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OVERSIGHT OF CONTRACT MANAGEMENT AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

HEARING

BEFORE THE

AD HOC SUBCOMMITTEE ON CONTRACTING OVERSIGHT

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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OVERSIGHT OF CONTRACT MANAGEMENT AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

WEDNESDAY, APRIL 28, 2010

U.S. SENATE,
AD HOC SUBCOMMITTEE ON CONTRACTING OVERSIGHT,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:34 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Claire McCaskill, Chairman of the Subcommittee, presiding.

Present: Senators McCaskill, Pryor, and Brown.

OPENING STATEMENT OF SENATOR MCCASKILL

Senator MCCASKILL. I am going to begin without Senator Brown, but I am sure he will be here momentarily and we will go ahead and get started since it is past the witching hour for this hearing to begin. So this hearing will now, in fact, come to order.

This is a hearing on contract management at the Centers for Medicare and Medicaid. Just over a year ago, this Subcommittee began its oversight of government contracts. Over the last year, the Subcommittee has held more than 10 hearings on issues ranging from private security contractors to contract databases, covering areas from Afghanistan to Alaska. These hearings share a common focus: Making government contracting more efficient, more transparent, and more accountable.

Today's hearing examines one of our government's most important agencies, the Centers for Medicare and Medicaid Services (CMS), which is within the Department of Health and Human Services. CMS is responsible for administering Medicare, Medicaid, and the Children's Health Insurance Program, which provides health care coverage for almost 100 million Americans.

Over the last year, Medicare and Medicaid have gotten a great deal of attention as we in Congress have worked to pass comprehensive health care and health care insurance reform legislation. This is not a hearing about that legislation. I was pleased that the health insurance reform was signed into law. We needed reform to ensure that the health care didn't bankrupt average Americans and we also needed it to reduce our country's deficit.

But that is not what we are here to talk about today. This hearing is about how CMS manages the Medicare and Medicaid programs, and most importantly, the contracting in those programs.

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We are here in the Subcommittee because, in fact, those programs are largely administered by contractors.

Medicare contractors pay providers, enroll physicians, process appeals. They also answer questions from the public. The 1–800–MEDICARE hotline, that is brought to you by a contractor who made $258 million last year for that contract. It is contractors who provided day-to-day administration of the Medicare and Medicaid and Children's Health Insurance Programs.

Welcome, Senator Brown.

Senator BROWN. Sorry I am late.

Senator MCCASKILL. That is OK.

It is also contractors who provide oversight of Medicare and Medicaid to the tune of almost $855 million in contracts last year alone. In total, CMS spent nearly $4 billion in contracts in 2009.

The importance of the tasks performed by CMS contractors highlight the need for these contracts to be properly managed and overseen by CMS officials. According to GAO, however, that kind of oversight is exactly what CMS isn't currently doing. Last October, GAO reported significant deficiencies with contract management and internal controls at CMS. This report follows a 2007 report with almost the same findings, and report after report documenting problems with CMS's financial management. In fact, Medicare has been on the GAO's high-risk list for 20 years, in part because of its management problems, including management of contractors.

Despite all the reports documenting mismanagement, nothing seems to improve. Today, we want to ask what is necessary to ensure that CMS makes the necessary improvements to make sure that it is the best possible custodian of taxpayers' dollars as we move forward.

In preparation for this hearing, my staff examined in detail one CMS program administered by the Medicare Secondary Payer Recovery Contractor (MSPRC). Without objection, I would now ask that the Majority Staff Fact Sheet about MSPRC be admitted into the record.[1]

Senator BROWN. No objection.

Senator MCCASKILL. The MSPRC is supposed to recover money for the Medicare program in cases where Medicare isn't a primary payer for a beneficiary's medical expense. One example is when a Medicare beneficiary is covered by their employer's health plan or if they have expenses that should be covered by Workers' Compensation or liability insurance.

Last year, a group of lawyers in Kansas City contacted my office to bring to my attention how frustrated they were with CMS because they were trying to pay them. They were trying to send CMS money and no one was home to take the money. Imagine the irony of those phone calls in the context of the debates that were ongoing at that time. Here we were, discussing every day the incredible deficits that our country is facing because of the Medicare program, struggling with very controversial and difficult and complex decisions as to how we should reform the system, and I have lawyers calling me saying, we are trying to send them a check and no one will take it. That is when I realized we needed to do a hearing on

[1] The Majority Staff Fact Sheet appears in the Appendix on page 64.

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contract oversight at CMS. They had been trying to return money to Medicare and the agency would not take it.

The MSPRC had significant performance problems. In 2001, independent auditors found that the contractor, a tribally-owned business called Chickasaw Nation Industries, failed to respond to communications from beneficiaries, attorneys, and insurance companies. CMS also found problems with the contractor's internal controls and case management. Reportedly, the MSPRC has now significantly improved its performance.

In 2003, CMS recovered only 38 cents for every dollar spent on recovery. Today, the contractor reports that it is recovering $8.97 for every dollar spent on recovery. One of the things we are going to try to do today in this hearing is determine whether or not that figure is accurate, according to CMS.

The improvements on this contract would be encouraging, but the overall picture painted by GAO should be a wake-up call for CMS on the need to take swift action. I hope CMS will listen carefully to what GAO and the Members of the Subcommittee have to say about how to improve their management and oversight of contracts.

I am encouraged that we now have a nominee in Dr. Donald Berwick to be Administrator of CMS and I hope that my Senate colleagues will recognize that leadership is needed here and at other Federal agencies. We need to begin to work together to put the President's nominees in place so that government can work at its very best for the taxpayers of this country. If there are any measures that can be taken to improve their stewardship of taxpayer dollars, this Subcommittee will work with CMS to achieve those goals.

I look forward to hearing the witnesses' testimony and hope that this hearing represents a step forward in ensuring that the costs of health care are kept under control by solid, aggressive contract management at CMS.

Senator Brown.

OPENING STATEMENT OF SENATOR BROWN

Senator BROWN. Thank you, Madam Chairman. I appreciate it. I try to be punctual. I lost track of time. I apologize.

Senator MCCASKILL. That is OK.

Senator BROWN. As you know, this is my second meeting as Ranking Member of this Subcommittee, and again, it is an honor to join with you, Madam Chairman, in exploring the important issues of this Subcommittee and I look forward to trying to tackle these tough issues.

I just want to submit my opening statement and make it part of the record and then I just want to ad lib a little bit, if that is all right.[1]

The bottom line is, with all due respect, I am very concerned about where the taxpayer dollars are going and the oversight of those $4 billion and counting of tax-obligated dollars in CMS—the complaints, the lack of oversight, some of the failure to grab monies that are owed the government and the people of the United States

[1] The prepared statement of Senator Brown appears in the Appendix on page 64.

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in a timely manner. I am curious as to whether it is a tools and resources problem, where you need more of something. Is it an IT problem? Is it an oversight problem? Where and how can we streamline this process to make sure that we can save the taxpayers money and get more bang for our dollar? That is my bottom-line concern.

In listening to the Chairman's comments and opening statement, I think she shares very similar concerns about, if someone is trying to pay us, I mean, just show me where the check is. I will hand-deliver it. We will go get it. If they want to give money, we should be sending somebody out for them to get the money and get it in the system and get reimbursed as quickly as possible.

I am going to reserve the opening statement. I certainly appreciate it. It is easier to do it on the record, which I will submit that. But I just want to get down to business and start asking questions. Thank you.

Senator MCCASKILL. Thank you, Senator Brown.

Let me introduce the witnesses today. Kay Daly is the Director of the Financial Management and Assurance team at the U.S. Government Accountability Office (GAO), in my opinion, the premier government auditing agency in the world, where her responsibilities include financial management systems, improper payments, contracting costs analysis, and health care financial management issues. Ms. Daly joined GAO in 1989 and has participated on a number of high-profile and groundbreaking assignments.

Rodney Benson serves as the Director of the Office of Acquisition and Grants Management at the Centers for Medicare and Medicaid Services. In this position, he is responsible for the award and administration of all contracts and discretionary grants for CMS. Mr. Benson has served in this position since October 1997.

It is the custom of this Subcommittee to swear in all witnesses that appear before us, so if you don't mind, I would like you to stand and take the following oath.

Do you swear that the testimony that you will give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. DALY. I do.

Mr. BENSON. I do.

Senator MCCASKILL. Let the record reflect that the witnesses answered in the affirmative. We will be using a timing system today. We would ask that your oral testimony be no more than 5 minutes. We are not strict in this Subcommittee. We would ask that you submit your written testimony for the record in its entirety.

And we will turn to you first, Ms. Daly.

TESTIMONY OF KAY L. DALY,[1] DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DALY. Thank you so much, Madam Chairman and Members of the Subcommittee. I am pleased to be here today to discuss contract management at the Centers for Medicare and Medicaid Services (CMS). CMS administers Medicare and Medicaid, two pro-

[1] The prepared statement of Ms. Daly appears in the Appendix on page 27.

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grams that are included on GAO's high-risk list, and relies extensively on contractors to assist in carrying out its basic mission.

In fiscal year 2008, CMS reported that it had obligated about $3.6 billion under contracts for a variety of goods and services, including contracts to administer, oversee, and audit claims made under the Medicare program, provide information technology systems, and operate the 1–800-MEDICARE help line.

In November 2007, we reported pervasive deficiencies in internal control over certain contracts that were used by CMS. We reported that CMS's internal control deficiencies resulted in millions of dollars of questionable payments to contractors, primarily because CMS did not obtain adequate support for billed costs from certain contractors. Internal control—that is the plans, methods, and procedures used to meet missions—are the first line of defense in safeguarding assets and protecting our taxpayer dollars.

Our follow-up audit was a comprehensive, in-depth review of internal controls over CMS's contract management practices. This review, which culminated in a report in October 2009, again found pervasive deficiencies in internal control over contracting and payments to contractors. The internal control deficiencies occurred throughout the contracting process and increased the risk of improper payments or waste. These deficiencies were due in part to a lack of agency-specific policies and procedures to ensure that the Federal Acquisition Regulation (FAR) and other control objectives were met.

As a result of our work, we estimated that for at least 84 percent of FAR-based contract actions made by CMS in fiscal year 2008 contained at least one instance in which a key control was not adequately implemented. Not only was the number of internal control deficiencies widespread, but also many contract actions had more than one deficiency. We estimated that at least 37 percent of FAR-based contract actions made in fiscal year 2008 had three or more instances in which a key control was not adequately implemented.

For example, based on our statistical sample of the fiscal year 2008 contract actions, we estimated that for at least 59 percent of those contract actions, the project officer did not always certify the invoices. We noted in our 2007 report that CMS had used negative certification. That is a process whereby it pays contractor invoices without knowing whether they were reviewed or approved in order to ensure that the invoices are paid timely. This policy continued throughout 2008. In one case, although a contractor submitted over 100 invoices for fiscal year 2008, only eight were certified by the project officer. The total value of this contract through January 2009 was about $64 million.

The control deficiencies we identified in our statistical sample stemmed from a weak overall control environment. CMS's control environment was characterized by the lack of strategic planning to identify the necessary staffing and funding, reliable data for effectively carrying out contract management responsibilities, and follow-up to track, investigate, and resolve contract audit and evaluation findings for purposes of cost recovery.

GAO has made a total of 19 recommendations to address the shortfalls in contract management we identified in the two audits and the agency has agreed with each of our 19 recommendations,

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but has disagreed with our determination that actions to address about five of those were not sufficient. We believe that the limited actions CMS management had taken to date on those recommendations had fallen short of what our expectations were and did not always address our intent.

In conclusion, the continuing weaknesses in the contract activities and limited progress in addressing the known deficiencies really raises questions on whether they have got the appropriate tone at the top regarding contract management. Until CMS management takes actions to address those additional recommendations and deficiencies that were identified in our report, its contracting activities will continue to pose a significant risk of improper payments, waste, and mismanagement.

So, Madam Chairman and Members of the Subcommittee, this concludes my prepared statement and I would be happy to answer any questions you may have.

Senator MCCASKILL. Thank you, Ms. Daly. Mr. Benson.

TESTIMONY OF RODNEY L. BENSON,[1] DIRECTOR, OFFICE OF ACQUISITION AND GRANTS MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. BENSON. Thank you, Chairman McCaskill and Ranking Member Brown. I am Rodney Benson, the Director of the Office of Acquisition and Grants Management (OAGM), an office within the Centers for Medicare and Medicaid Services. I welcome today's opportunity to speak with the Subcommittee on contract management oversight at CMS.

CMS is committed to the highest degree of integrity in the performance of its many responsibilities, and more specifically in the management and oversight of its contracting activities. We serve the aged, disabled, and poor of our Nation—the most vulnerable of our population.

I am extremely proud of the contracting staff of OAGM and the important work we do in overseeing its many contracts. OAGM staff is dedicated to meeting the mission of Medicare and Medicaid programs and our more than 100 million beneficiaries. Furthermore, OAGM's managers, contracting officers, and contracting staff are highly skilled and dedicated to the agency. I can assure you that the staff of OAGM is committed to excellence in everything we do.

However, we are aware there is always room for continued improvement and new approaches to effective oversight. CMS appreciates the attention that GAO has given to our contracting processes and the issues they have raised. The thorough and thoughtful work of GAO and this Subcommittee is serving as an important catalyst to drive new improvements to CMS's contracting functions and internal controls and has helped to enhance our contracting oversight.

Our work is highly technical and complex, yet we have an obligation to the American taxpayers to perform our work in accordance with applicable acquisition laws and policies. I firmly believe that

[1] The prepared statement of Mr. Benson appears in the Appendix on page 45.

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the most significant internal control to ensure the proper performance of CMS's contracting functions is the knowledge and skills of our contracting staff. We have worked hard to recruit people with technical and contracting expertise and to provide the CMS acquisition workforce with necessary skills, resources, and leadership to perform their jobs effectively.

To this end, we have instituted a number of changes and initiatives to ensure the appropriate resolution of GAO's findings. We conduct monthly internal training for contracting staff that includes topics such as invoice review and approval, acquisition data entry, contract types, and the use of competition. We also made available to our staff a web-based acquisition tool that gives access to the information they need to be efficient and effective.

Furthermore, we have senior leadership in place working alongside our staff as experienced resources and efforts to guide and mentor our staff as they acquire the knowledge and abilities they need to perform their jobs well and advance to the GS–1102 certification levels.

We recently created a deputy position which is responsible for acquisition policy and for strategically placing OAGM in a position to meet CMS's contracting needs. We were extremely fortunate to have a very senior and experienced government executive who has an extensive background in government contracts and is a Certified Public Contracts Manager assume this position for our organization.

We also hired a new Director for our Division of Policy and Support who is responsible for issuing acquisition policies, establishing internal controls, and acquisition career development. This individual came with a wealth of experience and expertise in acquisition policies and acquisition workforce development and was recruited from the Veterans Affairs Acquisition Academy Internship School for this position.

We have also created a new Cognizant Contracting Officer position which will be devoted to ensuring the proper oversight of our cost reimbursement contracts.

We have developed a detailed and comprehensive plan to address every one of GAO's findings. We have engaged an audit firm to review our plans and ensure that we have it right. The firm has extensive expertise regarding internal controls that apply to all Federal activities, which will provide us with guidance about best practices in other agencies and ensure we put in place the internal controls that will fully address GAO's concerns. This same firm will assist us in developing a comprehensive and strategic acquisition workforce plan.

A lot remains to be done. You can be sure that you have the commitment of CMS to improving our contracting oversight. I am sincerely grateful for the work that GAO has done for our agency. I am also appreciative for the interest and the support of this Subcommittee.

Thank you again for the opportunity to talk with you this afternoon about CMS's contracting activities.

Senator MCCASKILL. Thank you both very much for being here.

Let me start out with you, Ms. Daly. You found in the latest work that the contract management, the problems were, and I am

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quoting the report, "pervasive." That is a troubling word to use when we have $4 billion worth of contracts. In light of your findings, including staffing issues, data problems, lack of contract management and controls, what do you think, if you had to prioritize the problems and if Mr. Benson called and said, list them for us, what would you put at the top of the list that they need to go after first?

Ms. DALY. Well, Senator McCaskill, that is a very good question. There were, like I said, pervasive problems when 84 percent of the contracts we looked at had at least one key control failure. There are a number of issues I mentioned in my oral statement; for example, negative certification, is one that is troubling to me in that——

Senator MCCASKILL. Explain negative certification so that people who are not familiar with the term understand it.

Ms. DALY. Certainly. Negative certification is a process where the invoices, when they come in, they are paid within the time frame without being first reviewed and approved. So they will not be paid if someone raises their hand and says, "don't pay this, there is an issue with it." But if not, it moves forward and it is paid. So if there is an issue——

Senator MCCASKILL. So there is an assumption that the invoice be paid unless someone raises something negative?

