S. HRG. 107–372

MEDICARE AND SOCIAL SECURITY BENEFITS: TURNING OFF THE SPIGOT TO PRISONERS, FUGITIVES, THE DECEASED, AND OTHER INELIGIBLES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

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MEDICARE AND SOCIAL SECURITY BENEFITS: TURNING OFF THE SPIGOT TO PRISONERS, FUGITIVES, THE DECEASED, AND OTHER INELIGIBLES

WEDNESDAY, APRIL 25, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Nickles, Thompson, and Baucus.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I thank everybody for coming. I want to also thank Senator Baucus, who will be here shortly, for his support during this investigation. I also thank our fellow members, and do that on both sides of the aisle, for taking time out of their schedules, when they are able to be here, to be here at all.

In addition, for all of you who are witnesses, thank you very much for the work that you have put into this subject to make your information available to the committee, and some of you for coming from a long distance. Your testimony today will assist the committee greatly in determining how best to address the matters raised.

The Federal Government, the largest, most complex organization in the world, annually spends hundreds of dollars for grants, payments, and procurement of goods and services.

In fiscal year 1999, we had nine agencies reporting improper payments of $20.7 billion. Obviously, nine government agencies are not all of the agencies of the Federal Government.

This hearing, however, is going to focus on improper payments at two agencies within the committee's jurisdiction, the Department of Health and Human Services and the Social Security Administration.

Today, the committee will examine the basis for improper payments of Health and Human Services, Medicare, and Medicaid programs, and the Social Security Administration's Social Security and Disability programs. Improper payments in these programs totaled $17.5 billion, resulting from errors or fraud.

Now, to better understand the reasons for the improper payments at HHS and Social Security, the committee reviewed 12 dif-

ferent types of improper payments made by the two agencies, totaling $800 million. There were improper payments to inmates, fugitive felons, the deceased, deportees, and other ineligibles.

The reasons for these improper payments vary. However, we have learned that there was a lack of communication between the Federal, State, and local governments. Also, they work with incompatible software and hardware.

Further, we have found that improper payments result from insufficient oversight, weak internal controls, and late or non-existent system checks. This lack of attention to benefit payments opens the door to fraud, waste, and abuse of government payments and scarce taxpayers' dollars.

To facilitate the discussion today, the committee will focus on payments to prisoners by Health and Human Services, and the Social Security Administration. In 1996, Congress passed a law prohibiting SSI payments to fugitive felons and parole violators.

The Social Security Administration has been working to involve all States in data matching projects. These projects will ensure these people do not receive SSI payments from the Federal Government while the local authorities are still pursuing fugitives.

The SSA will explain why 5 years have passed with so few States actually participating in the project. In addition, the committee will examine whether OASDI payments should also be prohibited for fugitives, like the other law.

The committee will also examine the status of Medicare and Medicaid payments for prisoners. We have the legislative auditor from Louisiana describing his 5-year quest for clarification from HHS about whether Federal or State government is responsible for medical expenses of State prisoners.

When Senator Baucus comes, I am going to stop wherever we are in the program for him to make an opening statement. I would ask Senator Thompson: Most of the time we do not have time for opening statements, but did you have anything you wanted to say?

OPENING STATEMENT OF HON. FRED THOMPSON, A U.S. SENATOR FROM TENNESSEE

Senator THOMPSON. Just, Mr. Chairman, I appreciate your having these hearings today.

I think, as you know, in the Governmental Affairs Committee we spent quite a bit of time on this. What we have found, of course, is that only a very few agencies even bothered to report, even tried to keep up with this.

I think it is somewhat ironic, with the problems that HHS has and Social Security has, at least they are doing something. They are making an attempt to report their problems. They have got real problems, but they make an attempt to report their problems.

Out of the thousands of programs that the government has, only a handful are actually reporting or trying to make an estimate as to what their figures are for waste, fraud, and abuse. In 1998, we came up with payments of $19 billion, but the GAO told us it was only the tip of the iceberg.

So I think one of the things that we have to do, is have the committee chairmen of these various committees that have jurisdiction over these various agencies do exactly what you are doing. That is,

ask them to come forward. What are you doing? How are we going to get a handle on this?

Then we have got to ask ourselves whether or not perhaps we need legislation to require all of these agencies to make a good-faith effort to make an estimate of the exact numbers. I think that people would be startled and amazed if we ever got a government-wide figure in terms of waste, fraud, and abuse. What you are doing here today, I think, is a step in that direction.

The CHAIRMAN. Obviously we benefit from your membership on this committee, as well as your chairmanship of another committee, to help us make sure we are aware of everything we ought to be doing in this area. I would look to you for some advice.

Prior to introducing witnesses, I would like to show a short video clip from NBC's "Fleecing of America" that sets the stage for a discussion today. I think the tape provides a summary of the issues relating to Social Security payments to fugitive felons.

So, would you start the tape, please?

[Whereupon, a videotape was played.]

The CHAIRMAN. That will give you some idea from one case. So we have a very distinguished panel of people, and even a witness that has a great deal of first-hand experience with what we are talking about.

The first witness, is Mr. Jerome Horn. He was apprehended last month for parole violation involving his 1987 armed robbery conviction. He was receiving Supplemental Security and Disability Income, as well as Medicaid coverage for his medical condition.

I appreciate Mr. Horn's willingness to participate in the hearing today to share his story and his views with the committee. I would also give special thanks to the U.S. Marshall Service for accompanying Mr. Horn and going out of their way to make possible this testimony to happen.

We have James G. Huse, Inspector General at Social Security; Fritz G. Streckewald, Acting Assistant Deputy Commissioner, Office of Disability Income and Security Programs at Social Security; Dr. Daniel Kyle, legislative auditor, State of Louisiana. If Senator Breaux comes and wants to give further introduction, I will have him do that. But, obviously, he is detained elsewhere.

We have Michael F. Mangano, Acting Inspector General, Department of Health and Human Services; and Michael McMullan, Acting Deputy Administration, Health Care Financing Administration.

So, Mr. Horn, we are going to start with you. Well, let me take care of a couple of administrative things.

First of all, all of you may have longer statements than the 5 minutes that you have been allotted. You do not have to ask to have those included. They will be automatically included without your asking, if you desire. We hope that you will give us your entire statement.

Last, even for those of us who are able to come to this hearing, we may not be able to ask all of the questions we want to ask. So, you will get letters and questions in writing. I would like to have a response in 2 weeks. For those of you who have not been involved in that process, my staff will help.

Also, at the 5-minute buzzer, I do not like to have it be a hard-and-fast rule so you stop in the middle of a sentence. But try to

plan so you can make a summation of your final one or two points after the five minutes have passed.

Then we will have all of you testify, then we will ask questions. We will start with Mr. Horn.

Mr. Horn, would you proceed?

STATEMENT OF JEROME HORN, FUGITIVE FELON/PAROLE VIOLATOR, ESSEX COUNTY JAIL, NEWARK, NJ

Mr. HORN. Yes. Good morning, ladies and gentlemen. This is an opening statement from me.

Mr. Chairman and members of the committee, I want to thank you for inviting me here today to tell my story, and maybe help with the issue that is being discussed.

I am currently an inmate at the Essex County Jail in Newark, New Jersey. I have been there since last month, after I was arrested for violating my parole.

Parole started after I got out of prison in 1987, but I stopped reporting to my parole officer in 1997. The truth is, even though I knew that I was being a fugitive, I just thought, due to my health conditions, I just stopped reporting. I just thought that I had paid enough for the crime I had committed. I had turned my life around away from crime and did not want to report any more.

I found out after my arrest that the police were able to find me after they matched up my fugitive warrant with Social Security files. They were then able to find where I was receiving my Social Security checks in Patterson, New Jersey. I was not exactly hiding, but I had no idea that they could find me this way.

I was convicted of armed robbery in 1981 and spent 6 years in Rahwey State Prison. While I was in prison, I found out that I have a heart condition that puts me at risk of sudden death.

After I got out of Rahwey in 1987, I went to live with my mother in Newark. I applied for Social Security benefits, and my medical treatment was covered by Medicaid. I do not receive any other checks from a government program because of my heart problem. I cannot work, so I do not have any insurance.

In 1997, I moved to Patterson, New Jersey, but I kept my checks going to my mother's house in Newark. That was about the same time that I stopped reporting to my parole officer.

I moved again about 6 months ago to a new place in Patterson, but this time I sent my change of address to Social Security and started getting my checks there. Everything was going along just fine until last month, when the police showed up to arrest me.

Yes, I did know that I was a fugitive and that the parole people were looking for me, but I did not know that there was anything wrong with me getting my Social Security checks.

I was told that my story would help provide you with a little more perspective on this issue, and for that I am glad to help. But to be totally honest with you, I am also here to help myself. I am truly sorry for having violated my parole and I hope that the parole board will look kindly on my being here.

I have a son that I am very close with, and because of my heart problem, I want to spend as much time with him as I possibly can.

Thank you again for inviting me to tell my story. I will be glad to answer any questions that you may have.

[The prepared statement of Mr. Horn appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Horn.

Now, Mr. Huse?

STATEMENT OF JAMES G. HUSE, JR., INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, BALTIMORE, MD

Mr. HUSE. Good morning, Chairman Grassley, Senator Thompson.

Let me, first, thank you for the opportunity to speak with you today on a matter of importance to the people of the United States: improper payments made by Federal agencies, including the Social Security Administration.

As we fast approach the critical years during which SSA will pay out more in benefits than it receives from the current workforce in contributions, payment accuracy is more important than it ever has been.

Payment accuracy has been a primary focus of our Office of the Inspector General since its formation in 1995. The area in which my office has made the most progress is that of Supplemental Security Income, or SSI, payments to fugitive felons.

In 1996, Congress enacted legislation prohibiting the payment of SSI to fugitives from justice. That legislation required SSA to provide law enforcement officials with the current address, Social Security number, and photograph of any SSI recipient in fugitive status.

In light of our OIG status as a law enforcement organization, the Commissioner then asked my office to perform this function. We began investigating fugitive felon cases immediately.

In the years since we undertook this responsibility we have worked with SSA on two fronts. First, we have worked with other Federal, State, and local law enforcement agencies to locate and apprehend wanted felons, and we have notified SSA of each fugitive on SSI so that payments could be suspended.

Second, we have worked both with SSA and with outside law enforcement agencies to expand our ability to identify fugitive felons for apprehension and payment suspension.

In 1999, we entered into agreements with the U.S. Marshall Service and the FBI to expand our access to fugitive information. In 2000, we entered into a similar agreement with the National Criminal Information Center. SSA agreed to pursue matching agreements with the States to provide us with State fugitive data. Twelve States and three major cities have already entered into such agreements, and more are in the pipeline.

Our efforts to increase the inbound flow of information have reaped immediate rewards. We have identified over 28,000 fugitives receiving SSI payments since the program's inception 4 years ago. Almost half of those occurred in fiscal year 2000. As we expand our capabilities to obtain accurate fugitive information, we expect that number to continue to grow.

The savings are significant, more than $34 million in fiscal year 2000 alone. While it is this bottom line that is directly relevant to our mission, a critical fact is often overlooked.

Our agents participated in the arrests of more than 1,000 of the almost 14,000 fugitive felons identified in fiscal year 2000. To

maximize our resources, we focus our arrest activities on the most dangerous criminals.

So while the cost savings is significant, we think it is even more important that we were instrumental in removing more than 1,000 potentially violent criminals from the street.

For example, a Michigan man wanted for allegedly shooting four people, one fatally, was recently arrested by one of our agents, as was a California man wanted for assault with a deadly weapon on a police officer. We also maximize our resources by making multiple arrests in a single operation.

In Detroit, in the course of a 3-day operation, we arrested 82 individuals wanted for offenses ranging from armed robbery to criminal sexual assault. The savings effectuated by suspending SSI payments to these individuals is the topic of this hearing, and I do not wish to undersell its importance. But this committee and the public should understand that this project goes beyond cost savings. It saves lives.

There are also three other improper SSI payment areas that my full testimony covers in some depth. These are, first, improper payments to deceased auxiliary beneficiaries; second, payments to child beneficiaries who are 18 years of age and are no longer full-time students; and third, disability insurance payments paid to persons who also receive State worker's compensation benefits.

In each of these areas, our Office of Audit has issued reports to SSA and progress is being made to address the recommendations from these reports.

In a sense, most of the work that we do at SSA OIG deals with payment accuracy. The sum of our audit, regulatory, and investigative efforts on a daily basis has a direct impact on reducing improper payments.

Thank you, Mr. Chairman, for the opportunity to be here today. I will be happy to take questions when you have them.

[The prepared statement of Mr. Huse appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Streckewald?

STATEMENT OF FRITZ G. STRECKEWALD, ACTING ASSISTANT DEPUTY COMMISSIONER, OFFICE OF DISABILITY AND INCOME SECURITY PROGRAMS, SOCIAL SECURITY ADMINISTRATION, BALTIMORE, MD

Mr. STRECKEWALD. Good morning, Chairman Grassley, members of the committee, Senator Baucus. Thank you for inviting me here to discuss the findings of several audits conducted by the Office of the Inspector General.

I want to briefly discuss the efforts the agency has undertaken to strengthen and maintain the integrity of the Old Age, Survivors, and Disability Insurance and Supplemental Security Income (SSI) programs in the areas addressed by the audits.

I will summarize my written testimony and ask that the full, written statement be placed in the record.

One focus of the Inspector General (IG) audits is the issue of fugitive felons. Under law, a fugitive felon is not eligible to receive SSI benefits. However, this prohibition does not apply to the OASDI program.

Under our Fugitive Felon Project, we work closely with law enforcement agencies throughout the United States. We conduct computer matches with many of the available sources of warrant information, including the Federal Bureau of Investigation's National Crime Information Center, which is a major national repository for felon warrant information.

SSA has signed agreements with the U.S. Marshall Service and the FBI, which gives us access to all Federal, and many State and local, warrants. Unfortunately, only about 30 percent of all outstanding warrants are reported to the NCIC.

Eleven states report all of their warrants to the NCIC. Because the remaining 39 states report some, but not all warrant information, SSA and the Inspector General are actively pursuing matching agreements with the other states.

SSA currently has signed agreements with 12 of these States to obtain additional warrant information that is not reported to the NCIC. We also have agreements with the three major metropolitan police departments: New York City, Baltimore, and Philadelphia.

In order to protect individuals from invasions of their privacy, these data matches and exchanges are done pursuant to agreements that comply with Privacy Act requirements.

When we obtain warrant information from any of these sources, we first match those records against SSA files to verify identity. A second match is then conducted against our SSI beneficiary files to determine if any fugitives are receiving SSI payments. The results of the second match are forwarded to the Inspector General for action.

Over 22,000 fugitive SSI beneficiaries were identified through this process during fiscal years 1998 through 2000, and over 2,800 of these fugitives were apprehended, after working with law enforcement agencies. The Inspector General refers its findings to SSA so that we can suspend benefits.

SSA has gained experience identifying and suspending benefits as a result of our enforcement of prisoner suspension provisions, and I would like to discuss that experience, briefly.

Beginning in 1994, SSA undertook several initiatives with State and local entities to ensure that Social Security and SSI payments are not made to prisoners. Today, SSA has monthly prisoner reporting agreements with correctional facilities, covering 99 percent of the U.S. inmate population.

SSA is authorized to share prisoner information with other agencies administering Federal or federally-assisted cash, food, or medical assistance programs. We are working with these agencies to make sure that prisoners do not receive improper payments from the Federal Government.

At this point, let me also briefly address three other beneficiary categories with payment integrity concerns. That is, payment to deceased beneficiaries, worker's compensation offset cases, and monitoring school attendance by child beneficiaries over the age of 18.

SSA processes over two million death reports annually. We compile and maintain a comprehensive database containing death information provided by family members, funeral homes, all of the States, and some territories, the Department of Veterans Affairs,

the Health Care Financing Administration, banking institutions, and other sources.

SSA independently verifies death reports from other government agencies before terminating benefits. We have identified ways to improve the death reporting operation, and within the next 2 months we will pilot a National Electronic Death Registration Project in New Jersey.

Several IG reports have raised concerns about the administration of worker's compensation provisions. Social Security Disability benefits are reduced when a worker is also receiving periodic or lump sum worker's compensation payments from Federal, State, or local government programs.

SSA asks the worker when he or she applies if they will be receiving any worker's compensation payments that would require offset, and we rely primarily on the beneficiaries to voluntarily report changes in worker compensation status and payments. Payment errors occur when the beneficiary fails to inform SSA of such changes.

To address this problem, SSA has instituted a number of measures, including a new process to re-verify worker's compensation payment status every 3 years. We also have established a computer matching agreement with Texas, and we have a similar agreement with the U.S. Department of Labor.

Finally, let me describe the new process to monitor school attendance by child beneficiaries over 18. In our personal contact with every student, we stress the student's responsibility to report any changes in their school attendance to SSA.

In addition, the school must verify the students' attendance before any benefits are paid, and we strongly encourage the school to report any change in the students' status directly to SSA.

In conclusion, let me assure you that we at SSA believe that the public's confidence in the integrity of the Social Security program is absolutely critical. For this reason, one dollar of every four dollars in SSA's administrative budget is dedicated to program stewardship and integrity.

I would be happy to answer any questions you may have.

[The prepared statement of Mr. Streckewald appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Kyle?

STATEMENT OF DANIEL G. KYLE, PH.D., CPA, CFE, LEGISLATIVE AUDITOR, STATE OF LOUISIANA, BATON ROUGE, LA

Dr. KYLE. Good morning, Mr. Chairman and members of the U.S. Senate Committee on Finance. Thank you for allowing me to offer my testimony here in Washington today.

