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PATIENTS FIRST: A 21ST CENTURY PROMISE TO ENSURE QUALITY AND AFFORDABLE HEALTH COVERAGE

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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PATIENTS FIRST: A 21ST CENTURY PROMISE TO ENSURE QUALITY AND AFFORDABLE HEALTH COVERAGE

THURSDAY, JUNE 28, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEES ON HEALTH,
AND OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittees met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present Subcommittee on Health: Representatives Bilirakis, Ganske, Norwood, Bryant, Brown, and Capps.

Members present Subcommittee on Oversight and Investigations: Representatives Greenwood, Bilirakis, and DeGette.

Staff present: Erin Kuhls, majority counsel; Julie Corcoran, majority counsel; Kristi Gillis, legislative clerk; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; and Karen Folk, minority professional staff; and Chris Knaur, minority investigator.

Mr. BILIRAKIS. This joint hearing of the Subcommittees on Health and Oversight and Investigations is the fourth in a series held jointly by the Subcommittees on Health and Oversight and Investigations this year as part of our initiative to improve Federal health care programs and to put patients first. To that end, we are continuing our review of the programs, policies and operations of the Centers for Medicare and Medicaid Services or as I like to refer to it, as C-M squared S—it's actually CMS—formerly known as the Health Care Financing Administration.

Today we will examine Medicare's existing contracting authority and proposals to refine this authority with the goal of securing the efficient and responsive delivery of high quality services to Medicare beneficiaries.

Medicare contractors play a critical role in the Medicare program. These contractors process and pay claims, identify potential fraud, respond to inquiries, and educate beneficiaries and providers. The relationship between Medicare and its contractors and the complexities of the current contracting system are important factors to consider when discussing ways to protect and strengthen the program for the future.

Today's hearing presents a forum to discuss the current Medicare contracting environment and the various reform proposals expected

to promote greater efficiency, enhance contractor performance, and improve services to beneficiaries.

I am pleased to welcome our witnesses, and I want to thank them all for joining us today. Our first witness is Tom Scully, the Administrator of CMS, who will present the Administration's contracting reform proposal and explain the need for such reform.

Michael Mangano, the Acting Inspector General of the Department of Health and Human Services, will testify about past contractor integrity issues and weaknesses in CMS' oversight and management of its contractors. He will be joined by Leslie Aronovitz, director of health care issues for the General Accounting Office, who will report on the merits and challenges of expanding Medicare's claims processing contracting authority.

I would also like to welcome Scott Serota, the Acting President and CEO of the Blue Cross and Blue Shield Association, and Tim Cullen, the Chairman of United Government Services, LLC, one of Medicare's largest claims administration contractors.

Finally, I am pleased to welcome Alfred Chiplin, the managing attorney of the Health Care Rights Project at the Center for Medicare Advocacy. Representing Medicare beneficiaries, Mr. Chiplin will testify about one of the most important contractor functions. That is the beneficiary outreach and education.

I look forward to a productive hearing today, and I want to thank our witnesses for their participation. I am hopeful that this discussion will lead to improvements in the administration of the Medicare program and ultimately, and most importantly, to improvements in the quality of care provided to Medicare beneficiaries.

I yield to Mr. Brown for his opening statement.

Mr. BROWN. Thank you, Mr. Chairman. I appreciate this hearing today. I would like to thank Tom Scully, and welcome him to our committee for the first time as the CMS, I guess, administrator. I remember he was sort of hiding inconspicuously until we mentioned it in the back of the room when we had the four former HCFA administrators. We all appreciate your being here for that and listening to some old hands at this to help you do your job now. We welcome you here.

Medicare contractors perform core functions for the biggest insurance company, biggest insurance program in the country. Their resources are limited. Their responsibilities are considerable. Because of frequent statutory and regulatory changes, the program that they administer is ever-changing. We should appreciate the important role that Blue plans and other contractors have played in the program's 36-year success. That is not to say we should maintain the status quo. Contract reform is necessary and long overdue. But it would be unfair to ignore the contributions made by contractors, particularly given the immense challenges that they face.

A couple of years ago, I worked with a provider in my district for nearly a year as that provider wrestled with its carrier over a post-payment audit. It was an eye-opening experience. The carrier lost records, used a new coverage standard to evaluate old claims. By the way, that new and significantly different coverage standard had never been approved by HCFA. Made sampling errors that inflated the overpayment by hundreds of thousands of dollars. It

would take longer than my 5 minutes to recount all those frustrations. No provider should have to go through that.

