Social and Economic Studies back in the spring of 1978——

Senator MOYNIHAN. My, you are a scholar.

Ms. FORNEY [continuing]. "When the earned income disregard is sizable we can find ourselves in situations where persons with absurdly high earnings can still receive welfare benefits."

Senator MOYNIHAN. Yes. No question about that.

Ms. FORNEY. The additional lure of a block grant program is the reduction of staff at the Federal level for quality control which would now become a total State concern.

In summary, good quality control with Federal backing is a must if the present programs are to continue.

In lieu, permit the States to operate their own programs through the block grant proposal and relieve the Federal Government of oversight and quality control, but a key to either pursuit is appropriate training of the most important person in the entire system, the eligibility worker.

The Eastern Regional Council also strongly supports other measures before your committee, known as the Talmadge amendments, which, I now understand, have been put into House bill 3236, and we certainly are delighted with this action and hope that we can see early passage soon.

Thank you so much.

Senator MOYNIHAN. I thank you.

It is just exactly 2 and I have just exactly 5 minutes to make an appointment with Secretary Goldschmidt. But I thank you for very good testimony. You are always so cheerful and generous and informative and you are a very powerful voice of dissent from the conventional wisdom in this field which has not been very productive.

Ms. Forney, I thank you, and with that, the hearing is closed.

[The prepared statement of Ms. Forney follows:]

TESTIMONY OF

Dorothy M. Forney
Eastern Regional Council on Welfare Fraud
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before the

FINANCE SUBCOMMITTEE ON PUBLIC ASSISTANCE

Hearings on Public Assistance Amendments

November 16, 1979

The Eastern Regional Council on Welfare Fraud appreciates the opportunity to testify before your committee. It is heartening to know that at least one federal body is interested in controlling error, fraud, waste and abuse in our nation's ever-expanding welfare and income redistribution programs.

When several bills were before the Congress in the last session, some measures of correction to the problems in the system were proposed and appeared to be well on their way to implementation through legislation. However, although the initial proposals failed passage, some slight reform was achieved in the Social Security Amendments of 1977.

There is still much work to be done. Several bills now before your committee will serve as the means to achieve the true reform the public seems to be demanding.

Much of my testimony will be repetitious of the material presented in 1977 since little has changed since that time. The points cited then are still valid.

Since my last appearance before you, our national expenditure for federal income transfer programs has increased to nearly $250 billion, according to the Institute for Socioeconomic Studies. The HEW Inspector General has submitted two reports indicating Medicaid fraud is rampant -- estimated as at least 10% by the former HEW secretary; and no one dares speculate on corresponding figures in AFDC. I will return to this latter statement shortly.

Food stamp fraud estimates -- a USDA problem -- range from 10% to 30%, depending on the source.

As you are well aware, there are three main types of fraud: Vendor fraud (most prevalent in the medical programs); recipient fraud (including unreported income, changes in family composition; multiple social security numbers and addresses; non-payment of child support, and others); and employee fraud (failure to discontinue a recipient by using the name and sending the check to a vacant lot or an accomplice, use of food stamp vouchers, and/or collusion with other employees). Several persons in my state have recently been apprehended as a result of a crack-down on employee fraud.

But this testimony is not limited to fraud. Error, waste and abuse are also serious problems. Only through enactment of several bills before you now, and further control of the system, will it be possible to improve the gloomy picture we see twice a year in HEW's shocking statistics.

Let me cite briefly some of the ineligibility and error figures for some of the large cities. The figures are for the period of April to September, 1978, which are the latest available, and are those reported by the states themselves:

New York City, N. Y.	10.3%	Wayne County, Mich.	11.3
Los Angeles Co., Ca.	3.5	Philadelphia, Pa.	24.1
Cook County, Ill.	17.6	District of Columbia	23.3

The national figures of admitted ineligibility and error today stand at 9.4%. They range from 31.2% in Alaska to 0.6% in Nevada.

In a program as vast as welfare, in which nearly 11 million persons* participated in the AFDC program, 4.2 million in SSI, 15.9 in food stamps, 21.3 in Medicaid, .8 in general assistance, and 6.6 received the benefits of earned income tax credit in 1977 (the numbers have increased since then), a small margin of error is to be expected. However, because we have not had an adequate quality control system, because HEW has never exercised a sanction even though it was available, and because we lack a strong training program -- for these and many other reasons, it is impossible for HEW or anyone to present a true picture of the state of our welfare programs.

* "The Administration's 1979 Welfare Reform Proposal" -- American Enterprise Institute, September, 1979.

I must call to your attention a GAO report issued February 14, 1978, entitled "The Federal Government Should But Doesn't Know The Cost Of Administering Its Assistance Programs." In the report the Comptroller General of the United States revealed that the federal government doesn't even have the vaguest idea of what it costs to run its own programs and commented, "Without this information the administrative efficiency of programs cannot be evaluated systematically."

Referring back to my earlier statement that no one should dare to speculate on fraud figures in any of HEW's program, any figures which are presented must be viewed askance. The old myth that there is less than 1% fraud in federal welfare programs has no basis in fact.

To substantiate my claim, even though this has nothing to do with fraud but does point up the shortcomings of government reports, let me cite a few quotes from the April, 1978 Medicaid Statistics report from HEW (which was issued early this year): "Data presented in this publication are generated as an adjunct to the Medicaid claims processing and payment operation. Thus information is based on bills paid and not services rendered during the month. Consequently, the data provided through this process are not professed to represent a true picture of the incidence of illness among Medicaid eligibles and are subject to fluctuations unrelated to the provision of medical care. Monthly data are collected and presented to meet pressing current demands for minimum information on medical care financed under Title XIX. However, states are required to provide more significant and detailed annual data on the numbers of persons receiving medical services, the number of units of such services, and the corresponding amounts of payments."

When one further examines the report, however, there are a number of annotations which indicate that any data in the report is probably good guess work -- no more. For example, one annotation: "Florida did not report recipients or payments by basis of eligibility of recipient and is excluded from all applicable tables. Data submitted for the month were estimated by the state."

Another: "Colorado reported recipients and payments by basis of eligibility only." Another: "The recipient counts for New York are understated because recipients of outpatient clinics, physicians' services and prescribed drugs in New York City are not reflected in the reported totals."

And one last: "In addition to Colorado and Florida, Massachusetts, Nevada, and Pennsylvania are excluded from Tables 10-13 because children and adults in families were not reported separately. Connecticut, Illinois and West Virginia were able to report children and adults separately but were unable to differentiate medical vendor payments between adults and children in families. These States are excluded from the total percentage computation in Table 11. Colorado and Pennsylvania did not differentiate other Title XIX recipients by age and are excluded from Table 14."

This is only a sample of the "exceptions" contained in the report, but it places the reliability of such government reports in true jeopardy. HEW/HCFA cannot be blamed for their figures -- they can only use the data which is reported. But they can be criticized for not insisting on rendition of appropriate information of a standardized nature so that all the apples will be in one table, rather than apples, oranges and bananas.

I cite the above only to emphasize that until a true quality control system is installed at the federal level, and until it accurately reflects what is going on throughout the system, neither Congress, the President, nor the American public will know the real cost of welfare programs or the actual extent of error, waste, fraud and abuse.

In 1977 when AFDC was wrapped into the Social Security Administration, Quality Control became an integral part of the program. During our testimony that year, we suggested that the logical place for quality control should be under the Welfare Inspector General's jurisdiction. Allowing it to remain in the program which it is supposed to oversee is something akin to letting the fox watch the chickens during the night.

Wherever Quality Control is located, however, it should be one of the most important tools available to all overseers of welfare programs. Therefore, it should be fully equipped with mechanized systems so that everything from total dollars spent to the least error committed is readily accessible.

It should provide management information which will improve administration, such as efficient delivery of cash to those truly in need, effective deterrence of admission to the rolls of those who are not in need, and swift prosecution of those who defraud.

"Administrative error" is one of the most widely used excuses for overpayments and underpayments. When quality control is relaxed or non-existent, administrative errors will continue to rise and fraud will become even more prevalent. Only through a strong, efficient, totally mechanized quality control system can the federal government hope to begin to clean up its house under the present system of management. Without it, the federal pocketbook will continue to be at the mercy of the states which are careless and wasteful, lacking incentives to be otherwise with the existing open-ended system.

Complex, confusing and restrictive regulations at all levels constitute another major problem. A good quality control system would reveal the problem areas and weaknesses in the system, and would point the way for HEW to make appropriate corrections.

In addition, cross-checking of information with other jurisdictions should be encouraged and, in fact, be required as a part of good management. In these days of instant mobility of the population, it is possible for those intent on committing fraud to move from county to county and state to state with little inconvenience. Because there is no mandated mechanization of information which would be instantly available to an eligibility worker, it becomes a simple procedure to join the rolls in more than one jurisdiction. *(As an example, I call your attention the report of the Taskforce on Welfare Reform dated October 12, 1979, in which testimony disclosed that "motorcycle gang members are engaged in welfare fraud schemes, using stolen or falsified identification for obtaining food stamps, unemployment benefits and medical assistance. -- "Report on the Activities of Outlaw Motorcycle Gangs by the Taskforce on Welfare Reform - October 12, 1979".)*

Earlier this year the Department of HEW had proposed establishment of a National Recipient System, which would have permitted a number of cross-checks at the local level with other states through a central registry system -- something our organization has espoused for several years. The agency in charge of development of the system placed all the necessary safeguards for privacy in it, but its implementation was subsequently stymied by the Government Operations Committee in the House. We regret this action since this

would have been a fine tool for those who are charged with seeing to it that only the eligible needy receive assistance.