In serving as Louisiana's legislative auditor, I have a number of responsibilities. I hold my appointed position within the legislative branch of State government. I have served in that capacity since 1989.

As a legislative auditor, I serve as fiscal advisor to the legislature and as auditor of the fiscal records of the State, its agencies, and political subdivisions. My responsibilities include financial compliance, performance, and investigative audits.

As authorized by the U.S. Congress, I am also the auditor in Louisiana of Federal monies received by the State. My annual single audit meets the requirements of the Single Audit Act, as amended in 1996, and the associated U.S. Office of Management and Budget Circular A–133. It is as auditor of the Federal monies received by my State that I am here today.

During my tenure as legislative auditor, I have issued several financial-related audits of Louisiana's Medicaid program, which is administered by the States's Department of Health and Hospitals.

Among these are the following. In 1995, I reported that Louisiana paid a national accounting firm approximately $100 million to assist the State in enhancing revenues from Medicaid disproportionate share payments.

In that same year, I reported that Louisiana paid approximately $20 million to an independent contractor to assist in establishing Medicaid eligibility for patients treated in State-operated hospitals.

At your invitation, I am here today to address my most recent, and yet unresolved, concern. Specifically, Louisiana is using Medicaid to fund health care of State-incarcerated prisoners who are afforded medical care in State-operated hospitals.

The Louisiana University State Health Science Center, Health Care Services Division, estimates that the cost to treat prisoners at its nice facilities has averaged $21 million over each of the past 4 years.

The Federal financial participation relative to Louisiana's Medicaid program is, therefore, estimated to be approximately $15 million each year for such care.

In November of 1996, my office sent a letter to the Health Care Financing Administration seeking clarification of Louisiana's practice of including prisoner days in the allocation formula for disproportionate share payments.

Louisiana allocates disproportionate share payments adjustments to State-operated hospitals to cover costs incurred by hospitals in serving patients who are not deemed Medicaid-eligible.

My staff expressed its view that title 42, part 435, section 1008 of the Code of Federal Regulations provides that Federal financial participation is not available in expenditures for service provided for individuals who are inmates of public institutions.

In that letter, we stated that it was our understanding that, on June 11, 1996, HCFA approved an amendment to the Louisiana Medicaid State Plan. That amendment provided that prisoners receiving services in State hospitals are deemed indigent, in accordance with Louisiana law.

Despite the applicable Code of Federal Regulations, this amendment allowed Louisiana to include prisoner days in the allocation formula for disproportionate share payments.

Therefore, Medicaid contributes approximately $15 million each year for the health care costs of State-incarcerated prisoners.

Throughout my career as a legislative auditor, my general counsel has advised me that one cannot do indirectly what he or she is not allowed to do directly. I, therefore, question how HCFA can allow Louisiana, or any other State, simply by passing a State law, to include prisoner medical care in the Medicaid disproportionate

share payments when the Code of Federal Regulations specifically States that such costs are not allowable.

HCFA offered no resolution to my 1996 letter. In 1999, I asked the State Department of Health and Hospitals to defend its position relative to this practice. The department provided an opinion from its counsel in Washington, Covington & Burling. They opined that Louisiana's practice is fully in accordance with law and the approved State plan.

The department further contended that the regulations governing disproportionate share payments and those regarding direct Medicaid funds and eligibility are mutually exclusive.

Subsequent to receiving the Department's legal opinion, I again wrote to HCFA in 1989, received no response, and later decided to go to the Inspector General of the U.S. Department of Health and Human Services.

As to this date, I have not received any written communication either supporting or challenging Louisiana's position.

I will continue to try to get an answer to this question. Thank you.

[The prepared statement of Dr. Kyle appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Mangano?

STATEMENT OF MICHAEL F. MANGANO, ACTING INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MANGANO. Thank you, Mr. Chairman and members of the committee. I appreciate this opportunity to update you on the work that we have been doing on improper payments within our department.

You may be aware that just recently we released our latest review of improper payments in the Medicare program for fiscal year 2000. In that review, we found that about $11.9 billion in the last fiscal year was spent improperly. That equates to about 6.8 percent of the $174 billion in Medicare fee-for-service payments.

I might add, though, that that is a reduction of about 50 percent from the first time we did that review back in 1996, when the rate was up to 14 percent, or $23 billion.

These improper payments can range anywhere from simple billing mistakes, all the way up to outright fraud and abuse. They are usually caused by medically unnecessary, unsupported, or non-covered services, or coding errors made by the health care providers.

These errors make up the largest category of improper payments within our particular department. But, even having said that, we still believe that most health care providers in this country are dedicated to providing high-quality care and are honest in their dealings with the Medicare program.

At the same time, we have got to continue to be concerned about all errors, even if they are totally innocent. According to the Congressional Budget Office and the Medicare trustees, the 50-percent reduction in improper payments can be a major factor in the reduction of the Medicare inflation rate over the last several years to the lowest rate in history, as well as extending Medicare solvency of the trust fund an additional 30 years over the last 5 years.

Another factor causing improper payments in the Medicare and Medicaid program has been their sometimes-antiquated, complex, and incompatible computer technology. I would like to illustrate these vulnerabilities by highlighting some of the problems that we have investigated in our work dealing with payments made on behalf of deceased and incarcerated beneficiaries.

In our inspection of the Medicare payments for services after death, we found that Medicare paid $20.6 million in one particular year for services that started after the beneficiary's date of death.

About $12.6 million of this was in cases where we had not received the date of death information from the Social Security Administration. But about $8 million was equated to those situations in which the Health Care Financing Administration actually had the date of death within their payment service system, but the system did not alert the contractors to prevent the payment for those bills.

Similarly, working with the State of Ohio, auditors found that they had paid, over a 6-year period, $82 million for Medicaid recipients who had these payments made after the patient had died.

I might add that 30 percent of all Medicaid beneficiaries in the State of Ohio who had died that year did not have that information included in their files, so the payment would continue.

We are currently conducting a series of audits on Medicare payments provided on behalf of beneficiaries in the custody of Federal, State, and local law enforcement organizations.

Medicare will not pay for these benefits unless the authorities require all prisoners to pay for their health care, and the State or local jurisdiction provides a vigorous attempt to collect these payments.

Our audit found that $32 million in Medicare fee-for-service payments on behalf of about 7,400 incarcerated beneficiaries were made in calendar years 1997 through 1999. We are also in the process of reviewing Medicaid payments for services to inmates.

The problems of ensuring appropriateness of payments in a complex program environment are not limited just to Medicare and Medicaid. Just last month, we have joined with the Omaha Police Department and the Douglas County Sheriff's Office to arrest a total of 36 fugitives over 2 days who were on fugitive warrants at the same time they were receiving benefits through the Temporary Assistance for Needy Families program in Douglas County, Nebraska.

This project showed that, with more effective matching programs in place, we could identify other fugitive felons who are receiving benefits from other programs of our department.

The good news I have to tell you this morning, is that the Secretary has named reforming the management and systems of our department as one of his top priorities. In recent testimony, he has talked about pledging to identify additional resources and ways to develop a uniform financial accounting system for the department, improved information technology, and maximizing the ability for systems to share information.

Mr. Chairman, this commitment to investing in systems infrastructure in rooting out improper payments is absolutely necessary

if we want to better use the valuable resources available for the care of beneficiaries in the programs of our department.

That completes my oral testimony. I will be happy to answer questions then the appropriate time comes.

[The prepared statement of Mr. Mangano appears in the appendix.]

The CHAIRMAN. Thank you.

Ms. McMullan?

STATEMENT OF MICHAEL McMULLAN, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. MCMULLAN. Senator Grassley, Senator Baucus, and distinguished committee members, thank you for inviting me here today to discuss the Health Care Financing Administration's efforts to ensure that Medicare does not make improper payments to services provided for incarcerated beneficiaries.

I would like to thank the Office of the Inspector General for their valuable assistance in helping us to identify improper payments in this, and other instances, and to help ensure the integrity of the Medicare trust funds. I would also like to thank the Social Security Administration for the assistance they provide us.

Medicare pays for the health care of almost 40 million beneficiaries, involving nearly one billion claims from more than one million physicians, hospitals, and other health care providers.

This year, we expect to make more than $230 billion in Medicare payments. We have made substantial progress over the last several years in reducing errors and eliminating fraud from the Medicare program through a variety of ways.

As reported in the OIG's recent Chief Financial Officer's Audit, we have reduced Medicare's error rate by half and, for the second year in a row, we received a clean financial opinion.

On an ongoing basis, we independently identify improper payments or irregularities through our own detection efforts and, when appropriate, refer these anomalies to the OIG and law enforcement for further investigation.

We have taken steps to eliminate improper payments identified through reviews by the OIG and others, such as those highlighted in the OIG's recent report we are here to discuss today.

These reviews serve as valuable and important road maps in directing us to needed improvements in many different areas of our programs. Despite these collective efforts, we know that improper payments still occur and that there is room for improvement.

I assure you that remain committed to taking appropriate actions to remedy these problems and ensure we continue to meet our fiduciary responsibilities of protecting the Medicare trust funds from errors and fraud.

Under the law, Medicare has no obligation to pay for health care services provided to incarcerated beneficiaries in Federal facilities. Medicare only pays for health care services for beneficiaries incarcerated in State and local facilities when special conditions have been met.

We have instructed our contractors to presume the claims from, and on behalf of, prisoners in State and local facilities that have not met these conditions and should be denied. However, currently we have no centralized data source for identifying individuals who are incarcerated.

The OIG identified that Medicare had improperly paid for health care services provided to incarcerated beneficiaries during a 3-year period. The exact amount of the improper payments and Medicare's liability has not yet been determined.

The OIG noted that this error is largely due to our contractors having no reliable mechanism for determining whether a claim has been submitted on behalf of an incarcerated beneficiary.

We are grateful for the OIG's recommendation on how to ensure we collect the necessary data to ensure that these improper payments do not occur in the future.

As part of our comprehensive plan for program integrity, we have contracted with program safeguard contractors to review systems' vulnerabilities. We will charge one of these contractors to determine the risk associated with payments to providers caring for incarcerated beneficiaries and how best to mitigate these risks.

In addition, the program's safeguard contractor will perform post-payment reviews to identify and recover any over-payments we have made.

I assure you that we are moving forward and will continue to thoroughly examine how we can best obtain information on incarcerated beneficiaries and provide this information to our contractors so that we can minimize the possibility of improper payments in the future.

I am happy to answer the committee's questions.

[The prepared statement of Ms. McMullan appears in the appendix.]

The CHAIRMAN. Senator Nickles?

Senator NICKLES. Mr. Chairman, I need to run. I just want to compliment you for having the hearing, and thank our panelists for doing it. This is enlightening, although it is troubling.

I am bothered to think, when we think we have tightened up the DSH program, to find out that some States may be using inmates to qualify for additional methods. I think, if they cannot be stopped administratively immediately, then we can stop that with a little language. I will be happy to work with you on that.

I also appreciate some of the other suggestions that were made, and I will work with you. I am still struggling with which should be done administratively, what should be done legislatively, or maybe a combination of both. But I will work with you and other members of the committee to try and make sure that we do that.

Again, I want to thank our panelists, and thank you, for having this hearing. It has been very helpful.

The CHAIRMAN. Yes. At the very least, if something can be done administratively, we ought to expect the administrators to do it accordingly, right now. Thank you.

Senator NICKLES. Thank you, Mr. Chairman.

The CHAIRMAN. I now call on Senator Baucus, for both an opening statement that he was not able to make because he was busy

elsewhere, then second, you can go right into your 5 minutes of questioning when you are done with that.

Then if Senator Thompson is under any particular time constraints, I could let you go after Senator Baucus, before I ask a series of questions, if you want to.

Senator THOMPSON. How could I say no to that? [Laughter.]

Senator BAUCUS. Well, you could.

The CHAIRMAN. So do not start the clock on Senator Baucus until he is done with his opening statement.

Senator BAUCUS. I will just take, roughly, 5 minutes, anyway.

First, Mr. Chairman, I highly compliment you for holding this hearing. This is what Congress should do, namely, have oversight hearings on basic matters that affect our government to see how things are working or things are not working, and what we can do to help make them work better, in addition to just passing laws.

After the laws are passed, it is not very glamorous, but the real work, and I think the more effective work, is what you are doing here, holding a hearing on a very important subject.

I guess the basic question I have of all the witnesses, is to what degree is the solution essentially just more resources, getting computers up to date, not only HCFA computers, but State and other Federal agency computers, whether it is Justice or State computers, so they could match more quickly and then have the resources to get the data. That is, of course, one subject we have to work on. Then there are other questions like, how does law enforcement work with the other agencies, and vice versa?

But let me just, first, address the question on resources. Maybe some of you witnesses could just give us a sense of how hard you are working to try to solve this problem, but where you are stymied because of lack of resources, if that is it, or where else you are stymied.

Who wants to jump in and try to get a handle on that one?

Mr. HUSE. I would be very glad to start this discussion out.

Senator BAUCUS. All right.

Mr. HUSE. I speak for the Social Security Administration's Office of the Inspector General.

Senator BAUCUS. Right.

Mr. HUSE. Given the enormity of the task we have, just with respect to fugitive felons, under the SSI program, I think with what we have present right now, we are reaching all of the expectations we could possibly get to with the resources that are extant.

To make this better, we really need to break down this Tower of Babel, if you will, that we have in terms of different, competing information systems around the country.

For example, there is not one simple place you can go to determine whether someone is a felon in this country. In some States a person may be a felon, in others that may be a misdemeanor.

So in order to clear through all of these records and then match them against our own, we have to go into a very complicated process of matching agreements which are required by the Computer Matching Act. Perhaps there could be some adjustment there that would help us not have to renew that every 18 months, as that Computer Matching Act requires.

If we removed some of these daunting obstacles away by providing incentives in terms of good information technology for State and local law enforcement so that we can have a common format to pass these records through, we would make this an awful lot simpler. But that does require resources that we do not have now.

Senator BAUCUS. I heard somewhere that HCFA computers require computer code written in code that is not taught any more.

Mr. HUSE. I will give that one to HCFA.

Ms. MCMULLAN. I will answer that question in just a second. But, just to reinforce the issue, the primary issue that we are dealing with here is knowing who these people are and being able to identify individuals who are incarcerated and felons.

In the case of SSA, it requires collecting information from a variety of different local and State officials and the Federal prison system. We would like to be able to ride on the back of SSA's computer matching, because we get all of our data on individuals from SSA and Medicare.

That is an impediment that could be solved, with your help, by just reducing the burden of the Computer Matching Agreement.

To get to your issue on HCFA, our Medicare claims processing systems are, indeed, rooted in code that was original written in the late 1960's and 1970's. Some of that code is written in languages that are no longer used because there have been improvements in technology.

The largest reason for that, is the complexity of the systems that we have built to process the wide variety of Medicare claims. But what you have heard is true.

Senator BAUCUS. So how much is needed? Not gold-plated, but what kind of resources could significantly address the problem of matching data?

Mr. STRECKEWALD. Senator, if I may, I think, from Social Security's perspective, it is really an issue of resources and improving our processes. Certainly, more resources would help. We need to improve our reporting infrastructure, we need to invest in better computer systems, and we need to invest in training so people know how to use these systems and they understand how to get the best results from them.

We need to make these matching agreements work. They are very time consuming because they are negotiated piece by piece. But beyond that, we are committed to improving the process itself.

On death, we have a very promising process in place that, if it works, will get us information from the very beginning of the death process, which is a multi-piece process. We are piloting that in New Jersey next month and it has some promise.

On students, we re-engineered the way we deal with students, and we get much better information from them. So we are doing a combination of looking where our resource needs are, improving our infrastructure, and also improving our processes.

Senator BAUCUS. Now, do you have business plans with benchmarks so you have a rough sense of the number of fugitives receiving payments who should not receive payments, a rough number of felons receiving payments who should not, or the number of those over 18? I mean, all of these various categories here.

Do you have a plan in various agencies so that six months from now, a year from now, you are going to get the numbers down to quantifiable levels, so that when we meet with you a year from now we can go over all of that?

Mr. HUSE. We will bring you results. We have, I think, good results now.

Senator BAUCUS. So what are your plans? What percent reduction do you expect to achieve in the next year?

Mr. HUSE. Those are definitely affected by resources. In other words, to get to the universe of the full potential, we cannot do that with the resources that we have right now.

Senator BAUCUS. All right. What resources do you need?

Mr. HUSE. That is a very complex question, and I would be pleased to provide you with an answer to that after we did some math for you. We included it in our budget.

The CHAIRMAN. But can you give him an answer in writing before we get a final report done?

Mr. HUSE. We can do that.

Senator BAUCUS. Yes. I would like that. I know it is tough, but we will find a way.

Mr. Chairman, to the degree that the answer here is resources, we have got to find out what resource needs are. I do not care what the rules and regulations are, and administration, OMB going around agency heads, and all that kind of a thing. I do not care about that stuff. I just want to find out what the need is here.

I ask each of the various agencies here to, separately and together, compare notes here. What is needed here, in a rough estimate? Get it to us within a matter of a couple, 3 weeks, and we will follow up.

I would also like a plan. That is, assuming you had the resources, what is the percentage reduction of violations that you intend to achieve a year from now?

Mr. HUSE. That is fair.

Senator BAUCUS. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. All right. Thank you.

Maybe included in that would be some sort of pay-back.

Mr. HUSE. Return on investment.

The CHAIRMAN. Yes.

Mr. HUSE. Sure.

The CHAIRMAN. Senator Thompson?

Senator THOMPSON. Yes. Thank you, Mr. Chairman.

Before we get too far down this road of more resources as being the main problem, let me answer the Senator's question, I think, referring to the Social Security Performance Plan for fiscal year 2002. The actual 1999 overpayments, the accuracy rates, was 94.3. The goal for 2001 is 94.7. So, basically, their goal for 2001 is essentially the same as what they have got now.