For the sake of providers and beneficiaries and the integrity of the Medicare program, contractors need to be held to higher standards. They need additional resources. They require more oversight. They should be held accountable not only for paying claims accurately and minimizing fraud and abuse, but for delivering high quality consumer service to beneficiaries and to providers. That means providing timely and accurate and consistent information. It means treating providers with respect and fairness. It means coordinating and maintaining open communications with CMS.

CMS should be held accountable for making sure these goals are met, which means hiring the right contractors and working more closely with them to ensure that Medicare coverage is properly administered.

Congress, we should be held accountable for giving CMS the authority, the flexibility, and the funding it needs to manage and pay contractors for Medicare properly. My guess, Mr. Chairman, is that even more than CMS oversight, improving contractor performance depends but increasing the resources we provide to these contractors. We cannot expect Medicare contractors to provide appropriate customer service unless we give them the resources they need to do the job. Fiscal intermediaries and carriers are Medicare's frontline. If CMS truly wants to improve its image, it should fight for those resources.

I thank the chairman.

Mr. BILIRAKIS. And I thank the gentleman, and I agree with him. If they truly want an increase in those resources, they should be presenting them and fighting for them. That is something that has not been taking place.

The Chair is pleased to recognize the chairman of the Oversight and Investigations Subcommittee, who has done a terrific job on this issue, Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I don't have a formal statement, but would comment that when we first decided to go into the issue of HCFA reform, one of the first things that this committee did was to go to Baltimore to visit the HCFA, then HCFA facility. We met with the acting director and many of the senior staff. We sat around a table and said tell us what we should be looking at when it comes to trying to improve the way this organization provides services. I think the very first comment that was made was change the contractor system. That it is essentially a relic that goes back to the origins of Medicare, and reflected the political and the other realities of that time and not the current situation.

So I am delighted that the Administration has submitted a plan, and that it seems to be so far at least, relatively uncontroversial. I look forward to working with you to enact it.

Thank you, Mr. Chairman. I yield back.

Mr. BILIRAKIS. The gentlelady from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. I don't have a formal opening statement either. I would just like to welcome Mr. Scully and wish you godspeed on your challenges that lie ahead, and look forward to working with you.

I yield back the balance of my time.

Mr. BILIRAKIS. Thank you, gentlelady.

The vice chairman of the subcommittee, the Health Subcommittee, Dr. Norwood.

Mr. NORWOOD. Thank you very much, Mr. Chairman. I ask unanimous consent that my statement be placed in the record, and take this opportunity to thank both of the chairmen here for having this hearing. It is a subject of great interest to many Americans, particularly those that are patients and treat patients. We are right on the subject.

I want to thank Mr. Scully. I think we have got a good man at the helm at times where we do need to make changes.

I look forward to hearing your testimony this morning, Mr. Scully.

Mr. Chairman, I yield back.

Mr. GREENWOOD. I believe that concludes our opening statements.

Mr. Scully, as you are aware, this is a hearing, it's a joint hearing between the Health and the Oversight and Investigations Subcommittee. It is the practice of the Oversight and Investigations Subcommittee to swear in its witnesses. Do you have any objections to testifying under oath?

Mr. SCULLY. No.

Mr. GREENWOOD. Okay. I should also inform you that you have the right to an attorney. Do you with to be represented by counsel?

Mr. SCULLY. No, I do not.

Mr. GREENWOOD. You do not? You are a brave man, Mr. Scully. In that case, if you will raise your right hand, I will give you the oath of office.

[Witness sworn.]

You are now under oath. We look forward to your testimony.

TESTIMONY OF THOMAS SCULLY, ADMINISTRATOR, CENTER FOR MEDICARE AND MEDICAID SERVICES

Mr. SCULLY. Thank you, Mr. Chairman, and Chairman Bilirakis, Mr. Brown, and Ms. DeGette, and Mr. Norwood. I hope this is the first of many cooperative and friendly reform appearances before the committee. I have worked with the committee a lot in the past, and I look forward to working on a lot of issues. As you mentioned, I think this is one of the highest priority ones.

First, I would say that I have an agreement with the Secretary that I have to pay him a buck every time I mention HCFA, so maybe if I do that by accident, which I know it's tough, during the hearing, I will pass around a collection plate at the end.

I do have a written statement for the record. I would like to give an abbreviated version of that. Let me start by in my written statement I have a quote from a former deputy administrator of what was then HCFA, now is CMS, who once said there is substantial evidence that the Medicare cost-based contracts do not contain sufficient incentives for efficient, innovative, and cost-effective operations. Since contractors are reimbursed for whatever reasonable costs they incur, they have no financial motivation to be innovative and attempting to improve service to beneficiaries or in saving money. In other areas of the Federal procurement of this mag-

nitude, contractors are required to compete for the business, and are rarely reimbursed under the kind of no risk, cost-based contracts which are used in Medicare.