If we are to eliminate from the rolls those who do not belong there, it is absolutely necessary that an exchange of information among the many agencies which dispense cash assistance be established.

Among the several data with respect to fraud which should be part of a good quality control system are these: Number of cases filed; numbers of investigations under way; plea bargains obtained; restitution figures; cases settled in other ways; as well as prosecutions and convictions. The state administrations should then be informed of the total picture (and be required to contribute their information in a timely fashion and on a standardized basis) so that they as well as the general public have an accurate assessment of what is actually taking place.

As an example, Pennsylvania has nearly 200,000 cases awaiting action for fraud, overpayment, and abuses of its welfare program. Because these cases have not reached prosecution, they are not included in any statistics which have been reported anywhere.

Only with the total picture of what is happening at the local level will HEW be able to assess its program realistically and decide where they need shoring up.

Inquiries directed to several members of the Eastern Regional Council who are fraud unit administrators and supervisors in local jurisdictions yielded the response that good management is one of the biggest problems in welfare administration. If quality control were to monitor such management, discover the procedures that work best in controlling fraud and abuse, and provide training for those jurisdictions which are most culpable, this would be progress.

Another facet of quality control is photo identification. The installation of a photo I.D. system in Pennsylvania a few years ago has reduced the duplicate check syndrome from more than 20,000 per month to less than 2,000 per month in Philadelphia alone.

Finally, another idea whose time has come is banning more than one Social Security number. Congress almost accomplished this two years ago,

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but not quite. Senator Long's verbal suggestion in a child support meeting held in Washington March 1, 1978 was unique. Perhaps every birth certificate should be stamped with a Social Security number, he said, so that each individual would have his own number for life. A great idea!

Let me reiterate. Until HEW insists on efficient quality control methods, assists the states in making installations of appropriate systems, and uses its power of sanctions when the results demand that they be imposed, no amount of lip service will change the present morass in which we find ourselves.

Therefore, the Eastern Regional Council strongly recommends support by the Congress for increased funds for computerization of information for efficiency in management, planning and evaluation, and prevention of fraud.

The key word is prevention. It is better to keep someone from committing fraud than to have to prosecute it.

The Medicaid program was given a boost in this respect two years ago when the anti-fraud and abuse amendments became law. Matching funds of 90% to 10% were provided for development and implementation of computer systems, and 75% to 25% for continuing operation. The results have been cost-effective so far, and the program is still in its infancy. The most cash assistance programs can obtain today is 50% - 50%. More is needed if the states are to be encouraged in their efforts to combat fraud.

There is another element involved in good quality control. The word is training. For too long local jurisdictions have used inadequately trained workers at the most important post -- admission to the system. Regulations, both state and federal, are extremely complex, and often conflicting. Confusion in interpretation from jurisdiction to jurisdiction causes innumerable problems. And workers become disheartened when legal aid attorneys are able to twist verbiage to the advantage of their clients. Morale becomes low and the daily grind of determining eligibility becomes routine: Permit entry to the rolls, no matter what. No one wants to battle "legal aid."

If there were uniform interpretations of the many rules and regulations throughout the entire system, and the states were permitted to give only those benefits and services outlined in federal regulations rather than

adding as many as they desire, some semblance of sanity could be returned to a program that is sorely needed for the truly needy. However, if runaway spending is allowed to continue and if programs are further escalated, there will be no one left to pay for them.

Therefore, we recommend that adequate eligibility worker training in fiscal management be instituted at once, mandated at the local level, and funded 90%-10% by HEW. You would not consider permitting a lawyer to practice law without attending law school and passing bar exams; you would not permit a doctor to practice medicine unless he attended medical school and passed certain requirements; nor would a teacher be allowed to teach without being properly accredited. Why, then, do we permit untrained and inadequately trained workers to dispense more than $250 billion annually?

Some states have instituted limited training programs on their own. However, nothing is required at the federal level, even though a large share of the money dispensed emanates from the federal government.

We urge consideration of this important point: Adequately funded training in fiscal management for eligibility workers, to be required by HEW as a requisite for program operation.

Let us take a look at another proposal which may well become the real answer to the question of whether welfare can be returned to respectability and if it could better be done by the states themselves.

Several years ago the state of California asked for and received a waiver from HEW to take some innovative steps to bring its welfare programs under control. When the smoke had cleared -- after many legislative battles within the state and hand-wringing by dissident groups-- more than 200,000 ineligible persons were removed from the rolls, grants were increased by 41% inside of two years, and substantial refunds in income taxes were made to the taxpayers. The point had been made that a state, if left pretty much alone, could manage its own programs far better than the federal government at far less cost.

There is now such a bill before you which deserves the most careful scrutiny. Senate Bill #1382 (the companion bill in the House is #4460), sponsored by Senators Long, Dole, Talmadge, Packwood, Benson, Schweiker, Boren, and Hayakawa would approach real welfare reform better than anything

that has been before the Congress for several years.

First, the bill provides a finite amount of money (rather than the open-ended funding now available), based on 1979 costs for cash assistance (the most realistic approach) plus an additional billion dollars to be given the states for fiscal relief, based on population. In addition, several low-benefit states (if the House bill is preferred) or several lowest per capita states (the Senate version) would receive an additional $400 million to offset increased costs.

Second, the bill provides block grants, indexed for inflation, population and high unemployment rates. The block grant approach is crucial here because it is the best incentive to efficient operation that has ever been proposed. While the states would receive the same money they received in 1979 (plus the indexed increases), they would be permitted to keep any money saved through efficient management to use for any social welfare program they desire. There would be no need for a highly sophisticated quality control superstructure within the federal government -- the states would now have a strong incentive to put their own houses in order.

There would be no need for further matches by the federal government since the initial match of 1979's expenditures would be the only one to take place.

Other key provisions of the bill include permitting the states to have a work requirement and a provision that would allow ten states to operate their programs without imposition of federal regulations.

It is our understanding that two states have already been suggested to make the experiment. The plan would obviously save the taxpayers a substantial amount of money, and would provide the impetus for innovation. To follow only one set of rules would be an unequaled opportunity for the states to prove their ability to administrate. The shackles of federal regulations have been grating too long and creating inequities between the working population and the welfare population which are reaching intolerable limits.

If the experiment works in the first two states selected, it should and could then be extended to others.

A further feature of S-1382 is the provision that after a five-year trial period, the overall grant would be reduced 2% each year (although the indexing would continue).

Advantages would accrue through the savings that would be realized through decrease in numbers of a burgeoning bureaucracy and simplification of administration, the necessity for the states to control their own programs through closed end funding, and the opportunity to ideate.

Despite present federal controls, intervention and complex regulations (which seem to be constantly changing), more states could do what some jurisdictions have already done in spite of these controls, and do even more. I refer here to the following:

Florida: Began income matching in 1972.

Texas: Conducts 34 training programs in fraud prevention and eligibility worker efficiency

Utah: Installed a workfare program

Wisconsin: Extradites non-supporting parents.

San Francisco County, Cal. Reduced its error rate from 17% to less than 2% as a result of innovations.

Vermont: Developed "Project Access"; monthly retrospective accounting; centralized computers on-line for all workers.

Bergen County, N. J.: Initiated local workfare plan

Connecticut: Turned welfare fraud over to State Police. Established a threshold supplement for fuel costs; provided a grant for Home Nursing Service to keep people out of nursing homes; gave a 14.2% welfare increase. Introduced a "winter standard" between December 8 and March 31 to help over winter months.

Philadelphia Family Court: Speeded up collections in child support through innovations in court procedures

Pennsylvania: Established Pennsylvania Employment Program, using private employment agencies.

Another possible solution has been offered in S. 1579 (sponsored by Senators Boren and Long). The bill would permit five-year block grants to the states and allow them to operate independently of HEW regulations. The same HEW funding would be provided the states chosen to participate as in previous years. The great advantage would be removal of federal restraints on operation, close attention at the local level to the details of administration, and the opportunity to prove that a program free of federal mandates

can operate more efficiently and less costly than under current modes of oepration.

If proved successful, as we believe it will, the block grant idea could be extended to the rest of the states to save many millions of dollars and restore a measure of desirable home rule.

The focus of most of my testimony has been on quality control. There are several other points I would like to raise which I hope will be favorably considered by the Committee as it delves into the problems of the welfare system.

Specifically, we strongly support the following:

S-1672. This bill would increase the matching rate for anti-fraud activity at the state and local levels from 50% to 75%, and would include funding for prosecutors' offices even though they may not be separately identified as welfare fraud units. However, only the activity connected with welfare fraud would be recompensable.

S-1674. The bill permits disclosure of information concerning AFDC recipients or applicants to any governmental agency authorized by law to conduct an audit or similar activity in connection with administration of AFDC as well as the Committee on Finance and the Committee on Ways and Means.

S-1676. Allows matching for compensation of judges and other court personnel under the child support program, and would permit payments directly to the court for activity in this connection.

S-1678. Certain tax return information would become available to state and local AFDC and child support agencies.

These are just a few of the Talmadge amendments we hope the Congress will consider. We also strongly support S-1669, S-1670, S-1671, S-1672, S-1675, and S-1677.

The Eastern Regional Council supports the concept contained in House Committee Report #96-331 which requires the secretary of HEW to issue regulations requiring all states to reduce AFDC and Medicaid erroneous excess payment to 4% by September 30, 1982, in equal amounts each year beginning in

the 1980 fiscal year. Failure to do so will result in penalties, according to the report.

Legislation has been introduced to countermand this bright effort on the part of the Congress, which we hope will be defeated. It may be necessary to modify the harshness of the mandate, but only through such stiff impositions of requirements and penalties can HEW ever hope to realize improvement in management of the welfare system.