So my suggestion here is that, a good deal of the problem has to do with the Results Act which Congress passed and is now supposed to be off and running, where these agencies are supposed to be setting forth their goals and the way that they are going to achieve those goals, and then they come back and report as to whether or not they have been able to achieve them.

The problem with the Social Security Administration is that it sets extremely low goals for itself. It sets as its goal for next year essentially the amount of waste, fraud, and abuse that they have this year. So, that is a financial management problem. I think all of this comes under the rubric of financial management.

Certainly, everybody could use less money and so forth, but the GAO has told us pretty consistently now that our entire government is fraught with problems with regard to financial management. It is one of the two or three major problems. It is resulting in what you are seeing here today, which is the tip of the iceberg.

As I pointed out earlier, we are looking at, in 1999, $20 billion just in 21 programs. We have got thousands of programs. We are looking at 21 of them, and come up with $20 billion, and we do not even have any idea as to the ones that we are not receiving information on because we do not require these other programs, these other agencies, to report or even try to come up with estimates, in many cases.

I think the Inspector General of the Social Security Administration has done a good job. They estimate and they point out that three of these major programs have been estimated, but they are not reducing. Your numbers are a lot smaller than HHS numbers.

But the problem with the Social Security Administration, is that you are not making any progress. They just continue on basically at the same level every year. The question is, how do we get past that? HHS has made major reductions, but is still at $11.9 billion for 2000 in terms of these overpayments.

But that is just Medicare. We do not look at Medicaid here. I know that the Inspector General has recommended that we come up with a system to estimate improper payments as far as Medicaid is concerned. What is the status of that?

Mr. MANGANO. Just in the last year, there was, I think, about $3.5 million that was given to the Health Care Financing Administration to start some pilot projects on coming up with ways to identify improper payments in the Medicaid program.

One of the difficulties that is going to be involved in this one, is it is not as neat as Medicare. Medicare is a national program. We can take samples across the country and find out what the improper payment rate is.

With States, the Medicaid program is a little different in every particular State, and that is because it is administered by those States and they have some flexibility in terms of the services that they can offer and not.

Our office has pledged to work with the Health Care Financing Administration in coming up with some ways to identify improper payments to those States. We are anxious to get started to work and see if we can get to that level where we can have——

Senator THOMPSON. The Department of Agriculture, of course, estimates improper payments in its food stamp program, and it is also administered by the States, right?

Mr. MANGANO. That is correct.

Senator THOMPSON. So it can be done. Just to point out the importance of getting a handle on Medicaid, I noticed here in one of our results that we came up with, in a criminal case, as I say, this

is just a little indicator, just one instance, it cost the taxpayers more than a billion dollars.

Federal and State investigators uncovered a massive criminal scheme to fraudulently bill California's Medicaid program for medical supplies. They are now investigating another scheme out there in the same program worth millions of dollars. But this medical supply scheme, a Medicaid scheme in one State, was over $1 billion. So that is the kind of potential monies that we are talking about. We have no idea right now in terms of what Medicaid fraud might be.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thompson.

Again, I said that, as we pursue this, both from pushing the administration to do whatever they can do administratively, as well as any change in law, we would like to have the benefit of your help, particularly the work you did in your committee.

Mr. Horn, are you still receiving Social Security checks at your last place of residence, and if so, how do you know that you are?

Mr. HORN. The last one that I recall receiving was last month, before I was arrested.

The CHAIRMAN. And you have had communication so that you know that you have received it?

Mr. HORN. Yes.

The CHAIRMAN. You actually have control of the money that you received in that check?

Mr. HORN. Yes.

The CHAIRMAN. All right.

I would like to ask Commissioner Streckewald, what action has the Social Security Administration taken to address and implement the recommendations of the IG report on Payment to Fugitive Felons and Parole Violators?

Mr. STRECKEWALD. Mr. Chairman, the IG has highlighted several areas that we think, and agree with him, need improvement. We agree with the findings and we are working to implement them, specifically, extending our efforts to work out matches with the States.

We have 12 matches with the States, and we hope to have matches with the rest of the 39 states that do not report all of their information to the computer file of the FBI. We hope to have those completed within the next year.

The CHAIRMAN. I think there are 11 States and 2 cities that are reporting information about warrants as of this date.

Mr. STRECKEWALD. We have reached matching agreements with 12 States and 3 cities.

The CHAIRMAN. All right.

Mr. STRECKEWALD. There are still roughly two-thirds of the States that do not report all of their information. We are working with them right now.

The CHAIRMAN. Are you having some problems with the U.S. Department of Agriculture in getting a sharing agreement?

Mr. STRECKEWALD. It is more of an issue that there is no central repository of the information at USDA. We looked at it, we talked to them, and right now it is not technically feasible to use their information in our matching operation. But we are going to stay in

touch with them and, if the opportunity arises, we will take advantage of it.

The CHAIRMAN. Yes.

Mr. Horn, now that you reside in a State facility, do you need Social Security checks, and is the State providing all of your needs, medical or otherwise?

Mr. HORN. Well, somewhat, they do. The State provides some medications. But, overall, a lot of the medications we have to pay for ourselves. So, Social Security was a great help to me.

The CHAIRMAN. So you feel you need your Social Security check then for some medical supplies that the State would not otherwise give you.

Mr. HORN. Yes.

The CHAIRMAN. I do not know anything about New Jersey and how it provides health care for people that are in jail or prison. But you are telling me then the State of New Jersey would not provide you with all of the medicine or other medical needs that you require or that your doctor would prescribe. Is that what you are saying?

Mr. HORN. Yes.

The CHAIRMAN. Mr. Horn, do you believe that you should receive disability payments while fleeing from authorities?

Mr. HORN. I figure that when I was working, that they were taking money out of my check. So I thought, quite naturally, that I was entitled to it.

The CHAIRMAN. Also, Mr. Horn, how would you be affected if your Social Security disability checks were cut off while you were in prison?

Mr. HORN. I would have to get by the best I can.

The CHAIRMAN. If you were in prison as opposed to being in jail where you are now, would the State of New Jersey take care of all of your health care needs? You say the present facility you are in will not.

Mr. HORN. Yes. Well, it is the same way in the prison. They take care of some of your needs, some of them we have to pay for.

The CHAIRMAN. All right. So, in other words, the prison system has a doctor. The doctor makes a determination that you need something.

Mr. HORN. Yes.

The CHAIRMAN. In some instances they pay for it, but in other instances they do not.

Mr. HORN. Yes.

The CHAIRMAN. Is that true of you, or is that true of all prisoners?

Mr. HORN. All prisoners.

The CHAIRMAN. For Commissioner Streckewald, the chief financial officer report of fiscal year 1999 reflects approximately $4 billion in improper payments at the Social Security Administration.

Specifically, $1.6 billion in SSI, $1.3 billion in Old Age, Survivors' Insurance, and $1 billion in Disability Insurance, obviously, a substantial sum of money, potentially wasted if not recouped.

My understanding is that, if improper payments are not recouped quickly, the chances of recoupment decrease significantly. If that is

true, what is the Social Security Administration doing to address the loss of funds, and particularly in a timely manner?

Mr. STRECKEWALD. Mr. Chairman, we recover as much of the debt owed as possible. We recover from people who are receiving benefits. Obviously it is much easier to recover money from their checks. So, we receive about 90 percent of the overpayments that are owed by people who continue to receive benefits.

We also estimate that 60 percent of any debt would be recovered over a 7-year period. Last year, we recovered over $2 billion worth of debt, which exceeded our GPRA goal.

I think you are right, though. Some of the authorities that were granted us in recent legislation, along with the debt collection plans that we have in place, will allow us to increase that figure.

The CHAIRMAN. Along the lines of what Senator Nickles said just before he left, that however it needs to be done, administratively or by law, do you have, particularly in what Dr. Kyle testified to, the States, through the disproportionate share program, et cetera—I guess I am asking the wrong person. I have got to ask HCFA that.

So let me ask you, following up on that. Is there any sort of rule of thumb, what you have in your mind, how much of that can be done administratively and what we have to do, if we have to change any law?

In other words, if it can all be done administratively to take care of the situation Dr. Kyle laid out, I would like to have you do that because it takes forever to get a bill passed around here, regardless of how justified the change in law might be.

Ms. MCMULLAN. Right. The statute is broad on this issue. The issue in Louisiana is essentially that the State has determined that inmates are indigent, and are charged off against the disproportionate share hospitals.

In Louisiana and Pennsylvania, we approved that practice. We are re-looking at that practice now so it can be solved administratively, in working with the States, to reduce the ambiguity in the way that that is applied.

But Medicaid has many different layers of complexity in the way that these issues are resolved, so it is taking us some time to have the conversations with all of the States to make sure that we do not, in correcting the problem, create a different sort of a problem.

The CHAIRMAN. All right. So, at least in that instance, it can be done administratively.

Ms. MCMULLAN. Yes, it can.

The CHAIRMAN. All right. What can I say, other than, I hope you get at it right away? You are at it.

Ms. MCMULLAN. We are actively working with the States on this issue.

The CHAIRMAN. All right.

Mr. MANGANO. Mr. Chairman, can I add something to that answer?

The CHAIRMAN. Yes.

Mr. MANGANO. I think in the work that we have done everything can be done administratively. But it is a cumbersome process, because you have got to identify folks, you have got to be able to match, et cetera.

But there is one thing that would help legislatively, and maybe I could just put a bug in your ear on this, and maybe at some point it might be useful to do.

In thinking about this testimony last night, I was struck by the simplicity of the Social Security Administration in terms of, they have, by law, the authority to just stop making Social Security payments once a person is in jail for a period of time.

The Health Care Financing Administration does not have that kind of flexibility with the Medicare and Medicaid programs. As we talked about in the testimony, if a State requires all prisoners to pay for their health care and they vigorously go out and collect this information, they can count that. They can allow Medicare and Medicaid to pay for those bills.

If Medicare and Medicaid had the same kind of legislative requirement that Social Security has, that is, you shut off payment after a person becomes incarcerated, it would make that process a whole lot simpler, it would be fairer, and much easier to administer.

The CHAIRMAN. Well, it has got to be an oversight by Congress. There could not be any philosophical reason for treating prisoners with one program differently than from another, probably a difference in time in which the law was enacted, an oversight.

As you think about it, if you applied the common sense test, can you think of any reason why the same common sense that applies to Social Security could not also apply to Medicaid, or is there some reason?

Mr. MANGANO. I think the only common sense is it gives States an opportunity to put off some of their costs on the Federal Government in the case of the Medicaid program. In the case of Medicare, the Medicare is a guaranteed payor. If Medicare is liable to pay for it, Medicare will pay for it.

But when you look at the fairness issue, in Social Security, persons who are on Old Age, Survivors, and Disability Insurance, they have earned that benefit. The same case could be made for Medicare, so it is very similar that way.

In Medicaid, it is not necessarily an earned benefit, but rather because of a person's indigent status that they would be eligible for it. So, I can think of no reason why the Congress would not want to do it.

The CHAIRMAN. All right.

Back to Mr. Streckewald. I also want to address this to Mr. Huse. You have already touched on it to some degree, but getting back to Congress passing the law in 1996 prohibiting Supplemental Security Income payment to fugitive felons and parole violators. That was five years ago, yet your agency has not reached substantive data sharing agreements with States. We have mentioned the 12 States and 3 cities.

What is the reason for the delay, and when could we expect the law to be in effect nationwide?

Mr. STRECKEWALD. The law was passed in 1996. Right away, within 1 month or 2 months, we sent out instructions to all of our field offices letting them know what to do when we become aware of a fugitive felon.

What took longer was to work with the Inspector General and start to seek out the sources of information that we needed around the country and the different files that would allow us to get a collection of the fugitive felons and the warrants that are out there.

So we worked with the IG to get the agreement with the FBI and their national crime statistics, which provided us with about 28 percent of the warrants that are out there. Then we began working with individual States negotiating agreements. That is where we are now. We have 12 States and, 3 cities, and we hope to be completed within a year.

The CHAIRMAN. Do you have anything to add, Mr. Huse?

Mr. HUSE. I do not disagree with that at all, Mr. Chairman. I think we had three challenges when the law was passed. The first, was we had to identify who were fugitive felons. That turned out to be an awful lot more difficult task than anyone ever imagined.

I think everyone had the notion that we have one system of records that are universal and that transcend boundaries. But, in fact, as I used the term, it was a Tower of Babel and confusion.

Then, because of privacy issues, complicated issues in terms of the Computer Matching Act, then also other considerations in terms of being absolutely sure that we had identified the right felon, which is imperative here, it has taken us some time to establish the infrastructure to do this. But, I think we have made very significant effort in that respect.

The next challenge was, because we know we are limited by finite resources to do this, we had to prioritize and go after, really, what were the most important possibilities with this legislation, which, as I said, I think if you look at fugitive felons, you go after the violent and most provocative felons, first.

The third challenge really rests with you, the Congress. I think, to maximize the potential of the 1996 Act and to extend it to include Title II fugitive felons, we are going to look at resources and a way to do this to its fullest possibility. That is my two cents.

The CHAIRMAN. Let us follow up on what you just said. I understand that there has been some problem with these agreements between Social Security and FBI. What recommendations do you have to improve the efficiency of the program, which is computer matching, between Social Security and the Information Technology Center?

Mr. HUSE. The FBI is doing a good job with the universe of records that we are bringing to them, which is the 28 percent of the possibility in terms of fugitive felons here.

Once we complete all of the matching agreements across the United States, that universe is considerably broader. At that point, their capacity to do this, or anyone's, really becomes constricted by the finite possibilities you have to complete this work.

I think the answer goes back to looking at resources and where best to place those. I think, when we are dealing with these State records, perhaps that is a function we should just do ourselves at Social Security OIG. Again, we need to build that capacity to do that. But, one way or the other, we have to put that capacity in to meet this universe that is out there.

I want to add one point, though, Mr. Chairman. From the day that the law was passed, we actually went out and started to work

on this. We did it with hand records, hand searches, and individually responding to law enforcement across the country.

Really, over time, we have some significant results there. About $34 million worth of savings resulted from that. So, we did not ignore the law, but there were unintended consequences to build a comprehensive infrastructure. I think we can stand here and say we have tried to do that.

The CHAIRMAN. Are you learning to do it smarter, as opposed to working harder then?

Mr. HUSE. I think we are. I think we are.

The CHAIRMAN. Mr. Horn, during the time that you were violating parole, was Medicaid paying for your medical treatments?

Mr. HORN. Yes, they were.

The CHAIRMAN. Ms. McMullan, we have touched on a limited number of benefit programs in what is an incredibly large HCFA universe that you deal with, with a distinct possibility that these problems run throughout the agency.

With this in mind, and I understand that this is a very broad question, but could you describe the Health Care Financing Administration's approach to addressing the kind of improper payments being discussed here today?

Ms. MCMULLAN. The Health Care Financing Administration has actually developed a comprehensive program integrity plan that we would be glad to share with the committee. Essentially, we are looking at developing a mechanism that allows us to pay right the first time, essentially, looking to determine and first identifying areas of vulnerability, understanding what is creating those area of vulnerability, and then addressing the root cause.

By that, I mean if providers are billing for services that are not covered or that we do not, in our view, believe are medically necessary, then we need to go back to the provider and help them understand what is a permissible bill.

The same way on documentation errors, which represent some portion of the error rate for Medicare, is understanding what information needs to be in the medical record that is behind a claim so that we can determine that we are appropriately paying.

So, we have a multifaceted approach to looking at how we can improve getting the billing right at the beginning, because it is much less expensive to pay right the first time than to do post-payment reviews and post-payment audits.

Having said that, we also have a program to look at doing trend analyses and using other statistical methods to identify anomalies in our billing records, then investigating those to determine what is causing those, and, when we determine that overpayments have occurred, to recover those overpayments.

So we are looking at improving the front end, then having a surveillance system at the end to make sure that we catch anything that slips through the system.

The CHAIRMAN. Dr. Kyle, at the time my staff first contacted you you had not contacted other State auditors. Let me ask you if you have had an opportunity to do that and know whether the situation as it is in Louisiana is the case in other States, which obviously then would increase the cost to the Federal Government very dramatically.

Dr. KYLE. Mr. Chairman, I do not know of any other States who are currently doing this. I have had inquiries from North Carolina and New Mexico, and they are watching very closely what is done with this because they are interested in doing the same thing. I have not talked with any of the other States.

My concern would be, we have been waiting 5 years now for an answer to this question. Our first inquiry was in November of 1996. We are to audit for compliance, and I have a Federal regulation that says they cannot do this, yet, a State-approved plan by HCFA that they can.

I would hope that, whatever corrective action is taken, that it would be prospective. I believe that Louisiana has acted in good faith with a HCFA-approved plan, and I would hate to see them have to go back and pay back this money.

The CHAIRMAN. Well, it might be a case of changing it without making them pay back as well. I do not know. If my State had received money that they thought they were receiving legally, I guess I would not want to have to pay it back either. But that does not mean the policy is right. Hence, forward, it could be changed.

Ms. McMullan, not in response to just what Dr. Kyle said, but maybe the broader issue of his entire testimony, any sort of response you would have to what Louisiana is doing, the potential for other States, and anything else that he has had to say, I think we should have on record what your agency might feel about his approach.

Ms. MCMULLAN. I think that is commendable, in the same way that we appreciate the assistance of the Office of the Inspector General, for the States to raise issues as part of their unified audit where they see there are inconsistencies between regulation and application. It is useful for us to look at that.