Those are not my words, but from 1980, from Earl Collier, who was the deputy HCFA administrator, deputy to Leonard Schaeffer, I think, at the time, who some of you know. My point there is that really nothing has changed in 21 years.

Twelve years ago, when I was at OMB, I pushed contractor reform. I think we had 72 contractors then. We are down now to 49. But these issues have been around for a long time, through Democratic administrations, Republican administrations. There has been a consistent belief in management circles that the right thing to do is reform the contractor process. It has never happened. I think the reason for that is it has always been a relatively low priority for various administrations. It ended up just kind of dwindling in the lower end of what was important, and never happened.

In this administration, it is absolutely the opposite. Secretary Thompson, as you know, also spent a week at HCFA, excuse me, CMS. There is the first buck.

Mr. GREENWOOD. It was HCFA then. That doesn't count.

Mr. SCULLY. Thank you. He spent a week at the then HCFA, now CMS, and learned a lot of things, and I think went from being quite a skeptic about CMS to being very supportive of lots of our efforts. But the one thing that really hit him as pretty outrageous was the way the contractor system worked. He has prodded me virtually every day since to make this a top priority. It is a top priority for him as well, to get this fixed. I think that as all the members of this committee have talked to him, and I think all of them have, realize, it's hard to talk to him for more than 5 minutes without CMS contractor reform coming up.

So it is a very big personal issue for the Secretary, for this administration. I hope we can work cooperatively with all of our contractors to get this done this year. I will refer later to some of the other testimonies, but I think in reading Scott's testimony and some of the other testimony from GAO, there may be a lot more common ground than there has been in the past, and I think that is terrific.

As you mentioned, Mr. Chairman, the design of the program is really from 1965. It just doesn't work, doesn't make a lot of sense. Our contractors do a great job. I won't get into reevaluating our budget request this year, but they do have a huge workload. Arguably in some cases, they do heroic jobs, and there are many concerns and many complaints, some Blue Cross complaints in their testimony this morning about change orders. They are very legitimate. We will do our best to work some of those out.

But the existing contracting system gives CMS very little flexibility, allows us to have very little ways to encourage innovation or accountability from the contractors. I think in any rational evaluation of it would say that it is very ripe for reform.

I think the angle we all have is to have higher quality customer service for our beneficiaries and for providers, to make sure that the 40 million people on Medicare get better quality services. That is what we are trying to do today, every day at CMS, is to find every way we can to fix the systems.

Just to run through the basic ideas in our bill, which in fact was I believe submitted to Congress formally this morning, is first I think we believe the Secretary needs to have the ability to find and select the best qualified contractors to do the job through a full and open contracting process. Today on the Part A side, for instance, and this has been going on forever, from the beginning of the program, the hospitals have the ability to pick their fiscal intermediaries. As many of you know, I used to be in the hospital business, and I used to lobby myself to keep that every year. I always thought it was pretty wild we got away with that, to be perfectly honest. I don't think that there's really any rational reason why hospitals in the current environment should be allowed to nominate individually their providers. It is a vestige of the 1965 law, and I just don't think that there really is a real substantive reason for that to still occur.

Blue Cross Blue Shield Association is the prime contractor for fiscal intermediaries. Out of the 28 fiscal intermediaries who process Medicare claims, we only have direct contracts with three. Twenty five of them are subcontractors through the Blue Cross Blue Shield Association. I think we have a very good relationship with them, but the structure of the existing contract to go through the association just doesn't make sense.

We can't contract directly, for instance, with one of your other companies on the panel today, is United Wisconsin. Blue Cross of Wisconsin, United Government Services, who is one of our bigger contractors, we contract with them through the National Blue Cross Blue Shield plan, which I don't think makes much sense.

We need to have the freedom to contract more open and more sensibly. We would like very much to work with the Blues to pull this off. I think it is going to take a number of years. It is going to have to be phased in. I read Scott Serota's testimony last night. I think that a lot of his ideas I agree with. We don't want this to be CMS trying to come in and push the Blues out of the program. If we got to our eventual goal of 18 to 20 contractors in 5 years, I think we could do that very cooperatively.