We also believe that sanctions designed to reduce error and ineligibility rates, which resulted from the Michel amendment in 1978, should be imposed with modification. The harshness of a three-year moratorium could be detrimental. But Washington should remind the states that this time it means business and they must bring their programs under control.

I am pleased also to add to supporters of this testimony the minority members of the Pennsylvania Senate, who endorse the points contained herein.

[Thereupon, at 2 p.m. the hearings in the above-entitled matter were closed.]

[By direction of the chairman the following communications were made a part of the hearing record:]

TESTIMONY OF KEITH PUTMAN

Administrator, Oregon Division of Adult and Family Services

November 16, 1979

COMMITTEE ON FINANCE
SUBCOMMITTEE ON PUBLIC ASSISTANCE

PROPOSALS FOR DEALING WITH WASTE AND ABUSE IN SOCIAL SECURITY ACT PROGRAMS

Mr. Chairman, members of the Committee:

I am Keith Putman, Administrator of the Adult and Family Services Division for the State of Oregon. Among other programs, we administer Titles IV (except for IV B), the AFDC Program; and Title XIX, the Medicaid Program. I have worked for the agency since 1962, and have held a number of positions which have enabled me to see the administration of these programs from a number of vantage points. Oregon adopted a quality control program even before one was mandated by DHEW. My background is primarily with systems, procedures and research--as opposed to social work.

The statement of this Committee, contained in your October 22, 1979 Press Release shows that you are already aware of--to use your phrase--"the paradox" that efforts of states to reduce error may produce higher costs. I believe those higher costs are generated in both the administration of the program, and in the program itself. I hope you will forgive me if some of this testimony is on subjects you already understand fully. However, I am fairly certain that much of this testimony will either be new, or will provide greater insight as you deliberate this problem.

My remarks will address primarily the AFDC Program, and proposed rules of DHEW to impose fiscal sanctions on states who cannot reduce their "error" to 4% or less. Most of my remarks are equally true of the Medicaid Program. The DHEW gives, as it's reason for the proposed rules, that Congress believes the "error" in the AFDC Program is unacceptably high.

The "error" with which we are concerned comes, primarily from three sources: Inaccurate or untimely data from clients which produces an erroneous payment; "error" which is error by definition only--i.e., elimination of the error would not change the amount of the payment; and error based on the agency's failure to act on known data. The manner in which the three types of error can be reduced are very different. Of the three, the latter one--failure of the agency to act on known data--is the most vexing. I will not suggest, in this testimony, that the federal government should help finance such error when it is uncontrolled or excessive. But, I will suggest that imposing penalties for the first two causes should not be considered without some fundamental changes being made first.

I have six main themes. For each of these themes, I will suggest specific action of the Congress.

1. The manner in which error is counted in the AFDC Program produces a grossly exaggerated estimate of the numbers of federal dollars being spent in "error." Let me cite the three most flagrant examples. These make up precisely half of the "error" cited by DHEW for the State of Oregon.

a. No social security number. Having a social security number (or having "applied" for one) is a condition of eligibility prescribed by law. Yet, it makes little sense that a newborn infant cannot be included in its mother's grant until an application for a social security number has been filed for the child. Recent changes in federal rules will reduce this problem to some extent. However, the point remains that a client's need is no less real with a social security number than without one. I agree that clients should have social security numbers, but I do not agree that federal dollars should be withheld from the states and the impression given to the general public that tax dollars are being wasted when benefits are paid to a person who lacks a social security number. This is especially true when the present system does not recognize that an application for a social security number has been made until the client produces whatever documentation the Social Security Administration requires prior to assigning a number. To alleviate this problem, the Social Security Administration should permit states to assign social security numbers, subject to later verification by Social Security. Until (or unless) such a system can be adopted, lack of a social security number should not be considered an error.

b. Failure to assign child support rights. We agree that assignment of child support rights to the state, as a condition of eligibility, is sound social policy. To this end, Oregon has legislation which automatically assigns child support rights to the state for any person who receives public assistance. Yet, for a considerable number of months we were assigned an error in quality control for

lack of having the parent sign a separate piece of paper--redundantly making an assignment which was already a matter of statute. With the signing of that redundant document, our error rate dropped. But, the net effect was an increase in administrative cost without so much as a penny reduction in payments to clients. Regulations or law should always focus on purpose, not method.

c. Failure to register a client with the WIN Program. Oregon had a work search requirment for the AFDC client long before the WIN Program or its predecessors were enacted by Congress. We believe in the WIN Program. Oregon has the second highest WIN benefit/cost ratio in the nation. Yet, federal funding for the WIN Program permits our employment security office to actively work with less than one out of five persons who are registered. It seems to us, that until the WIN Program begins to run out of clients there is very little program loss caused by the incidental failure to register a client. The real loss in the WIN Program is that 80% of the clients who are mandatorily registered with the WIN Program are receiving no services aimed at finding them jobs. We suggest that "error" due to the states' failure to register a client for the WIN Program not be counted so long as the pool of registrants exceeds the federal funding for services in the WIN program, and the number of unregistered clients is below 4%.

d. An additional exaggeration of the error rate of which this Committee should be aware, is that errors are cited when the state fails to carry out provisions of its "state plan" even when that "state plan" detail is not required by federal law or rules. Thus,

an action may be cited as an error in one state which is not cited as an error in another state.

Oregon respectfully suggests to Congress that no federal fiscal penalties be levied for any action which, when remedied, does not result in a decrease in program expenditures. Further, we suggest that no federal penalties be levied for failure to act under its "state plan", when that action is not required by federal law or regulation. Failure to make this allowance will discourage states from taking permitted (but non-mandatory) steps which could reduce program waste or abuse.

2. Many of the actions of states to reduce so-called "error" has actually increased program costs. Let me give an example: Each year some clients will receive an income tax refund. Most states do not allow clients to keep such windfall income, requiring instead that such money be used to reduce the grant in the month the money is received. Many clients did not report the receipt of their income tax refunds, and these cases were later cited as Quality Control errors. We determined that it was impossible to reduce that particular "error" to any marked degree without oppressive and expensive measures. So, we simply modified our "state plan" to permit clients to "keep" their income tax refund as part of their allowable cash reserves. Welfare costs in Oregon are now higher by precisely the amount we formerly recovered from income tax refunds. But our error rate dropped. The appearance to the taxpayer is that we reduced welfare costs by reducing "error". The opposite is true. Actions similar as this have probably occurred many times and in many states.

3. There are structural features in the Social Security Act and in the regulations promulgated under that Act which produce errors.

Let me cite two examples:

a. Bradford v. Juras is a decision made by a 3-judge Federal Court in Oregon which prohibits recoupment of client caused overpayments through the mechanism of a small reduction of the monthly grant. Regulations of DHEW clearly permit this action. However, the Federal Court held that Congress, by permitting this action in some Titles of the Social Security Act, but by remaining silent on the practice in Title IV (AFDC), clearly did not wish to permit such a practice. The effect of this decision is that clients have no financial incentive to report changes in income or the number of persons in the household when such a change would reduce or close the grant. For practical purposes, even falsehoods go unpunished because of both the expense and reluctance of district attorneys to prosecute for fraud when the amounts involved are small. There is a constant danger that Bradford v. Juras could spread to other states. We believe that so long as there is no penalty to the client, that the state should not be penalized instead. Congress should amend Title IV of the Social Security Act so as to specifically permit recoupment of overpayments through grant reduction.

b. Inability to presume that income of the unmarried "second adult" in a household is available to the parent and child. Under federal regulations, reinforced by federal court decisions, the state cannot presume that a fully employed "boyfriend" living with an AFDC mother, is making any contribution toward her care, or the care of her children. If the "boyfriend" voluntarily makes a

contribution, and so informs the agency, that contribution is duly subtracted from the grant payment. If, however, he makes a contribution but denies it, and that contribution is later discovered by the quality control team, an overpayment exists and the state's error rate goes up. Keep in mind that he isn't required to make a contribution. But if he does, and we don't discover it, an overpayment exists. If the couple marry, then his income becomes presumptively available. This is a powerful disincentive to marriage. Oregon suggests that the fundamental underpinnings of the AFDC Program adopted in the mid-1930's needs to be reexamined in light of profound changes in life styles which have occurred since then. We believe that income of any adults in an ADC household who are sharing bread and/or board should be presumptively available for the children in the same manner now required for a parent. Indeed, we suggest that a number of social benefit programs, in which benefits are reduced because of a marriage, should be reexamined in this same light.

4. Some methods of reducing program costs actually cause error. The best example of this is seen when a state attempts to reduce welfare costs by finding employment for clients. Yet, employed clients, as a class, have exceedingly high error rates due to unreported or inaccurately reported earning and work expenses. If a client is receivng a $300 grant, earns $250, but reports only $200, welfare costs will drop, but a $50 error will be cited. Earnings which are primarily from commissions, tips, and other similar sources are almost impossible to "track" on a routine basis. I am confident that the Internal Revenue Service will

verify this. Some states (Oregon is one) actively encourage clients to find and accept full or part-time employment. Yet, the states' error rate will go up in proportion to its success in finding jobs for clients. Oregon suggests that error attributable to client underreporting on non-reporting of income be exempt from any penalties which might be imposed.