Ms. DALY. Exactly. So that is one case where you can become part of a pay-and-chase cycle that we see a lot of times with other agencies: That once the dollars have gone out the door and then you realize there is a problem, then that has to be addressed. So that is certainly very troubling.

There is also the issue of getting incurred cost audits done, and all of the audits done very timely. CMS does a lot of cost reimbursement-type contracts, so it is critical that the contractors for those contracts have good cost accounting systems in order to be able to bill accurately to the Federal Government. At CMS, we found error rates as high as about 50 percent in getting those contract audits done timely. And then again, there were issues with contract closeouts, the last chance the government has to recoup those costs. So I think it is very important. Those are some of the key issues that need to be addressed sooner rather than later.

Senator MCCASKILL. So just to boil it down in, I hope—not that I mind the terminology used by auditors—to make sure that in plain language what you are saying is because so many of the contracts, the amount of money these contractors are paid are based on assertions they make about what their costs are in performing those contracts, and the only way the government has to "keep them honest" is by auditing those costs.

So if you have a cost plus contract or a cost incurred contract, there is not an incentive on the part of the contractor to keep costs down, because whatever their costs are, they are going to get paid. So there is not any incentive. It is not a fixed cost. It is costs incurred.

So the incentive is to turn in big bills. So if the audits aren't done, if the agency that is paying the money is not doing the audits, if they don't have a constant sense that someone is looking over their shoulder, that is where you can have runaway costs. And it is even worse if it doesn't happen—a serious accounting doesn't

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happen before the closeout because once the closeout happens then the only way you get that money back is with very expensive lawyers. Is that a fair summary of what cost incurred auditing and closeout means?

Ms. DALY. I can tell you have been here before. [Laughter.]

Senator MCCASKILL. OK. I just want to make sure that everybody understands that this is not just terminology that is thrown around. This is real money that we are probably letting go out the door that we shouldn't.

What allowed CMS—and I would like both of you to weigh in on this—how did we get to the point that we have such a large reliance on contracting? I have said in this Subcommittee many times, I am not against contractors, but it does appear that our government, especially in the last decade, has really expanded contracting without the requisite acquisition personnel and oversight to manage it. So any hope we had of saving money by contracting out, I think at this point I would characterize as a pipe dream because I don't think that has been the case at all based on the work of this Subcommittee.

So let us start with you, Mr. Benson. Why do you think that the contracting has become the meat and potatoes at CMS instead of the appetizer or dessert?

Mr. BENSON. Well, Senator McCaskill, I have 35 years of experience in government contracting, most of it working with the CMS in various capacities, and I could give you a long story, but I will spare you. And I think the reason for the reliance goes to our statutory authorities.

For most of CMS's existence, we had major contracts with Medicare Intermediary Carriers. They are our legacy contractors. They paid the claims. They had the call center. They did the fraud and abuse for us. They did the audit recovery, the MSP recovery work. They did everything. All our work was performed by these contractors.

Over time—and it was pursuant to statutory authority. There was authority in the Social Security Act that actually required, for example, for paying Part A claims, we contracted with fiscal intermediaries, and they were organizations who were nominated by providers to make payments to them.

Senator MCCASKILL. Is that right?

Mr. BENSON. Yes, very unique statutory authorities.

Senator MCCASKILL. I did not realize that.

Mr. BENSON. Congress really controls what we do. Congress started reengineering the Medicare program to a large degree. They formed the Medicare Integrity Program, so we were required to contract out the fraud and abuse functions to different contractors. They have contracted out, like different kinds of reviews. We have contractors called Qualified Independent Contractors (QIC). We have so many acronyms. But they do second-level appeals of decisions again, pursuant to statutory authorities.

So we had statutory authorities that require that we contract out certain functions. As an agency, too, in order to manage the program more efficiently and effectively, we started also pulling out functions from the Medicare intermediary carriers. It used to be that our data centers, we had individual data centers at every one

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of those contractors. When I first started, there were like 135 of them. You can imagine, that was pretty inefficient and ineffective. Now, we have consolidated data centers. We maintain the software for paying the claims ourselves.

We have been able to manage the program on a much smaller budget, much more efficiently and effectively, by consolidating those functions. But we started out from the get-go pursuant to a statutory scheme with having the program managed by contractors and it evolved to where, as I said, pursuant to the statutory schemes and in order to manage to the program in the most efficient and effective manner possible, we use a number of different contractors to manage our program.

Senator MCCASKILL. Well, there was not a statutory requirement that you consolidate data centers with a contractor.

Mr. BENSON. There was not a statutory requirement.

Senator MCCASKILL. And there is not a statutory requirement that you do the Medicare help line with a contractor.

Mr. BENSON. There is not a statutory requirement, ma'am, there is none.

Senator MCCASKILL. There are some, obviously, that are statutory. But the preference for contractors, do you think that it is saving money?

Mr. BENSON. That is a very difficult question to answer. But you say, saving money. It certainly is saving money over the way we had historically administered the program.

Senator MCCASKILL. But that has a lot to do with combining data centers, not necessarily hiring contractors to do the work.

Mr. BENSON. Right.

Senator MCCASKILL. I mean, you guys realized efficiencies, but the work that you did to realize those efficiencies could have been done by government employees and contractors and you still would have enjoyed the efficiencies.

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. OK. GAO found the internal controls at CMS were deficient and resulted in inadequate strategic planning for both staffing and resourcing. I understand that you are planning to hire Grant Thornton to conduct a staffing study for you. First, when do you expect the study to be complete?

Mr. BENSON. We expect the study to be complete, I believe by the end of May, beginning of the summer.

Senator MCCASKILL. And is this study going to also show you what the right mix of contractors and government employees are?

Mr. BENSON. No, ma'am. We are really looking for this study, it is an acquisition capital workforce plan. It is going to focus on the workforce for the acquisition function.

Senator MCCASKILL. All right. Should I be worried that we need to hire somebody to tell you that?

I am curious what they cost. What are you paying Grant Thornton for this?

Mr. BENSON. I am not exactly sure, but there is a lot of work that is on the Grant Thornton task order because they are particularly focusing on the internal controls. Altogether, I believe we are paying about $500,000, but that is for a fairly robust task order. This is just one part of it, that the workforce developed.

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Senator MCCASKILL. I would like to see the task order——

Mr. BENSON. Sure.

Senator MCCASKILL [continuing]. That we are paying a half-a-million dollars for.

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. GAO has given you a pretty specific list about internal controls, and they didn't charge you for it. I am concerned in some ways that we feel that we need to contract out somebody to tell you how many folks you need to do just acquisition. How many people do you have working in acquisition?

Mr. BENSON. We currently have a ceiling of 126, and we have just over 100 of those that would be devoted to the acquisition function.

Senator MCCASKILL. And what is the payroll on those 100 employees on an annual basis?

Mr. BENSON. We don't budget for an office exactly by total payroll. Our average salary would be around a GS–13. I don't know exactly whatever that would compute to, and I don't know the overall——

Senator MCCASKILL. Clearly, you are not a GS–13 anymore or you would know.

I am just trying to think in my mind, calculate what we are spending on figuring out how many people we need versus what we pay how many people we are using a year. That is a pretty hefty price tag, so I would be anxious to see the task order.

Let me turn it over to Senator Brown now for some questions and I will return for a number of questions after he has an opportunity to question.

Senator BROWN. Thank you, Madam Chairman. You actually asked one of my questions, which is how much the Grant Thornton contract is going to be, and I mirror your thoughts. We had GAO that did a nice review, made recommendations, yet we are then going to an outside entity, paying them another half-a-million dollars which we don't have, and what if they come back and confirm what they said? I mean, are we better off, worse off? I don't get it.

Mr. BENSON. Senator, the main purpose of the Grant Thornton task order is to help make sure that we put the right internal controls in place. They have experience working throughout the government with other Federal agencies. They are an audit firm, think like an audit firm, and they can help us to make sure that our internal controls are exactly right.

Senator BROWN. But you guys have been doing this for quite a while. I mean, if the audit control is on right now, what do we have to say with what has happened in the past in terms of collecting money, hiring contractors. I mean, if this stuff has been broken, because apparently you are doing a study to find out what needs to be done better, what confidence should we have in what has been done prior to this?

Mr. BENSON. Well, Senator, improvement and change is a continuous and an iterative process. We try to bring every resource we can to make sure we are doing things in the right way.

Senator BROWN. OK. I think a GS–13 makes about $85,000 and you have 120, 126 employees, just for the record. But in your initial

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statement, you said we are a highly technical and complex agency. Am I correct that you are still doing your billing manually?

Mr. BENSON. It is not our billing, exactly. We do receive invoices from contractors in hard copy, and that is because we are in the process now of developing a new internal accounting system. We haven't been able—it wouldn't be a wise investment today of resources to build the interfaces between our acquisition system and the accounting system because we are in the process now of developing a new overall accounting system for the agency.

Senator BROWN. Because it seems to me that if you are highly technical and complex and yet we are still doing billing manually, it doesn't make much sense to me. Let me just tell you what my impression is after doing the research and having some experience dealing with your agency back home in the State Senate. There are some efficiency problems and they bother me greatly, because as somebody who prides himself in being a fiscal conservative, I want to make sure that not only me as a taxpayer, but everybody else as taxpayers are getting the best value for their dollar.

And now that we have done a health care bill that is going to basically provide you more money and resources to apparently go out and get fraud when we haven't even collected some of the monies from the fraud and abuse that we have already identified, it seems like we are just adding good money after bad.

I personally, Madam Chairman, have a little bit of trepidation and confidence as to whether you can, in fact, save money when we give you additional money to go and seek out that fraud and abuse. What are your comments on that?

Mr. BENSON. Well, in my position, I am responsible for the contracting function itself. We have a center that is devoted to the actual program work around the program integrity work.

Senator BROWN. Is that under your jurisdiction?

Mr. BENSON. It is not under my jurisdiction.

Senator BROWN. That is your answer? So you don't have any comments on that? OK. That is fine.

Would you agree or is it true that the CMS is, in fact, addressing a lot of the concerns—or let me backtrack. Do you think it is possible for you to address the concerns in the GAO report, and if so, what time frame are we talking about and how much will it cost?

Mr. BENSON. Sir, that is a great question, and we intend to fully address every single one of those GAO findings. We take them very seriously and we are committed to addressing each one of them. We are putting together schedules and plans. We have plans in place to address those findings quickly and aggressively.

And as far as the cost, beyond the Grant Thornton task order, the assistance we are getting there, we will be doing that entirely with our own staff. So there wouldn't be any additional cost.

Senator BROWN. So are you responsible at all as to how the fraud money is allocated, for fighting fraud? Does that——

Mr. BENSON. No, sir, I am not.

Senator BROWN. Madam Chairman, I am going to just table for a minute and give it back to you. I just want to get my thought process organized a little bit. Thank you.

Senator MCCASKILL. OK. Senator Pryor, welcome to the hearing. We are glad you are here.

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OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Thank you. Thank you for doing this today, Madam Chairman.

Let me start with you, Mr. Benson, and talk about where you see most of the waste, fraud, and abuse in Medicare and Medicaid contracts. What is the biggest problem?

Mr. BENSON. Well, in terms of our contracting itself, we haven't encountered a lot of fraud. We had waste or abuse. We haven't really encountered a whole lot in terms of any sort of GAO IG report of our contractors.

Senator PRYOR. Ms. Daly, what are the biggest areas of concerns from your standpoint? Where is most of the fraud, waste, and abuse in the system?

Ms. DALY. Well, Senator Pryor, in our 2007 report, we had identified some issues that we were concerned about that appeared to be waste. It looked as though there were some contractors that were subcontracting with each other. Therefore, because of that, instead of having CMS directly contract with them, a contractor when it contracts with someone else can have their add-on fees for serving that function be paid by the government also. So I think there was a total of close to $3.6 million that we thought was questionable because of that and should be addressed.

Senator PRYOR. And when you talk about contracting, just for clarification, are you talking about where CMS actually as an agency enters into a contract, or are you talking about for services provided under Medicare and Medicaid?

Ms. DALY. Sir, I am referring to cases which CMS enters into a contract, not as part of the provider providing care to an American citizen.

Senator PRYOR. OK. I think you said in your written testimony that GAO estimates that there is at least 46 percent of fiscal year 2008 contract actions that did not meet the Federal Acquisition Regulation requirements, is that right?

Ms. DALY. Well, yes sir. We were specifically referring to the controls in that area. For example, they considered whether the cost accounting system had been approved prior to contract award, and these are in the cases where it is a cost reimbursement contract. So what I think is very important for cost reimbursement contracts, is that the contracting systems that are being used by those contractors be reviewed and approved ahead of time to make sure that what is billed to the government are fair charges.

Senator PRYOR. OK. And do you know if the agency is addressing that?

Ms. DALY. I am not aware of the status of addressing that particular recommendation.

Senator PRYOR. Mr. Benson.

Mr. BENSON. We are addressing those recommendations. We are taking our obligations in the administration of cost reimbursement contracts very seriously. We have done a number of things, primarily of which is to create a contracting officer's position which is entirely focused on ensuring the proper administration of cost contracts.

Senator PRYOR. OK. Will that result in less waste?

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Mr. BENSON. Well, sir, it will result in making sure that the contract terms are adhered to. I am not sure that I consider that to be waste, exactly, but we want to make sure that the contract terms and the rules in the FAR are strictly followed.

Senator PRYOR. OK. Ms. Daly, are there, I guess I would call them best practices for the Federal Government in contracting?

Ms. DALY. Well, Senator Pryor, the Federal Acquisition Regulations certainly serve as the basis for all of government contracting throughout all the agencies. I am not aware of any particular best practice studies that may have been done, but I am certain that there may be vendors out there willing to help you with that.

Senator PRYOR. Is there room for improvement over at CMS?

Ms. DALY. From our work, it shows that there is clearly room for improvement.

Senator PRYOR. And why is CMS not doing the things that they should be doing?

Ms. DALY. Well, what we saw were some of the root causes was that they had not determined the appropriate level of staff and resources needed to do what they had been tasked with doing. So it is basically they needed to analyze what their workload was and then identify what resources are needed to accomplish those tasks.

We also noted that their policies and procedures had not kept pace with what the Federal Acquisition Regulations called for, and they have been working to try to address that. One of the things they had done was they had implemented a web-based system that provides the staff with access to the FAR and other things, but we still think they need to customize that so it explains how it should be done at CMS: How to use the specific forms; what is appropriate for them; and what supervisor it goes to; those kinds of things, to help them in doing their day-to-day activities.

Senator PRYOR. And tell me about the Contract Review Board. Is there a Contract Review Board and how is CMS doing with that?

Ms. DALY. The Contract Review Board was what appeared to be a promising control to put in place to help ensure that some of the regulatory and quality assurances were provided, but unfortunately, it wasn't fully implemented as envisioned. They did not do the number of reviews that they had expected to do, nor were all of their reviews acted upon. So its value as an internal control was not the best that it could be.

Senator PRYOR. Mr. Benson, do you know why the Contract Review Board did not do all the reviews that they were supposed to do and why they did not follow up?

Mr. BENSON. Well, the Contract Review Board was something that we created internally to try to enhance the effectiveness and efficiency of our contracts. We are in the process now of revising that policy and we are really going to bolster it, making sure that we look at more of our contracts, that we really do a thorough job with that board. And I am going to, as a result of our new review policy, going to be reviewing contracts over $50 million personally. So we are in the process now of trying to make sure that we do have an effective Contract Review Board.

Senator PRYOR. And Ms. Daly, you also included in your written testimony that GAO found that in 54.9 percent of the contracts,

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CMS did not promptly perform or request an audit of direct costs. Do you want to comment on that?

Ms. DALY. Yes, sir. I think that has been one of the problematic areas at CMS. The audit of direct costs generally occur towards the end of the contract and it is very important that be done very promptly and very timely so that you are sure that the contractor has billed for the amounts correctly.

Senator PRYOR. And how does CMS's number compare with the other government agencies?

Ms. DALY. I am not aware of statistics related to that for other agencies, so I could try to get back to you with that information.

Senator PRYOR. Thank you. Madam Chairman, that is all I have. Thank you.

Senator MCCASKILL. Thank you very much, Senator Pryor.

Mr. Benson, one of the things that is most frustrating to people who do audit work is when they do a report and then they come back and they do another report and the things they reported on the first one don't appear to have been fixed. That is a waste of money for the taxpayers who are paying the folks at GAO, because if they produce a product and nobody pays any attention to it, that is the same as all those hours of work just basically going up in smoke.