The reality of the Medicaid program is, because there are more than 50 different applications of the rules and the statute, it takes us longer to determine the effects of any changes that we make in policy. When we initially reviewed the Louisiana policy, we approved the plan. We had a recent application by another State that we denied pending the final resolution, and it does take a long time. I apologize, on behalf of the agency, for not having responded to Dr. Kyle's inquiries.

But the fact that there are so many different applications for Medicaid across all of the States and territories, and the breadth of the statute, it takes us a long time to determine how to best implement these kinds of issues and having an even-handed approach across all States.

The CHAIRMAN. Mr. Mangano, you indicate in your statement that you have issued a study on the use of Medicare to fund medical care for inmates. Is there a similar situation occurring with Medicaid monies, and do you expect to conduct more studies on the subject?

Mr. MANGANO. Yes, indeed, we do. In addition to the work that we have done in the Medicare area, we are also going to be doing work in other States, as Dr. Kyle has identified in his particular State.

We are, next, going to be moving into the State of Florida. We have been working with Dr. Kyle and Louisiana. The next State we

are picking is Florida. Florida is probably the largest State in terms of Medicare and Medicaid payments in the country.

The CHAIRMAN. Also, in your report on Medicare payments for inmates, and that was issued today, you identified $32 million in payments. Based on current law and regulations, could you make an estimate of how much of this $32 million in Medicare payments for inmate medical care may be improper?

Mr. MANGANO. We are going through the process right now. In the testimony, I indicated that Medicare would pay for this if two conditions existed. One, that the State required all inmates to pay for their health care, and two, that they were vigorous in their attempt to collect it.

Now, it is a rebuttable condition in which the State has to provide it to Medicare, so Medicare could deny all of these payments. In order to really get to the answer here of many were improper, we are doing two things.

One, we are starting to review some of the State laws to find out if the State or the local community actually did require all inmates to pay for their health care. Then the second thing we are going to have to do, is probably go to those local communities and find out, are they being vigorous in their attempts to collect that money.

Now, in the real world Medicare could say, we are just not going to pay for these things until you have proved to us that those conditions exist. But the $32 million that we have right now is the amount of money that we have identified that potentially could be improper, but we do not have a final answer as to how much of that actually is improper until we do those next two steps.

The CHAIRMAN. Again, how does HCFA determine whether a Medicare beneficiary is incarcerated, and in turn, whether said individual's health needs should be paid for by Medicare?

Mr. MANGANO. Do you want me to answer that?

The CHAIRMAN. Well, I am addressing it to you, but either one.

Mr. MANGANO. The Medicare program has told its contractors that they are not supposed to pay for that care for a person that is incarcerated. The difficulty that they have right now, though, is they have no way of knowing. That is why we had recommended in our report that they ought to use at least what we consider the best repository of information today, and that is the Social Security information.

I am very pleased to say that HCFA has agreed that they are going to develop an inter-agency agreement to collect that information from Social Security. Once they get that information, they are going to have to put edits into their payment systems so that they can actually identify the person when the bill is coming in.

Once those two pieces have been put together, they will have at least the beginnings of an effective way to deny payment in those cases where it should be denied.

The CHAIRMAN. Again, you state in your Medicare report that HCFA does not identify Medicare beneficiaries. I guess you have answered this, in the sense that HCFA does not know and they are in the process of finding out who is.

Mr. MANGANO. That is correct.

The CHAIRMAN. And there is not anything that he said that you disagree with, Ms. McMullan?

Ms. MCMULLAN. No, there is nothing that he said that I disagree with. The only thing that I would use this opportunity for, is to just reinforce something I said earlier. We rely on the Social Security Administration to give us information about all of our beneficiaries because they, first, are Social Security beneficiaries.

So, to the extent that Social Security has matching agreements, we would like to be part of those rather than having to repeat them on behalf of the Medicare program. We can try to work that out administratively, but that may take a legislative fix.

The CHAIRMAN. As I have read the Medicare law, Medicare will not pay for services if the beneficiary has no legal obligations to pay for the service and if the services are paid by government entities. Is that right?

Ms. MCMULLAN. That is correct.

The CHAIRMAN. All right. With that in mind, are States or other governmental entities that are presumed responsible for medical needs of their prisoners taking advantage of this law by making prisoners responsible, and thereby unnecessarily shifting the cost to Medicare?

Ms. MCMULLAN. We are only required to pay when the beneficiary is not responsible themselves. It is State and local law that governs whether or not a State and local institution requires their inmates to pay on their own behalf.

In the Federal prison system, it is unequivocal: we do not pay. But State and local law governs whether or not an individual that is imprisoned at the State and local level are required to pay.

The CHAIRMAN. So there are 50 different answers to the questions.

Ms. MCMULLAN. Many more than that, when you get down to the city and county level.

The CHAIRMAN. All right.

Mr. MANGANO. Mr. Chairman, if I could add to that. In the review that we did on Medicare payments for persons who were incarcerated, while it was $32 million that we had identified here, it is a growing phenomenon. In 1997, it was $7.5 million. In 1998, it was $10.5 million. In 1999, it was $14 million.

The beneficiaries that we looked at that made up these figures were a little over 7,000. According to the Social Security records, there were 38,000 persons incarcerated that were eligible for both Social Security and Medicare.

So I think that underlying the question that you have, is we are seeing a growing phenomenon developing here. If you just took that equation out and said that all States were doing this, you could have a $70 million problem in a very short order of time. So, there could be a situation where more and more will start claiming these payments on Medicare's part.

The CHAIRMAN. Well, it is obvious that HCFA is not collecting the information. If Congress has not said to collect the information, it is probably difficult to hold HCFA responsible for anything. But has HCFA thought about collecting this information on their own?

Ms. MCMULLAN. It is much more efficient for us to rely on the Social Security Administration because they have a much broader mandate to collect the information than we. We can just draw,

from those individuals who are part of the Social Security records that are getting Medicare, the information that they have.

The CHAIRMAN. But that is half of the equation. The other half is whether or not the State or local government is paying for it.

Ms. MCMULLAN. Right. That is true.

The CHAIRMAN. There is no effort to collect that.

Ms. MCMULLAN. There is no data collection system that we are aware of that that type of rule set is available on a State and local level.

Mike mentioned, and something that we are looking at as part of their analysis in the OIG, as well as our program safeguard, is that if the significant majority of State and local laws are that they pay for the health care services of the individuals that are incarcerated, we can presumptively deny those claims and offer the beneficiary the due process rate to appeal if they have evidence that the institution is requiring everyone in that institution to pay.

That is a possible alternative that we are investigating which would be much more cost effective than trying to build a system of rules at the State and local level.

The CHAIRMAN. My last question, Mr. Mangano. You referred to a study related to Medicaid payments in Ohio on behalf of the deceased involving millions of dollars of improper payments. Has there been any followup on a national level to determine if other States are having similar problems?

Mr. MANGANO. Yes, Mr. Chairman, there is. After we saw the results in Ohio, we decided this could be a bigger problem nationally.

We have just recently acquired the information database that we need from the Social Security Administration, and we are starting to do a national review. We will probably pick out the 10 States that had the largest number of cases and do that national review.

Based on the results of that, if it still appears to be a large problem nationally, we will work with individual States and offer them our assistance in helping them do the reviews in their individual States.

The CHAIRMAN. Well, I thank all of you for your testimony. It has been very helpful. I think your testimony will be helpful to the committee in determining how best to stem the tide of lost taxpayers' money as a result of government error or fraud.

We have heard today about improper payments. It is not as simple as one might think. It is complex and there are no quick fixes. Health and Human Services Inspector General and the Social Security Inspector General have both studied these problems, and I thank you for continuing to do so. The extent to which you have developed recommendations that need to be followed through on will be very helpful.

I would like to have both HCFA and Social Security report to me on a quarterly basis. If that is a problem, let us know. But I think I would like to receive quarterly reports towards implementing the recommendations. I found that that has been very helpful to us in Congress in not being a problem for HCFA when it comes to nursing homes, if we could do something similar to that in this instance.

We have also heard today that there may be ways in which Congress can address some of these problems through legislation. We

obviously will take a good, hard look at those options. I talk about, rightfully so, how it is difficult to pass legislation. But, if that is necessary, we have to pursue it. I hope that my colleagues on both sides of the aisle would be supportive of that effort.

Also, it is clear that something needs to be done to determine the barriers to effective communication and transfer of information between Federal, State, and local governments.

It is quite obvious, between State governments and Federal Governments, it might be very difficult. But I guess what bothers me is how difficult it seems to be sometimes within our own Federal Government, where we ought to all be on the same team trying to accomplish the same goals.

To this extent, I expect to request a study that will assist the committee in fashioning some common-sense solutions to this. I am going to leave the record open for 2 weeks, as I have indicated, for members to submit questions for additional information that you folks have promised.

For the additional information that Mr. Huse has said he would give us, if that is too short of a period of time, let my staff know.

Mr. HUSE. Thank you, Mr. Chairman.

The CHAIRMAN. The hearing is adjourned. Thank you all very much.

[Whereupon, at 11:37 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JEROME HORN

Mr. Chairman and Members of the Committee, I want to thank you for inviting me here today to tell my story and maybe help with the issue that is being discussed.

I am currently an inmate at the Essex County Jail in Newark, New Jersey. I've been there since last month after I was arrested for violating my parole. My parole started after I got out of prison in 1987, but I stopped reporting to my parole officer in 1997. The truth is, even though I knew that I would be a fugitive, I just thought that I had paid enough for the crime I committed. I had turned my life around, away from crime, and didn't want to report any more.

I found out after my arrest that the police were able to find me after they matched up my fugitive warrant with the Social Security files. They were then able to find where I was receiving my Social Security checks, in Patterson, New Jersey. I wasn't exactly hiding, but I had no idea that they could find me this way.

I was convicted of Armed Robbery in 1981, and spent six years at Rahway State Prison. While I was in prison, I found out that I have a heart condition that puts me at risk of sudden death. After I got out of Rahway in 1987, I went to live with my mother in Newark. I can't work because of my heart problem so I don't have any insurance. I applied for Social Security benefits, and then Medicaid covering my medical bills. I don't receive checks from any other government programs.

In 1997, I moved to Patterson, New Jersey, but I kept my checks going to my mother's house in Newark. That was about the same time that I stopped reporting to my parole officer. I moved again six months ago to a new place in Patterson, but this time I sent my change of address to Social Security and started getting my checks there. Everything was going along just find until last month when the police showed up to arrest me. Yes, I did know that I was a fugitive and that the parole people were looking for me, but I didn't know that there was anything wrong with me getting my monthly SSI checks.

I was told that my story would help provide you with a little more perspective on this issue and for that I'm glad to help. But to be totally honest with you, I'm also here to help myself. I am truly sorry for having violated my parole, and I hope that the parole board will look kindly upon my being here today. I have a son that I am very close with and because of my heart problem, I want to spend as much time with him as I possibly can. Thank you again for inviting me to tell my story. I'll be glad to answer any questions that you may have.

[COMMITTEE STAFF NOTE: Although Mr. Horn stopped seeing his parole officer in 1997, he was not officially placed in fugitive status until May 1999. As far as the Social Security Administration is concerned, the amount of improper payments made to Mr. Horn (over 11 months) amount to $7,290. However, if you were to count back to when he stopped seeing his parole officer, the amount (over approximately 41 months) would be more than $29,000. The SSA may not recover the money.]

U.S. Senate

Committee on Finance

Statement for the Record

Social Security Administration Improper Payment Issues

James G. Huse, Jr.
Inspector General of the Social Security Administration

April 25, 2001

Good morning, Chairman Grassley and members of the Committee. Let me first thank you for the opportunity to speak with you today on a matter of immeasurable importance to the people of the United States—improper payments made by Federal agencies, including the Social Security Administration. As we fast approach the critical years during which SSA will pay out more in benefits than it receives from the current workforce in contributions, payment accuracy is more important than it has ever been.

This is not to say that we are addressing this issue for the first time. Shortly after SSA's independence and the creation of an Office of the Inspector General in 1995, Congress asked my predecessor to describe the internal and external challenges facing our office, then in its infancy. He identified four critical areas. One was payment accuracy. As our office has grown in the years since, payment accuracy has remained a primary focus.

One of the first issues we explored in the improper payment arena was the payment of benefits to prisoners. In an audit report issued less than a year after SSA independence, we found that SSA did not have the ability to identify all prisoners in detention, and that where improper payments to prisoners could be identified, such payments were not terminated in a timely manner. We estimated that the annual cost to SSA in erroneous payments to prisoners was $48.8 million, and we recommended that SSA seek legislation to facilitate the exchange of information with Federal, state, and local prison authorities. Such legislation was enacted in 1999, removing the need for computer matching agreements between SSA and prison authorities. The elimination of this time-consuming process had an overwhelming effect; according to SSA statistics, payments to more than 69,000 prisoners were suspended in FY 2000, based on more

than 260,000 prisoner alerts that were received in large part because of that legislation. Progress has been promising and the efficiency of this program should continue to improve as the 1999 legislation paves the way for even more expansive communication between SSA and prison authorities.

The area in which my office has made the most progress is that of Supplemental Security Income, or SSI, payments to fugitive felons. In 1996, Congress enacted legislation prohibiting the payment of SSI to fugitives from justice. That legislation required SSA to provide law enforcement officials with the current address, Social Security number, and photograph of any SSI recipient in fugitive status. In light of our status as a law enforcement organization, the Commissioner asked my office to perform this function, and we began investigating fugitive felon cases immediately.

In the years since we undertook this responsibility, we have worked with SSA on two fronts. First, we have worked with other Federal, state, and local law enforcement agencies to locate and apprehend wanted felons and we have notified SSA of each fugitive on SSI so that payments could be suspended. Second, we have worked both with SSA and with outside law enforcement agencies to expand our ability to identify fugitive felons for apprehension and payment suspension. In 1999, we entered into agreements with the U.S. Marshals Service and the FBI to expand our access to fugitive information. In 2000, we entered into a similar agreement with the National Criminal Information Center, and SSA agreed to pursue matching agreements with the states to provide us with state fugitive data—11 states and 2 major cities have already entered into such agreements, and more are in the pipeline.

Our efforts to increase the inbound flow of information have reaped immediate rewards. We have identified over 28,000 fugitives receiving SSI payments since the program's inception 4 years ago; almost half of those identifications occurred in FY

2000. As we expand our capabilities to obtain accurate fugitive information, we expect that number to continue to grow.

The savings are significant—more than $34 million in FY 2000 alone. While it is this bottom line that is directly relevant to our mission, a critical fact is often overlooked. Our agents participated in the arrests of more than a thousand of the almost 14,000 fugitive felons identified in FY 2000. To maximize our resources, we focus our arrest activities on the most dangerous criminals. So, while the cost savings are significant, we think it even more important that we were instrumental in removing more than a thousand potentially violent criminals from the street. For example, a Michigan man wanted for allegedly shooting four people, one fatally, was recently arrested by one of our agents, as was a California man wanted for assault with a deadly weapon on a police officer. We also maximize our resources by making multiple arrests in a single operation. In Detroit, in the course of a three-day operation, we arrested 82 individuals wanted for offenses ranging from armed robbery to criminal sexual conduct. The savings effectuated by suspending SSI payments to these individuals is the topic of this hearing, and I don't wish to undersell its importance. But this Committee, and the public, should understand that this project goes beyond cost savings—it saves lives.

The fugitive non-payment legislation passed in 1996, however, addresses only half of the issue. Only SSI recipients are barred from receiving benefits while in fugitive status. Fugitives continue to legally receive retirement, survivors, and disability insurance from SSA under title II of the Social Security Act. Further, these fugitives continue to enjoy Privacy Act protections that prohibit SSA and my office from providing law enforcement officials with the information necessary to locate and apprehend them. This disparity between title II and title XVI has been justified on several grounds, and it is not my place to make the policy determination that must be made. It is, however, my place to point out the costs of having the Federal government finance felons' attempts to

elude capture, both in terms of losses to the Social Security trust fund and in terms of public safety.

An audit report issued by my office found that the trust fund would have saved at least $108 million dollars had the 1996 legislation included both title XVI and title II benefits in its prohibition. Moreover, the report found that the trust fund loses $39 million a year as a result of the disparity in treatment between the two types of benefits. As I stated earlier, this waste of Federal funds goes to the heart of our mission, and our inability to stop these payments is frustrating. What is more frustrating to us as a law enforcement organization is that these benefits were paid to some 17,300 fugitives, many of whom could have been apprehended had my office been able to provide law enforcement agencies with felons' addresses. The loss of money is disturbing; the thousands of criminals that could have been incarcerated but remain free is worse. Congress may want to consider legislation, this session, that will permit us to treat felons as felons, regardless of the types of Social Security benefits they are using to finance their flight from justice. However, I must caution the Committee that if this legislation is enacted, a significant amount of resources would be needed to continue to ensure the integrity of the matching and validation process.

A third area of improper payments that we have addressed is that of deceased beneficiaries. Our Office of Audit recently issued a draft report dealing with deceased auxiliary beneficiaries—deceased dependents of living beneficiaries who continue to receive benefits after death. In this report, we matched all 11.7 million auxiliary beneficiaries against SSA's Master Death File and found that SSA had paid an estimated 881 deceased auxiliary beneficiaries $31 million in OASDI benefits after their dates of death. Another draft report examines the system SSA uses to keep its death records up-to-date to ensure that benefits are terminated as soon as possible after a

beneficiary's death. Both audits indicate that while progress has been made, much remains to be done in ensuring that benefits do not continue to be paid to the deceased.