5. States are at least as vitally interested in avoiding error and waste as is Congress. In the larger states, the cost of the AFDC is born almost equally between the state and federal government. Various referendum and other citizen pressure to reduce the cost of government is felt more directly and intensely at the state level than at the federal level--regardless of the sincerity of federal offices and members of Congress. We suggest that Congress has underestimated that interest, and that penalties are not needed. Indeed, penalties will have the probable effect of further reducing client benefits. There have been, I understand, proposals to prohibit states from reducing welfare benefits should any penalties be applied. I seriously doubt that such an objective could be accomplished in fact. If states were prohibited from reducing AFDC benefits to regain lost federal dollars due to error penalties, I am confident that other state-funded programs would be reduced instead or, program benefits scheduled for increases would not be increased. No matter how it is viewed, it is the clients who will suffer--and probably not the ones who caused the errors in the first place.

6. Penalties against the states for error in the AFDC Program cannot be justified in view of the error rate in the federally administered programs. A case in point is the SSI Program, now administered by DHEW, but administered by the states prior to 1974. The SSI Program

primarily serves the aged, blind, and disabled. When states administered the SSI Program it, too, was subject to Quality Control scrutiny. That program, serving primarily stable, unemployable adults, always showed a Quality Control error rate which was a fraction of that found in the AFDC Programs. Yet, the SSI Program today is administered by the federal government and is showing an error rate in excess of the 4% being suggested as the penalty point for the states in the AFDC Program.* I do not believe that whatever errors the federal government commits in the relatively simple SSI Program are irrelevant to what the states should produce in the more complex AFDC Program. Thus, I cannot resist a pleading of equity--that the federal government should not impose on states a standard of performance which it cannot produce.

There is much, much more which could be said to illustrate our points. However, we will stop here and summarize how we believe Congress should respond to the issue of penalizing states for "excessive error" in the AFDC Program:

1. Do not impose penalties until Congress fully understands what is included in the present reports of "error."

2. If penalties are to be imposed, then make the following modifications:

a. Do not penalize states for errors which, if eliminated, would not reduce program or administrative costs. With special reference to the WIN Program, impose no penalty for failure to register a client as long as at least 96% of the "mandatory" clients are registered, and the number registered exceeds the available

federal funding for serving them.

b. Do not penalize states for error related items in their *state plans which are not required by federal rules.

c. Amend Title IV of the Social Security Act to specifically permit states to recoup overpayments by the mechanism of reducing the grant by a small amount until the overpayment is recovered.

d. Amend Title IV of the Social Security Act so that income of any adult in the household be presumed available for the care of the children, whenever that adult is a parent of a child, or is sharing the household as though married to the parent of the child.

e. Exempt from penalty, error caused by a client failing to accurately report earnings.

Thank you for this opportunity to contribute to the legislative process.

* SSI Quality Control figures show 5.2% for Oregon for last complete study for April 1978 through September 1978. Partial data for Region X covering October 1978 through March 1979 is 3.97%.

Comments Upon Proposed Rules, Fiscal Disallowances for Erroneous Payments in the Aid to Families With Dependent Children and Medicaid Programs (42 CFR Part 431, 45 CFR Part 205)

by

Montana Department of Social & Rehabilitation Services

There are several regulations required by HEW in the administration of the AFDC program which we believe contribute to erroneous payments and prevent destitute people benefits they are entitled to.

We believe that technical errors created by Federal Regulations should not be considered as a dollar error for fiscal disallowance. Technical errors are:

a. The requirement that recipients have Social Security Number's which does not, in any way, reduce the recipients' need and the standard of assistance for which they would be eligible except in an arbitrary/technical requirement. Social Security requirements, such as certified birth certificates cause undue delay and hardship to applicants and recipients. Many states charge a fee to furnish records of birth. No other segment of our population is required to have children obtain Social Security Number's.

b. The requirement that an assignment of support be initiated is another technical error. If support

has not been paid, there should be no dollar error in these cases. It should not be required that an assignment be obtained against a deceased parent.

c. WIN Work Registration is a technical problem prevailing in Montana due to the rural nature of the state. Dollar errors are cited on nonregistered recipients.

d. In order to be cost effective in Montana our Quality Control sample has to be very small. It is costing us $250 per case review yet the sample is so small that we are unable to design Corrective Action for Counties or on a regional basis. Sanctions against the state are developed from an even smaller sample of Federal rereview cases. The margin for error is so great that one case is projected completely out of proportion with what the situation really is.

The Quality Control Sample consisted of 180 cases, eleven of which were drops for various reasons, leaving 169 completed cases. There were 15 ineligible cases, amounting to $2,296.00, 12 overpaid ($838.00) and 11 underpaid ($373.00).

Eight (8) of the fifteen (15) ineligibilities, plus one more covered by a variance, resulting from a federal re-review, were caused by lack of a Social Security Number.

The eight errors resulted in $1,257.00 in erroneous payments in the sample and represented 54.7% of the totally ineligible payments of $2,296.00

It is easy to see that 55% of all erroneous payments were caused by technicalities. As soon as a Social Security Number, an Assignment of Support or a WIN registration is obtained, the error no longer exists. I am not saying they are not errors, but I do not believe they should be included in computation of the payment error rates.

We believe that Fiscal Sanctions should be applied to moneys actually misspent rather than to technical errors where no money is involved such as a person having no Social Security Number, Assignment of child support, or failure to register properly for WIN.

Requirements under WIN registration need to be changed in a Rural State like Montana. Montana has 56 counties with employment offices in 23. 33 counties in Montana have no employment offices. WIN requi_es every AFDC head of household to register for employment. A recipient is required to be interviewed for job placement or training if he has a potential for work within a 50 mile radius of his residence. This requirement causes errors because staff and recipients are aware that even if recipients are registered there is little or no potential that it will lead to job placement

for recipients beyond the 50 mile radius. No job service available locally. This requirement is not cost effective because of the limited number of job opportunities in sparsely settled rural areas. To require a person to travel 50 miles one way for employment is not sensible in light of the high cost of gasoline. Something should be done to conserve fuel. These recipients are least able to purchase fuel.

We would also like to see further definition and interpretation of reduction of disallowance because a State has made a good faith effort, but did not meet the target error rate. Example is, sudden and anticipated workload changes which result from changes in Federal Law and Regulations. Would this reduce the overall error rate or just the errors which can be attached to the Federal change?

Eligibility criteria for base period of April, Sept. 1978 is different than it is today. Rotrospective budgeting changes increase and the error rate until staff becomes familiar with the new regulations. Welfare reform legislation creates an additional change in regulations.

New programs are frequently added to the burden that a worker must carry. Example Fuel Assistance Program. State appropriatious are made on a biennial budget for a staff. Programs must be added to the work load of present staff until a State Legislature approves a new budget.

The statistical methods used will likely subject Montana this state to certain long-term loss of Federal Financial Participation (FFP), which will be, in any practical sense, impossible to escape. This loss will occur from the laws of chance much as if we were playing against loaded dice.

When the sample is taken and an estimate of our caseload is made, that estimate is in error because we have measured only a fraction of the caseload. This error from sampling is a mathematically determined quantity and has nothing to do with the accuracy or quality of our review procedures or findings. The exact mathematical equations depend on what is being estimated (proportions, ratios, mean, etc.); but in all cases, the sampling error is a function of the sample size in absolute terms. A large sample has a small error and a small sample has a larger sampling error.

For a small quality control sample such as the 150-200 reviews each six months that Montana would have, the confidence interval is on the order of + or - 3%. The confidence interval is the statistician's way of saying that he is pretty sure that the true population value is between certain limits. For example, if our sample measured an error rate of 8% among the cases in the sample, the caseload value is likely to be between 5% and 11%. In this case, 5% would be the lower bound or limit of our estimate, and 11% the upper limit.

For a larger sample, say approximately 1200 reviews, the

confidence interval would be on the order of + or - 0.5% (½ of 1%). This would be the approximate size quality control sample that would be pulled in states such as California or New York.

The Quality Control instrument, as all measuring instruments, has inherent limitations on its accuracy. These regulations imply that the Quality Control samples can measure the rate of erroneous payments without error. This is false. These regulations also require loss of FFP on all occasions that a QC sample shows a measurement that exceeds their targets. This is underserved. To illustrate the problem that this causes, let us assume that a 4% target is established for erroneous payments and that this State attains this target and that in our real world caseload, our erroneous payment rate is exactly 4%. At this level, we have met the Federal goal and should suffer no loss of FFP. However, as we select samples and try to use them to estimate this 4% error rate, our samples will show different values. Sometimes, the sample will be high, other times low. When our sample gives an erroneously high estimate, we would lose FFP under the proposed regulations. When a low estimate is attained, no FFP is lost. Thus, in the long run, we would suffer a loss of FFP approximately half the time, whenever our QC sample attained a high measurement. This occurs even though we meet the Federal goals. This loss will occur purely by chance.

These regulations purport to assure equal treatment of states. But they do not take into account samplying error. Although all states will be subject to loss of FFP due to sampling error, the largest states, with their larger samples and correspondingly lower sampling errors (i.e., + or - ½ of 1% vs. + or - 3%) will be subject to relatively less loss of funds. This fails the equal treatment intent of the regulations.

STATEMENT OF:

Houston Welfare Rights Organization, Inc. (Houston, Texas),
Philadelphia Welfare Rights Organization (Philadelphia, Pa.),
United Peoples Welfare Rights Organization (Fairmont, W. Va.),
Franklin County Welfare Rights Organization (Columbus, Ohio)

Introduction

This statement is submitted on behalf of the Houston Welfare Rights Organization, Inc. (Houston, Tex.), Philadelphia Welfare Rights Organization (Philadelphia, Pa.), United Peoples Welfare Rights Organization (Fairmont, W.Va.), and Franklin County Welfare Rights Organization (Columbus, Ohio). These organizations, whose members include welfare recipients and low income persons, support steps which are reasonably designed to assure that the AFDC system is administered fairly and efficiently so that all families receive their full entitlement. Each organization has actively pursued these goals in various ways including litigation which succeeded in forcing HEW to reinstate the review of denials and terminations (called "negative case actions") in the AFDC and Medicaid Quality Control programs (WROAC v. Califano) and joining the states in recent litigation opposing the massive AFDC and Medicaid outbacks threatened by the Michel amendment to the 1979 HEW appropriations (APWA v. Califano).