Two years later, after there were nine recommendations, GAO is indicating that on seven of the nine recommendations, they had not been fulfilled. Let us talk about that. Give me your best excuse as to why you need longer than 2 years to do something as basic as criteria for negative certification. Why would that not get fixed in 2 years? That is pretty basic to paying attention to the money going out the door.

Mr. BENSON. Ma'am, I agree, and I don't want to make excuses. We took actions as a result of the original GAO findings. GAO came back and said what we did was not sufficient. So this time, we want to get it right. This time, we are going to make the changes. For example, we changed our invoice review policies, but GAO didn't feel we went far enough in making those changes. So now we are going to do what we need to do on all those findings to make sure that we satisfy GAO's findings.

Senator MCCASKILL. Because of all of the things that must occur as it relates to our Medicare program over the coming years, there is going to be a lot of scrutiny on your agency. I cannot stress enough that a very basic would be getting the GAO stuff done. You talk about cranky. If this GAO stuff doesn't get done, like immediately, it is a real problem because this is really not low-hanging fruit.

It is my understanding that the original report found $90 million in questionable contract payments. Now, we are not talking about payments to medical providers here. We are talking about payments you made to contractors. You have stated that your current investigation and an audit will address $67 million of those costs.

Now, here is the problem. The $90 million they identified was for years 2004, 2005, and 2006. The audit you did where you found $67 million was in 2008. So you didn't even audit the right year to address what they found in the previous years. Do you see what I am saying?

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Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. Now, that doesn't inspire confidence.

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. Do you want to speak to that and make me feel better?

Mr. BENSON. When we got the initial GAO report, our practice is to resolve audit findings when we do the close-out audit of the contracts. We had intended to do those contract audits expeditiously. We didn't. We now have a very concrete plan to get those audits done in the next few months and we are going to make sure that no payments under those contracts were made inappropriately.

Senator MCCASKILL. Why are all these contracts cost incurred? Why aren't they fixed price?

Mr. BENSON. Well, the Federal Acquisition permits us to use cost——

Senator MCCASKILL. I am not asking if you can. I am asking you why.

Mr. BENSON. Because our program is subject to continuous change and we have contract statements of work that are subject to continuous change, and a cost reimbursement contract is generally appropriate when the government can't draft a statement of work with sufficient, like, certainty to assure—to shift the risk to the contractor of performance. And because of the statutory changes, the regulatory changes, the changes in the Medicare program, we just have not been able to develop statements of work with sufficient certainty to facilitate fixed price solutions.

Senator MCCASKILL. Is the Medicare hotline cost incurred?

Mr. BENSON. Yes, it is.

Senator MCCASKILL. How can that not be fixed cost?

Mr. BENSON. Ma'am, if I could, may I get back to you? I think there is a per call cost and then there are certain aspects of it that are fixed price, but I need to clarify that for the record, if I may.

INFORMATION SUBMITTED FOR THE RECORD

The 1–800–MEDICARE Beneficiary Contact Center (BCC) is a performance-based, cost-plus-award fee (CPAF) task order. A CPAF task order is appropriate in order to meet CMS's objectives of enhanced customer service while increasing efficiency of operations. In this case, a CPAF task order is being utilized because the workload of the BCC is uncertain with large cyclical variances and added spikes in call volumes, which does not permit costs to be estimated with sufficient accuracy to use a fixed price vehicle. To manage a normal load of calls from Medicare beneficiaries, there are currently 2,650 customer service representatives. During the fall when call volumes rise during open enrollment periods for the Medicare Advantage and Part D plans, more than 4,000 staff is employed. We have also seen times when BCC needed over 6,000 staff members to service calls.

Additionally the Agency must respond to a dynamic environment, which includes legislative changes or responses to media attention. This CPAF pricing arrangement allows the government to provide technical direction as required, and evaluate performance with a structured process that considers both objective and subjective criteria.

Senator MCCASKILL. Well, let me just say that a per call cost for a Medicare hotline, doesn't seem to pass the common sense test to me. You are going to have to hire so many people to man the hotline whether the phone is ringing or not. It seems to me you ought to be able to resource a hotline with sufficient folks and set a price for that and get some bids and do it on a fixed price.

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I have watched so many contracts get out of control when it is cost incurred, cost plus, and the incentives are on the wrong side of the table. They are not on the taxpayers' side of the table, they are on the contractors' side of the table. They are easier to administer, admittedly, because you don't have to work as hard on the scope. You don't have to work as hard on what it is that you are laying out in terms of what is going to be performed on the contract, and I realize that is challenging in the Medicare-Medicaid environment, but it doesn't appear to me that you all are even focusing on a way that you can move as many contracts that is practicable to a fixed-cost price.

We may follow up with more specific information about cost incurred, cost plus versus fixed price on the various areas that Medicare and Medicaid are, in fact, contracting now. I think it is important.

The Subcommittee asked GAO to provide some additional background on some of the case studies. There was a company called Palmetto GBA. You awarded a cost reimbursement contract to them despite the contracting officer's knowledge that this contractor had an inadequate accounting system. So this is what I was just discussing, except it is even worse, because not only have you given them cost plus, cost incurred, you are giving it to a contractor that you already know doesn't have an appropriate accounting system to keep track of what they should be charging you. Why would that occur? Why would a contracting officer give a contract to a company when you knew they had inadequate accounting in order to document what we owe them?

Mr. BENSON. That should not occur, ma'am.

Senator MCCASKILL. OK. I think we agree on that. Is the contracting officer that did that, have they been disciplined? Have they been held accountable?

Mr. BENSON. They have not been disciplined. We have done internal training to reinforce to all of our contracting officers the FAR requirement that a contractor have an approved accounting system.

Senator MCCASKILL. OK. In another, GAO found the contractor submitted over 100 invoices of which only eight had been certified by the project officer. Now, your policy provides that the project officer review each contractor invoice, recommend payment approval or disapproval, and sign a certification form. The contract value of this particular contract was more than $90 million. What happened here? Why weren't these invoices being reviewed?

Mr. BENSON. Again, they should have been reviewed. We have done a lot of training of both our contracting staff and our project staff. We are also taking the GAO recommendation, which was to start having managers review some sample to make sure that, in fact, all the invoices that are in a contract file have been approved by both the project officer and the contracting officer. That is our policy.

Senator MCCASKILL. Well, I think one of the things that is going to have to start happening, if things have been this loosey-goosey over there, that you are awarding cost incurred contracts to people who don't have an approved accounting system and you have got eight out of 100 invoices that have been certified when 100 percent

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should be certified, I think just saying to people, we really mean it this time, it may take more than that. You may have to, as somebody who is managing this effort, you may have to say to these employees, you are going to be disciplined if this stuff occurs. We have watched, especially in the Department of Defense, when people don't get disciplined, nobody takes it seriously. It is like Monopoly money to them.

This is really important, that we hone in or home in—I have been told that I should say home in—on this problem because this is a huge amount of money. And candidly, if the contractors know that you are not paying close attention, they are on the front lines. That encourages the kind of environment where they don't have to pay close attention. And now we are talking about hundreds of billions of dollars.

Let me turn it over to Mr. Brown for any of his questions.

Senator BROWN. Thank you. You have been in this position since 1997, is that accurate?

Mr. BENSON. Yes, sir.

Senator BROWN. And I am listening and I am learning. I know I don't know it all, Madam Chairman, but I think we are bonding because the question you asked about the recouping of 90——

Senator MCCASKILL. I just had this thought for a minute. [Laughter.]

Senator BROWN. We are bonding.

Senator MCCASKILL. We are bonding.

Senator BROWN. We are reading each other's minds, because I am curious as to the fact that, I mean, when she was asking the question, I said, my gosh, she is cheating. She is looking at my notes here. [Laughter.]

And what I am finding is that in a November 2007 report, that $88 million or $90 million from prior years hasn't been recouped and it is 2010. And you say, well, we are working on it. We are doing this. We have got more checks and balances. We are doing this and doing that. With all due respect, how long does it take to collect the money and get reimbursed from the people that have been overpaid or there have been losses or whatever?

Mr. BENSON. Sir, as I said, we have a plan in place and we are going to be as expeditiously as possible addressing every one of those findings and making sure that we have made any appropriate adjustments——

Senator BROWN. Well, who is responsible, though, for having—I mean, why does it take coming to the hearing, or why does it take the GAO recent report to deal with a GAO report that is from 2007? That one hasn't been addressed yet. So what confidence would I have or would the American taxpayers have or this Subcommittee Chairman and the Members have to think that the new report is going to be adhered to?

Mr. BENSON. Sir, our office needed some change and some improvement. We are making those changes now. We are going to address those findings.

Senator BROWN. Well, you have, you say, it is a highly technical and highly specialized office, and I am presuming that the contract approval officers have training. They have been schooled. They are certified. And yet they haven't bothered to check to see if basic

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common sense stuff that should have been done when signing off on a contract wasn't done.

And now you are getting more bodies, you are getting more money, and you are getting more opportunity, I hate to say it, for problems. What assurances do we have, once again, if these same people who have made these mistakes or didn't adhere to their basic training are still making these decisions, what confidence should I have?

Mr. BENSON. Sir, I understand. As I said, we have made some really significant changes——

Senator BROWN. Well, like what? I have heard that, like, 10 times.

Mr. BENSON. Thank you. One of the things we have done, as Ms. Daly pointed out, we have instituted an automated system for all our contracting staff that sets forth in a very concise way all the requirements of law and regulation. We are customizing that with all our own internal rules. So, first of all, contracting officers have, or contract professionals have the tools they need to make sure they know the policies, they have the policies right there at their fingertips and they are following them.

Senator BROWN. All right. What tools are you talking about that they have now that they didn't have before?

Mr. BENSON. We have a Web-based tool that is in a very comprehensive way——

Senator BROWN. Is it a checklist that they have to go through when they are signing off on a contract?

Mr. BENSON. Exactly. It has checklists——

Senator BROWN. So that hasn't been in place before?

Mr. BENSON. We instituted it just over a year ago.

Senator BROWN. OK.

Mr. BENSON. And we also have been developing a contract checklist in concert with the Department of Health and Human Services that are going to also—it was one of the GAO's recommendations that in a meaningful way should assure that contracting officers have complied with all the steps in awarding a contract.

Some of the other things we have done, and I think this is really significant, is made some really significant leadership changes. I think I said earlier in my opening statement that we have created a second deputy position to help us focus not only just the strategic aspects of managing our office, but on the policies, the internal controls, somebody who is very experienced in government acquisition.

Senator BROWN. Who was handling that stuff before?

Mr. BENSON. Well, before, it was really more or less on my plate and the other managers in the office.

Senator BROWN. So how many managers are in the office?

Mr. BENSON. Well, previously, we had myself and a deputy, and then we have two groups in the office, two group directors, and we have seven divisions. So we had nine people.

Senator BROWN. So now you have a new deputy that has this amazing experience, so he is going to solve all the problems, or she?

Mr. BENSON. Well, I believe that when you assign accountability and responsibility to somebody, things get done.

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Senator BROWN. But didn't the head of CMS give that accountability and responsibility to you guys?

Mr. BENSON. Yes. So we have created a position to help us really focus and make sure we get this right. We have also created a—well, not created, we have hired a new Director for our Division of Policy and Support, someone who, first of all, comes to us from the Veterans Affairs Acquisition Workforce Academy, who has extensive experience in workforce development, is a nationally recognized expert in that field, as well as extensive experience and expertise in developing acquisition policy.

Senator BROWN. But don't the taxpayers have the right to make sure that you do get it right, because we are not talking about a few hundred thousand dollars here. We are talking about hundreds of millions of dollars. You are getting a pay increase now to do your job to find fraud, and yet we haven't even been able to collect the overpayments from 2004, 2005, 2006, 2007. You haven't been able to follow through in this 2007 report. We had another report that talks about waste and other types of things.

I tell you, Madam Chairman, I am concerned, and I am hoping to submit some additional questions about the fact that you are getting all this money and you have all—we are going to do this, we are going to do that, we haven't done this, we haven't done that. I don't have much confidence. I know I am new here, but maybe I am looking at it in a different way to try to figure out who is responsible.

I know you are not the top guy, but you are one of the senior people. Is it fair to say that—and my initial question which I tried to get, and I wasn't saying it quite correctly. Is it true that you are responsible for approving or issuing the contracts and hiring the contractors that are responsible for pursuing fraud and improper payments? Is that your responsibility?

Mr. BENSON. It is the responsibility of my office, yes, sir.

Senator BROWN. OK. So who is overseeing those contractors to make sure that they are doing their jobs in pursuing the fraud and waste and improper payments and then making sure that they collect the money and give it back to the Treasury of the United States?

Mr. BENSON. Yes, sir. In the award and administration of contracts, there is a team of government officials involved. We perform the contracting officer function in my office, which is the legal aspects of awarding, negotiating, and awarding a contract in accordance with the FAR. We also have a program staff. There is an official there, the contracting officers, technical representative, but there is a project manager, a program manager. They oversee and manage the program aspects of a contract.

Senator BROWN. So if that is the case, then if we have all these people doing all these jobs, why haven't we still collected—I am still getting back to the basic—why haven't we still collected the money that is outstanding that should be coming back that the GAO has identified?

Why is it taking so long? I mean, we could use the money. You know that, right? We are almost at a $13 trillion debt.

Mr. BENSON. Yes, sir.

Senator BROWN. So who is responsible?

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Mr. BENSON. Well, as I said earlier, I think, our normal process for resolving audit findings like that are to perform an audit of the contract and to resolve those findings at the time we close out the contract. We realize that process here was taking too long, so we are going to put particular attention, specific attention, expedited attention on those findings——

Senator BROWN. All right. So when is the 2004 contract going to be closed? Is that closed?

Mr. BENSON. It is not closed yet. Again, we are going to be taking expedited action to address that.

Senator BROWN. All right. I know I am taking a lot of time, Madam Chairman, but Ms. Daly, what confidence do you have that—you have heard my line of questioning. I don't want to throw stones, believe me. I just want to solve problems and try to find out how we can better help your agency to perform a very valuable function for our citizens. What confidence do you have with all the new money that they are getting that they will be able to fulfill all of the concerns that the Chairman and I have?

Ms. DALY. Well, Senator Brown, Mr. Benson has made some very important promises to all of us here and I am certainly hopeful that he will follow through with those and make sure that CMS does take action, because just as you have noted, there is a lot of money at stake here. The Medicare and Medicaid programs are two of the largest in the Federal Government. To make sure that the contractors handling those programs and ensuring that we combat improper payments so that we can try to prevent them, is critical. I think this year, improper payments for Medicare and Medicaid totaled something like $55 billion, and addressing that will be exceptionally important.

So what has been entrusted to Mr. Benson and his staff is critical. I don't know that I could put a particular rating, if I had to, on it, but I am encouraged that they seem to have a good attitude about trying to fix things.

Senator BROWN. You are being very generous. I am wondering, do you have a time frame that we have made a recommendation that they implement these things, or is it open-ended like some of these other things?

Ms. DALY. Well, yes, sir. Our recommendations in general are open-ended. We would like, of course, them to be fixed as soon as possible. We generally start to follow up anywhere 6 months to a year after the recommendation has occurred, and then we hope to have everything closed out no later than 4 years, which is one of GAO's performance metrics.

Senator BROWN. Great. Thank you.

Senator MCCASKILL. Let me ask, when I visited with you about Palmetto a minute ago, I didn't realize at the time that it was the fourth-largest contractor. Since this contract was entered into with you all full well knowing that they did not have a qualified accounting system to have the kind of contract they have, what has happened to address that in the interim? Do they now have the appropriate accounting system?

Mr. BENSON. Yes, ma'am, they do.

Senator MCCASKILL. OK. I wanted to make sure I didn't leave that detail hanging. I believe we spend over $130 million a year

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with that contractor and it puts them in the top five of the companies that you contract with.

The Medicare Secondary Payor Recovery Contractor, which really—that whole problem is what piqued my interest in this area, that we were having a hard time getting Medicare to accept money that Medicare was owed—never a good sign. This is a cost-plus-fee contract also, correct?

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. Once again, I don't understand why this area would be particularly complicated, why you would need to make this cost incurred. Did they receive the full amount of the award fee?

Mr. BENSON. Ma'am, I will have to get back to you on that. I don't know the answer.