In the interim, our Office of Investigations continues to pursue the most egregious cases—instances in which a beneficiary has died and a friend, family member, or representative payee conceals the death in order to steal the deceased's benefits. In the first quarter of FY 2001, we have already opened 128 such cases. By way of example, a Georgia man acting as representative payee for two Social Security beneficiaries was recently sentenced to 18 months in Federal prison for failing to report the death of both of his charges—he collected over $133,000 in benefits after their deaths. In Tennessee, a woman who failed to report her mother's 1983 death was sentenced to 13 months' confinement, and ordered to repay the more than $184,000 that she stole over the 17 years following her mother's death.

These cases highlight the need for better communication between SSA and the appropriate Federal, state, local, and private sources that can provide information concerning the deaths of SSA beneficiaries. Our Audit Reports provide useful recommendations, and I am confident that SSA will continue to improve its processes in this area. While it does so, we will continue to pursue those who conceal the deaths of beneficiaries in order to profit at SSA's expense.

A fourth improper payment issue that my office is monitoring involves payments to child beneficiaries who are over age 18 and are no longer full-time students. Generally, the children of retired, deceased or disabled beneficiaries who remain full-time students are entitled to benefits until they reach age 19 or complete their secondary education, whichever occurs first. In an audit issued September 30, 1999, we found that SSA was not adequately monitoring student enrollment status, resulting in improper or unsupported payments totaling at least $21.5 million a year. As a result, we recommended that SSA request assistance from school officials in identifying and

reporting any changes in student attendance that could affect benefits. In addition, SSA is complying with our recommendation to better train those SSA employees who monitor student beneficiaries. This should ensure that proper supporting documentation of student status is developed and retained throughout each student's entitlement period. I am optimistic that such measures will reduce the Agency's vulnerability to persons who misrepresent school attendance in order to continue to receive benefits to which they are not entitled.

The final improper payment issue that I will discuss today relates to Disability Insurance benefits paid to persons who also receive state workers' compensation payments. In general, the Social Security Act requires SSA benefits to be offset for beneficiaries who receive state-administered benefits. This reduction in benefits prevents a disabled worker from receiving more in disability payments than he or she earned prior to becoming disabled. Without this offset, injured workers might be disinclined to aggressively seek the rehabilitation necessary to return to work. Because SSA does not have direct access to state workers' compensation databases, the Agency primarily relies on beneficiaries to voluntarily report changes in workers' compensation benefits.

In recent audit reports issued in September 1998 and November 1999, my office found that unreported receipt of, changes in, or termination of Workers' Compensation benefits resulted in substantial payment inaccuracies, including an estimated $214.4 million in overpayments and $111.4 million in underpayments. In response to our reports, SSA performed its own studies and found for this period a total estimated past and future error of $1.07 billion in underpayments and $261 million in overpayments. As a result, SSA formed a workgroup to develop a plan to significantly improve its payment accuracy involving Workers' Compensation offsets. While we are cognizant of the fact that SSA has devoted significant resources to close out the first population of about

61,000 cases in approximately 21 months, we know there remain thousands of cases to be reviewed. I believe it is important that SSA devote sufficient resources to resolve these cases in as expeditious a manner as possible.

Of the cases SSA has already reviewed, there were about 250 beneficiaries who were each underpaid more than $30,000—a total of $10.7 million in underpayments. One of these individuals failed to be paid $450 in monthly benefits for fifteen and a half years. Additionally, there were several cases where individuals were underpaid more than $65,000.

Under SSA's current approach to the Workers' Compensation closeout, it will take years to complete the planned actions. During this extended period, while SSA is identifying and rectifying errors, overpayments will continue to accumulate, and underpayments will build, causing hardships for many beneficiaries. In the end, SSA will find that many of the affected beneficiaries have died. In these cases, beneficiaries will have been deprived of benefits while they were alive or paid excess benefits that may now never be reclaimed. In one case, a beneficiary was underpaid approximately $65,000; the error was discovered in April 2000, but the insured had died four months earlier. While the underpayment was remitted to his surviving spouse, the beneficiary was deprived of his full monthly benefit for almost seven years prior to his death.

There have, however, been encouraging developments. SSA has complied with recommendations from GAO and from my office to pursue data matching agreements with the Department of Labor and individual states. An agreement with Texas, which we identified as the state with the third-highest workers' compensation rate, was executed and a pilot project is underway to ensure that the SSA benefits of Texas workers' compensation recipients are being properly offset. Additional states will follow once this pilot project proves successful. Moreover, an agreement with the Department of Labor, recommended in a 1983 GAO report, is anticipated to produce useful data this summer.

These five areas constitute some of our most significant work in the realm of payment accuracy. But in a sense, everything that the OIG does on a daily basis, from investigating Social Security number misuse to imposing civil monetary penalties, has a direct impact on payment accuracy. For the past six years, we have been the overseers of the Trust Fund, and in that short time, have had a significant impact on payment accuracy and all aspects of SSA's programs and operations. We enjoy a productive working relationship with SSA officials, the Congress, and the Administration, and look forward to continuing to protect SSA and its beneficiaries from fraud, waste, and abuse in the years to come. Thank you for the opportunity to be here today, and I'd be happy to address any questions the committee might have.

PREPARED STATEMENT OF DANIEL G. KYLE, PH.D., CPA, CFE

Good morning Mr. Chairman and members of the United States Senate Committee on Finance. Thank you for allowing me to offer my testimony here in Washington today.

In serving as Louisiana's Legislative Auditor, I have a number or responsibilities. I hold my appointive position within the Legislative Branch of Louisiana state government. I have served in that capacity since 1989. As Legislative Auditor, I serve as fiscal advisor to the Legislature and as auditor of the fiscal records of the state, its agencies, and political subdivisions. My responsibilities include financial and compliance, performance, and investigative audits.

As authorized by the United States Congress, I am also the auditor in Louisiana of Federal monies received by the state. My annual single audit meets the requirements of the Single Audit Act as amended in 1996, and the associated U.S. Office of Management and Budget Circular A–133.

It is as auditor of the Federal monies received by my state that I am here today. During my tenure as Legislative Auditor, I have issued several financial-related audits on Louisiana's Medicaid Program, which is administered by the state's Department of Health and Hospitals. Among these are the following: In 1995, I reported that Louisiana paid a national accounting firm approximately $100 million to assist the state in enhancing revenues from Medicaid disproportionate share payments. In that same year, I reported that Louisiana paid approximately $20 million to an independent contractor to assist in establishing Medicaid eligibility for patients treated in state-operated hospitals.

At your invitation, I am here today to address my most recent, and yet unresolved, concern. Specifically, Louisiana is using Medicaid to fund health care of state-incarcerated prisoners who are afforded medical care in state-operated hospitals. The Louisiana State University Health Sciences Center, Health Care Services Division estimates that the cost to treat prisoners at its nine facilities has averaged approximately $21 million over each of the past four years. The Federal financial participation relative to Louisiana's Medicaid Program is, therefore, estimated to be approximately $15 million each year for such care.

In November of 1996, my office sent a letter to the Health Care Financing Administration seeking clarification of Louisiana's practice of including prisoner days in the allocation formula for disproportionate share payments. Louisiana allocates disproportionate share payment adjustments to state-operated hospitals to cover costs incurred by the hospitals in serving patients who are not deemed Medicaid eligible. My staff expressed its view that Title 42, Part 435, Section 1008, of the Code of Federal Regulations provides that Federal financial participation is not available in expenditures for services provided to individuals who are inmates of public institutions. In that letter, we stated it was our understanding that on June 11, 1996, HCFA approved an amendment to Louisiana's Medicaid State Plan. That amendment provided that prisoners receiving services in state hospitals are deemed indigent in accordance with Louisiana law. Despite the applicable Code of Federal Regulations, this amendment allowed Louisiana to include prisoner days in the allocation formula for disproportionate share payments. Therefore, Medicaid contributes approximately $15 million each year for the health care costs of state-incarcerated prisoners.

Throughout my career as Legislative Auditor, my general counsel has advised me that one cannot do indirectly what he/she is not allowed to do directly. I, therefore, question how HCFA can allow Louisiana (or any other state), simply by passing a state law, to include prisoner medical care in the Medicaid disproportionate share payments, when the Code of Federal Regulations specifically states such costs are not allowable.

HCFA offered no response to my 1996 letter. In 1999, I asked the state Department of Health and Hospitals to defend its position relative to this practice. The department provided an opinion from its counsel in Washington, Covington and Burling. They opined that Louisiana's practice is fully in accordance with law and the approved state plan. The department further contended that the regulations governing disproportionate share payments and those regarding direct Medicaid funds and eligibility are mutually exclusive.

Subsequent to receiving the department's legal opinion, I again wrote HCFA in 1999. After receiving no response, I decided later that year to send my concerns to the Inspector General of the U.S. Department of Health and Human Services. As of this date, I have not received any written communication from the appropriate Federal agency either supporting or challenging Louisiana's use of Medicaid to fund prisoners' health care through disproportionate share payments.

In conclusion, I will continue to try and determine if Louisiana's practice of using Medicaid to fund health care costs of state-incarcerated prisoners is permissible under current Federal law. If the practice is found to be impermissible, I ask that Louisiana be afforded prospective treatment, since Louisiana feels it has acted in good faith and in accordance with its state plan that has been approved by HCFA. I am prepared to address any questions that the committee may have.

Testimony
Before the Finance Committee

United States Senate

"IMPROPER PAYMENTS"

Testimony of Michael Mangano
Acting Inspector General

April 25, 2001
10:00 a.m.
216 Dirksen Senate Office Building

Office of Inspector General
Department of Health and Human Services
Michael Mangano, Acting Inspector General

Testimony of **Michael F. Mangano**
Acting Inspector General
Department of Health and Human Services

Good morning Mr. Chairman. My name is Michael F. Mangano. I am the Acting Inspector General for the Department of Health and Human Services (HHS). It is my pleasure to be here today to give you an update on our work with regard to improper payments in Departmental programs.

Today, I will provide an overview of the types of payment errors revealed by our most recent Health Care Financing Administration (HCFA) audit. Over the past five years, the Office of the Inspector General (OIG) has undertaken audits of Medicare's fee-for-service claims to estimate the extent of payments that did not comply with Medicare laws and regulations. These payment errors, comprised of improper provider billings, make up the largest category of inappropriate payments in the Medicare program. These errors can include simple billing mistakes as well as fraudulent billings. We continue to believe that most health care providers do their best to provide high quality care and are honest in their dealings with Medicare. At the same time, we must be concerned about all errors, even those which are totally innocent. Our annual measurement of Medicare payment errors not only allows HCFA to focus on the areas where increased compliance is needed, but also enables HCFA to identify approaches to building a better Medicare program.

I will also describe instances of specific inappropriate payments made as a result of the complex, antiquated, and incompatible technology environment in which Departmental programs operate. These examples include Medicare and Medicaid payments made on behalf of deceased or incarcerated beneficiaries, as well as Temporary Assistance for Needy Families (TANF) payments made to fugitive felons. Taken together, these problems indicate systemic vulnerabilities which could lead to much more serious losses of funds if not remedied.

MEDICARE PAYMENT ERROR RATE

We recently released our report *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments* (A-17-00-02000) in which we present the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by HCFA. It is important to note that this is an error rate estimate and not a fraud estimate. These improper payments could fall on a continuum anywhere from simple inadvertent mistakes to outright fraud and abuse.

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. We found that the contractors' claim processing controls were generally adequate for: (1) ensuring beneficiary and provider Medicare eligibility; (2) pricing claims based on information submitted; and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments. Our historical analysis of payment errors from

FY 1996 through FY 2000 identified four major payment error categories: medically unnecessary services, unsupported services, coding errors, and noncovered services.

Medically unnecessary services, the largest error category this year, amounted to $5.1 billion in improper payments. This category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. The following is an example of services that were determined not medically necessary:

- A physician was paid $3,305 for 40 hypnotherapy sessions with an Alzheimer's patient. The medical records stated that the patient was neither attentive nor cooperative during the initial mental status exam. Since the patient could not participate in that exam, the medical reviewer determined that hypnotherapy treatment was not medically necessary, reasonable, or appropriate for a 95 year old Alzheimer's patient.

Unsupported services represented the largest error category in three of the last 5 years. In FY 2000, they accounted for an estimated $4.3 billion in improper payments. Such services include those where there is insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed ($2.3 billion) or where there was no documentation to support the services provided ($2 billion). An example of unsupported services follows:

- A hospital was paid $722 for outpatient radiation therapy services. The medical records contained no documentation to support the provision of these services. After repeated unsuccessful attempts to obtain such documentation, the claim was denied.

Coding errors represented $1.7 billion in improper payments (the net of upcoding and downcoding errors). For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. Physician and inpatient Prospective Payment System (PPS) claims accounted for over 90 percent of the coding errors over the 5 years reviewed. An example of incorrect coding includes:

- A hospital was paid $19,452 for providing a diagnostic related group service to a patient admitted with a chronic inflamation of the membrane lining the abdominal wall. The principal diagnosis code was shown as another infection. The medical reviewers concluded that the diagnosis code should have been related to an infection due to a dialysis catheter. As a result, $7,125 was denied.

Noncovered services and other errors consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. Such services include most routine physical examinations; eye and ear examinations to prescribe or to fit glasses or hearing aids; and, most routine foot care.

Since we developed the first error rate for FY 1996, HCFA has closely monitored Medicare payments and has instituted appropriate corrective actions. The HCFA has also worked with

provider groups to clarify reimbursement rules and to impress upon healthcare providers the importance of fully documenting services. Additional initiatives on the part of the Congress, HCFA, the Department of Justice, and the Office of Inspector General have focused resources on preventing, detecting, and eliminating fraud and abuse. All of these efforts, we believe, have contributed to reducing the improper payment rate by almost half -- from $23 billion, or about 14 percent of Medicare program expenditures, in FY 1996 to $11.9 billion, or about 6.8 percent of the $173.6 billion in Medicare payments, in FY 2000.

The decrease in improper payments has had a positive effect on Medicare's financial situation. From 1991 to 1996, the Congressional Budget Office (CBO) reported that Medicare's rate of inflation averaged 10.9 percent per year. In FY 1998, the rate of inflation for the Medicare fee-for-service program dropped to the lowest in the program's entire history (since 1965) -- 1.5 percent. Overall, CBO calculated the average Medicare inflation rate for FY 1997 to FY 2000 at 3.2 percent. CBO commented that: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules." (The Budget and Economic Outlook: Fiscal Years 2002-2011, CBO, January 2001)

As of 1996, the Trustees of the Medicare Part A Trust Fund projected that the Trust Fund would be insolvent in 1999. However, over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. One of the primary contributing factors cited by the Trustees has been "the continuing efforts to combat fraud and abuse." (Status of the Social Security and Medicare Programs, Trustees Annual Report, March 1999). We believe that these positive economic findings with respect to the financial integrity of the Medicare program, which will positively impact on both taxpayers and beneficiaries, are due in large part to the fact that the vast majority of health care providers are engaged in submitting accurate claims to HCFA and providing high quality, medically necessary services.

INAPPROPRIATE MEDICARE AND MEDICAID PAYMENTS

Numerous OIG audits and investigations have revealed instances where antiquated and complex computer systems have resulted in inappropriate payments being made on behalf of Medicare beneficiaries and Medicaid recipients. Several recent OIG audits and inspections examined whether the Medicare or Medicaid programs were being billed for services which occurred after the date of a beneficiary's death and whether these programs were paying for such services. We have also recently completed work to identify inappropriate payments made on behalf of incarcerated Medicare beneficiaries.

Payments Made on Behalf of Deceased Beneficiaries

Medicare Services: In our inspection, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), we found that Medicare paid an estimated $20.6 million in 1997 for services that started after a beneficiary's date of death. These payments were made because of several system problems. Approximately $12.6 million was paid because Medicare had not yet received beneficiary date of death information from the Social Security Administration (SSA) Master Beneficiary Record at the time the claim was processed. For example, for one beneficiary who died in May 1997, HCFA did not receive the date of death information until October 1997. This

delay allowed three months of rental payments for a nebulizer to be paid in June, July, and August 1997.

The remaining $8 million was paid for services where the beneficiary's date of death was in its system at the time the claim was processed and approved for payment, but HCFA's Common Working File system, the system used by fiscal intermediaries and carriers to process fee-for-services claims, did not prevent the claims from being paid. Over half of the $8 million was for durable medical equipment claims. For example, for one beneficiary who died in November 1997, HCFA received the date of death information in that same month. However, in January 1998, HCFA paid claims on behalf of that beneficiary for durable medical equipment items with service dates in December of 1997.

We also found some payments for services where HCFA's Enrollment Database, which contains entitlement data for Medicare beneficiaries, and the Common Working File contained different dates of death. In one example, a beneficiary received four services relating to ambulance transport on May 12, 1997. Although data from the Enrollment Database indicated that the beneficiary died on May 9, 1997, the Common Working File contained a different date of death of May 13, 1997. In such examples, we found no indication of which file contained the accurate date of death and therefore do not know whether or not the claims were paid in error.

As a result of our findings, we recommended that HCFA require contractors to conduct annual post-payment reviews to identify and recover payments made for services after death; revise their Common Working File system edit to ensure that durable medical equipment payments are not made for deceased beneficiaries; and periodically reconcile date of death information between the Enrollment Database and Common Working Files. In January 2001, HCFA implemented the system change necessary to revise the Common Working File edits to prevent payment of durable medical equipment services billed after the beneficiary's date of death. HCFA has also recently issued instructions to Medicare contractors requiring them to conduct the necessary post-payment review activities to identify payments made on behalf of deceased beneficiaries. However, HCFA indicated that there is no way to systematically compare the Enrollment File and Common Working File to determine which date of death is accurate without a manual review; therefore, they will need to take into account contractor workload while implementing this recommendation.