If you took our existing 49 contractors and consolidated them in the overlaps of Part A and Part B, as you can see in those charts, we would already be at 30. So our real goal here is to find the 18 to 20 best contractors over the next 5 years, and get from the 30 contractors we currently have overlapping down to a little less than 20, and be able to pick them a little more sensibly, and incentivize them a little more sensibly. We would like to do that in partnership with the Blues and the other carriers and FIs, and do it in a cooperative way. So I hope that no one perceives this as an adversarial process, but hopefully a cooperative process.

As I said, there are 28 fiscal intermediaries and 20 carriers. Part A is fiscal intermediaries, Part B is carriers to process current fee-for-service Medicare claims. In 1989, when I first got involved, we had 72, so there has been some contraction. On average in the last 10 years, we have lost—we have had four contractors a year pull out of the program. So there is a natural contraction and consolidation going on in the program anyway. What we would like to do is structure a little more rationally, push maybe a little quicker

consolidation, and cooperatively work with our contractors to get to a more rational program.

We would also like, as a second step, to have legal authority to contract on an incentive basis rather than a cost basis. I don't think there are many cost-based systems left in the government. There certainly aren't many left in Medicare. On the payment side, we have gone to DRGs, PPS, virtually everything, and gotten away from cost-plus contracts. I think the evidence in Medicare is abundant that cost-plus contracts aren't rational and don't work. Whether you go through hospitals, outpatient clinics, virtually every sector of Medicare, we can go into perspective payment or some type of bundled payment. I believe we should do virtually the same type of thing on the contractor side.

We need to start looking at contractors, the contracts based on performance, whether they are cost-plus which is what a lot of people, including some of our contractors suggested, whether we start to look at more fixed price per member per month contracts. I think we need to start working with our contractors to be more innovative and come up with new ideas.

I am planning to start some demonstration programs this fall, hopefully with the agreement of the committee, to start looking at some of these ways to come up with new, more innovative contracts, to make them better. I hope we will do that with you and your staff's support.

The only one agreement I would point out with some of the other testimony you are going to hear later this morning is I do think that whether we have a merged Part A or Part B in the program payments, it doesn't make much sense on the contractor's side to have different payments for fiscal intermediaries and carriers. I do think that even though it should probably be done gradually and gently, it is rational to merge the carrier NFI process to come up with a merged Part A and Part B contractors payment system.

So in summary, let me just say that I think having read last night the GAO testimony and the Blue Cross testimony, which are the ones I had, I think our differences here are not that great. I think the issue is we need change. Change is long overdue. It probably needs to be phased in to make sure it comes off in a rational, productive way. I do think we need one system that is 15 to 20 contractors, with Part A and Part B merged.

Many of the complaints that Blue Cross has about change orders and helter skelter direction from the agency at CMS, I am determined to fix. I think a lot of those complaints are legitimate, and we will do the best we can to make the system work better. We would like to have a friendly transition with our partners and ease into a more rational system. We can find the best performance-based contractors, provide them with some risk and reward to be better contractors for our beneficiaries and our providers, and come up with a long-term, more rational, more incentive-based partnership.

So I was very happy to read the Blue Cross testimony and the GAO testimony that you will hear later. I think there is a lot of common ground to work with, and I hope we can work closely with our contractors, GAO, the inspector general, and the committees to

make this a more rational system, hopefully this year, so I won't have to come back 12 years from now and give the same talk.

Thank you very much, Mr. Chairman.

[The prepared statement of Thomas Scully follows:]

PREPARED STATEMENT OF THOMAS SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Bilirakis, Chairman Greenwood, Congressman Brown, Congressman Deutsch, distinguished subcommittee members, thank you for inviting me here to testify about Medicare contracting reform.

A former Deputy Administrator in the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS), once said, "There is substantial evidence that the Medicare cost-based contracts do not contain sufficient incentives for efficient, innovative and cost-effective operations. Since contractors are reimbursed for whatever "reasonable costs" they incur, they have no financial motivation to be innovative in attempting to improve service to beneficiaries or in saving money. In other areas of federal procurement of this magnitude, contractors are required to compete for the business and are rarely reimbursed under the kind of no-risk, cost based contracts which are used in Medicare." These are not my words, but words that were spoken in 1980 by Deputy Administrator Earl Collier at a Ways and Means Health Subcommittee hearing on fee-for-service contractors. My point is that contracting reform has been needed for decades, but nothing has changed.

Efforts to reform Medicare's contracting arrangements have been around for years. When I was at the Office of Management and Budget from 1989 to 1993, I pushed it without success. Let me assure you, however, that no Administration, Secretary, or Administrator, has been nearly as committed to fixing this situation than this one.