It goes without saying that inefficiency and improper expenditures hurt poor children since they waste funds which should be spent on the provision of assistance to those families who are desperately in need of such assistance. In addition, erroneous actions result in incorrect denials or reductions of aid due to families as well as overpayments and thereby cause a direct loss. Improved administration and error reduction could both increase the number of poor people receiving the aid to which they are entitled and insure that the funds devoted to assistance programs are actually used to provide aid.

In addition, there is no doubt that the current public image of the programs as chaotic and error-prone has eroded public

support for them and that substantial improvements in program management could increase the public's willingness to devote increased resources to these programs. We would note in this regard, however, that the degree of public distrust of the programs is far out of proportion to the actual problem and all too often wrongly focuses on the program beneficiaries as the cause of the problem. Unfortunately, much of this public attitude seems to be the direct result of HEW's own overstatements and omissions. The agency's repeated public statements on fraud, error and abuse seem to be more designed to make headlines than to inform, and such statements in combination with the failure to speak out on other fundamental program defects convey the erroneous impression that overpayments are the only significant problem in the programs and that all errors are due to client actions.

For all of these reasons the above-named organizations support fair and reasonable steps to improve program administration, recognizing the direct benefit to themselves as well as the general benefit to all citizens from such improvement. However, some recent HEW and Congressional actions purportedly designed to promote error reduction simply are not fair and reasonable ways to deal with the problem of errors but instead are likly to hurt legitimate recipients and may well increase errors. These actions include HEW's March 7, 1979 regulations imposing fiscal sanctions on states with overpayment rates above certain levels (44 Fed. Reg. 12578) and Congressional attempts to address error reduction through the Michel amendment (section 201 of the 1979 Labor-HEW Appropriations Act, Pub. Law 95-480) and related actions in the adoption of the 1979 Supplemental Appropriations Act (Pub. Law 96-38) and the still pending 1980 Labor-

HEW Appropriations Act (H.R. 4389); and HEW's response to these actions (44 Fed. Reg. 55314, Sept. 25, 1979). (We use the term overpayments throughout this statement to refer to both overpayments to eligible families and payments to families ineligible for any aid.) The result of these actions is simply to encourage, if not compel, states to concentrate on reducing only errors which result in overpayments and ignore errors which result in people being denied their full entitlement.

As discussed below, these policies cannot be supported for the following reasons. First, fiscal sanctions are not an effective means to assure cost-efficient and effective error reduction, and they impose additional unwarranted burdens on the intended program beneficiaries. Second, the existing fiscal sanctions policy is an unbalanced approach to error reduction which does nothing to address the problem of underpayments and erroneous denials and terminations of aid and may well result in increases in these erroneous actions. Third, these policies threaten the integrity of the Quality Control system as a remedial management tool. Moreover, the application of sanctions creates an undesirable conflict with other Congressional directives requiring error reduction to address underpayments and incorrect denials and terminations as well as overpayment errors, providing financial incentives rather than penalties for states which reduce errors, and questioning the validity of using a 4% tolerance level at this time.

This is not to say that there are not effective means available for improving administration and reducing errors but rather that fiscal sanctions are not such means. Our recommendations for

appropriate action to promote evenhanded error reduction are listed at the end of this statement.

1. <u>Fiscal Sanctions For Error Rates Will Harm Children In Need of Aid and Will Not Achieve Effective Error Reduction</u>

Unless we are to assume that states making overpayments are doing so deliberately despite the capacity to immediately put a stop to such erroneous payments, we have to accept that they do not have the capacity to produce instantaneous reductions in their error rates no matter how hard they try. Moreover, the type of precipitous action that will result from frantic ill-thought out attempts to reduce errors is as likely to increase as reduce errors. Accordingly, there can be no question that the adoption of fiscal sanctions and especially the adoption of such sanctions based on an arbitrarily selected tolerance level, such as the 4% level, will result in the application of sanctions to many states.

Faced with such reductions in federal funding for AFDC, state and local governments will either have to increase their own expenditures on such programs or decrease program costs. The predictable result is clear in light of the recent experience in response to HEW's announcement of an imminent $831 million cutback in federal matching for AFDC and Medicaid in the fourth quarter of fiscal 1979 to implement the Michel Amendment's directive that "fraud, abuse and waste" be reduced. For example, West Virginia was considering a 10 to 15 percent cut in AFDC benefits for July, August, and September 1979. Affidavit of Joan White Clay, Amy Rose Parks, and Gwendolyn Sanders, United People's Welfare Rights Organization, submitted in <u>APWA v. Califano</u>. As detailed generally in affidavits of plaintiffs and plaintiff-intervenors in that suit other states were planning

similar actions.

The consistent plea of states for fiscal relief in welfare programs is clear evidence of their inability or unwillingness to increase expenditures of their own monies. Even if this were not so, neither the responsible agencies nor the legislative bodies that would have to authorize increased expenditures would be eager to seek such increases and risk charges that such increases were necessitated by the state's incompetence, and the public is not likely to be sympathetic to such requests if they are so viewed. Thus poor people will pay the price for errors twice, once in the form of aid lost because of erroneous and wasteful actions, and once in the form of reduced benefit levels or other cuts to bring program costs down.

Moreover, fiscal sanctions are inherently inconsistent with the goal of true error reduction. The threat of a loss of federal funding is likely to encourage the grossest forms of error reduction with little or no thought to long-range improvement in program management, the cost-effectiveness of error reduction techniques, or careful evaluation of the results of changes.

In addition, the application of fiscal sanctions (as embodied in HEW's March 7, 1979 regulations and the even harsher policy directed by the Conference Report on the 1979 Supplemental Appropriations Bill) is inconsistent with the explicit Congressional decision to encourage error reduction by providing states with a financial incentive for successful error reduction efforts. Section 403(j) of the Social Security Act (Public Law 95-216), adopted in December 1977, provides that states which reduce their errors below a specified level will receive a share of the federal savings resulting

from such error reduction. This Committee suggested the choice of fiscal incentives instead of sanctions, noting that "instead of applying sanctions on the states, the dollar error rates would be used as the basis for a system of incentives which would give the States motivation for expanding their quality control efforts and improving program administration," S. Rept. 95-573, 95th Cong. 1st Sess. at 80 (1977).

Finally, a fiscal sanctions policy is inconsistent with HEW's own recognition that "...technical assistance, training, and positive incentives will have the greatest role in achieving continued error reduction ...." 43 Fed. Reg. 29312 (July 7, 1978). Given the harm likely to result from a fiscal sanctions policy the best course of error reduction would be one of positive efforts designed to assure that error reduction is real, sustained, and efficient. Certainly there is no evidence that states will strive to reduce errors only if there is a fiscal sanctions policy. Until there is a clear showing to the contrary, error reduction should be encouraged by less drastic and harmful means.

Ironically, the inevitable result of a fiscal sanction policy, namely the reduction of benefits to eligible families, is the very result which Congress has recognized must be avoided. Thus, the Conference Report on the 1979 Supplemental Appropriations Bill endorsed the imposition of fiscal sanctions on states with overpayment errors above a specified level on the understanding that "under no circumstances are any payments to legitimate recipients to be curtailed or even delayed" as a result of such sanctions. See also H.Rept. 96-400, 96th Cong. 1st sess., p. 26 (1979) re the still pending 1980 appropriations. However, Congress provided no mechanism

to insure that recipients would be protected from such harm and under existing federal law, there is no apparent way to ensure that benefits will not be reduced if sanctions are imposed.

Certainly HEW has not yet put forward any means to achieve this end. Thus, in its September 25, 1979 Notice of Proposed Rulemaking to implement the directive of the Conference, the only concrete way of protecting recipients that HEW mentioned was the Quality Control System. 44 Fed. Reg. 55316. However, at best, that system offers a method to identify errors and establish corrective actions to eliminate these causes, but it does nothing to prevent the kind of benefit reductions that states would make if they lost federal funds because of errors that are discovered.

HEW has indicated that it is studying the possibility of developing other policies that might in some way prevent reductions and we welcome that study. However, we believe that such study cannot acomplish its intended result without further legislative change. Moreover, we believe that there may be an irreconcilable conflict between a desire to impose sanctions and reductions in aid to legitimate recipients and that any device which might be proposed to achieve that end might prove to be unenforceable. Accordingly, we would submit that Congress should recognize that it cannot achieve its goal in this way and should reject fiscal sanctions in favor of methods which will truly improve the program by reducing errors without sacrificing the entitlements of needy families.

2. The Existing Error Reduction Policy is Not Even Handed and Will Encourage States to Increase Incorrect Denials and Terminations and Underpayments.

Although it is hard to imagine a greater tragedy than the improper denial of cash assistance to the nation's neediest families,

this is the likely result of HEW's current and proposed fiscal sanction regulations (44 Fed. Reg. 12578, Mar. 7, 1979; 44 Fed. Reg. 55314, Sept. 25, 1979) which apply only to overpayment errors above a specified level and ignore completely underpayments and negative case action errors. The message of this policy is clear: the errors that count are only those which cost the government money. Such a biased error reduction policy will not promote efficient administration and true error reduction, since it is likely to lead to an increase in erroneous denials and terminations and underpayments.