Medicaid Services: In 1994, the OIG began an initiative to work more closely with State Auditors in reviewing the Medicaid program. Through this initiative, the OIG/State Audit Partnership Plan was developed to expand Medicaid program audits and allow State Auditors to apply methodologies we have successfully used in our Medicare audits. As an example, the State of Ohio's Office of the Auditor examined whether Medicaid was paying for services on behalf of deceased recipients (*Payments for Medicaid Services to Deceased Recipients*, A-05-00-00045). The audit determined that, during a period of almost 6 years, the Ohio Department of Human Services (ODHS) paid $82 million for services to Medicaid recipients after the recipients' date of death. This amount consisted of 115,000 payments to over 4,000 different providers for services provided to almost 27,000 apparently deceased recipients. The average time to discover and recover an overpayment was just over five months after the recipient's date of death. About 93 percent of the unrecovered payments were in four categories of service: skilled nursing facility (75 percent of the unrecovered payments), intermediate care facility (7

percent), pharmacy (6 percent), and durable medical equipment (5 percent).

Subsequent analysis by the Ohio Department of Human Services confirmed that information in the Medicaid recipient master file is not always accurate. Ohio auditors determined that almost 30 percent of 34,330 Medicaid recipients who died during 1997, according to the Ohio Department of Health's Vital Statistics file, did not have a date of death entered on the recipient master file (meaning that providers could still bill and be reimbursed for Medicaid services). Moreover, 4.6 percent of the 24,463 recipients who had a date of death on the recipient master file had a death date that differed from the Vital Statistics death date by more than one day.

The Office of the Auditor recommended that the Ohio Department of Human Services recover the outstanding amount when feasible and cost effective, make corrections to prevent additional overpayments from being made for deceased recipients, and seek legislative authority to develop and apply sanctions against providers who do not timely report a recipient's death or who bill for or retain unearned reimbursements. The State has now recovered all of the overpayments identified in this audit.

Payments Made on Behalf of Incarcerated Beneficiaries

Medicare Payments: We are currently conducting a series of audits on Medicare payments provided on behalf of beneficiaries who were in the custody of Federal, State, or local law enforcement agencies at the time services were provided. Under current Federal law and regulations, payments for such services are generally unallowable. The State or other government component operating the prison is presumed to be responsible for the medical needs of its prisoners.

The rules for determining whether Medicare will pay are complex and administratively cumbersome. Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Regulations at 42 Code of Federal Regulations (CFR) 411.4(b)(1) and (2) state the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities *unless* the authorities require that all individuals pay for such services and enforce that requirement by pursuing collection for repayment. The State or other Government component operating the prison is presumed to be responsible for the medical needs of its prisoners. According to HCFA's procedural manuals for its contractors, this is a rebuttable presumption that may be overcome only at the initiative of the Government entity. The entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. It must pursue collection, including the filing of lawsuits to obtain liens against an individual's assets outside the prison and income from non-prison sources.

The Social Security Administration, on the other hand, has a simple rule regarding payments to prisoners. A person's Social Security benefits are suspended if he/she is incarcerated for a month or more.

In our report *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries*

(A-04-00-05568), we found that the Medicare program is vulnerable to improper payments for services provided to incarcerated beneficiaries. According to data provided to us by the SSA, there were 38,600 Social Security beneficiaries entitled to Medicare who were incarcerated as of July 2000. We used this data to determine whether Medicare claims have been paid on behalf of any of these beneficiaries during Calendar Years 1997 through 1999. To date, we have identified $32 million in Medicare fee-for-service payments on behalf of 7,438 incarcerated beneficiaries during Calendar Years 1997 through 1999. We also found that some incarcerated beneficiaries were enrolled in Medicare managed care plans during their incarceration.

We are in the process of determining the amount of Medicare payments made on behalf of incarcerated beneficiaries which may be improper. We are concerned, however, because, in general, no Medicare payments should be made for services rendered to prisoners unless certain strict conditions are met by the government component (i.e., Federal, State, or local) which operates the prison. We are now determining if the government components operating prisons meet the strict conditions for Medicare payments to be allowable. The development underway includes researching State laws to determine if prisoners are required to repay their medical expenses. If such a law exists, the government entity must then prove that it enforces this requirement. Examples we are investigating include:

- Medicare paid $25,423 for services to an inmate charged with killing his mother.
- In another State, Medicare paid a facility $97,283 on behalf of nine inmates who were incarcerated for various crimes including arson, attempted assault, breaking and entering, and burglary.

The HCFA does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments. To minimize this risk, we recommend that HCFA formalize its efforts to obtain additional data from SSA in the daily transmission of enrollment data, which identifies incarcerated beneficiaries, and design and implement system controls in the Enrollment Database and Common Working File to alert contractors when a Medicare claim is submitted for services for an incarcerated beneficiary. We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained during our review.

Medicaid Payments for Inmates of Public Institutions: We are in the process of reviewing Medicaid payments for services provided to inmates of public institutions. Our involvement began with information received from the Louisiana Office of Legislative Auditor. The Auditor was concerned that the Louisiana Department of Health and Hospitals was including the cost of services provided to inmates in determining its Medicaid net uncompensated care costs for disproportionate share hospital payments made to State operated hospitals. The Louisiana Office of Legislative Auditor had interpreted that neither disproportionate share hospital payments nor Federal financial participation payments are allowable for services provided to inmates of public institutions, specifically prisoners in a penal institution.

Based on audit work to date, we found that HCFA has not established a definitive coverage

policy that is consistent with the intent of the governing statute that generally prohibits Federal financial participation payments for inmates of public institutions. The current Medicaid coverage policy contains a provision allowing for Federal financial participation payments for services provided to inmates of public institutions when the inmate is an inpatient in a medical institution. We believe this provision is contrary to the intent of the Medicaid statute. We believe the intent was to ensure that Medicaid funds are not used to finance care that has traditionally been the responsibility of the State and local governments. Also, HCFA has no specific guidance on the availability of disproportionate share hospital payments to hospitals for uncompensated care provided to inmates. We expect to complete our review this summer.

Other OIG Work

In addition to the improper payments described above, we have also done extensive work through audits and inspections to identify duplicate payments made in the Medicare and Medicaid programs. For example, we have examined if Medicare fee-for-service payments were made on behalf of beneficiaries enrolled in Medicare managed care plans. This work involves identification of specific overpayments, as well as identification of the system vulnerabilities, which have allowed such payments to occur. Additionally, we have work underway to identify whether Medicare payments are being made on behalf of deported aliens. Preliminary results indicate that such payments are being made.

TANF BENEFICIARIES WHO ARE FUGITIVE FELONS

The problems of ensuring the appropriateness of payments in a complex program environment are not limited to Medicare and Medicaid. This is illustrated in the following account of income assistance payments which we discovered were being made to fugitive felons.

The U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance, oversees the Temporary Assistance for Needy Families (TANF) program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 increased the flexibility of the States in operating the TANF program. The Act allows States to provide assistance so that children may be cared for in their own home; promote job preparation, work and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation and maintenance of two parent families. Section 408 of the Act identifies prohibitions and other requirements for the TANF program including a requirement that States not use any part of the grant to provide assistance to any individual who is fleeing to avoid prosecution, custody or confinement after conviction for a felony, as defined under the laws of the place from which the individual flees.

Project Cornhusker is an initiative of our Office to reduce fraudulent TANF payments in the metropolitan area of Omaha, Nebraska. This is the first such joint project we have undertaken with local law enforcement to identify individuals with felony fugitive warrants who are recipients of federal assistance in violation of the Welfare Reform Act of 1996. As part of this effort, the active felony warrants for Douglas County, including Omaha, were matched with the active TANF beneficiary files maintained by the Nebraska Department of Health and Human Services. This computer match produced 64 wanted individuals.

On March 21 and 22, 2001, OIG agents assisted the Douglas County Sheriff's Office and the Omaha Police Department in the arrest of 24 individuals wanted for felonies committed in their jurisdiction. These arrests were made possible because of the cooperation of the Nebraska Department of Health and Human Services, local police and OIG. Twelve additional arrests were made without OIG assistance.

The majority of the arrested subjects were wanted for non-violent crimes, such as felony theft, bad checks, burglary and crimes against property. Three subjects were arrested on warrants for assault, one with a deadly weapon. Specific information concerning some of the arrests are identified below:

- A subject was arrested and found to have three Social Security cards in another individual's name. He also had a birth certificate in that subject's name with two passport photos of himself. This information was sent to the Social Security Administration, Office of Inspector General, Office of Investigations.
- An individual was arrested and found to be in possession of black tar heroin.
- Upon request, an individual present during the arrest of a TANF recipient produced identification. A check of law enforcement records showed that the individual was currently wanted in Louisiana for failure to pay court ordered child support. He was subsequently arrested on that charge.

Because of the success of this effort, we are considering replicating this type of joint initiative in the future.

MODERNIZING DEPARTMENT INFRASTRUCTURE

The Secretary of the Department of Health and Human Services has named reforming the management of the Department's operations as one of his top priorities. Specific priorities include improving the management of HCFA and making appropriate investments in Department management and infrastructure.

Improve the Management of the Health Care Financing Administration:. The demands on HCFA have grown dramatically in the last few years. On the one hand, the agency needs adequate resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs; on the other hand, it must be recognized that patients, providers and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. The Department has therefore begun a thorough examination of HCFA's missions, its competing demands, and its resources.

Invest in Department Management and Infrastructure: The Secretary has noted that one of the major challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing its programs.

In the area of financial management, the Secretary has proposed an additional $50 million

investment in a unified financial accounting system. The OIG has found major problems with the Department's current system structure, which involves separate accounting systems operated by multiple agencies. Department plans to replace these antiquated systems with one or two unified financial management systems should help to increase standardization, reduce security risks, and allow HHS to produce timely and reliable financial information needed for management decision-making, and provide accountability to the external customers.

In the information technology arena, the Secretary has proposed $30 million to improve information technology systems through investments in the Information Technology, Security and Innovation Fund. As seen in my examples today, these systems are highly antiquated, incompatible, and vulnerable to exploitation. The Secretary has proposed that funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize vulnerabilities while maximizing cost savings and the ability to share information.

We fully support these proposals and continue to promote adequate departmental resources to ensure efficient and effective claims processing, policy development and regulation, and quality assurance. We remain concerned that the currently inadequate internal controls leave the Medicare program vulnerable to potential loss of funds, misstated financial statements, disclosure of sensitive information, and disruption of critical claim processing. Further, out-of-date and overly complex computer systems are not adequately preventing inappropriate program payments.

Over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. The expanded solvency projection provides a window of opportunity to develop a departmental technology infrastructure for the 21st century. Over time, such an investment will lead to further savings -- by reducing payment errors of all types and by making program operations more efficient.

This concludes my testimony. I would be happy to answer any questions.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS FOR SERVICES PROVIDED TO INCARCERATED BENEFICIARIES

APRIL 2001
A-04-00-05568

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries
(A-04-00-05568)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides you with the results of the first in a series of audits of Medicare payments for services provided to incarcerated beneficiaries.

The Medicare program is vulnerable to improper payments for services rendered to incarcerated beneficiaries. According to data provided to us by the Social Security Administration (SSA), there were 38,600 Social Security beneficiaries entitled to Medicare who were incarcerated as of July 2000. We used this data to determine whether Medicare claims have been paid on behalf of any of these beneficiaries during Calendar Years (CY) 1997 through 1999. To date, we have identified $32 million in Medicare fee-for-service payments by Medicare contractors to providers on behalf of 7,438 of the 38,600 incarcerated beneficiaries during this period. We are analyzing additional data we obtained from the Health Care Financing Administration (HCFA) to identify incarcerated beneficiaries enrolled in Medicare managed care plans.

We have not yet determined the amount of Medicare payments made on behalf of incarcerated beneficiaries which may be improper. We are, however, extremely concerned because, generally, no Medicare payments should be made for services rendered to prisoners unless certain strict conditions are met by the government component (i.e., Federal, State, or local) which operates the prison. The HCFA, however, does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments.

As a result, the Medicare program is at risk for making improper payments for services provided to incarcerated beneficiaries because HCFA has not succeeded in:

- obtaining beneficiary data from SSA that identifies incarcerated beneficiaries; and

- implementing systems controls in the Enrollment Data Base (EDB) and Common Working File (CWF) to alert contractors when a Medicare claim is for services provided to an incarcerated beneficiary.

To minimize this risk, we recommend that HCFA take the following procedural and systematic measures:

- formalize its efforts to obtain additional data which identifies incarcerated beneficiaries from SSA in the daily transmission of enrollment data; and

- design and implement systems controls in the EDB and CWF to alert contractors when a Medicare claim is submitted for services provided to an incarcerated beneficiary.

We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained during our review. Since the data we received from SSA is current only through July 19, 2000, we believe it would be legally preferable for HCFA to obtain current information directly from SSA rather than using the data we obtained. Implementing these recommendations will help HCFA meet its program integrity goal to reduce improper payments under the Medicare program.

In their written response to our draft report, HCFA officials shared our concerns that improper payments may be occurring and agreed with the intent of our recommendations. They hesitated, however, to fully commit to implementing systems controls to alert their contractors of imprisoned beneficiaries at this time. They stated further study is necessary to determine the most appropriate source of incarcerated beneficiary data for their use.

The HCFA officials also indicated they must consider the contractor resources needed to manually review a claim for an incarcerated beneficiary because State and local laws need to be analyzed. After the issue has been studied further, they said another 12 to 18 months would be needed to plan and execute a data exchange and to implement systems controls.

The comments from HCFA are included in their entirety as the Appendix to this report.

BACKGROUND

The Office of Inspector General is conducting a series of audits on Medicare payments made on behalf of beneficiaries who were in the custody of Federal, State, or local law enforcement agencies at the time services were provided. Under current Federal law and regulations, payments for such services are generally unallowable.

Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Regulations at 42 CFR 411.4(b)(1) and (2) state the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities *unless* the authorities require that all individuals pay for such services and enforce that requirement by pursuing collection for repayment. The State or other government component operating the prison is presumed to be responsible for the medical needs of its prisoners. According to HCFA's procedural manuals for its contractors, this is a rebuttable presumption that may be overcome only at the initiative of the government entity. The entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. It must pursue collection, including the filing of lawsuits to obtain liens against an individual's assets outside the prison and income from nonprison sources. However, contractors are not enforcing these procedures because HCFA does not have sufficient controls to identify imprisoned Medicare beneficiaries. This condition places the Medicare program at risk for improper payments.

Section 202(x)(1)(A) of the Social Security Act, requires SSA to suspend Old Age and Survivors and Disability Insurance (i.e., Social Security benefits) to persons who are incarcerated. To implement this requirement, SSA, with the assistance of the Federal Bureau of Prisons and various State and local entities, developed and maintains a database of incarcerated individuals. On April 25, 1998, the President issued a *Memorandum for the Heads of Executive Departments and Agencies* (Memorandum) that directed agency officials to review their benefit programs and determine whether it was appropriate and cost effective to conduct a match of their benefit program databases with the SSA prisoner database. The Memorandum requires agencies that identify ineligible recipients to immediately suspend, reduce, or terminate benefits as permitted by law. The Memorandum also directed SSA to make its prisoner database available to all agencies, provide assistance, and to facilitate the agencies' quick and efficient access to the data. In addition, the Memorandum states that by May 1, 1999, agencies should have an operational computer system that matches their benefit program databases with the SSA prisoner database.

The SSA Master Beneficiary Record (MBR) identifies incarcerated beneficiaries and provides demographic and entitlement information on all Medicare beneficiaries. The MBR is the primary source of data for HCFA's EDB. Data about beneficiaries, such as dates of Medicare enrollment and termination, changes of address, etc., is transmitted to HCFA and used to update the EDB. Entitlement data from the EDB is subsequently used to update the CWF which is the Medicare benefits coordination and claims system. Medicare contractors are required by HCFA to submit claims to the CWF and obtain approval before paying claims.

SCOPE AND METHODOLOGY

Our objectives were to determine:

- whether HCFA has sufficient controls to identify incarcerated Medicare beneficiaries and prevent the improper disbursement of Medicare funds for medical services provided to beneficiaries while in custody of Federal, State, or local officials; and

- the amount of Medicare payments for incarcerated beneficiaries based on comparing SSA data identifying incarcerated beneficiaries with Medicare payment history.

To achieve our objectives, we reviewed applicable laws and regulations, Medicare reimbursement policies and procedures, pertinent provisions of the Social Security Act, and held discussions with HCFA and Medicare contractor officials. We also met with SSA officials and requested information from them identifying Medicare beneficiaries who are imprisoned or confined to mental institutions for criminal actions by court order because they are insane or incompetent to stand trial.

Our audit period is January 1, 1997 through December 31, 1999. We identified payments made to providers by contractors on behalf of the Medicare incarcerated beneficiaries identified by SSA. We are analyzing additional data we obtained from HCFA to identify incarcerated beneficiaries enrolled in Medicare managed care plans.

We held discussions with officials from Medicare contractors in Alabama, Florida, South Carolina, and Tennessee. We also sent written inquiries to these officials and incorporated their responses in the results of this review. In future audit work, we will contact selected providers and prison officials.