INFORMATION SUBMITTED FOR THE RECORD

In accordance with the most recent modification issued, the subject contract's current payment schedule is reflected below. The contract was initially awarded (i.e., structured) as a "Cost Plus Award Fee" (CPAF) contract. However, due to an unforeseeable growth in workload, CMS renegotiated and modified portions of the contract. Specifically, CMS renegotiated the contract to address the backlog in the workload volume, revise the CPAF pricing structure to include only a base fee and eliminate the award fee portion of the fee structure, and to revise the overall cost ceilings based on these changes. The revised pricing structure applies to all periods of the contract as shown in the chart below with the exception of Option Period 5, Contract line item 0006, which is an option period not exercised.[1]

Senator MCCASKILL. Was this awarded on a sole source basis?

Mr. BENSON. Not exactly. It was awarded pursuant to special authority under Section 8(a) of the Small Business Act, which permitted us to award a contract to this organization because they qualified as a Native Alaskan contractor.

Senator MCCASKILL. I thought they were from Oklahoma. They qualified under the Native American, not the Alaskan——

Mr. BENSON. Oh, I am sorry. Did I say Alaskan? Excuse me. American.

Senator MCCASKILL. So because they qualified in that program, you didn't have to compete it?

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. Well, I would be interested to know, a company that was not returning phone calls and taking money, if they got—how long has this contract been in place? Two-thousand-and-six, I see.

Mr. BENSON. Right. Yes, ma'am.

Senator MCCASKILL. You consolidated several of these into a single cost plus contract awarded on a sole source basis to Chickasaw Nation Industries. So I would be interested to know if they have been getting the award fees on the various years they have had the contract, since clearly there were pervasive problems with this contractor.

They are now claiming—in 2003, you have stated you only recovered 38 cents for every dollar spent on recovery activities. That would mean we were losing money trying to recover money.

Mr. BENSON. Yes, ma'am.

[1] The chart referred to appears in the Appendix on pages 56 and 57.

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Senator MCCASKILL. You don't need an accountant to tell you that is a bad outcome. The contractor is now claiming they are recovering $8.97 for every dollar we are spending on recovering this money. Do you have confidence that is a correct number?

Mr. BENSON. Ma'am, again, the programmatic responsibility, the officials that are responsible for that statistic are in another area of CMS. We can provide you more information regarding how that return on investment was arrived at. But I am not—I can't really speak to that.

INFORMATION PROVIDED FOR THE RECORD

The cumulative Return on Investment (ROI) from FY2007 through the first quarter of FY2010 for the MSPRC is $8.97. CMS believes that this amount is generally correct; however, the amount has not been audited.

The ROI is calculated using the following methodology:

1. Take the total amount collected and subtract the refunded amount (e.g. waivers, appeals, three party checks) to arrive at the "Actual Collected Amount;" then

Divide the "Actual Collected Amount" by the cost of the contract.

CMS cautions against comparing the FY2007 through first quarter of FY2010 ROI amount with the ROI from 2003. The cumulative total $8.97 reflects actual ROI for both group health plan (GHP) and Non-GHP (e.g. liability insurance, no-fault insurance, and workers compensation) collections during this period. GAO calculated the FY2003 ROI of $0.38 from GHP collections only; therefore, these are not directly comparable figures.

Senator MCCASKILL. Well, it is important, and let me just tell you, I know that you are going to say this maybe isn't under you, but here is why I think you should know about it. Are you involved in deciding whether they get an award fee? Is your office involved?

Mr. BENSON. Yes, ma'am, it would be.

Senator MCCASKILL. And wouldn't how well they are doing collecting money be relevant to whether or not they should get an award fee?

Mr. BENSON. It would be, yes.

Senator MCCASKILL. So that is my point here. We should not be giving award fees to sole source contractors that are cost-incurred contractors unless we are confident that they deserve an award fee because they have done an outstanding job. So I would hope in these kinds of contracts that you would not only be checking ahead of time to make sure they have the appropriate accounting system so we are getting charged the amount of money, but on the back end, that you know how well they have done.

There has been a way-too-common practice in government just to give award fees because everybody gets them. That needs to stop. I mean, that is like tipping 25 percent for bad service. We can't afford to do that in our government.

This is a sweet contract for them. They don't have to compete. It is big. Clearly, there wasn't a lot of oversight going on until all of a sudden Members of Congress started getting notified that they were hearing from their people at home that nobody would take their money.

So I would like you to follow up on those and find out, and if it takes me having to inquire in the program office or in the Secretary's office to find out—and I want to know when this contract is up and if there is any intention on competing it.

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And I will look into whether or not this is one of these exceptions that it doesn't matter how big they get. Do you know if this is a front or whether they are actually doing the work?

And let me explain what I mean by that for the record. You know what I mean?

Mr. BENSON. Yes, ma'am.

Senator MCCASKILL. I want to make sure everybody understands. This is this carve-out that we are busy campaigning against that certain contractors—typically in the 8(a) program, you get some leverage and advantage for being in the 8(a) program, but when you get to a certain size, you age out of the 8(a) program. Well, there is a carve-out, and that is if you are an Alaska Native corporation, you can be as big as you want to be for as long as you want to be, and even more importantly, you don't even have to do the work. You can apply as the contractor and then subcontract the whole thing, and really what you do is you rent out your corporation for purposes of not having to compete.

Is this a situation that they have subcontracted for all the work?

Mr. BENSON. Ma'am, I am not exactly sure what proportion of the work is subcontracted. We can provide that information.

INFORMATION SUBMITTED FOR THE RECORD

CNI is performing approximately two-thirds of the work in the MSPRC contract and is subcontracting out the remaining third. The Small Business Administration's guidelines require 8(a) firms to directly perform 51 percent of the contract workload. CMS works closely with CNI, and all our contractors, to ensure the appropriate balance between work performed by the prime contractor vs. that of any subcontractors.

CNI's subcontractors for this contract are:

a. Cahaba Government Benefit Administrators (Cahaba)
b. Group Health Incorporated (GHI)
    1. JP Morgan Chase
    2. United Systems of Arkansas
    3. Neil Hoosier and Associates
c. ViPS

Senator MCCASKILL. I think that is important. I have nothing against the 8(a) program, but within the 8(a) program, it needs to be fair, it needs to be balanced, and it needs to be equal. Because you are an Alaska Native corporation should not allow you to get non-compete contracts that you actually aren't doing the work on.

You have told the Subcommittee staff that you are exceeding the goal for small businesses. I am curious if that is because the CNI has such a big contract.

Mr. BENSON. Actually, those dollars aren't counted in our small business goals and it is because we use money that was appropriated under statute for the Medicare Integrity Program. I am not sure why, but it is considered to be non-appropriated funds. So, actually, no, it is not counted in that goal.

Senator MCCASKILL. OK. Do you know how many contractors your assertion that your goal has been met, do you know how many contractors go into that? What I am trying to get at is we found that in some of these agencies, they say they are making their goal for small contractors, but it is because they sometimes have one or two big ones as opposed to many smaller businesses.

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Mr. BENSON. To the best of my knowledge, we don't have those big contractors like you are talking about, like a CNI, in that base. It is a number of smaller contractors.

Senator MCCASKILL. OK. That is terrific.

Let me also ask you, the MSPRC rule, there is a new rule that they have put in, and in October of last year, for some reason, they changed the number of consent forms that primary plan and third-party administrators have to sign. I think the need for beneficiary consent is legally required and important, but I am trying to figure out why we went from one to three forms. That is usually a bad sign, that we have to go from one form to three forms. And what is happening is that it is our understanding that it is causing these files to stay open for months because there aren't three forms.

If you can track down who the person was that thinks we need three forms instead of one, I would be happy to have a conversation with them in this hearing room about it, because I don't—somebody needs to explain why that is necessary.

Mr. BENSON. Yes, ma'am. We will provide you that information.

Senator MCCASKILL. Thank you very much. I have no more questions. Do you have any more questions, Senator Brown?

Senator BROWN. Thank you, Madam Chairman. One more.

What percentage of contractors are actually getting award fees? Do you know that? And if not, you could provide it to me in writing.

Mr. BENSON. I will provide that, sir.

INFORMATION SUBMITTED FOR THE RECORD

As you requested, we are providing, under separate cover, an overview of award and incentive fee contracts. It includes an analysis that is based on contract actions from October 1, 2008 through October 31, 2009. This information was originally prepared for Senator Carper but addresses your concerns as well.[1]

Senator BROWN. Because if it is 100 percent, I mirror what your thoughts are on this. It is almost like your analogy, tipping for bad service. There is no incentive to do well. It is a disincentive if they know, at the end of the term, regardless of how they do, they are going to get an automatic bonus. It is a joke. So I wanted to just ask if you could submit that to the Subcommittee.

Senator MCCASKILL. I want to thank both of you for being here today. I want to thank Senator Brown. We will note for the record that bonding was put on the record today. I think that is a good sign, right, Senator?

Senator BROWN. A most flattering——

Senator MCCASKILL. I like that.

I do want to say sincerely, Mr. Benson, that it is time for you to be aggressive. We have this new health care bill that is going to put even more pressures and responsibilities on accountability, and this Subcommittee is not going anywhere. Whether I am here or not, the Subcommittee is going to be here, and I can assure you, we are going to keep looking. I see the role of this Subcommittee as giving voice and volume to many of these GAO audits that have been done so that we don't come back in another 2 years and have

[1] The analysis submitted by Mr. Benson appears in the Appendix on page 62.

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another seven findings that were repeated from the findings before that, repeated from the findings before that. That has to stop.

Accountability has to begin within your agency. And if you need tools, if you don't have the tools to do the job, now is the time to speak up and let us know, because we are not going to take that as an excuse 2, 3, or 4 years down the line when we have problems implementing the new law because you are not ready and you don't have the proper internal controls or contract oversight management in place.

Thank you, Mr. Benson, and thank you, Ms. Daly.

The hearing is adjourned.

[Whereupon, at 3:51 p.m., the Subcommittee was adjourned.]

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APPENDIX

United States Government Accountability Office

GAO

Testimony

Before the Ad Hoc Subcommittee on Contracting Oversight, Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m. EDT
Wednesday, April 28, 2010

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Pervasive Internal Control Weaknesses Hindered Effective Contract Management

Statement of Kay L. Daly
Director
Financial Management and Assurance

GAO
Accountability * Integrity * Reliability

GAO-10-637T

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Highlights

Highlights of GAO-10-637T, a testimony before the Ad Hoc Subcommittee on Contracting Oversight, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

In November 2007, GAO reported significant deficiencies in internal control over certain contracts the Centers for Medicare and Medicaid Services (CMS) awarded under the Federal Acquisition Regulation (FAR). This Subcommittee and others in Congress asked GAO to perform an in-depth review of CMS's contract management practices. This testimony is based on GAO's October 2009 report on these issues and summarizes GAO's findings on the extent to which CMS (1) implemented effective control procedures over contract actions, (2) established a strong contract management control environment, and (3) implemented GAO's 2007 recommendations.

GAO used a statistical random sample of 2008 CMS contract actions to assess CMS internal control procedures. The results were projected to the population of 2008 CMS contract actions. GAO reviewed contract file documentation and interviewed senior acquisition management officials.

What GAO Recommends

GAO's October 2009 report included 10 recommendations to improve oversight and strengthen CMS's control environment and reaffirmed 7 recommendations from our November 2007 report. CMS concurred with the new recommendations, but generally disagreed with GAO's assessment of progress on the 2007 recommendations. GAO's analysis confirmed only limited progress at that time.

View GAO-10-637T or key components. For more information, contact Kay L. Daly at (202) 512-9095 or dalykl@gao.gov.

April 28, 2010

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Pervasive Internal Control Weaknesses Hindered Effective Contract Management

What GAO Found

GAO reported in October 2009 that pervasive deficiencies in CMS contract management internal control increased the risk of improper payments or waste. Specifically, based on a statistical random sample of 2008 CMS contract actions, GAO estimated that at least 84.3 percent of fiscal year 2008 contract actions contained at least one instance where a key control was not adequately implemented. For example, CMS used cost reimbursement contracts without first ensuring that the contractor had an adequate accounting system, as required by the FAR. These deficiencies were due in part to a lack of agency-specific policies and procedures to help ensure proper contracting expenditures.

These control deficiencies stemmed from a weak overall control environment characterized primarily by inadequate strategic planning for staffing and funding resources. CMS also did not accurately capture data on the nature and extent of its contracting, hindering CMS's ability to manage its acquisition function by identifying areas of risk. Finally, CMS did not track, investigate, and resolve contract audit and evaluation findings for purposes of cost recovery and future award decisions. A positive control environment sets the tone for the overall quality of internal control and provides the foundation for effective contract management. Without a strong control environment, the specific control deficiencies GAO identified will likely persist.

As of the date of GAO's October 2009 report, CMS had not substantially addressed seven of the nine recommendations made by GAO in 2007 to improve internal control over contracting and payments to contractors.

GAO's 2009 Assessment of CMS Actions to Address Prior Recommendations

	GAO recommendation	GAO assessment
1	Develop policies for pre-award contract activities.	No action taken
2	Develop policies regarding cognizant federal agency responsibilities.	Actions insufficient
3	Develop policies that clarify roles and responsibilities during the invoice review process.	Completed
4	Develop guidelines regarding sufficient detail to support contractor invoices.	No action taken
5	Establish criteria for negative certification for payment of invoices.	No action taken
6	Provide training on the invoice review policies.	Actions insufficient
7	Develop a centralized tracking mechanism for employee training.	Completed
8	Develop a plan to reduce the backlog of contracts eligible for closeout.	Actions insufficient
9	Review the questionable payments identified in GAO's 2007 report.	Actions insufficient

Source: GAO. See GAO-10-60 for further details.

To the extent that CMS has continuing weaknesses in contracting activities, it will continue to put billions of taxpayer dollars at risk of improper payments or waste.

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Madam Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss contract management at the Centers for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS). CMS administers Medicare and Medicaid, two programs included on our high-risk list,[1] and other programs such as the State Children's Health Insurance Program. CMS relies extensively on contractors to assist in carrying out its basic mission, including program administration, management, and oversight of its health programs. In fiscal year 2008, the most recent fiscal year for which data were available at the time we completed our work, CMS reported that it obligated $3.6 billion under contracts for a variety of goods and services. CMS's acquisitions include contracts to administer, oversee, and audit claims made under the Medicare program; provide information technology systems; provide program management and consulting services; and operate the 1-800 Medicare help line.

In November 2007, we reported[2] pervasive deficiencies in internal control over certain contracts used by CMS for start-up administrative services to implement programs enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[3] We reported that CMS's internal control deficiencies resulted in millions of dollars of questionable payments to certain contractors, primarily because CMS did not obtain adequate support for billed costs. Internal control—the plans, methods, and procedures used to meet missions, goals, and objectives—is the first line of defense in safeguarding assets and preventing and detecting fraud and errors and helps government program managers achieve desired results through effective stewardship of public resources.

Because of concerns about the implications that these weaknesses may have on all CMS contracts generally subject to the requirements of the Federal Acquisition Regulation (FAR),[4] we were asked to perform a comprehensive, in-depth review of internal controls over CMS's contract

[1]GAO, *High Risk Series: An Update*, GAO-09-271 (Washington, D.C.: Jan. 22, 2009).

[2]GAO, *Centers for Medicare and Medicaid Services: Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments*, GAO-08-54 (Washington, D.C.: Nov. 15, 2007).

[3]Pub. L. No. 108-173, 117 Stat. 2066 (Dec. 8, 2003).

[4]48 C.F.R. ch. 1.

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management practices. My remarks today are based on the findings and recommendations included in our subsequent report issued in October 2009.[5] That report addressed the extent to which (1) CMS implemented effective internal control procedures over contract actions to help ensure proper contracting expenditures and (2) CMS established a strong control environment for contract management. Our report also discussed the extent to which CMS implemented the recommendations we made in 2007 to improve internal control over contracting and payments to contractors. For this testimony, because of the relatively short time between the request to testify and the hearing date, we did not have sufficient time to update the status of CMS's actions to implement our prior recommendations.

Scope and Methodology

To address the extent to which CMS implemented control procedures over contract actions, we focused on contracts that were generally subject to the FAR (i.e., FAR-based),[6] which represented about $2.5 billion, or about 70 percent, of total obligations awarded in fiscal year 2008. The FAR is the governmentwide regulation containing the rules, standards, and requirements for the award, administration, and termination of government contracts. Based on the standards for internal control,[7] FAR requirements, and agency policies, we identified and evaluated 11 key internal control procedures[8] over contract actions, ranging from ensuring contractors had adequate accounting systems prior to the use of a cost reimbursement contract to certifying invoices for payment. Contract actions include new contract awards and modifications to existing contracts. We conducted our tests on a statistically random sample[9] of 102

[5]GAO, *Centers for Medicare and Medicaid Services: Deficiencies in Contract Management Internal Control Are Pervasive*, GAO-10-60 (Washington, D.C.: Oct. 23, 2009).