The pressure to reduce overpayments which will result from the sanctions, together with the exclusion of underpayments and incorrect negative case actions, insures that some administrators will turn to measures that are likely to reduce overpayments at the expense of increased underpayments and especially increased erroneous negative case actions. The increase in erroneous denials and terminations is likely to be even greater than the increase in underpayments. Since a payment to an ineligible family is generally more costly than an overpayment to an eligible family, denials and terminations have a much higher potential for reducing overpayment dollars.

Welfare agencies have in the past obstructed the applications process to hold down welfare rolls and some will no doubt resort to such practices in response to the threat of one-sided sanctions for overpayments. Indeed, pressure to avoid overpayments is certain to lead to greater delay in processing applications and increased failures to meet established time limits, and many agencies may even seek to obscure the increase in erroneous negative case actions by devices such as increases in turn-aways without acceptance of an application.

As discussed below, the existing Quality Control System is inadequate to even monitor such actions accurately. HEW's above-

noted suggestion that it will use the QC system to insure that states provide recipients their full entitlement does not even deal with the monitoring deficiencies since it does not include plans for necessary improvements in the system, much less provide an adequate means to assume that such actions do not occur in the first instance.

We are not alonein the belief that pressure to reduce overpayments without equal attention to underpayments and erroneous negative case actions will lead to a biased system. Program experts, including HEW staff, have recognized that focusing on one category of errors to the exclusion of others will have this result. For example, a recent Urban Institute study on errors in the AFDC program observed that:

> "There are several ways in which corrective actions to reduce errors can result in decreased accessibility to benefits by legitimate claimants.
>
> Pressure on eligibility workers to rule conservatively on discretionary matters and thereby reduce ineligibility and overpayment errors may generate an increase in underpayment errors and incorrect denials of eligibility." Bendick, M., Lavine, A., Campbell, T., "The Anatomy of AFDC Errors" The Urban Institute, Washington, D.C. (April 1978), pp. 36-37 (footnotes omitted).

Similarly an HEW summary of a 1970 state-federal meeting on QC reports:

> "Although a few state representatives felt there could be a cutback in reviewing negative actions, many of the participants expressed a desire to maintain at least the present scope and extent of review in this area. The group was advised by a statistical authority that reducing or eliminating negative actions would result in

introducing a bias into the entire administration of the assistance program. (This is because local agency staff knowing that only active cases are under review, might tend to deny borderline cases.)" HEW State Letter No. 1079 (SRS-APA-PE), March 19, 1970, 9-10.

If simple failure to review negative case actions in a system in which no penalties could attach is capable of biasing the system against allowances and continuation of aid, the effect of a fiscal penalty which ignores such actions would well nigh be akin to an instruction to disallow and terminate.

Congress also has previously recognized the problems that could flow from an unbalanced approach to error reduction and has disavowed such approach. Section 403(j) as enacted by Section 402 of Pub. L. 95-216 provides a financial reward to states that have succeeded in lowering all their AFDC error rates, including overpayments, underpayments, and negative case action errors. The House Ways and Means Committee also emphasized the importance of balanced error reduction programs in its report on H.R. 13335 (95th Cong. 2d Sess.) which would have provided fiscal relief based in part on error reduction.

That proposal would have included underpayments as well as overpayments in calculating the incentive in recognition of the fact that the goal of error reductioin was not simply cost savings, but efficient and proper administration. Negative case action errors were not included only because the base period for calculating the incentive was a period during which HEW did not require states to review negative

case actions. The Committee, however, stressed the importance of the principle of including negative case errors in the definition of errors for other purposes and noted that "[i]n fulfilling this goal [of efficient and proper administration] it is as important to insure that eligible needy families receive the aid to which they are entitled as it is to insure that payments do not exceed entitlements." It also recognized that excluding underpayments would put pressure on the states to err on the side of disallowances in their attempts to reduce overpayments and would jeopardize the integrity of the QC system. H. Rept. No. 95-1373, 95th Cong., 2d Sess., pp. 8-9.

In sum, in both section 403(j) and H.R. 13335, the members of Congress most familiar with the program expressed their concern about the effect of concentration on overpayments in a fiscal incentive program and favored a balanced incentive system. A fiscal sanction policy applied only to overpayments has an even greater potential for the results that Congress fears and has sought to avoid, since states would lose money for excessive overpayments rather than just being denied bonuses.

Accordingly, we do not think the remedy for the biased error reduction policy is to impose sanctions on states with excessive underpayments and negative case action errors. Rather, all fiscal sanctions based on error rates should be abandoned and genuine error reduction should be pursued through a variety of means such as a balanced and rigorously implemented Quality Control system, appropriate concentration in corrective action plans, and adequate technical and management assistance.

We would note in this connection that section 403(j) itself could be improved upon. Such an improvement is proposed in section 123 of H.R. 4904 which conditions eligibility for the incentive on a state's meeting both a specified standard for dollar error rates with respect to overpayments, and underpayments, and a specified case error rate for negative actions. However, we would suggest that that proposal does not go far enough because it does not consider the state's negative case action error rate in the actual calculation of the incentive. This could be accomplished as follows using the error levels now set out in §403(j) of the Act.

To be eligible for an incentive, a state's dollar error rate and negative case action error rate would each have to be below 4%. The next step would be to determine what percent of the federal savings a state is entitled to based on its dollar error rate. This percentage would be increased proportionately according to the state's negative action error rate as shown in the following table:

The negative case action error rate:	The percent of Federal Savings the state would retain would be increased by:
at least 3.5% but less than 4.0%	10%
at least 3.0% but less than 3.5%	20%
at least 2.5% but less than 3.0%	30%
at least 2.0% but less than 2.5%	40%
less than 2%	50%

For example, a state with a 3% dollar error rate and a 3.6% negative case action error rate would get 22% of the federal savings described in section 403(j)(2). That is, the 20% of federal savings based on its dollar rate is then increased by 10% based on its negative action error rate to yield 22%.

Increasing the percent of the federal savings according to the state's success in lowering negative action error rates fulfills Congress' intent of considering all errors and rewarding states for reducing all errors.

3. <u>The Fiscal Sanction Policy Threatens the Integrity of the Quality Control System.</u>

The primary purpose of the Quality Control system is to improve administration of the program by identifying the causes of erroneous actions and developing corrective action plans to eliminate the particular causes of error which have been identified. Basing fiscal sanctions on Quality Control results jeopardizes the ability of that system to serve as an effective means of reducing errors.

First, since primary responsibility for QC reviews is placed in the hands of the agencies that are responsible for administration of the programs under review, the system can only achieve its purpose if those agencies are committed to a full and probing implementation of the system. Basing fiscal sanctions on QC results necessarily creates pressure on the administering agencies to avoid the identification of errors in such reviews. There is no justification for so hamstringing the one established effective tool for error reduction in order to advance an error reduction policy of dubious merit such as fiscal sanctions.

Second, the bias in the fiscal sanction policy will militate against the use of Quality Control as an even handed tool for the reduction of all errors. Since the sanction will be based solely on overpayments, states will be encouraged to devote their limited resources solely to efforts to develop corrective action for the causes of overpayment errors and thereby avoid the sanction.

States have already responded to the recent restoration of negative case action reviews to QC with the complaint that they do not have enough resources to handle it all. See 42 Fed. Reg. 37206 (July 20, 1977). There is also some evidence that many federal and state officials already consider negative action reviews to be a low priority item because of the emphasis on reducing overpayments. Final Report, HEW Service Delivery Assessment of AFDC Negative Case Actions, January 15, 1979, pp. 24-26.

For there to be a real commitment to negative case action QC review, officials at all levels must not only consider such reviews of equal importance to the review of active cases, but HEW must take concrete steps to improve the negative action Quality Control review system. As it is, small sample sizes and inadequate error coding prevent an accurate identification of the extent and causes of error, thereby thwarting corrective action.

Moreover, consideration must be given to means to strengthen the review process to provide a more accurate review of the disproportionate number of denials and terminations based on procedural reasons rather than a finding of ineligibility. For example, the QC review of a denial for failure to furnish a requested document is not an adequate review if the only question is whether the document was requested and not furnished, not whether the request was appropriate, the failure was because the individual needed aid to obtain the document, or the evidence already in file established eligibility under any reasonable burden of proof. Thus while California reported a negative action error rate of 3.3% for the July-December 1977 period, over half of its negative actions for this period were based on failure to furnish requested information, withdrawal of application, or request for discontinuance. See Form

SRS-QC-401.2 submitted to HEW by California. A similar pattern of disproportionate denials and terminations for administrative reasons exists in other states, e.g. Michigan, Nevada, Kansas, Kentucky, Idaho, and Colorado. See Form SRS-QC-401.2 submitted by each of those states for July-December 1977. HEW has itself identified such administrative or procedural denials as warranting further study. Service Delivery Assessment, supra, pp. 21-22. Similarly, HEW should consider how a review system can be established to deal with the problem of so-called informal denials which result from unrecorded pre-screening and turn-aways.

Finally, applying fiscal sanctions based on a tolerance level which has no empirical support and therefore cannot be shown to be a reasonable standard for state administration is grossly unfair to the states and to the poor families who will bear the brunt of any fiscal sanction. Existing regulations establish tolerance levels based on the states' actual QC error rates and thus at least set a standard which bears some relation to state performance. However, proposed HEW regulations to "implement" the directive in the Conference Report on Public Law 96-38 and the pending 1980 Appropriations Bill, require that states achieve a 4% payment error rate by 1982 and base interim tolerance levels on the 4% goal. The subject of whether there should be tolerance levels in QC has been debated over the years, but there has been agreement in the courts, HEW and Congress that at this time there is no empirical basis for a 4% tolerance level for fiscal sanctions. See State of Maryland v. Mathews, 415 F. Supp. 1206 (D.D.C. 1976); 44 Fed. Reg. 12581 (Mar. 7, 1979); Testimony of Eugene Eidenberg, HEW Deputy Under Secretary before the House Ways and Means

Subcommittee on Unemployment Compensation, June 14, 1978; H. Rept. 95-1373, supra at p. 7; H.R. 4904, §§130-132, Cong. Rec. H10325, Nov. 7, 1979 and the accompanying H. Rept. 96-451, Part 1 at 149-50. Sections 130 and 131 of H.R. 4904 recognize this problem and require HEW to complete a thorough study of error rates by December 31, 1980. (To the extent that such sections appear to approve the use of fiscal sanctions generally, we think these provisions are themselves misguided.)