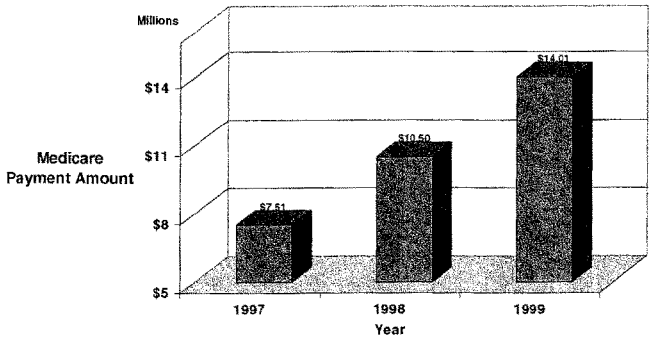
Our work began in December 1999 and was performed at: (1) HCFA and SSA headquarters in Baltimore, Maryland, and (2) our offices in Baltimore; Atlanta, Georgia; and Jacksonville, Florida. Our audit was conducted in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

The Medicare program is vulnerable to improper payments for services rendered to incarcerated beneficiaries. Our analysis of data provided by SSA of incarcerated Medicare beneficiaries and HCFA's claims data indicates that Medicare is making an increasing amount of payments on behalf of incarcerated beneficiaries. To date, we have identified $32,024,582 in payments by Medicare contractors to providers for services rendered to

7,438 incarcerated beneficiaries for CYs 1997 through 1999 ($7,511,386, $10,502,203, and $14,010,993, respectively). We are analyzing additional HCFA data to identify incarcerated beneficiaries enrolled in Medicare managed care plans.

Medicare Payments for Incarcerated Beneficiaries



The Medicare program is currently at risk of making improper payments for services for incarcerated beneficiaries because HCFA has not succeeded in (1) obtaining beneficiary data from SSA that identifies incarcerated beneficiaries, and (2) implementing systems controls in the EDB and CWF to alert contractors when a Medicare claim is for services provided to an incarcerated beneficiary. To minimize this risk, we recommend that HCFA implement the following procedural and systematic measures:

- formalize its efforts to obtain additional data which identifies incarcerated beneficiaries from SSA in the daily transmission of enrollment data; and

- design and implement systems controls in the EDB and CWF to alert contractors when a Medicare claim is submitted for services provided to an incarcerated beneficiary.

Until these recommendations are implemented, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the

file we obtained during our review. Implementing these recommendations will help HCFA meet its program integrity goal to reduce improper payments under the Medicare program.

The HCFA should take immediate action to obtain data from SSA to identify incarcerated beneficiaries.

The HCFA has issued instructions to its contractors that Medicare generally should not pay for care provided to incarcerated beneficiaries. The HCFA does not, however, routinely obtain the names of such individuals. As a result, Medicare contractors cannot enforce HCFA's "no payment" policy.

To comply with the President's Memorandum, HCFA needs to assist its contractors by obtaining additional prisoner data from SSA. The HCFA officials have indicated that they have held informal discussions (some as far back as several years) with SSA officials regarding obtaining prisoner data. So far, these informal discussions have not been fruitful in obtaining the needed data.

During our meetings with SSA officials, we learned the MBR contains two data elements which must be used in conjunction to identify incarcerated beneficiaries: the Ledger Account File (LAF) code and the Reason for Suspension or Termination (RFST). If the MBR indicates an LAF code of *S7* and an RFST of *prison* or *mental*, the beneficiary is incarcerated and the services rendered to the beneficiary may be ineligible for Medicare reimbursement. In the current daily data exchange with HCFA, SSA provides the LAF code, but not the RFST. The LAF code of *S7* alone is not sufficient to identify incarcerated beneficiaries because this code also identifies two other conditions which do not affect Medicare coverage.[1] With the additional RFST data element, HCFA would have the information necessary to identify incarcerated beneficiaries.

The SSA officials provided us with a file which identified Social Security beneficiaries entitled to Medicare, who, according to SSA records, were incarcerated. This data shows that as of July 19, 2000, there were 38,600 Medicare beneficiaries who were incarcerated.

Because the necessary exchange of prisoner data is not transpiring, Medicare overpayments have occurred for services rendered to incarcerated beneficiaries that should have been paid by other entities. For example, a Florida regional medical center billed Medicaid and Medicare over $100,000 for medical services provided to prisoners held in a county prison that should have been paid by a private company under contract with the county. The HCFA

[1] The LAF code *S7* is also used by SSA to identify disabled beneficiaries who refused vocational rehabilitation and disabled beneficiaries who are working but still entitled to Medicare under section 226(b) of the Social Security Act.

and State agency officials first became aware of this condition as a result of an area newspaper's investigative report. Once the overpayment was detected, the medical center agreed to refund the money.[2] This situation indicates that neither HCFA nor the contractor had sufficient information to prevent the overpayment. Until this information is made available to contractors, the Medicare program remains at risk of similar occurrences.

The HCFA should design and implement systems controls in the EDB and CWF to prevent improper payments for incarcerated beneficiaries.

Although systems controls exist within the EDB and CWF to prevent erroneous payments for numerous reasons, none exist to prevent erroneous payment for services for incarcerated beneficiaries. We contacted four Medicare contractors to determine if they had systems controls to prevent improper payments made on behalf of incarcerated beneficiaries. Officials from one contractor indicated that they have systems controls, but no routine means of identifying incarcerated beneficiaries so the controls may be implemented properly. Officials from another contractor stated they have not implemented these types of systems controls, but such controls were possible if the data were available. They further advised us, however, that the lack of a central data source on incarcerated beneficiaries precludes any systems controls that they implement from being effective. Officials at the remaining two contractors stated they have not implemented systems controls to detect the improper payments for incarcerated beneficiaries.

Our analysis of Medicare fee-for-service claims identified to date for CYs 1997 through 1999 shows that the number of potentially improper claims is increasing. Consequently, we believe HCFA's existing systems controls are inadequate to prevent the improper disbursement of Medicare funds for services provided to incarcerated beneficiaries. Furthermore, the lack of such payment edits indicates that HCFA's payments are not in compliance with the provisions of sections 1862(a)(2) and (3) of the Social Security Act and 42 CFR 411.4(b)(1) and (2).

The HCFA needs to obtain the necessary data from SSA before this recommendation can be implemented. Once this information is obtained, such action would help HCFA meet its program integrity goal of reducing improper payments.

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[2] As a result of this disclosure, the contractor: (1) issued an educational letter to providers explaining the Medicare criteria for billing Medicare for services provided to incarcerated beneficiaries, (2) included in its coordination of benefits hospital audits an audit step to identify all contracts for medical services provided to incarcerated beneficiaries, and (3) advised the HCFA regional office of this condition. In response to the contractor's notification, HCFA issued a memorandum on September 21, 1999 to all Region IV carriers and intermediaries advising them of this condition and reiterating Medicare's payment policy.

We are continuing our work to quantify the amount of improper Medicare payments that have been made on behalf of incarcerated beneficiaries.

RECOMMENDATIONS

As a remedy to prevent future improper payments, we recommend that HCFA:

- take appropriate steps to obtain the RFST data element as part of its daily data exchange with SSA to identify incarcerated beneficiaries; and

- design and implement systems controls in the EDB and CWF to alert contractors when a Medicare claim is submitted for an incarcerated beneficiary.

We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained.

HCFA COMMENTS AND OIG RESPONSE

As general comments in their written response to our draft report, HCFA officials shared our concerns that improper payments may be occurring and agreed with the intent of our recommendations. They hesitated, however, to fully commit to implementing systems controls to alert their contractors of imprisoned beneficiaries at this time. They stated further study is necessary to determine the most appropriate source of incarcerated beneficiary data for their use.

The HCFA officials also indicated that they must consider the contractor resources needed to manually review a claim for an incarcerated beneficiary because State and local laws need to be analyzed. According to HCFA officials, after the issue has been studied further, another 12 to 18 months would be needed to plan and execute a data exchange and to implement systems controls.

Below are the specific responses HCFA made to our recommendations and our resultant comments. Included as an Appendix are HCFA's comments in their entirety.

OIG Recommendation

The HCFA should take appropriate steps to obtain the RFST data element as part of its daily data exchange with SSA to identify incarcerated beneficiaries.

HCFA Comments

Officials from HCFA believe that further investigation of the SSA data is needed before HCFA takes any action to obtain information from SSA to identify incarcerated beneficiaries. They contend that the MBR data from SSA has inherent limitations such as omission of the name of the facility, location, date of incarceration, and date of release. They pointed out that the current data does not include incarceration data for Medicare-only beneficiaries. They also stated that they are working diligently to determine the most appropriate source of incarcerated beneficiary data for Medicare's use.

OIG Response

Although we agree that further discussions with SSA are desirable to determine the best source of complete data, we are concerned that HCFA did not indicate a target date when such a study would be completed. In addition, we believe that sufficient information is already available to identify a significant portion of incarcerated Medicare beneficiaries. By obtaining one additional field already on SSA's MBR, HCFA could identify for further development incarcerated beneficiaries who are eligible for both Medicare and Social Security. By using the existing MBR field, we acknowledge incarceration data will not be available for Medicare-only beneficiaries. We continue, however, to recommend that HCFA obtain readily available information for this large portion of incarcerated beneficiaries while further discussions with SSA are underway.

We disagree that the MBR does not contain the date of incarceration because the Date of Suspension or Termination field on the MBR in conjunction with the LAF and RSFT codes provides this information. We acknowledge that the prison facility information is not currently available from the MBR. The SSA does, however, have this information in a separate database. Consequently, HCFA officials should request this information in their future discussions with SSA.

OIG Recommendation

The HCFA should design and implement systems controls in the EDB and CWF to alert contractors when a Medicare claim is submitted for an incarcerated beneficiary.

HCFA Comments

Officials from HCFA indicated that, assuming the SSA data is valid, the exchange in data and the recommended system improvements will require an estimated 12 to 18 months to execute. In addition, they point out that contractor staff will need to conduct potentially time-consuming manual reviews of claims and analyze the applicability of State and local laws to accurately determine Medicare's liability.

OIG Response

We realize that the system improvements will take time. Any delays in this implementation, however, could result in significant payments for incarcerated beneficiaries from the Medicare trust funds.

We acknowledge that contractor development of claims will be necessary and potentially time-consuming. It is, however, required according to existing regulations and HCFA contractor manuals. We also note that the burden of proof rests with the prison authority, not Medicare. In addition, once files are established and procedures are streamlined, less manual effort will be required because of increased awareness of prisons and providers, resulting in increased compliance.

OIG Recommendation

The HCFA should periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained.

HCFA Comments

The HCFA officials stated that prior to implementing our recommendation, they would need to investigate the issues to determine the applicability of post-payment recovery efforts. They pointed out that HCFA's business relationship is with the provider of the service and/or the beneficiary. Consequently, any post-payment recovery action taken (after contractor development of each case) would be against the provider or beneficiary, not the penal institution. In addition, the provider or beneficiary would have appeal rights if a claim were denied.

OIG Response

We agree that any post-payment recoveries should be principally directed at the applicable providers. We also recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, however, Medicare will continue to make payments for incarcerated beneficiaries. As a result, we continue to recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained.

In a technical comment, HCFA officials also asked for an explanation of why Medicare payments for incarcerated beneficiaries doubled between 1997 to 1999. Our future work in this area may answer this question. We note that recent statistics indicate the prison

population is steadily growing. We believe this increase in payments adds support to our position that immediate actions needs to be taken, rather than waiting for more discussions with SSA.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: APR - 2 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries* (A-04-00-05568)

Thank you for the opportunity to review and comment on the above-referenced draft report, which presents the results of OIG's review of Medicare payments for services provided to incarcerated beneficiaries. OIG believes that the Medicare program is vulnerable to improper payments for services rendered to these beneficiaries. To date, OIG has identified $32 million in Medicare fee-for-service payments by contractors to providers on behalf of 7,438 incarcerated beneficiaries during calendar years 1997 through 1999. However, OIG has not yet determined how much of this $32 million was paid incorrectly, and HCFA's actual liability is unknown at this time.

To prevent future improper payments, OIG recommended that HCFA take procedural and systematic measures to formalize its efforts to obtain additional data from the Social Security Administration (SSA) in the daily transmission of enrollment data, which identify incarcerated beneficiaries, and design and implement systems controls in the Enrollment Data Base (EDB) and Common Working File (CWF) to alert contractors when a Medicare claim is submitted for services to an incarcerated beneficiary. While we agree with the intent of OIG's recommendations, further research is needed to determine HCFA's vulnerability in the area of incarcerated beneficiaries. Since these determinations must be made on a claim-by-claim basis, we suggest selecting and analyzing a random sample of the claims in OIG's database to determine how much of the $32 million payment was actually paid incorrectly. Once the extent of the problem is determined, a strategy can be established to correct significant problems either on a prepayment or a postpayment basis.

We have carefully reviewed the subject report and share OIG's concern that improper payments may be occurring. HCFA believes that this is an important area for examination and appreciates the effort that went into this report. HCFA looks forward to working with OIG on this issue. Our detailed comments on the OIG recommendations follow.

OIG Recommendation

OIG recommends that HCFA take appropriate steps to obtain the reason for suspension or termination data element as part of its daily data exchange with SSA to identify incarcerated beneficiaries.

HCFA Response
Further investigation of the data available from SSA is needed. Since reviewing the draft report, HCFA has become aware of some inherent limitations in the SSA data. For example, the SSA Master Beneficiary Record fields used in the OIG study identify those beneficiaries who receive Social Security cash benefits and are reported as incarcerated, but do not provide the facility name or location, nor do they contain the date of incarceration or the date of release.

Hence, the data may omit individuals who have been released. This data source needs to be evaluated in light of new information obtained on other available data. HCFA and OIG staffs recently met with SSA staff and became aware of another data source, which contains prisoner data, including the date of incarceration and information about the facility. However, SSA staff indicated that those in Federal facilities and the uninsured (i.e., Medicare-only beneficiaries) would not be included in a data exchange with HCFA. We are working diligently to determine the most appropriate source of incarcerated beneficiary data for Medicare's use.

OIG Recommendation
OIG recommends that HCFA design and implement systems controls in the EDB and CWF to alert contractors when a Medicare claim is submitted for an incarcerated beneficiary.

HCFA Response
Assuming further research indicates that use of the SSA files/data is valid, exchange of data will take some time to plan and execute. For example, we (or SSA in some instances) would need to:

- Restructure HCFA's EDB to add a new data element to indicate a beneficiary's incarcerated status;
- Make systems changes in SSA's files to accommodate HCFA's needs;
- Change HCFA's CWF to house incarcerated beneficiary data;
- Change HCFA's claims processing systems to accept CWF data;
- Develop and execute all necessary data use and computer matching agreements; and
- Develop a memorandum of understanding with the Department of Justice to receive data on Federal prisoners, if warranted.

We estimate that implementing these changes would require 12-18 months.

Equally as important, the following issues also need to be considered:

- Manual Review of Claims. It is important to note that the data alone would not provide the information needed to make an accurate determination on an individual claim. An accurate determination will require manual review of the claim by contractor staff. Since resources are limited, the Agency must consider this activity in light of its other prepayment review demands.

- Applicability of State Laws. In addition to manual claims review, state and local (e.g., county, city, or other municipal level) laws regarding the billing of health services for incarcerated inmates need to be analyzed to determine the extent to which beneficiaries are held liable for these services.

- Managed Care Claims. We need to better understand how the law affects our beneficiaries in managed care arrangements.

Though not a formal recommendation, OIG recommends that HCFA periodically obtain a file on incarcerated beneficiaries for postpayment reviews from SSA similar to the file OIG obtained. Because HCFA's business relationship is with the provider of service and/or the beneficiary, any postpayment recovery would be against the provider or beneficiary, not the penal institution. This recovery could happen only after the case development described above, namely, contact with the penal authority, both to confirm that the beneficiary was in fact under its jurisdiction at the time of the Medicare service and to determine the policy regarding payment for medical services. If a denial of the claim resulted from this research, the provider or beneficiary would have appeal rights. Accordingly, HCFA will need to investigate the totality of the issues to determine the applicability of postpay recovery efforts to this workload.

Again, we appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises.

Attachment

Technical Comment

Page 5, Graphic—We suggest that the report include an explanation of why the Medicare payments for incarcerated beneficiaries doubled from $7.5 million in 1997 to $14 million in 1999.

PREPARED STATEMENT OF MICHAEL MCMULLAN

Senator Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me here today to discuss the Health Care Financing Administration's (HCFA) efforts to ensure that Medicare does not make improper payments for services provided to incarcerated beneficiaries. I would also like to thank the Office of Inspector General (OIG) for their valuable assistance in helping us to identify improper payments and ensure the integrity of the Medicare Trust Fund.

We have made substantial progress over the last several years in reducing errors and eliminating fraud from the Medicare program through a variety of methods. As reported by the OIG in their recent Chief Financial Officer's Audit, we have reduced Medicare's fee-for-service payment error rate by half, from 14 percent in fiscal year 1996 to 6.8 percent, meeting our 2000 Government Performance Review Act goal. Moreover, for the second year in a row, we received a clean opinion from the OIG. We also independently identify improper payments or irregularities, through our own detection efforts, and, when appropriate, refer these anomalies to the OIG and law enforcement for further investigation. In addition, we have taken steps to address and eliminate improper payments identified through reviews by the OIG and others, such as those highlighted by the OIG in their recent report, *"Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries"* that I will discuss today. These reviews serve as important roadmaps in directing us to needed improvements in many different areas of our programs.

We acknowledge, that despite these collective efforts, improper payments still occur and that there is room for improvement. I assure you we remain committed to taking appropriate action to address these areas of concern and ensure that we continue to meet our fiduciary responsibilities of protecting the Medicare trust funds from errors and fraud.

BACKGROUND

Medicare pays for the health care of nearly 40 million beneficiaries, involving the processing of nearly one billion claims from more than one million physicians, hospitals, and other health care providers. As the administrator of the Medicare program, we must strive to ensure that Medicare pays only for the services allowed by law and that we remain accountable for more than $210 billion in Medicare payments we make each year.