[6]Certain CMS contracts, such as the claims administration contracts referred to as fiscal intermediaries and carriers, generally are not subject to FAR requirements.

[7]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[8]We determined a control to be "key" based on our review of the standards for internal control as well as the FAR, Health and Human Services Acquisition Regulations, and agency policies and whether inadequate implementation would significantly increase the risk of improper payments or waste.

[9]We selected a stratified random sample of 102 contract actions from a population of 2,441 total contract actions recorded in CMS's procurement system, PRISM, during fiscal year 2008.

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FAR-based contract actions CMS made in fiscal year 2008 and projected the results of our statistical sample conservatively by reporting the lower bound of our two-sided, 95 percent confidence interval. We tested a variety of contract actions including a range of dollars obligated, different contract types (fixed price, cost reimbursement, etc.), and the types of goods and services procured. The actions in the sample ranged from a $1,000 firm-fixed price contract for newspapers to a $17.5 million modification of an information technology contract valued at over $500 million. For each contract action in the sample, we determined if the 11 key internal control procedures were implemented by reviewing the contract file supporting the action and, where applicable, by obtaining additional information from the contracting officer or specialist or senior acquisition management. We also tested the reliability of the data contained in CMS's two acquisition databases.

To address the extent to which CMS established a strong control environment for contract management, we obtained and reviewed documentation regarding contract closeout, acquisition planning, and other management information and interviewed officials in the Office of Acquisition and Grants Management (OAGM) about its contract management processes. We also evaluated the extent to which CMS had addressed recommendations we made in our 2007 report.[10] We used the internal control standards as a basis for our evaluation of CMS's contract management control environment. Appendix I of our October 2009 report provides additional details of our scope and methodology.

This testimony is based on our October 2009 performance audit, which was conducted from July 2008 to September 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Except for certain Medicare claims processing contracts, CMS contracts are generally required to be awarded and administered in accordance with

[10]GAO-08-54.

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general government procurement laws[11] and regulations such as the FAR; the Health and Human Services Acquisition Regulations (HHSAR);[12] the Cost Accounting Standards (CAS);[13] and the terms of the contract.

Since 1998, CMS's obligations to fiscal intermediaries, carriers, and Medicare Administrative Contractors (contractors that primarily process Medicare claims) have decreased approximately 16 percent. In contrast, obligations for other-than-claims processing contract activities, such as the 1-800 help line, information technology and financial management initiatives, and program management and consulting services, have increased 466 percent. These trends may be explained in part by recent changes to the Medicare program, including the movement of functions, such as the help line, data centers, and certain financial management activities, from the fiscal intermediaries and carriers to specialized contractors.

MMA required CMS to transition its Medicare claims processing contracts, which generally did not follow the FAR, to the FAR environment through the award of contracts to Medicare Administrative Contractors. CMS projected that the transition, referred to as Medicare contracting reform, would produce administrative cost savings due to the effects of competition and contract consolidation as well as produce Medicare trust fund savings due to a reduction in the amount of improper benefit payments. Additionally, the transition would subject millions of dollars of CMS acquisitions to the rules, standards, and requirements for the award, administration, and termination of government contracts in the FAR. Obligations to the new Medicare Administrative Contractors were first made in fiscal year 2007. CMS is required to complete Medicare contracting reform by 2011. As of September 1, 2009, 19 contracts had

[11]Title 41, United States Code.

[12]48 C.F.R. ch. 3.

[13]48 C.F.R. ch. 99. These standards are mandatory for use by all executive agencies and by contractors and subcontractors in estimating, accumulating, and reporting costs in connection with pricing and administration of, and settlement of disputes concerning, all negotiated prime contract and subcontract procurements with the U.S. government in excess of $500,000. Certain contracts or subcontracts are exempt from CAS, such as those that are fixed price or those with a small business. Additionally, contractors that received less than $50 million in net awards in the prior accounting period are subject to only certain CAS standards, known as modified coverage. The FAR incorporates the CAS, see 48 C.F.R. §30.101(b).

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been awarded[14] to Medicare Administrative Contractors, totaling about $1 billion in obligations.

The *Standards for Internal Control in the Federal Government*[15] provide the overall framework for establishing and maintaining internal control and for identifying and addressing areas at greatest risk of fraud, waste, abuse, and mismanagement. These standards provide that—to be effective—an entity's management should establish both a supportive overall control environment and specific control activities directed at carrying out its objectives. As such, an entity's management should establish and maintain an environment that sets a positive and supportive attitude towards control and conscientious management. A positive control environment provides discipline and structure as well as the climate supportive of quality internal control, and includes an assessment of the risks the agency faces from both external and internal sources. Control activities are the policies, procedures, techniques, and mechanisms that enforce management's directives and help ensure that actions are taken to address risks. The standards further provide that information should be recorded and communicated to management and oversight officials in a form and within a time frame that enables them to carry out their responsibilities. Finally, an entity should have internal control monitoring activities in place to assess the quality of performance over time and ensure that the findings of audits and other reviews are promptly resolved.

Control activities include both preventive and detective controls. Preventive controls—such as invoice review prior to payment—are controls designed to prevent errors, improper payments, or waste, while detective controls—such as incurred cost audits—are designed to identify errors or improper payments after the payment is made. A sound system of internal control contains a balance of both preventive and detective controls that is appropriate for the agency's operations. While detective controls are beneficial in that they identify funds that may have been inappropriately paid and should be returned to the government, preventive controls such as accounting system reviews[16] and invoice reviews help to

[14]Of the 19 contracts awarded, 6 were under protest and were not yet operational as of September 1, 2009.

[15]GAO/AIMD-00-21.3.1.

[16]An accounting system review is used to determine whether a contractor's accounting system is adequate for determining costs applicable to a contract.

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reduce the risk of improper payments or waste before they occur. A key concept in the standards is that control activities selected for implementation be cost beneficial. Generally it is more effective and efficient to prevent improper payments. A control activity can be preventive, detective, or both based on when the control occurs in the contract life cycle.

Additional, detailed background information is available in our related report, GAO-10-60.

Pervasive Deficiencies in Control Procedures at the Contract Level Increase the Risk of Improper Payments or Waste

Our October 2009 report identified pervasive deficiencies in internal control over contracting and payments to contractors. Specifically, as a result of our work, we estimated that at least 84.3 percent[17] of FAR-based contract actions made by CMS in fiscal year 2008 contained at least one instance in which 1 of 11 key controls was not adequately implemented. Not only was the number of internal control deficiencies widespread, but also many contract actions had more than one deficiency. We estimated that at least 37.2 percent[18] of FAR-based contract actions made in fiscal year 2008 had three or more instances in which a key control was not adequately implemented. The internal control deficiencies occurred throughout the contracting process and increased the risk of improper payments or waste. These deficiencies were due in part to a lack of agency-specific policies and procedures to ensure that FAR requirements and other control objectives were met. CMS also did not take appropriate steps to ensure that existing policies were properly implemented or maintain adequate documentation in its contract files. Further, CMS's Contract Review Board process had not been properly or effectively implemented to help ensure proper contract award actions.[19] These internal control deficiencies are a manifestation of CMS's weak overall control environment, which is discussed later. Additional, detailed information on our testing of key internal controls is available in our October 2009 report.

[17]Based on the results of our work, we are 95 percent confident that the percentage of contract actions that did not meet at least one control test is at least 84.3 percent.

[18]Based on the results of our work, we are 95 percent confident that the percentage of contract actions that did not meet three or more control tests is at least 37.2 percent.

[19]CMS's OAGM established the Contract Review Board as a key control procedure to help ensure contract award actions are in conformance with law, established policies and procedures, and sound business practices.

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The high percentage of deficiencies indicates a serious failure of control procedures over FAR-based acquisitions, thereby creating a heightened risk of improper payments or waste. Highlights of the control deficiencies we noted included the following.

- **We estimated that at least 46.0 percent of fiscal year 2008 CMS contract actions did not meet the FAR requirements applicable to the specific contract type awarded.**[20] For example, we found that CMS used cost reimbursement contracts without first ensuring that the contractor had an adequate accounting system. According to the FAR, a cost reimbursement contract may be used only when the contractor's accounting system is adequate for determining costs applicable to the contract.[21] To illustrate, of the contract awards in our sample, we found nine cases in which cost reimbursement contracts were used without first ensuring that the contractor had an adequate accounting system. In addition to these nine cases, during our review of contract modifications we observed another six cases in which cost reimbursement contracts were used even though CMS was aware that the contractor's accounting system was inadequate at the time of award. In one instance, the contracting officer was aware that a contractor had an inadequate accounting system resulting from numerous instances of noncompliance with applicable Cost Accounting Standards. Using a cost reimbursement contract when a contractor does not have an adequate accounting system hinders the government's ability to fulfill its oversight duties throughout the contract life cycle and increases risk of improper payments and the risk that costs billed cannot be substantiated during an audit.

- **We estimated that for at least 40.4 percent of fiscal year 2008 contract actions, CMS did not have sufficient support for provisional indirect cost rates**[22] **nor did it identify instances when a contractor billed rates higher than the rates that were approved**

[20]We identified 25 contract actions to which FAR requirements specific to the contract type awarded applied, of which 16 contract actions did not meet the control test. Based on the results of our work, we are 95 percent confident that the total percentage of contract actions that did not meet the control test is at least 46.0 percent.

[21]48 C.F.R. §§ 16.104(h), 16.301-3.

[22]The FAR states that provisional indirect cost rates shall be used in reimbursing indirect costs such as fringe benefits or overhead costs under cost reimbursement contracts and are used to prevent substantial overpayment or underpayment of indirect costs. 48 C.F.R. § 42.703-1(b). Provisional indirect cost rates, sometimes called a materials handling rate, may also be used on some time and materials (T&M) contracts. 48 C.F.R. §§ 16.307(a)(1), 52.216-7.

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for use.[23] Provisional indirect cost rates provide agencies with a mechanism by which to determine if the indirect costs billed on invoices are reasonable for the services provided until such time that final indirect cost rates can be established, generally at the end of the contractor's fiscal year. When the agency does not maintain adequate support for provisional indirect rates, it increases its risk of making improper payments.

- **We estimated that for at least 52.6 percent of fiscal year 2008 contract actions, CMS did not have support for final indirect cost rates or support for the prompt request of an audit of indirect costs.**[24] The FAR states that final indirect cost rates, which are based on a contactor's actual indirect costs incurred during a given fiscal year, shall be used in reimbursing indirect costs under cost reimbursement contracts.[25] The amounts a contractor billed using provisional indirect cost rates are adjusted annually for final indirect cost rates, thereby providing a mechanism for the government to timely ensure that indirect costs are allowable and allocable to the contract. CMS officials told us that they generally adjust for final indirect cost rates during contract closeout at the end of the contract performance rather than annually mainly due to the cost and effort the adjustment takes. However, CMS did not promptly close out its contracts and had not made progress in reducing the backlog of contracts eligible for closeout. Specifically, in 2007, we reported that CMS's backlog was 1,300 contracts, of which 407 were overdue for closeout as of September 30, 2007. This backlog continued to increase, and CMS officials stated that as of July 29, 2009, the total backlog of contracts eligible for closeout was 1,611, with 594 overdue based on FAR timing standards.[26] Not annually adjusting for final indirect cost rates increases

[23]We identified 62 contract actions to which provisional indirect cost rates applied, of which 36 contract actions did not meet the control test. Based on the results of our work, we are 95 percent confident that the total percentage of contract actions that did not meet the control test is at least 40.4 percent.

[24]We identified 34 contract actions to which final indirect cost rates applied, of which 23 contract actions did not meet the control test. Based on the results of our work, we are 95 percent confident that the total percentage of contract actions that did not meet the control test is at least 52.6 percent.

[25]48 C.F.R. § 42.703-1(b).

[26]48 C.F.R. § 4.804 states that firm fixed price contracts should be closed within 6 months; contracts requiring the settlement of indirect costs rates, such as cost reimbursement contracts, should be closed within 36 months; and all other contracts should be closed within 20 months. These time frames begin in the month in which the contracting official receives evidence of physical completion of the contract. Generally, files for contracts using simplified acquisition procedures should be considered closed when the contracting officer receives evidence of receipt of property and final payment.

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the risk that CMS is paying for costs that are not allowable or allocable to the contract. Furthermore, putting off the control activity until the end of contract performance increases the risk of overpaying for indirect costs during contract performance and may make identification or recovery of any unallowable costs during contract closeout more difficult due to the passage of time.

- **We estimated that for at least 54.9 percent of fiscal year 2008 contract actions, CMS did not promptly perform or request an audit of direct costs.**[27] Similar to the audit of indirect costs, audits of direct costs allow the government to verify that the costs billed by the contractor were allowable, reasonable, and allocable to the contract. Not annually auditing direct costs increases the risk that CMS is paying for costs that are not allowable or allocable to the contract.

- **We estimated that for at least 59.0 percent of fiscal year 2008 contract actions, the project officer did not always certify the invoices.**[28] CMS's Acquisition Policy Notice 16-01 requires the project officer to review each contractor invoice and recommend payment approval or disapproval to the contracting officer. This review is to determine, among other things, if the expenditure rate is commensurate with technical progress and whether all direct cost elements are appropriate, including subcontracts, travel, and equipment. We noted in our 2007 report[29] that CMS used negative certification—a process whereby it paid contractor invoices without knowing whether they were reviewed and approved—in order to ensure invoices were paid in a timely fashion. In October 2009 we reported that negative certification continued to be CMS's policy to process contractor invoices for payment. This approach, however, significantly reduces the incentive for contracting officers, specialists, and project officers to review the invoice prior to payment. For example, in one case, although a contractor submitted over 100 invoices

[27]We identified 36 contract actions to which an audit of direct costs applied, of which 25 contract actions did not meet the control test. Based on the results of our work, we are 95 percent confident that the total percentage of contract actions that did not meet the control test is at least 54.9 percent.

[28]We identified 90 contract actions to which certification of invoices applied, of which 61 contract actions did not meet the control test. Based on the results of our work, we are 95 percent confident that the total percentage of contract actions that did not meet the control test is at least 59.0 percent.

[29]GAO-08-54.

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for fiscal year 2008,[30] only 8 were certified by the project officer. The total value of the contract through January 2009 was about $64 million. In addition, based on a cursory review of the fiscal year 2008 invoices submitted for payment, we found instances in which the contracting officer or specialist did not identify items that were inconsistent with the terms of the contract or acquisition regulations. For example, we found two instances where the contractor billed, and CMS paid, for items generally disallowed by HHSAR.[31] Reviewing invoices prior to payment is a preventive control that may result in the identification of unallowable billings, especially on cost reimbursement and time and materials invoices, before the invoices are paid. CMS increases its risk of improper payments when it does not properly review and approve invoices prior to payment.

Weak Control Environment Hindered CMS's Ability to Manage Its FAR-based Acquisition Process

The control deficiencies we identified in the statistical sample discussed in our October 2009 report stemmed from a weak overall control environment. CMS's control environment was characterized by the lack of (1) strategic planning to identify necessary staffing and funding; (2) reliable data for effectively carrying out contract management responsibilities; and (3) follow-up to track, investigate, and resolve contract audit and evaluation findings for purposes of cost recovery and future award decisions. A positive control environment sets the tone for the overall quality of an entity's internal control, and provides the foundation for an entity to effectively manage contracts and payments to contractors. Without a strong control environment, the control deficiencies we identified will likely persist. Following is a summary of the weaknesses we found in CMS's overall control environment:

- **Limited analysis of contract management workforce and related funding needs.** OAGM management had not analyzed its contract management workforce and related funding needs through a comprehensive, strategic acquisition workforce plan. Such a plan is critical to help manage the increasing acquisition workload and meet its contracting oversight needs. We reported in November 2007[32] that staff

[30]The contractor submitted separate invoices for different contract line items, which resulted in the high number of invoices in 1 fiscal year.

[31]48 C.F.R. § 315.404-4(d)(4). The HHSAR generally disallows facilities capital cost of money. In cases when the contractor includes the cost in its proposal, the agency is required to reduce the amount of the profit objective by an equivalent amount. In the two instances where CMS paid facilities capital cost of money, the cost was either expressly disallowed by 48 C.F.R. § 52.215-17 or the profit objective was not reduced.

[32]GAO-08-54, p. 18.