Clearly, in the absence of any factual support for the tolerance level selected, imposing fiscal sanctions on states with overpayment errors over 4% is simply arbitrary and unjust and further exacerbates the fundamental problems posed by sanctions.

* * * * * * *

Recommendations:

1. Congress should bar HEW from imposing fiscal sanctions on the basis of QC results.
2. Congress should direct HEW to assist states to engage in an even handed program of error reduction which gives the same

attention to erroneous denials and terminations and underpayments as it does to overpayments.

3. At this time, HEW should encourage error reduction by a variety of positive means. These should include strengthening the negative case action QC review process, enforcing corrective action requirements, providing technical and management assistance to the states (for example, assistance in writing clearer regulations, developing forms, training workers, and developing prompt processing systems), and providing to qualifying states the incentives permitted under section 403(j) of the Social Security Act.

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NEW JERSEY DEPARTMENT OF HUMAN SERVICES

TESTIMONY SUBMITTED BY COMMISSIONER ANN KLEIN

TO THE SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON PUBLIC ASSISTANCE

REGARDING WASTE AND ABUSE IN AFDC AND MEDICAID

November 16, 1979

Summary

The debate over waste and abuse in AFDC and Medicaid must not overshadow the fact that these are essentially sound programs which are delivering the necessities of life to thousands of low income children and adults. Although they are complex programs to administer, New Jersey has been able to improve their management without hurting clients. For example, the Department has developed a computerized management information system for Medicaid, and is currently developing one for AFDC, which quickly spot sources of error and abuse so that further waste can be prevented.

The Department of Human Services is extremely concerned about Congress's recent action mandating all states to achieve a 4% payment error rate in AFDC and Medicaid by Fiscal Year 1982 or face fiscal sanctions. Although we have made considerable progress in reducing waste and abuse, it is not certain whether New Jersey and most other states will be able to meet this arbitrary quota. The causes of error and how to best reduce them are still not fully understood; HEW only recently initiated a study of this problem. Furthermore, many factors which may increase errors are beyond state control; for example, complex federal regulations or employee strikes. These fiscal penalties are unreasonable and may be detrimental to recipients' welfare, and thus Congress should rescind them,

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Mr. Chairman, Distinguished Members of the Subcommittee:

I am Ann Klein, Commissioner of the New Jersey Department of Human Services. Although most of my testimony concerns waste and abuse in AFDC and Medicaid, I would first like to redress an imbalance which I believe is developing in the debate on this issue. We seem to be losing sight of a key fact: AFDC and Medicaid are essentially sound programs which are delivering the necessities of life to thousands of low income children and adults. These benefits are being delivered on an increasingly efficient basis: In New Jersey, for example, 95 cents of every AFDC dollar is correctly distributed.* A recent national appraisal of the Medicaid program indicated that it is mostly responsible for the poor's increased access to health care, reduced infant mortality rates, and other improvements in health. Despite the image given by many critics, these programs are, on the whole, achieving their intended purposes.

I am concerned that an overemphasis on quality control issues, resulting in unreasonably strict administration, will dilute these programs' effectiveness in targeting benefits to those most in need. Much of the recent debate about error and waste has focused on a desired outcome -- a 4% error rate -- rather than the means and potential costs of reducing these errors. New Jersey could probably lower its AFDC error rate by lowering its payment standards and thus eliminating many families with earnings from the program. Our AFDC program would be simpler and errors would be reduced, but at what cost? If program effectiveness and program integrity are to be pursued simultaneously, the causes of waste and abuse must be our focus, not merely the error rate statistics.

Despite the complexity of the Medicaid and AFDC programs, some states have been able to improve their management without hurting clients. New Jersey is a good example of a state whose efforts are yielding substantial payoffs.

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*Excluding technical errors, such as lack of Social Security number and assignment of support rights, which once corrected, do not affect eligibility or amount of payment.

For example, our computerized Medicaid Management Information System screens Medicaid claims to assure recipient and provider eligibility, to pay the correct amount, to catch duplicate claims, and to prevent abusive practices such as overutilization or inappropriate services. Known Medicaid savings and recoveries totalled $13.3 million in New Jersey last year. Further savings were created through the deterrent effect that a well-publicized program integrity system has on potential abusers, and by the fact that we can quickly spot causes of error and abuse and take prompt action to correct them.

As for our AFDC program, New Jersey has halved its payment error rate since 1974, in large part because of corrective actions taken after each review period to address specific sources of error.

A major corrective action currently underway is the computerization of the state's 148,000 AFDC cases. This system is expected to reduce error and fraud by standardizing procedures, reducing paperwork, permitting quicker verification of data, and eliminating arithmetic errors. The computer will notify the income maintenance technician if particular information is lacking or is invalid. Daily error reports will facilitate prompt correction of errors, indicate error rates per supervisor and income maintenance technician, and reveal areas in which retraining is needed.

Although New Jersey has taken significant steps to reduce waste and abuse, and has achieved relatively low error rates, we are extremely concerned about the Appropriations Committees' recent action mandating all states to achieve a 4% error rate by the end of FY 82 or face fiscal sanctions.

One of the most arbitrary and unreasonable aspects of this 4% mandate is the fact that the Medicaid quality control system is only now being developed, and the national Medicaid error rate has not yet been determined. Whether a 4% goal is achievable in this program is totally unknown. Even in AFDC, with its on-going measurement of error, the causes of error and how to best reduce them are still not fully understood. It has only been within the past few weeks that HEW announced the initiation of a study to more

accurately determine causes of error in AFDC and Medicaid. A second arbitrary element in the Congressional mandate is the fact that many of these factors may be beyond state control — for example, new federal regulations, random sampling variation, employee strikes, unanticipated increases in caseload, to name a few. To mandate states to achieve a 4% error level without consideration for these factors and to permit almost no waivers may foster a meat-axe approach to reducing waste and abuse.

Mr. Chairman, the fact that you have called this hearing today indicates that Congress is willing to consider the issue of error and waste in Social Security Act programs more carefully than it has in the past. As the Subcommittee begins its work on this problem, I would like to make several recommendations which may expedite the development of solutions.

1. Error and waste must be defined more precisely.

   Estimates of error and waste in government programs should be adjusted to reflect likelihood of recovery or reduction, cost of recovery or reduction, and estimated accuracy of the data. For example, AFDC error rate statistics currently overstate potential savings due to reduced error, because HEW includes technical errors which, once corrected, entitle a needy family to full benefit payments. Correction of the error does not lower AFDC costs. It is misleading to include these types of errors in a statistic which supposedly represents incorrectly spent funds.

   I would also strongly urge that public statements about waste in government put fraud and abuse in proper perspective. The HEW Inspector General estimates that only 15% of lost funds are due to willful misrepresentation, excessive services, and other program violations. Our experience in New Jersey has shown that the extent of abuse may be even lower. Although individual examples of blatant fraud are much more likely to attract public attention, they cast a negative image over all recipients, the vast majority of whom are genuinely needy.

2. Congress and HEW must give greater consideration to the error implications of proposed laws and regulations.

   The "error proneness" of a program or regulation must be weighed

against the benefits derived from its specificity. Congress's recent action to reinstate unlimited medical and shelter deductions for elderly and disabled Food Stamp applicants, but not for other Food Stamp households, is a prime example of legislation which may generate many errors. Although I am not opposed to specific deductions for needy families, it is not administratively efficient to extend specific deductions to one segment of recipients and not another.

3. If penalties are to be used, they must be carefully constructed so that they are reasonable and enforceable, and so that they do not elicit responses which are inefficient and harmful to clients.
I agree with most states that fiscal incentives to improve performance are preferrable to fiscal sanctions. The special federal funding which New Jersey currently receives for its Medicaid management information system and quality control unit is cost-effective and, as Congress is currently considering, should be expanded to AFDC.

From a pragmatic perspective, however, I realize that penalties in some cases may be an effective deterrent to poor performance. Given the likelihood that Congress or HEW will continue to employ sanctions as well as incentives, I would urge that, in order to be effective and fair, penalties must be more carefully constructed and less draconian than they have in the past. Several years ago, for example, New Jersey was assessed a penalty of $9.2 million in Medicaid funds because the annual utilization review for one nursing home, out of 230 in the state receiving Medicaid funds, was a month late. Although this penalty mechanism was later rescinded and replaced with less punitive regulations, it is a prime example of a sanction so gross and unreasonable as to be unenforceable.

If penalties are to be imposed, they must be based upon reasonable goals derived from empirical evidence about the sources of error and poor performance, the dollar impact of the error, and the cost-effectiveness of reducing it. Since the 4% error rate penalty recently set by Congress meets none of these criteria, it should be removed from the FY 80 Labor/HEW Appropriations bill.

In summary, I would like to reemphasize New Jersey's commitment to improved management of AFDC and Medicaid while maximizing client welfare. I hope that Congress will reinforce states' efforts through carefully crafted legislation that encourages improved performance and prohibits cutbacks in benefits to these programs' recipients.