In their report, the OIG identified $32 million in Medicare fee-for-service payments, by our claims processing contractors, to providers on behalf of 7,438 incarcerated beneficiaries from 1997 through 1999. The OIG has not yet determined how much of this $32 million was improperly paid, so our actual liability for these monies is not known. Although these payments, if improper, represent only a small fraction of the total Medicare dollars paid out each year, they are nonetheless significant. Make no mistake. We take these irregularities seriously, have carefully reviewed the OIG's findings, and we are taking steps to correct these weaknesses.

Under the law, Medicare has no obligations to pay for health care services provided to incarcerated beneficiaries in Federal facilities. Medicare pays for health care services for beneficiaries incarcerated in State or local facilities under special conditions. First, the State or local law must require all individuals (Medicare and non-Medicare) to repay the cost of medical services they receive while they are incarcerated. Second, the State or local government must enforce the requirement to pay by billing individuals. We have instructed our contractors to presume that a claim form, or on behalf of, a prisoner in a State or local facility falls under this general exclusion and should be denied. It is the responsibility of the provider or the beneficiary to demonstrate that the State met the conditions and the claim should be paid. It is also important to note that Medicare is required under the statute to pay for health care services provided to incarcerated beneficiaries in Federally Qualified Health Centers.

Historically, HCFA has relied on the Social Security Administration (SSA) as the primary source of data and information on all Medicare beneficiaries. SSA provides us with information through a database called the Master Beneficiary Record (MBR). We exchange data with the MBR database on a daily basis and use the MBR's data to update our own Enrollment Database (EDB). We then use the EDB data to update our Common Working File (CWF). The CWF contains information about all Medicare beneficiaries and our claims processing contractors use the CWF to verify beneficiaries' entitlement to Medicare, among other things.

The MBR database, which the OIG used in their report, is maintained and updated daily by SSA and contains essential information for administering the Medicare program and for determining a beneficiary's enrollment in Medicare. It includes information such as the date or period of a particular beneficiary's entitlement to

Medicare, why a beneficiary is entitled to Medicare, as well as changes of address. The database also includes information indicating whether an individual's monthly Social Security cash benefits are suspended because of incarceration.

The MBR database does not, however, contain information critical for determining whether Medicare payment for health care services provided to incarcerated beneficiaries is appropriate, such as the specific data an individual became incarcerated or was released from prison. Without the precise days of incarceration, Medicare may wrongly deny payment to a physician, hospital, ESRD facility, or other provided when a beneficiary is still entitle4d to Medicare services. Moreover, the data may incorrectly list individuals as incarcerated, who have been released from prison and, as a consequence, Medicare may wrongly deny payment for services provided to beneficiaries who are, in fact, legally entitled.

ENSURING PROPER PAYMENTS

The OIG has identified several weaknesses in our processes for identifying incarcerated beneficiaries. They recommend that we take several procedural and systematic measures to obtain additional data from SSA in our daily transmissions of enrollment information. Although we are aware of the inherent limitations with the MBR data, we are working on solutions to this problem.

The OIG specifically recommends, as part of our daily data exchange with SSA, that we modify our existing data systems to accept the existing MBR data indicating whether a beneficiary is incarcerated. As an interim step, we are following the OIG's recommendation and creating an additional data field indicator in the EDB sot hat it can accept the current MBR data that indicate the beneficiary is incarcerated. We expect to have this and other necessary systems changes in place by March 2002 to access other data sources that may contain more comprehensive information, including more reliable information about the dates of incarceration. This is a critical element for determining whether Medicare payments is appropriate.

The OIG also recommends that we design and implement systems controls in our EDB and CWF, so that our contractors know when an improper claim is submitted for an incarcerated beneficiary and can reject the claim. We support the underlying concept of identifying claims submitted for incarcerated beneficiaries once a data source that meets our needs is obtained, and we are optimistic that this additional data source will allow us to determine whether payment is appropriate. However, this data is held in a database separate from the MBR and we will have to make complex changes to our systems and those of our contractors in order to use this data on a "pre-payment" basis. For example, we must work closely with SSA to plan the exchange between the new database and the EDB, establish the actual data exchange with SSA, as well as restructure our EDB, the CWF, and our contractor systems so that they can accept the new data. We anticipate that these changes will take 12–18 months to accomplish.

In addition to retooling our automated applications, there are a variety of legal and administrative tasks associated with the collection of the additional data. For example, interagency agreements, data use agreements, computer matching agreements, and memoranda of agreement between our Agency, SSA, and each of our contractors, must be established and are integral parts of collaborative administration of this, or any other, cross-entity data initiative.

It is important to note that the introduction of this additional data still may not be sufficient for determining, based on the data alone, whether Medicare should pay an individual claim. As a consequence, manual claims review by our contractors may be necessary. For example, if we do not have dates of incarceration, our contractors would have to manually review claims to accurately determine whether a claim for a certain service on a certain day is valid and should be paid. This is a time-intensive and costly way to decide whether a claim should be paid. Nevertheless, we are moving forward and will continue to thoroughly examine how we can obtain information on incarcerated beneficiaries and provide this information to our contractors so that we can minimize the possibility of improper payments in the future.

CONCLUSION

We appreciate the opportunity to share our response to the recommendations of the OIG regarding improper Medicare payments for services provided to incarcerated beneficiaries and we are moving forward to implement the changes they have recommended. We share your concern regarding this issue and the need to ensure that the Medicare Trust Fund is protected against errors and fraud. We have made substantial progress over the past several years in this regard. We appreciate the assistance of the OIG in helping us to target our efforts through their careful audits

and reviews. As requested by the Committee, my testimony only touches on the work of the OIG regarding improper payments related to incarcerated beneficiaries. However, as you are aware, the OIG has done similar work in other areas of the Medicare and Medicaid programs, and I am happy to answer the Committee's questions regarding all of these reviews.

PREPARED STATEMENT OF FRITZ STRECKEWALD

Mr. Chairman and Members of the Committee:

Thank you for asking me to appear before you today to discuss the findings of audits that have been conducted by the Social Security Administration's (SSA) Office of the Inspector General (IG). Today, I want to briefly discuss the efforts the agency is undertaking to strengthen and maintain the integrity of the Old Age, Survivors and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs in the areas addressed by these audits. But first I would like to describe the scope and magnitude of our Agency's activities as administrator of the Social Security program.

Importance of Social Security and SSI

SSA paid almost $430 billion to 52 million OASDI and SSI beneficiaries last year. Each workday about 100,000 people visit our 1,300 field offices and over 240,000 people call our 800 number telephone service. Each workday we process an average of 20,000 initial claims. Every year we correctly credit over 250 million earnings items to workers' accounts, respond to 60 million telephone calls, and process about 6.6 million Social Security and SSI claims for benefits.

The public's trust in Social Security programs is absolutely critical. Because of the importance of program integrity, $1 out of every $4 in SSA's administrative budget is dedicated to program stewardship and program integrity. We must remain vigilant if we are to fulfill our role as stewards of the public trust.

Fugitive Felons

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 made it illegal for fugitive felons to collect SSI payments. This prohibition does not apply to the OASDI program. Under this law an individual is ineligible to receive SSI benefits during any month in which the individual is:

- fleeing to avoid prosecution for a crime which is a felony under the laws of the place from which the person flees;
- fleeing to avoid custody or confinement after conviction for a crime which is a felony under the laws of the place from which the person flees; or
- violating a condition of probation or parole imposed under Federal or State law.

SSA protects the integrity of the SSI program by stopping payments to fugitive felons and protects the public by providing information to law enforcement that assists in the apprehension of a fugitive fleeing from justice.

This Fugitive Felon Project utilizes a multi-faceted approach that requires extensive and cooperative efforts of many law enforcement agencies throughout the United States. SSA and our Office of the Inspector General are actively involved in this project by identifying and taking action against fugitive felons collecting SSI payments.

This project identifies individuals who are prohibited under the law from receiving SSI benefits by conducting computer matches with available sources of warrant information, which include the Federal Bureau of Investigation's (FBI) National Crime Information Center (NCIC) and the states. The NCIC is a major national repository for information on felons and other offenders. We also have signed agreements with U.S. Marshals Service and the FBI, giving us access to all Federal warrants.

Unfortunately only about 30 percent of all outstanding warrants are reported to the NCIC since the reporting of such information is voluntary and selective. Eleven states report all of their warrants to the NCIC. These states are Connecticut, Maine, New Hampshire, Alabama, Florida, Georgia, North Carolina, Arkansas, New Mexico, Kansas, and Missouri. The remaining 39 states report some, but not all warrant information to the NCIC.

In a joint effort to develop comprehensive sources of warrant information, SSA and the IG are actively pursuing matching agreements with those states that only provide some of their warrants to the NCIC. SSA currently has signed matching agreements with Alaska, California, Colorado, Kentucky, Nebraska, Massachusetts, New Jersey, New York, Rhode Island, South Carolina, Tennessee, and Washington to obtain the additional warrant information that is not reported to the NCIC. In

addition, we have agreements with three major metropolitan police departments, New York City, Baltimore and Philadelphia.

Negotiating these individual State and local agreements is a major undertaking. We need to address State and local variations in records, incompatible formatting of data, privacy concerns, and the lack of state and local central reporting repositories. Our regional fugitive coordinators and field office staff are working to negotiate matching agreements with all state and local authorities. Every effort is being made to automate the matching operations necessary to identify SSI recipients that have outstanding warrants.

One of the difficulties with such matches is that law enforcement agencies frequently do not have accurate identifying information for fleeing felons. Felons often use aliases and the law enforcement agency may not have an accurate Social Security Number (SSN). Therefore, their correct identification may be difficult. Unlike prisoners, fugitive felons are not incarcerated and may not have been convicted of a crime. For these reasons our matching operations are carefully designed to determine that the person being sought by law enforcement is the same individual receiving SSI. In order to protect individuals from unwarranted invasions of their privacy resulting from collections and use of information about them, all of our data matches and exchanges are done pursuant to agreements that comply with Privacy Act requirements, and we take security measures to limit access to the data.

When we obtain warrant information from the NCIC or from any other source, these records are first matched against SSA's files to verify identity information, such as name, date of birth, and Social Security number. Once the records are verified then a second match is conducted against our SSI recipient files to determine which of the fugitives are receiving SSI benefits. The results of the second match are then forwarded to the IG for processing. The two-step matching process performed by SSA takes four to ten days, from the time the warrant information is obtained from a participating Federal, state or local agency until the information is forwarded to the IG.

The IG must conduct thorough investigations of the warrant information matches to ensure that the fugitive felon warrants are valid and that the appropriate individuals are brought to justice. The IG works with the FBI Information Technology Center (ITC) to verify that the felony, probation or parole violation warrant is active. The ITC provides the address information about each SSI recipient to the appropriate law enforcement agency so that they can apprehend the individual. Over 22,000 SSI beneficiaries were identified during FY 1998–2000. Over 2,800 of these fugitives were apprehended.

After action by the appropriate law enforcement agency the IG refers their findings to SSA for appropriate action. SSA also provides feedback to the IG reflecting the actions taken and any overpayment that may have occurred.

Even though SSA is working to expand the number of matches through agreements with local authorities, much of the investigative process cannot be automated. Verification of warrant information requires direct contact with the local law enforcement personnel who issued the warrant. If the felon is no longer in the jurisdiction of the originating law enforcement agency, then additional contacts must be made with law enforcement personnel in the new jurisdiction in order to facilitate the fugitive's apprehension.

SSA needs to be very careful when reviewing warrants to make sure they are accurate, up-to-date, and that it pertains to the correct person. To arrest or to suspend benefits of the wrong individual would have severe consequences.

SSA has gained experience identifying and suspending benefits as a result of our enforcement of prisoner suspension provisions, and we would like to discuss the experience briefly.

Prisoner Suspensions

Social Security benefits are not payable to certain persons incarcerated as a result of a conviction of a crime and certain other confined individuals (for example, those found not guilty by reason of insanity). SSI benefits are not payable to anyone confined to a public institution for any reason.

Beginning in 1994, SSA undertook several significant initiatives with State and local entities to identify prisoners who should not be receiving OASDI or SSI benefits. Changes in agency enforcement efforts have increased program savings under the prisoner suspension provisions.

Today, SSA maintains over 2,600 incentive payment agreements, which provide monthly reports from approximately 5,500 facilities. An additional 1,200 facilities report to us monthly under agreements that do not provide for incentive payments. These agreements, like those for the fugitive felon program, incorporate strong privacy protections. This represents 95 percent of correctional facilities, including the

Federal Bureau of Prisons, all State prison systems, and most county and local jails. These reports cover 99 percent of the inmate population in the United States. With the support of these Federal, State, and local entities, SSA has made substantial progress in ensuring that incarcerations are timely and accurately reported and that benefits are suspended promptly. We continue to pursue the goal of having 100 percent of the prisoner data reported and continue to negotiate with the remaining correctional facilities.

SSA is able to share prisoner information with other agencies administering Federal or federally assisted cash, food, or medical assistance programs for purposes of determining eligibility. For example, SSA shares prisoner data with the Department of Veterans Affairs, the Department of Education, the District of Columbia and the fifty state agencies administering the food stamp program under the Department of Agriculture.

Deceased Beneficiaries

One of the issues in the IG report concerns payments made to deceased beneficiaries. SSA compiles and maintains a comprehensive database, the death master file (DMF), containing death information that includes reports from family members, funeral homes, all of the States and some territories, the Department of Veterans Affairs, the Health Care Financing Administration, the postal authority, banking institutions, and other sources. SSA independently verifies reports from other government agencies before terminating benefits. SSA processes over 2 million death reports annually.

Timely reports of death help prevent overpayments, which may occur because a spouse or a representative payee negotiates a check after the individual has died or the benefit was electronically deposited into a joint or payee account.

An intercomponent workgroup has identified ways the Agency could improve its death reporting operation. These improvements will be implemented through system enhancements and when completed will strengthen the processes we use to terminate deceased beneficiaries.

Within the next two months we will pilot an Electronic Death Registration under an agreement with the State of New Jersey.

Workers' Compensation Offset

OIG reports have raised concerns about the administration of the workers' compensation (WC) provision. Since 1965, the Social Security Act has provided for the reduction of Social Security disability insurance benefits when the worker is also eligible for periodic or lump-sum WC payments from Federal, State, or local government programs. During the application process, SSA asks the worker whether he or she is or will be receiving any workers' compensation payments that would require offset. If appropriate, offset is imposed and the worker is advised to report any changes to these payments.

Many different agencies administer WC payments and the records are often decentralized and are not always automated. In some States, the payments are administered at the State level; in other States, the payments could be made by many different private insurance carriers, or the employer could be self-insured. Because of the fragmented structure of WC programs, SSA relies primarily on beneficiaries to voluntarily report changes in WC status and payments. Payment errors occur when the beneficiary does not inform SSA of changes in the WC payments. To address this problem SSA has instituted a number of measures.

- In 1999, SSA began its review of WC cases in which offset was imposed before 1999—approximately 112,000 cases—as a 3-year project. Presently, the project is on target, and one-half of the cases have been reviewed and reworked. These cases are difficult to work and typically take about 10 hours to process. To ensure accuracy, each case receives a second review. Over FY 2000–FY2001, SSA is expending approximately 285 workyears on this project, representing a significant resource commitment. We plan to conclude the project by September 2002.
- We have developed a computer matching agreement with the State of Texas. Texas sent SSA 699,000 records involving WC payment data from 1991–2000 and we are currently validating this data before matching it with our beneficiary rolls. Implementation is scheduled for summer of 2001. Although few states have centralized records, we intend to use this agreement with Texas to help us in developing matching agreements with other States where records exist. In addition, we have an ongoing computer matching program with the Department of Labor (DOL) to identify disability beneficiaries who are receiving Federal WC payments administered by DOL.

- Beginning next month, we will implement a new procedure that requires processing centers to re-verify WC payments every 3 years. This is a significant improvement because it will enable us to periodically update with the beneficiary the WC information that is on our records.
- SSA has committed and continues to commit significant resources to improve the accuracy and timeliness of our processing of claims involving WC offset. Beginning this fall, improved automation will allow SSA field offices to be able to input post-entitlement WC changes. We have also provided and continue to provide specialized training to the employees of the program centers and field offices.

We recognize the importance of the IG findings regarding WC offset, and believe that SSA has demonstrated that we are working hard to improve our administration of the WC offset procedures. Through these actions, SSA is taking the necessary steps to correct the problems identified by the IG.

Student Monitoring

The final issue we wish to discuss is the process used to monitor school attendance by child beneficiaries who are over 18. As a result of SSA's own review and the IG recommendations, in March 2001 we began to implement a new process for monitoring school attendance.

We have established processes to:

- Obtain documentation from the student and certification from a school official of the students' continuing education plans *before* awarding benefits. Also, at that same time, the school official is being provided a form to be retained in the student's file. The school official is encouraged to notify SSA of any changes in the students' status (e.g., no longer a full-time student, drops out, marries).
- Contact the student directly (by phone or in person) when the certification of attendance from the school is initially returned to the field office (FO). At that time we explain to the student his/her reporting responsibilities and when entitlement to student benefits will end. The FO determines the correct termination date and inputs that information into our computer records; benefits for the student will end with the termination date unless they are previously terminated—e.g., because the student drops out of school.

Under the old process, we verified school attendance with the school at several points during the school year—which was very labor intensive and did not result in significant improvements in payment accuracy. Under the new process, we will obtain verification of the student's statement of attendance from the school before we pay benefits and encourage the school to report any changes in the student's status. In the personal contact with the student, we stress their responsibility to report to us any changes in their school attendance.

Conclusion

SSA is making continued progress to improve our management of all Social Security programs. We are committed to our role as stewards of the trust funds. We value our partnership with the IG to further these efforts and look forward to working with this Committee to assure public confidence in our programs.

I will be happy to answer any questions that you may have.