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resources allocated to contract oversight had not kept pace with the increase in CMS contract awards. In our 2009 report, we found a similar trend continued into 2008. While the obligated amount of contract awards had increased 71 percent since 1998, OAGM staffing resources—its number of full time equivalents (FTE)—had increased 26 percent. This trend presents a major challenge to contract award and administration personnel who must deal with a significantly increased workload without additional support and resources. In addition, according to its staff and management, OAGM faced challenges in meeting the various audit requirements necessary to ensure adequate oversight of contracts that pose more risk to the government, specifically cost reimbursement contracts, as well as in performing the activities required of a cognizant federal agency (CFA).[33]

Although officials told us they could use more audit funding, we found that OAGM management had yet to determine what an appropriate funding level should be. Without knowing for which contractors additional CFA oversight was needed, CMS did not have reliable information on the number of audits and reviews that must be performed annually or the depth and complexity of those audits. Without this key information, CMS could not estimate an adequate level of needed audit funding. The risks of not performing CFA duties are increased by the fact that other federal agencies that use the same contractors rely on the oversight and monitoring work of the CFA. A shortage of financial and human resources creates an environment that introduces vulnerabilities to the contracting process, hinders management's ability to sustain an effective overall control environment, and ultimately increases risk in the contracting process.

- **Lack of reliable contract management data.** Although CMS had generally reliable information on the basic attributes of each contract action, such as vendor name and obligation amount, CMS lacked reliable management information on other key aspects of its FAR-based contracting operations. For example, in our October 2009 report we identified acquisition data errors related to the number of certain contract

[33] A CFA is a contracting role established in the FAR. The FAR defines the CFA as the agency responsible for establishing forward pricing rates, final indirect cost rates (when not accomplished by a designated contract auditor), and administering cost accounting standards for all contracts in a business unit. 48 C.F.R. §§ 2.101. See 48 C.F.R. §§ 42.302(a), 42.703-1, 30.601. Generally, the CFA is the agency with the largest dollar amount of negotiated contracts, including options, with the contractor. The CFA concept provides an efficient way for contractors to receive a streamlined set of audits and reviews, thereby enabling them to receive and perform government contracts.

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types awarded, the extent of competition achieved, and total contract value. Standards for internal control provide that for an agency to manage its operations, it must have relevant, reliable, and timely information relating to the extent and nature of its operations, including both operational and financial data, and such information should be recorded and communicated to management and others within the agency who need it and in a form and within a time frame that enables them to carry out their internal control and operational responsibilities. The acquisition data errors were due in part to a lack of sufficient quality assurance activities over the data entered into the acquisition databases. Without accurate data, CMS program managers did not have adequate information to identify, monitor, and correct or mitigate areas that posed a high risk of improper payments or waste.

- **Lack of follow-up to resolve contract audit and evaluation findings.** CMS did not track, investigate, and resolve contract audit and evaluation findings for purposes of cost recovery and future award decisions. Tracking audit and evaluation findings strengthens the control environment in part because it can help assure management that the agency's objectives are being met through the efficient and effective use of the agency's resources. It can also help management determine whether the entity is complying with applicable acquisition laws and regulations. Contract audits and evaluations can add significant value to an organization's oversight and accountability structure, but only if management ensures that the results of these audits and evaluations are promptly investigated and resolved. For example, in an audit report dated September 30, 2008, the Defense Contract Audit Agency[34] questioned approximately $2.1 million of costs that CMS paid to a contractor in fiscal year 2006. As discussed in our October 2009 report, OAGM management confirmed that no action had been taken at that time to investigate and recover the challenged costs.

[34]Within the Department of Defense (DOD), the Defense Contract Audit Agency (DCAA) performs contract audits, including those required to fulfill DOD's responsibilities as a cognizant federal agency. When requested and for a fee, DCAA will perform contract audits for other agencies.

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GAO Has Made Numerous Recommendations to Improve CMS's Contract Management Controls

Seven of Nine GAO 2007 Recommendations Were Substantially Unresolved

As we reported in October 2009, CMS management had not taken substantial actions to address our 2007 recommendations to improve internal control in the contracting process. Only two of GAO's nine 2007 recommendations had been fully addressed. Table 1 summarizes our assessment of the status of CMS's actions to address our recommendations.

Table 1: GAO's October 2009 Assessment of Status of CMS Actions Taken to Address 2007 Recommendations

	GAO recommendation	GAO's 2009 assessment of status
1	Develop policies and criteria for pre-award contract activities.	No action taken.
2	Develop policies and procedures to help ensure that cognizant federal agency responsibilities are performed.	Actions insufficient. No policies or procedures developed.
3	Develop agency-specific policies and procedures for the review of contractor invoices so that key players are aware of their roles and responsibilities.	Completed
4	Prepare guidelines to contracting officers on what constitutes sufficient detail to support amounts billed on contractor invoices to facilitate the review process.	No action taken.
5	Establish criteria for the use of negative certification—a process whereby contractor invoices are paid prior to review and approval—to consider potential risk factors.	No action taken.
6	Provide training on the invoice review policies and procedures to key personnel responsible for executing the invoice review process.	Actions taken do not achieve intent of recommendation. Training was provided; however, invoice review policies had not been sufficiently revised to address our recommendations.
7	Create a centralized tracking mechanism that records the training taken by personnel assigned to contract oversight activities.	Completed
8	Develop a plan to reduce the backlog of contracts awaiting closeout.	Actions insufficient.
9	Review the questionable payments identified to determine whether CMS should seek reimbursement from contractors.	Actions insufficient.

Source: GAO. See appendix II of GAO-10-60 for further details.

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GAO Made 10 Additional Recommendations in October 2009 to Further Improve CMS Contract Management

In addition to reaffirming the 7 substantially unresolved 2007 recommendations, our October 2009 report included 10 recommendations to further improve oversight and strengthen CMS's control environment. Specifically, we made recommendations for additional procedures or plans to address the following 10 areas:

- document compliance with FAR requirements for different contract types;
- document provisional indirect cost rates in the contract file;
- specify what constitutes timely performance of (or request for) audits of contractors' billed costs;
- specify circumstances for the use and content of negotiation memorandums, including any required secondary reviews;
- specify Contract Review Board documentation, including resolution of issues identified during the CRB reviews;
- conduct periodic reviews of contract files to ensure invoices were properly reviewed by both the project officer and contracting officer or specialist;
- develop a comprehensive strategic acquisition workforce plan, with resource needs to fulfill FAR requirements for comprehensive oversight, including CFA duties;
- revise the verification and validation plan to require all relevant acquisition data errors be corrected and their resolution documented;
- develop procedures for tracking contract audit requests and the resolution of audit findings; and
- develop procedures that clearly assign roles and responsibilities for the timely fulfillment of CFA duties.

In commenting on a draft of our October 2009 report, CMS and HHS agreed with each of our 10 new recommendations and described steps planned to address them. CMS also stated that the recommendations will serve as a catalyst for improvements to the internal controls for its contracting function. CMS also expressed concerns about our assessment of key internal controls and disagreed with our conclusions on the status of CMS's actions to address our November 2007 recommendations. CMS stated its belief that "virtually all" of the errors we identified in our statistical sample related to "perceived documentation deficiencies." CMS also expressed concern that a reasonable amount of time had not yet elapsed since the issuance of our November 2007 report to allow for corrective actions to have taken place.

However, as discussed in greater detail in our October 2009 report response to agency comments, nearly 2 years had elapsed between our November 2007 and October 2009 reports and CMS had made little

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progress in addressing the recommendations from our November 2007 report. Further, a significant number of our October 2009 report findings, including weaknesses in the control environment, were based on observations and interviews with OAGM officials and reviews of related documentation such as policies and strategic plans. Finally, the deficiencies we identified negatively impact the key controls intended to help ensure compliance with agency acquisition regulations and the FAR.

In conclusion, Madam Chairman, while we have not updated the status of any CMS actions to address our October 2009 findings and recommendations, the extent to which control weaknesses in CMS's contracting activities continue, raises questions concerning whether CMS management has established an appropriate "tone at the top" to effectively manage these key activities. Until CMS management addresses our previous recommendations in this area, along with taking action to address the additional deficiencies identified in our October 2009 report, its contracting activities will continue to pose significant risk of improper payments, waste, and mismanagement. Further, the deficiencies we identified are likely to be exacerbated by the rise in obligations for non-claims processing contract awards as well as CMS's extensive reliance on contractors to help achieve its mission objectives. It is imperative that CMS address its serious contract-level control deficiencies and take action on our recommendations to improve overall environment controls or CMS will continue to place billions of taxpayer dollars at risk of fraud, or otherwise improper contract payments. We commend the Subcommittee for its continuing oversight and leadership in this important area and believe that hearings such as the one being held today will be critical to ensuring that CMS's continuing contract management weaknesses are resolved without further delay and that overall risks to the government are substantially reduced.

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Madam Chairman and Members of the Subcommittee, this concludes my prepared statement. I would be happy to answer any questions that you may have at this time.

GAO Contacts and Acknowledgements

For further information regarding this testimony, please contact Kay L. Daly at (202) 512-9095 or dalykl@gao.gov. In addition, contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony are Marcia Carlsen and Phil McIntyre (Assistant Directors), Sharon Byrd, Richard Cambosos, Francine DelVecchio, Abe Dymond, John Lopez, Ron Schwenn, Omar Torres, Ruth Walk, and Danietta Williams.

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STATEMENT OF

RODNEY L. BENSON

DIRECTOR, OFFICE OF ACQUISITION AND GRANTS MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

OVERSIGHT OF CONTRACT MANAGEMENT
AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE

U.S. SENATE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS,
AD-HOC SUBCOMMITTEE ON CONTRACTING OVERSIGHT

APRIL 28, 2010

CENTERS for MEDICARE & MEDICAID SERVICES

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Testimony of
Rodney L. Benson

Director, Office of Acquisition and Grants Management
Centers for Medicare & Medicaid Services

Before the

U.S. Senate Committee on Homeland Security and Governmental Affairs,
Ad-hoc Subcommittee on Contracting Oversight

On

"Oversight of Contract Management at the Centers for Medicare & Medicaid Services"

April 28, 2010

Chairman McCaskill, Ranking Member Brown, and distinguished Subcommittee members, thank you for inviting me here to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of contracts and acquisitions. Today, I would like to share with you the initiatives that CMS has undertaken, in concert with the Administration and the Department of Health and Human Services (HHS), to ensure proper oversight of its contracts and acquisitions.

CMS appreciates the thoughtful work of this Subcommittee and the Government Accountability Office (GAO), and the recommendations made to improve our programmatic oversight. CMS recognizes the importance of strong contract management. We are committed to assuring the efficient and effective administration and oversight of our contracting activities.

I serve as the Director of the Office of Acquisition and Grant Management (OAGM) within CMS. In my capacity as the Director of OAGM, I am responsible for the award and administration of all CMS acquisition contracts, both those subject to the Federal Acquisition

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Regulation (FAR) and other contracts. OAGM is also responsible for the award and administration of CMS discretionary grants, interagency agreements, and the use of purchase cards. In addition, OAGM develops internal acquisition policies and procedures and performs a multitude of functions to support CMS contracting staff.

Current CMS Contract Management Landscape

By way of background, CMS is an Agency within HHS that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Through these three programs, CMS is responsible for providing health care to more than 100 million beneficiaries and expends more than $700 billion per year.[1] Medicare and Medicaid alone account for 35 cents of each health care dollar spent in the United States.[2]

Since Medicare's inception, contractors have carried out much of its day-to-day administration. These contractors process claims, reimburse providers, and perform audit and program integrity work in consultation with and under the oversight of CMS staff. Similarly, CMS collaborates closely with States and State health care agencies who directly administer the Medicaid and CHIP programs. As our programs grow over time, the amount of contracting also has grown. In Fiscal Year (FY) 1998, CMS awarded approximately $2 billion in contracts, of which approximately $1.7 billion was obligated to the Medicare fiscal intermediary and carrier contracts, which are not considered to be subject to the FAR. By contrast, in FY 2009, CMS awarded approximately $4 billion in contracts, which is inclusive of the legacy Medicare fiscal intermediary and carrier contract activities. Much of this growth in the last decade is due to the

[1] Budget in Brief, Fiscal Year 2011, U.S. Department of Health & Human Services, page 51.
[2] National Health Expenditures data 2009.

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statutory expansion of our programs. In addition, more of CMS' contracts now fall under FAR requirements, which require additional Federal oversight of contractors.

Given the dollars and numbers of contracts involved, CMS understands the importance of fulfilling its fiduciary responsibility through its oversight and monitoring activities. CMS has a number of initiatives in place to manage this increase in workload and meet CMS' contracting needs and our internal control and oversight requirements. For example, we develop an annual fiscal year comprehensive acquisition plan for CMS. This plan identifies all anticipated contract actions and specifies a schedule for the completion of each action. This advance planning enables us to schedule and plan our work over the course of the year, and facilitates the efficient processing of CMS' contracting needs. These planning activities also help us ensure that our procurement actions have the sufficient lead-time needed for the use of competitive contracting procedures, where appropriate. Building on CMS' annual acquisition planning activities, HHS now requires that all HHS operating divisions utilize this strategic planning approach.

In addition, CMS has strategically established acquisition vehicles to meet our programmatic needs effectively and efficiently. For example, we have established, through full and open competition, multiple award indefinite-delivery indefinite-quantity (IDIQ) contracts for areas where CMS has recurring needs. We are then able to compete task orders among the contractors holding an IDIQ contract on an expedited basis. We have put into place multiple award IDIQ contracts for information technology requirements, for beneficiary outreach, for research and development projects, and for our 1-800-MEDICARE call center needs. The availability of these streamlined contracting vehicles has been vital to support our programmatic needs and to

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meet our deadlines through a competitive acquisition strategy that must meet all requirements of the FAR.

While improving our oversight of contracts, we have simultaneously responded to new implementation needs, including Congressional mandates for new health care programs and benefits. For example, CMS awarded the contracts required to launch the Medicare prescription drug program, to establish the Medicare and Medicaid Integrity Programs, which are CMS' primary means of combating fraud and abuse, to pursue implementation of information technology initiatives, to advance outreach to Medicare beneficiaries, and to establish the 1-800-MEDICARE call center.

CMS is proud that it has met the FY 2009 benchmarks and performance metrics under the Department's Acquisition Dashboard, achieving a favorable rating of "Green" across all metrics. In addition, CMS exceeds the HHS goal for contract awards to small businesses.

CMS' Efforts to Improve Staffing of Contracting Oversight

We believe that the integrity and effectiveness of our contracting functions is dependent upon the skills and abilities of our Contracting Officers and other contracting professionals. The success of a Federal acquisition office in instituting and sustaining effective internal controls is dependent upon Contracting Officers' knowledge of, and adherence to, established policies and procedures.

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CMS has a team of Contracting Officers that are highly skilled and dedicated to the Agency. To maintain and enhance their skill set, we have established an Acquisition Career Manager position dedicated to providing the staff necessary training and experience to attain the knowledge and abilities required to advance through GS-1102 certification levels. We also conduct monthly internal training for contracting staff. The focus of this training has been on such topics as invoice review and approval, acquisition data entry, contract types, and the use of competition. Through these efforts, CMS promotes awareness and commitment among its contracting staff to comply with applicable requirements and achieve best value in the award and administration of CMS' contracts.

We also aggressively recruit experienced contracting professionals to support the contracting function. For example, recent changes in the Contracting Office's senior leadership include a deputy who has an extensive acquisition background and a certification as a public contract manager. We have also added a new Director for the Acquisition and Policy Staff who is a nationally recognized expert in acquisition workforce development, and the development and promulgation of acquisition policies and procedures.

In addition, CMS made available to its contracting professionals a web-based acquisition tool that gives easy access to information regarding all acquisition statutes and regulations, comprehensive instructions on all aspects of contracting processes and procedures, detailed acquisition methods, and templates for virtually every contract action. This very detailed and complete resource has facilitated the efficiency and effectiveness of the staff.

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CMS is Addressing the GAO Findings

CMS is committed to the highest degree of integrity in the conduct and management of its contracting activities. CMS continually seeks to strengthen its acquisition functions. We appreciate the work that GAO has done to review our contracting activities and believe the GAO's findings and recommendations have served as a catalyst for improvements to the internal controls for our contracting functions.

The various findings in GAO's reports broadly fall into four categories. GAO expressed concerns with certain CMS acquisition and invoicing policies, with certain aspects of CMS' management of cost-type contracts and with the accuracy of CMS' acquisition data. GAO also recommended that CMS develop and implement a comprehensive strategic acquisition workforce plan. I would like to share some examples of improvements that we have initiated.

CMS Acquisition and Invoicing Policies

We have made a substantial investment in the web-based acquisition tool and new staff resources that have and will continue to have a large impact on our internal contracting policies and procedures. This web-based tool is updated real-time to reflect acquisition regulatory and policy changes across the entire Federal Government. To respond to GAO's findings, we are tailoring the web-based tool to meet all CMS specific policies and plan to add our internal checklists. Taken together, these additional internal controls will ensure a well informed acquisition workforce and enhances our ability to ensure compliance with contracting laws and regulations to ensure best value for the taxpayer.