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November 29, 1979

STATEMENT ON WASTE AND ABUSE IN SOCIAL SECURITY PROGRAMS

In the AFDC program waste is commonly identified as the error rate. Abuse is commonly identified with fraud in the program which is also indicated in the QC error rate, special projects and various reports. All of this data is then conveniently lumped together to formulate the overall viewpoint: "This is what is wasted or lost! What shall we do?"

Let us look at North Carolina's fraud report for October 1979 through March 1979 for a study of the validity of the "facts" Congress has.

North Carolina's QC statistics indicate that overpayments were responsible for $4,683,500 (Ineligibles and Overpayments). Underpayments were responsible for $792,576 not being spent. Of the overpayments the total client error in North Carolina was $2,016,541, which breaks down as follows:

Unreported change	$1,289,252
Misrepresentation	585,130
Incorrect Information	142,158

Agency error was $2,666,959.

Somehow in the process of coding errors a non-legal finding of misrepresentation is made by Quality Control. Somehow the unreported changes by the client or others is separated from misrepresentation. Regardless, one fact is clear, these are errors beyond the actions of the agency. They are the products of other individuals. Even more clear is this fact, States are to be penalized for these errors.

I would like now to suggest an analogy "Should the Federal Reserve withold money from banks because they have been robbed?" The purpose of this analogy is simple-

fraud or abuse should not be treated as an error in penalizing states for their QC error rates. It should be used as an indicator of action at the local, state, federal and Congressional levels to assist the states in reducing this type of loss. Witholding funds, fiscal sanctions and 4% error rates will only increase problems in this area. This will mean an increase in the loss of much needed funds.

Let us look at errors the agency is responsible for. In North Carolina this was, as stated, $2,666,959 or 57% of the payment error rate, 7.01%. This indicates that agency responsible errors in North Carolina could have been 3.9% without the client error. However, in terms of lost money, let us investigate further.

Enumeration errors or Social Security number errors are technically "procedural" errors. This means that the agency failed to document or send in an applicantion for a recipients Social Security number. It does not affect eligibility or the amount of payment. These paper errors caused 8.49% projected increase in our error rate or $226,424.82. It hardly seems fair to insinuate this money was ever "lost". It seems far worse to imply that the errors should be used to withold money based on the state's error rate when the error never could lose money.

When speaking of errors, one should also look to Congress. There are errors caused by the lack of similarities or coordination between programs. As example, we have the AFDC income diregard which unfairly is different for applicants and recipients, an entirely new system of eligibility for Food Stamps, and another system for Medicaid. Congress should get its act together. There is also the problem of too many federal regulations and resulting excessive paper-work, lack of flexibility, inconsistent information from HEW and the regional offices, and a difference of perceptions of error rates in each state because of the many differences between states.

Differences in state programs can account for some of the abuse. In North Carolina, a family of 4 receives only $210 monthly AFDC payment, which forces cheating. One can understand when a family has too little income to support the needs, as the recipient usually says, "But I needed it."

Admittedly there is fraud and abuse and waste in the AFDC program. The fraud or client error should not be used to penalize the state. The agency error should be evaluated, in light of the QC error rate and become an indicator that corrective action is needed. Corrective action can only be achieved by deliberate work with each state, and with required monitoring of the programs administration within the state. A set of fallible statistics should not draw arbitrary error lines. Instead, we must look for welfare reform to correct the problems caused by federal inconsistencies and work with the states toward corrective action.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

November 27, 1979

HELEN B. O'BANNON
SECRETARY

TELEPHONE NUMBER
(717)-787-2600/3600

The Honorable Daniel P. Moynihan
United States Senate
Chairman, Subcommittee on Public Assistance
Committee on Finance
Washington, D.C. 20510

Dear Senator Moynihan:

I regret that I was unable to testify on November 16th, when the Public Assistance Subcommittee held oversight hearings on public assistance fraud and abuse. However, I understand that many of my colleagues in other states did testify on our problems and our attempts to reduce errors and fraud in the programs we administer.

For the record, I would like to submit some comments concerning our efforts in Pennsylvania and some of the concerns we have regarding the implementation of federally-imposed fiscal sanctions.

Thank you for your interest in resolving this most important matter.

Sincerely,

Helen B. O'Bannon

P.O. Box 2675, Harrisburg, PA 17120

The Commonwealth of Pennsylvania is committed to elimination of errors in our complex system of public assistance programs and prevention of fraud and abuse. Recently we have made significant headway in improving the integrity of our public assistance program. However, we do raise issue with the imposition of federal fiscal sanctions and with many of the provisions included in proposed regulations issued by HEW, which we believe go far beyond the intent of Congress.

We remain opposed to the entire concept of disallowances of Federal Financial Participation in connection with the Quality Control program.

It should be emphasized that the imposition of any financial penalties, resulting in the reduction of monies in our public assistance programs, will adversely affect the poor. We simply cannot, with reduced funds, maintain our programs and provide the necessary case management; every sanctioned system would have to consider reducing either the scope and eligibility of its programs or its staff complement. Either result would hurt the recipient and probably result in increased errors.

We suggest a constructive rather than punitive approach toward the administration of public assistance programs. Certain problems have already been identified that must be approached on the federal level before state and local governments can reduce error rates. For example, Urban Systems Research and Engineering, Inc. has documented in detail the deficiencies in Medicaid eligibility requirements and has summarized these problems by stating "the Medicaid eligibility provisions are so complex that they are almost entirely unworkable." We suggest that Congress direct HEW to attempt to correct problems in eligibility prior to contemplating any system of penalties for states. We laud attempts such as "Operation Common Sense" and the newly formed "Corrective Action Project" as methods for the Federal government to actively aid states in administering public assistance and medical assistance programs. Rather than a system of disallowances, we recommend administrative and legislative initiatives to simplify eligibility and to further attempts by federal agencies to provide technical assistance to the states.

Fiscal penalties have merit only when balanced with fiscal incentives. For example, HEW could provide financial incentives to the states to increase third party liability (TPL) activities. As a result, unnecessary Medicaid expenditures could be avoided. The proposed regulations give no consideration to states' efforts in TPL and other activities of this type which result in actual savings; rather, regulations proposed to penalize states that make procedural

eligibility errors which result in no dollar losses.

We oppose apparent Congressional and HEW regulatory intent which clearly places emphasis on the punitive aspect of the Quality Control process. By limiting the time in which states can initiate remedial action for deficiencies in their operations or procedures, federal regulations, if approved in their proposed current form, ignore the realities of corrective action and take a simplistic attitude toward the causes of Quality Control error. Once again, the Federal role should be one of assisting states in corrective action rather than imposing unrealistic penalties that ignore the process entirely.

We applaud apparent Senatorial intent (Magnuson - Javits colloquy in Congressional Record of September 27, 1979) to exclude technical or administrative errors in determining actual mispayments of public and medical assistance funds. We stress that administrative, procedural errors that do not result in actual mispayment should not be included in determination of misspent dollars. Proposed HEW regulations ignore such intent and fail to differentiate between technical errors and substantive case errors. Technical errors include instances in which a Social Security number is not obtained or a recipient is not registered with WIN. In both instances, "ineligibility" is readily corrected by completing the appropriate forms. During the period of the technical ineligibility, the recipient remains validly eligible for AFDC based on his financial need for the program. Once the enumeration process begins or once the recipient is registered for WIN, the AFDC payment is technically correct, yet no change in the AFDC payment results. The level of payment remains unchanged during the period of "ineligibility" and "eligibility." States should not be sanctioned for "misspent" dollars in such instances, since no change in AFDC payments results from the error or its correction.

The General Accounting Office has pointed out in its report Ohio's Medicaid Program: Problems Identified Can Have National Importance (HRD-78-98A, October 23, 1978): "the procedures HEW requires the states to use in making the Quality Control studies and reporting the results do not differentiate between technical errors and substantive errors. Therefore, true program losses due to ineligibility and potential savings available from eliminating eligibility determination errors are overstated." In an earlier report entitled, Legislation Needed To Improve Program for Reducing Erroneous Welfare Payments (HRD-76-164, August 1, 1977) GAO made a similar finding relative to the AFDC Quality Control program.

Again, I stress that it is unreasonable and unrealistic to impose fiscal sanctions based on a Quality Control system which, by its very nature, will result in an overstatement of states' payment errors.

The Department of Health, Education and Welfare has proposed designation of a national average for the various error tolerance levels. The implicit assumption here is that state program regulations are sufficiently homogeneous for accurate and appropriate averaging. They are not. It is impractical to think that a single tolerance level adequately addresses the variance in program size and complexity from state to state. In a state like Pennsylvania, for example, local assistance offices handle not only AFDC, Medical Assistance and Food Stamps, but also AFDC-U, the Medically-Needy Spend-Down program, General Assistance, and Emergency Fuel Assistance. One district office in Philadelphia serves 17,000 families. The error rate in this office may understandably be higher than that of a small suburban agency in a state where only the minimum federal/state programs are available. Any interim toler. .ce level that ignores the unique characteristics of each state as to demographics, caseload size, rate of caseload growth, and unemployment growth, is inherently unrealistic. Also, any system which fails to take into account programmatic differences encourages states to minimize the programs and benefits they provide. We do not think Congress intends to encourage states to reduce programs and services to the needy.

The Commonwealth of Pennsylvania will continue to be diligent in reducing errors and in identifying fraud in its public and medical assistance programs. But we request that the federal government cease this arbitrary imposition of fiscal sanctions. We remind you of the premise of cooperation inherent in the federal/state partnership and request that the federal departments assist states in improving their programs and refrain from putting roadblocks in our paths.

Thank you for this opportunity to go on the record concerning this most important and serious matter.

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