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In addition, consistent with GAO's recommendations, we have successfully instituted the use of HHS' standard checklists for all contract actions that identify the documentation required for each type of action. This provides a very effective internal control to assure that contract actions comply with applicable FAR requirements. We have also issued 64 separate internal policies that establish effective internal controls, such as processes for the approval of noncompetitive contract actions.

GAO expressed concerns that in some cases the contract files did not contain signed documentation to support the Contracting Officer's Technical Representative's (COTR) and Contracting Officer's review and approval of an invoice. For CMS' major contracting programs, we had in place robust processes and procedures that ensure the proper payment of invoices. We have now strengthened our policies to provide that in no event should an invoice be paid until the COTR and Contracting Officer have both signed the necessary documentation. We are continuing to monitor and explore ways to enhance further our processes to ensure acquisition staff compliance with these policies and procedures.

Administration of Cost Contracts

CMS' approach to contract type selection is to match the unique circumstances of the procurement with the appropriate contract type. In some instances, CMS' procurements are for complex requirements with significant technical risk and cost uncertainty; therefore, a cost-reimbursement type contract is most appropriate. As part of our internal controls, senior Agency leadership is engaged in determining when the use of cost-reimbursement contracts is warranted.

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Additionally, CMS has developed policies to direct contracting staff in their selection of the most suitable contract types and on the best way to the mitigate risks of cost-reimbursement contracts.

We have also established a senior-level position that will focus on the administration of CMS' cost reimbursement contracts focusing on the contract audit functions; including facilitation of the establishment of provisional and final overhead rates. We anticipate that this attention will resolve, and ultimately obviate, many of GAO's specific cost concerns.

Data Accuracy

Accurate data is a key component of the administration of contracts. CMS is committed to assuring that all acquisition data are accurately entered into the Federal Procurement Data System, and will continue its extensive efforts to train OAGM staff on data entry processes and procedures, and to assure that staff enters data appropriately. CMS processes require managers to check the data entry of their employees and provide for an independent review of data entered into FPDS, which has led to improved accuracy of data. CMS procedures to ensure data accuracy have been adopted as a best practice in other operating divisions of HHS, and CMS will continue to enhance these procedures to meet the data quality requirements expected under the Open Government initiative.

Acquisition Workforce Plan

We are currently developing a comprehensive strategic acquisition workforce plan. Our goal is to staff appropriately our acquisition functions, leading to an even more highly trained and skilled acquisition workforce at CMS. This plan will implement and supplement the HHS

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Acquisition Human Capital Plan that was recently submitted to the Office of Management and Budget.

We believe that these various enhancements and improvements to CMS' contracting policy and support functions, together with the significant increased focus on our internal controls and workforce, will improve our oversight and address many of the issues identified by GAO.

Conclusion

CMS is strongly committed to improving the health care provided to beneficiaries of the Medicare, Medicaid, and CHIP programs and ensuring effective management of these programs. As evidenced by my testimony today, CMS has taken significant actions to increase its oversight of contract management, and we continue to explore additional strategies to improve our performance. We appreciate the work that GAO has done to review our contracting activities, and believe that GAO's findings and recommendations will help us prioritize our efforts to improve continuously our oversight of contracts.

CMS agrees with the GAO that strong contract management is vital to ensuring effective programs and safeguarding taxpayer dollars. This Administration is committed to strong internal controls, oversight, transparency, and accountability and CMS will continue to ensure that contracts support program goals in a wise and judicious manner.

I look forward to answering any questions you might have.

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Post-Hearing Questions for the Record
Submitted to
Mr. Rodney L. Benson
From Senator McCaskill

"OVERSIGHT OF CONTRACT MANAGEMENT AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES"

Wednesday, April 28, 2010, 2:00 P.M.
United States Senate, Subcommittee on Contracting Oversight,
Committee on Homeland Security and Governmental Affairs

Question 1: When does the MSPRC contract expire?

Answer 1: The contract is structured with severable option periods as well as non-severable completion efforts. The final option period will run through November 1, 2011.

Question 2: Does CMS intend to compete the MSPRC contract when the current one expires?

Answer 2: Under the law, CMS has the option to renew the contract for an additional term. Specifically, Section 1893(d)(3) of the Social Security Act provides that a contract may be renewed without regard to any provision of law requiring competition if the Contractor has met or exceeded the performance requirements established in the current contract. The Agency has not yet made a decision whether we will compete the follow-on contract, or exercise the authority to us to renew the contract.

Question 3: Is CNI doing the work or have they subcontracted it out to other companies? Please provide the names of CNI's subcontractors, if available.

Answer 3: CNI is performing approximately two-thirds of the work in the MSPRC contract and is subcontracting out the remaining third. The Small Business Administration's guidelines require 8(a) firms to directly perform 51% of the contract workload. CMS works closely with CNI, and all our contractors, to ensure the appropriate balance between work performed by the prime contractor vs. that of any subcontractors.

CNI's subcontractors for this contract are:

a. Cahaba Government Benefit Administrators (Cahaba)
b. Group Health Incorporated (GHI)
    1. JP Morgan Chase
    2. United Systems of Arkansas
    3. Neil Hoosier and Associates
c. ViPS

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Question 4: For base year and all option years, please provide the following in regard to the MSPRC contract award fee: a) total amount available to be earned; and b) total amount awarded.

Answer 4: In accordance with the most recent modification issued, the subject contract's current payment schedule is reflected below. The contract was initially awarded (i.e., structured) as a "Cost Plus Award Fee" (CPAF) contract. However, due to an unforeseeable growth in workload, CMS renegotiated and modified portions of the contract. Specifically, CMS renegotiated the contract to address the backlog in the workload volume, revise the CPAF pricing structure to include only a base fee and eliminate the award fee portion of the fee structure, and to revise the overall cost ceilings based on these changes. The revised pricing structure applies to all periods of the contract as shown in the chart below with the exception of Option Period 5, Contract line item 0006, which is an option period not exercised.

	SLIN	PERIOD	Estimated Cost	Base Fee (0%-8%)	Award Fee (0-3.5%)	Total Estimated CPFF/ CPAF	Period of Performance
0001		Base Period *NonSeverable*	$11,208,473	$896,678	$0	$12,105,151	August 15, 2006 - July 31, 2007
0002		Option Period-1 *Severable*	$30,087,373	$2,406,990	$0	$32,494,363	November 15, 2006 - September 30, 2007
0003	0003AA	Option Period-2 Severable	$37,024,478	$2,961,957	$0	$39,986,435	October 1, 2007 - September 30, 2008
	0003AB	MIR Development *NonSeverable*	$342,624	$21,048	$0	$363,672	June 1, 2008 - April 30, 2010
	0003AC	ReMAS Modernization *NonSeverable*	$4,585,578	$366,846	$0	$4,952,424	September 30, 2008 - Dec.31, 2010
0004		Option Period-3 *Severable*	$42,589,365	$3,308,446	$0	$45,897,811	October 1, 2008 - September 30, 2009
0005		**Option Period-4 Severable**	**$38,748,967**	**$3,099,918**	**$0**	**$41,848,885**	**October 1, 2009 - September 30,2010**
		Subtotal	$164,586,858	$13,061,883	$0	$177,648,741	

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0007	0007AA	A/R Modernization *NonSeverable*	*$2,737,800NTE 50%ceiling*	*TBN*	*$0*	*$2,737,800NTE 50%ceiling*	August 1, 2009 - November 1, 2011
	0007AB	Global Resolved Cases *NonSeverable*	*$101,250NTE 50%ceiling*	*TBN*	*$0*	*$101,250NTE 50%ceiling*	August 1, 2009 - April 1, 2010
	0007AC	EDI *NonSeverable*	*$469,800NTE 50%ceiling*	*TBN*	*$0*	*$469,800NTE 50%ceiling*	August 1, 2009 - Oct. 31, 2010
	0007AD	Payments Thru Pay.Gov *NonSeverable*	*$334,125NTE 50%ceiling*	*TBN*	*$0*	*$334,125NTE 50%ceiling*	August 1, 2009 -Sept. 30, 2011
	0007AE	Right To Recover Letter *NonSeverable*	*$627,426NTE 50% ceiling*	*TBN*	*$0*	*$627,426NTE 50% ceiling*	August 1, 2009 -Sept. 30, 2010
	0007AF	Enhance MSPRC Website *NonSeverable*	*$459,540NTE 50% ceiling*	*TBN*	*$0*	*$459,540NTE 50% ceiling*	**September 1, 2009 - Sept. 30, 2010**
	0007AG	Sect. 111-Outreach *NonSeverable*	*$183,600NTE 50% ceiling*	*TBN*	*$0*	*$183,600NTE 50% ceiling*	**September 1, 2009 - Sept. 30, 2010**
	0007AH	RTR Brochure	$308,900	$24,712	$0	$333,612	9/1/09-8/30/10
	0007AJ	*5010 Change-Reqts Document NonSeverable*	$15,228	$609	$0	$15,837	*September 1, 2009 - Dec.31, 2009*
	0007AK	*Recovery Ops Ctr - Infrastructure Build-out*	*$1,564,443NTE 50% ceiling*	*TBN*	*$0*	*$1,564,443NTE 50% ceiling*	*July 1, 2009 -March 31, 2010*
	CLIN 0007 Subtotal		*$6,802,112NTE 50% Ceiling*	*$25,321*		*$6,827,433NTE 50% Ceiling*	*August 1, 2009 - Sept. 30, 2011*
SubTotal		All Work Exercised Cum-To-Date	$171,388,970	$13,087,204	$0	$184,476,174	Thru Mod 000017
0006		Option Period-5 *Severable*	$35,121,513	$1,756,076	$1,229,253	$38,106,842	October 1, 2010-September 30, 2011
Total Contract Target Ceiling			$206,510,483	$14,843,280	$1,229,253	$222,583,016	

Note: TBN = To Be Negotiated

Question 5: According to CNI, the MSPRC now recovers $8.97 for every dollar spent on recovery activities versus the $.38 for every dollar spent in 2003. Are these figures accurate? Please explain how the return on investment figures were derived.

Answer 5: The cumulative Return on Investment (ROI) from FY2007 through the first quarter of FY2010 for the MSPRC is $8.97. CMS believes that this amount is generally correct; however, the amount has not been audited.

The ROI is calculated using the following methodology:

1.) Take the total amount collected and subtract the refunded amount (e.g. waivers, appeals, three party checks) to arrive at the "Actual Collected Amount;" then
2.) Divide the "Actual Collected Amount" by the cost of the contract.

CMS cautions against comparing the FY2007 through first quarter of FY2010 ROI amount with the ROI from 2003. The cumulative total $8.97 reflects actual ROI for both group health plan

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(GHP) and Non-GHP (e.g. liability insurance, no-fault insurance, and workers compensation) collections during this period. GAO calculated the FY2003 ROI of $0.38 from GHP collections only; therefore, these are not directly comparable figures.

Question 6: Are the contracts for the Hotline cost-plus contracts?

Answer 6: The 1-800-MEDICARE Beneficiary Contact Center (BCC) is a performance-based, cost-plus-award fee (CPAF) task order. A CPAF task order is appropriate in order to meet CMS' objectives of enhanced customer service while increasing efficiency of operations. In this case, a CPAF task order is being utilized because the workload of the BCC is uncertain with large cyclical variances and added spikes in call volumes, which does not permit costs to be estimated with sufficient accuracy to use a fixed price vehicle. To manage a normal load of calls from Medicare beneficiaries, there are currently 2,650 customer service representatives. During the fall when call volumes rise during open enrollment periods for the Medicare Advantage and Part D plans, more than 4,000 staff is employed. We have also seen times when BCC needed over 6,000 staff members to service calls.

Additionally the Agency must respond to a dynamic environment, which includes legislative changes or responses to media attention. This CPAF pricing arrangement allows the government to provide technical direction as required, and evaluate performance with a structured process that considers both objective and subjective criteria.

Question 7: Please provide the Task Order for the work you have hired Grant Thornton to perform regarding the Acquisition Capital Workforce Plan you referred to at the hearing.

Answer 7: There is no separate task order for this work. This work was incorporated into an existing contract, bundled with multiple other changes to that contract. An addendum that explains the Grant Thornton Acquisition Capital Workforce Plan is attached.

Question 8: It is my understanding that in October of last year, someone changed the requirement for the number of MSPRC consent forms that primary plan and third-party administrators have to sign from one to three. Please confirm whether my understanding is accurate. If accurate, please provide an explanation of why this change is necessary. Was it the contractor or CMS policy that changed the requirement?

Answer 8: At CMS' direction, effective October 1, 2009, the MSPRC initiated new requirements for "proof of representation" and "consent to release" documentation. The Agency changed the requirements to better protect Medicare beneficiaries' privacy rights. In order to implement this documentation change as seamlessly as possible, the new requirements are effective only for cases established on or after October 1, 2010. However, in no case are more than two documents required.

The new model language for "proof of representation" and "consent to release" requires documentation specific to the actual relationship with the beneficiary to ensure information is released appropriately. If an agent is used to contact the MSPRC for beneficiary specific information, the liability insurer, no-fault insurer or workers' compensation must submit a

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document specifying the agency relationship, in addition to any other required documentation. (Absent the use of an agent, liability insurers submit only a "consent to release" document. No-fault insurers and workers' compensation may receive information directly without a "consent to release" document.)

CMS takes our role in protecting beneficiary privacy information seriously and will carefully monitor the situation. To date, neither beneficiaries nor their attorneys have expressed concerns to CMS about these requirements.

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GS-23F-819H/HHSM-500-2008-00346G
Modification 000009

Addendum to SOW to include within-scope A-123 effort related to the CMS Office of Acquisition and Grants Management (OAGM)

I. SCOPE

The contractor shall provide audit/consulting services review of internal controls of the CMS Office of Acquisition and Grants Management (OAGM) with an emphasis in support of the OMB Circular A-123.

A. Background

The General Accounting Office recently concluded a review of the OAGM. This October 2009 reported titled 'Deficiencies in Contract Management Internal Control Are Pervasive", addressed a follow up of a previous GAO report from 2007 as well as a series of 10 recommendations for developing policies to improve oversight and strengthen CMS's control environment. The October 2009 report indicated that the deficiencies were due in part to a lack of agency specific policies and procedures and cited control deficiencies from what was perceived as a weak overall control environment caused by inadequate strategic planning for staff and funding resources.

As well, in October 2009 the Office of Management and Budget (OMB) released a Memorandum titled "Acquisition Workforce Development Strategic Plan for Civilian Agencies – FY 2010-2014" which calls on each civilian agency to develop an annual Acquisition Human Capital Plan, the first is due to OMB the end of March 2010. The Department of Health and Human Services Office of Grants and Acquisition Policy and Accountability (OGAPA) has taken the lead role in for the development of the plan with input from individual agencies.

Finally, a cursory review of the contract and grants activity of the CMS OAGM would show that the workload in dollars alone has grown almost 80% in the past 10 years while seeing the workforce grow by only 16%. This, along with the increased requirements of professional certification for its acquisition workforce necessitates a review of the entire OAGM with respect to ensuring appropriate internal controls with respect to A-123, adequately responding to the GAO Report and the development of a CMS Acquisition Human Capital Plan to be used for both internal budgeting purposes and external submissions to the Department.

B. Tasks/Deliverables

The following tasks, at a minimum, shall be performed:

Ten days after contract award - Establish the project plan. Contractor shall, after an initial review of all necessary and relevant CMS/OAGM material, provide the project plan to accomplish the review.

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Modification 000009

Thirty days after contract award – provide first interim report.

Sixty days after contract award – provide second interim report.

Ninety days after contract award –
Provide an assessment of the OAGM internal controls as they relate to the A-123, Appendix A and provide recommendations to correct any deficiencies.

Provide a review, research and 'best practices' which will result in the updating of current OAGM policies and documentation or in the absence of such policies and documentation provide draft OAGM policies and documentation for those recommendations outlined in the GAO Report, to include but not limited to;

- Contract checklist to ensure contract file documents authorizations for letter contracts, adequacy of the contractors accounting systems, and determination and findings for time and materials contracts,
- Policies and procedures to document in the contract file provisional indirect cost rates used as a basis for reviewing the reasonableness of the indirect costs billed on the contractor invoices,
- Policies and procedures that specify what constitutes timely performance of audits of contractor statements of incurred cost for cost reimbursement and time and materials (T&M) contracts,
- Policies and procedures that specify circumstances under which negotiation memorandums should be used and the content of such in light of HHS Acquisition Regulations,
- Policies and procedures that specify Contract Review Board review documentation,
- Policies and procedures that require Division Directors to periodically assess, document, and report to senior management on the results of their review,
- Policy and procedures to revise the Verification and Validation Plan for Departmental Contracts Information System (DCIS) Accuracy and Improvements policy to require all relevant errors be corrected and their resolution documented,
- Policies and procedures for tracking contract audit requests, monitoring the results of contract audits and evaluations, and resolving the audit findings,

Provide a draft OAGM Acquisition Human Capital Plan that includes those recommendations contained in the October 2009 GAO Report and complies with the OMB October 2009 Memorandum. Included in this plan is the result of research and 'best practices' of methodologies of staffing models across the federal government.

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Overview of Award and Incentive Fee Type Contracts

As the Federal Acquisition Regulations (FAR) does not address the term "bonus awards", we interpreted your request to mean the use of award and incentive fees. Incentives take the form of a profit or fee adjustment formula intended to motivate the contractor to effectively manage costs; the fee is adjusted based on cost performance compared to pre-established targets and formula reflected in the contract.

In regard to the award fee process, typically an award fee plan is included in the contract and serves as the government's guide for comparing the contractor's performance against the established performance goals—technical, schedule, quality and cost. The plan defines the roles and responsibilities and identifies the performance requirements, method of review, evaluation criteria, and the relative importance of the criteria. A performance review board is convened during the established intervals in the plan to discuss the performance evaluation criteria and evaluate the contractor's performance. The contractor is then provided feedback on the results of the review, including areas where contractor performance may require improvement; and, an award fee rating and amount are determined.

Analysis of the Department of Health and Human Services Award and Incentive Fee Contracts:

An agency-wide review of the HHS Operating Divisions' contract award and incentive fee contracts and payments for the period October 1, 2008 through October 31, 2009, was conducted to address your specific concerns, and to ensure payment of these fees is in accordance with the relevant FAR provisions. We found that our Operating Divisions are diligent in their evaluation of contractor performance and fees were paid only when the contractors' performance was determined to be at least satisfactory and warranted payment of an award or incentive fee.

Regarding the number of award and incentive fee type contracts and corresponding contract dollars awarded for the designated period, HHS conducted an extensive review of 1268 contract actions reported as award or incentive fee types in the Federal Procurement Data System-Next Generation (FPDS-NG). Of those reported, 308 were confirmed as either award or incentive fee contract actions with a commensurate dollar value of $6,867,653,131. Of the total 308 contract actions, 188 were new fiscal year 2009 contract awards valued at $4,785,521,453. The remaining 120 contract actions, valued at $343,014,047, were fiscal year 2009 contract modifications to both existing and new contract awards.

For the designated period, the total payment to contractors was $2,246,103,060 based on actual invoice amounts reported as paid. In addition, based on contract award documentation, the amount of potential award or incentive fees that could be earned for the reported contract actions were $244,405,920; of this amount $60,133 is reported as actually paid out during the designated period.

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Regarding increases in estimated HHS program values, there was a $299,045,564 increase during the stated period resulting from either changes in program requirements or Department of Labor wage increases. These changes primarily affected HHS contracts including research and development contracts, support service contracts and long-standing health benefits contracts, such as Medicare and Medicaid.

With respect to the use of rollover fees, the Department found that there was only one occasion where the rollover of an award fee was approved. To ensure that Computer Science Corporation effectively managed the MARx program through the transition period and to guard against any degradation in service levels, the Centers for Medicaid and Medicare Services rolled the unused award fee portion, $195,833, from the prior 2008 award fee period to the current 2009 award fee period. The contract modification was signed May 19, 2009. The action was approved by the Award Fee Determining Official.

Regarding whether any programs have been identified by OMB, HHS, the Inspector General or any other entity as experiencing cost, schedule, performance or other management issues, there are none. Also, our review found that HHS has not paid any award or incentive fees to any contractor experiencing cost overruns; or who have been recently cited for regulatory violations.

Analysis of the Department of Health and Human Services Award Fee Contract Policy:

Current HHS Policy and guidance strictly adheres to all established OMB Policy and guidance related to the use and oversight of award fee contracts. OMB's 2007 memo instructing agencies to limit the use of roll-over fees was disseminated to each Head of Contracting Activity who in turn is responsible for communicating this guidance to their acquisition personnel.

Additionally, HHS's Office of Grants and Acquisition Policy and Accountability conducts periodic on-site Procurement Management Reviews (PMR) with the primary objective to assess the efficiency and effectiveness of HHS Operating Divisions' acquisition function to ensure procurement transactions are in full compliance with FAR and HHS Acquisition Regulation, policies and procedures through review of contract files, interviews, management records, and databases.

HHS does not have a formal mechanism in place to measure if the use of award and incentive fee type contracts is more effective than other contracts. However, in view of OMB guidance, and Government Accountability Office reviews, HHS is carefully reviewing its current and prospective award and incentive fee contracts to ensure use of the most appropriate contract type.

As a member of the Office of Federal Procurement Policy's (OFPP) Incentive Contract Working Group (ICWG), HHS collaborates on best practices and lessons learned with other federal agencies that commonly use award fee type contracts. We have found this process to be most effective, and one that led to HHS's participation in the drafting of the new FAR rule on the use of award fees. We will continue to work with OFPP to establish consistent government-wide award fee practices.

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Fact Sheet

NEW INFORMATION ABOUT THE MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR

Senator Claire McCaskill

Chairman, Subcommittee on Contracting Oversight

The Medicare Secondary Payer (MSP) program was established in 1980 to reduce Medicare costs by establishing that Medicare should not serve as the primary payer in situations in which other parties bear the primary responsibility to cover the Medicare beneficiary's medical expenses. For example, Medicare is the secondary payer for Medicare beneficiaries who are working and covered by their employer's group health insurance plan. Medicare is also the secondary payer when a Medicare beneficiary has expenses that are ultimately covered by worker's compensation insurance, automobile medical insurance, and no-fault and liability insurance.[1]

In 2006, CMS consolidated the MSP recovery contracts into a single $200 million cost-plus contract and awarded the contract on a sole-source basis to Chickasaw Nation Industries (CNI), a tribally-owned firm based in Oklahoma.[2] As the Medicare Secondary Payer Recovery Contractor (MSPRC), CNI's responsibilities include identifying mistaken MSP payments for recovery, determining amounts that are potentially subject to recovery, issuing recovery demand letters, and tracking MSP debt.[3] In 2009, CNI received $63.3 million under the MSPRC contract.[4]

On September 30, 2009, the Subcommittee initiated an investigation of the Medicare Secondary Payer Recovery Contractor.[5] The Subcommittee's investigation revealed that there have been ongoing performance problems on the MSPRC contract.

Significant Deficiencies: In July 2009, CMS' independent auditors concluded that the combination of control deficiencies found during their review constituted a "significant deficiency." The report defines a "significant deficiency" as "a deficiency in internal control, or combination of deficiencies ... such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected."[6]

Failure to Respond to Communications in a Timely Manner: CMS' independent auditors also found that CNI failed to meet contract requirements relating to communications with beneficiaries, attorneys, and insurance companies. For example, the MSPRC contract requires the contractor to respond to all telephone voicemails by the next business day and all correspondence within 45 business days. The independent auditors found that CNI failed to meet either deadline. In addition, the auditors found that CNI had failed to issue repayment demand letters within the required10 day timeframe in 39 of 45 cases sampled.[7]

The chart below indicates the progression of CNI's attempt to comply with correspondence requirements.[8]

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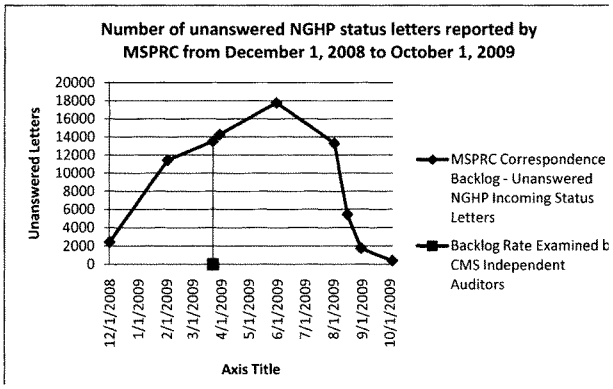

In the second half of 2009, CNI significantly improved its rate of response to communications. By October 2009, CNI failed to answer only 570 of the 18,890 non-group health plan (NGHP) status letters received within the 45 day required time frame.[9]

Lack of Internal Controls: In September 2009, CMS found that although CNI had reduced its backlog and improved case management, the MSPRC continued to fail to comply with contract requirements.[10] Significant internal control weaknesses included:

- Case Management: CNI failed to adequately manage its cases. Of nine liability cases reviewed, two had the wrong debtor, one had no follow-up for resolution, one did not have a demand letter issued for over a year, one case was not closed because MSPRC did not follow-up with the insurance company and for one case the debtor had to ask for a compromise three times.

- Accounting Problems: Cash and check receipts were posted to Accounts Receivable but were not reconciled to deposits or to the log submitted by the bank. CNI also failed to reconcile adjustments to Accounts Receivable. In addition, there was no reconciliation between actual cash deposited and cash collection reported to CMS.

- Debt Write-Offs: No internal controls existed to ensure the principal amount of the debt write-off did not exceed the amount approved by CMS. In one of nine debts reviewed, the amount written off significantly exceeded the approved amount and two cases had activity pending at the time of the write-off request. In addition, CNI failed to reconcile the amounts reported as written-off and the amounts approved by CMS.[11]

Insufficient Funding? CNI officials have acknowledged that the MSPRC failed to meet several contractual requirements related to the timely performance of its recovery duties. However, CNI told Subcommittee staff that many of its deficiencies were due to insufficient funding rather than deficient internal controls. According to CNI, CMS "didn't have enough money to do the job."[12]

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In the past several years, the MSPRC has made significant improvements in performance. In 2003 CMS recovered only $0.38 for every dollar spent on recovery activities.[13] According to CNI, the MSPRC now recovers $8.97 for every dollar spent on recovery activities.[14]

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[1] Congressional Research Service, *Medicare Secondary Payer: Coordination of Benefits* (July 10, 2008).

[2] U.S. Government Accountability Office, *Medicare Secondary Payer: Improvements Needed to Enhance Debt Recovery Process* (Aug. 2004) (GAO-04-783).

[3] Congressional Research Service, *Medicare Secondary Payer: Coordination of Benefits* (July 10, 2008).

[4] For data on contracting at CMS, Subcommittee staff relied on data obtained by GAO from CMS at the Subcommittee's request.

[5] Letter from Chairman Claire McCaskill to Acting Administrator Charlene Frizzera (Sept. 30, 2009).

[6] Grant Thornton, *OMB Circular A-123 Appendix A Review of Internal Control over Financial Reporting of the Centers for Medicare & Medicaid Services (CMS) Final Site Review Report: Medicare Secondary Payer Recovery Contractor (MSPRC) Fiscal Year 2009* (July 23, 2009).

[7] *Id.*

[8] *Id.*

[9] MSPRC Weekly Backlog Report (Oct. 18, 2009).

[10] Centers for Medicare and Medicaid Services, *Contractor Performance Evaluation (CPE) Review Report, Site Visit - Jackson, Mississippi* (Oct. 26, 2009).

[11] *Id.*

[12] Subcommittee on Contracting Oversight, *Staff Interview of Chickasaw Nation Industries President Wendell Gilliam* (April 12, 2010).

[13] U.S. Government Accountability Office, *Medicare Secondary Payer: Improvements Needed to Enhance Debt Recovery Process* (Aug. 2004) (GAO-04-783).

[14] Subcommittee on Contracting Oversight, *Staff Interview of Chickasaw Nation Industries President Wendell Gilliam* (April 12, 2010).

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Opening Statement by Senator Scott P. Brown

April 28, 2010

Subcommittee on Contracting Oversight

U.S. Senate Homeland Security & Governmental Affairs Committee

"Oversight of Contract Management at the Centers for Medicare and Medicaid Services."

This is my second hearing as Ranking Member in this subcommittee, and again it is an honor to join with Chairman McCaskill in exploring the important issues of this subcommittee that go to the core of how our government conducts business. I look forward to tackling these complex issues, asking the tough questions, and finding ways our government can fulfill its missions better, more efficiently, and most importantly with fewer taxpayer dollars.

Today we are tasked with examining how effectively the Centers for Medicare and Medicaid Services (CMS) manage the nearly $4 billion (FY 2008) in taxpayer dollars it obligates each year to contracts. CMS conducts a critical mission for my constituents and for the nation as whole, as it is responsible for administering Medicare, Medicaid, other key health care programs such as the State Children's Health Insurance Program (SCHIP). With an annual budget of approximately $650 billion, CMS serves approximately 90 million beneficiaries and, consequently, plays a crucial role in determining the overall direction of our health care system and how health care is provided in this country.

The recent passage of President Obama's Health Care legislation makes today's topic even more important. With even more taxpayer dollars flowing into these risk-susceptible programs as a result of this legislation, establishing effective accountability measures is critical. Implementing strong, internal controls serve as a front-line defense against improper payments. Experts 'conservatively' estimate that 3% of all health care spending or $68 billion is lost to health care fraud on an annual basis. And I suspect it is a great deal more. To put that amount

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into perspective, it's more than the gross domestic product (GDP) of three-quarters of the countries in the world. Unfortunately, as with any large government program, Medicare and Medicaid already wear a bullseye when it comes to fraud and abuse and often seem to be a target. The unscrupulous have found a cash cow in these programs -- which constitute over 20% of U.S. Federal Government spending. Health care fraud is not a victimless crime as it inevitably translates into higher premiums and costs for taxpayers.

Ultimately, success in reducing these improper payments will hinge on CMS' diligence and commitment to identifying where the problems are occuring , determining their causes, and making the systemic changes necessary to avoid them happening in the future. I maintain that it is more efficient and effective to protect these programs and beneficiaries from fraudulent providers and suppliers upfront, rather than to try to recover payments or redress fraud after it has already occurred.

CMS, as the agency responsible for administering Medicare has a massive and complex job to do. To do this, CMS relies heavily on a network of private contractors to conduct various program integrity activities which, when executed properly, are vital to maintaining the program's vibrancy for today's and tomorrow's seniors. These contractors perform many of the day-to-day tasks of administering the program, such as conducting provider audits, reviewing claims, identifying and investigating fraud and ensuring that Medicare pays only for services for which it has primary responsibility. However, in some cases these contractors are responsible for the oversight of other contractors.

Significant taxpayer dollars are already spent to go after these improper payments. Medicare program integrity activities are funded through the Health Care Fraud and Abuse Control (HCFAC) and Medicare Integrity Program (MIP), which were both established by the

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Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). The HIPAA legislation provided CMS and federal law enforcement agencies with dedicated funds to combat health care fraud. In addition, in 2009, Congress approved even more discretionary funds to enhance these efforts. Lastly, the President's 2011 budget request includes $561 million for Medicare and Medicaid program integrity activities. If approved, total funding for eliminating fraud in FY2011 would amount to $1.7 billion.

One of the central issues before us today is the question of whether CMS has instituted effective contract management internal controls to stem the flow of improper payments? With so much money to spend to mitigate this problem, and so much at stake in terms of providing quality care to beneficiaries and protecting the taxpayer, what is CMS doing to stop this fraud?

The growth in Medicare has been substantial from $221.8 billion in 2000 to over $468 billion in 2008. With this growth in Medicare spending, so too has CMS' reliance on contractors grown. CMS' obligations to contracts has increased from $2.1 billion in 1998 to $3.6 billion in 2008. However, by failing to keep a watchful eye on them, CMS puts taxpayer dollars at risk. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) which established, similar to the President's recent health care legislation, a new benefit, also required CMS to initiate acquisition reform in order to achieve cost savings through increased competition. This rapid increase in contract obligations and major legislative change unfortunately often leads to problems in execution, and I think it's safe to say it has happened in this situation. In a 2007 report (08-54) the GAO found that, "CMS management has not allocated sufficient resources, both staff and funding, to keep pace with recent increases in contract awards and adequately perform contract and contractor oversight." In a 2009 GAO report (10-60) GAO found, "pervasive deficiencies in CMS contract management internal

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control increase the risk of improper payments or waste." The report also stated that, "These control deficiencies also stem from a weak overall control environment as characterized primarily by inadequate strategic planning for staffing and funding resources."

In closing, in light of the current fiscal stress and looming deficits, the need to ensure that every federal dollar is spent as it was intended has never held more importance. The issue before us today is whether CMS is up to the task and prepared to respond effectively to their ever-expanding mission in a way that both improves health care quality and lowers costs. I look forward to discussing these critical issues with our witnesses today.

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