When Secretary Thompson went to CMS (then HCFA) for a week in May, he was briefed in depth on a wide variety of issues. He was already pretty worked up about our outdated computer and accounting systems before that week. The single issue that outraged him most during his intense week of Medicare and Medicaid briefings was the crazy and antiquated way that the Medicare contracting system works. He has been talking about the issue daily since, and he has been prodding me since, almost daily, to fix it. I am not always a slow learner—so this is at the top of the CMS reform list. In the past this has been low on the reform lists of prior administrations, from Carter and Reagan to Bush and Clinton. That is no longer the case. A strong Medicare demands a rational contracting system. The Secretary's intense interest can be a strong spur to drive this long overdue change—and we are excited to work with you, and our contractors, to fix the system.

Today, the Administration is proposing legislation to reform the current system, and I am pleased to discuss the details of that proposal. I look forward to working with the Committee in the coming months to achieve this important objective.

BACKGROUND

Since Medicare was created in 1965, the government has used private health insurance company contractors to process Medicare claims and perform related administrative services for beneficiaries and health care providers. Today, CMS uses 49 contractors, across the country, including the contract with the Blue Cross Blue Shield Association of America, to process nearly a billion claims each year, from over one million health care providers, and provide customer services to 33 million Medicare beneficiaries. These contractors employ over 21,000 people. This year, Medicare contractors will pay out more than $175 billion for beneficiary health care services, the vast majority of these transactions occurring electronically.

The fee-for-service contractors are governed by Medicare laws that impose outdated requirements and diverge from general federal acquisition laws in several respects. The current Medicare statute restricts the Secretary from competing the fee-for-service claim processing contracts to the most qualified entities. Rather, institutional providers, such as hospitals and nursing facilities, nominate the contractor, or fiscal intermediary, that processes and pays their Medicare Part A claims. While the statute does not require the Secretary to accept the nominations, it effectively ties the Secretary's hands because it also does not allow the Secretary to contract outside the nomination process. In 1965, the American Hospital Association nominated the Blue Cross Blue Shield Association of America to be the fiscal intermediary contractor, who subcontracts with local Blue Cross plans. That arrangement continues today. At the time, some providers nominated other commercial in-

surers to serve as their fiscal intermediaries. Mutual of Omaha is the only major commercial insurer among that original group that continues as an intermediary today. The statute was amended in 1977 to allow the Secretary to designate regional or national intermediaries for administering home health claims. These intermediaries, referred to as Regional Home Health Intermediaries (RHHIs), must already be fiscal intermediaries in order to participate.

For most Part B claims processing, the law is more prescriptive and requires that the Secretary select and use health insurers, referred to as carriers, to process claims and make payments to physicians, ambulance companies, and other suppliers. Similar to the RHHIs, the statute was amended in 1987 to permit the Secretary to designate regional carriers to process claims for durable medical equipment, prosthetics, orthotics, and supplies. These durable medical equipment regional carriers, or DMERCs, also must be health insurers.

CURRENT CONTRACTOR ENVIRONMENT

Today, there are 28 fiscal intermediaries and 20 carriers processing Medicare fee-for-service claims. Twenty-six of the fiscal intermediaries are Blue Cross plans and two are commercial insurance companies. On the Part B side, fifteen of the current carriers are Blue Shield plans and the remaining five are commercial insurance companies.

As you can see in Chart 1, some contractors, such as Nebraska Blue Cross, serve only one State. By contrast, many contractors serve multiple and sometimes non-contiguous states, resulting in a patchwork of coverage and service across the country. For example, on the Part A side, Wisconsin Blue Cross (known outside Wisconsin as United Government Services) serves Wisconsin and Michigan, as well as California and Nevada. The same holds true on the Part B side of Medicare as indicated in Chart 2. Some contractors are both fiscal intermediaries and carriers, for example, South Carolina Blue Cross/Blue Shield, also known as Palmetto, is a fiscal intermediary, carrier, DMERC and RHHI. This patchwork of coverage is a result of the large number of transitions by insurers out of the Medicare program. Since 1994, an average of four contractors has left the program each year (Chart 3).

Medicare's fee-for-service contractors are responsible for a wide range of Medicare program activities. The fiscal intermediaries and carriers receive and control Medicare claims from hospitals and other providers, as well as perform edits on these claims to determine whether the claims are complete and should be paid. In addition, the fiscal intermediaries and carriers calculate Medicare payment amounts and remit these payments to the appropriate party.

The role of the intermediaries and carriers goes beyond claims processing. For example, they conduct reviews and hold hearings on appeals of claims from physicians and providers; they respond to beneficiary inquiries; they make coverage decisions for new procedures and devices in local areas; and they conduct a variety of different provider services, such as enrolling new providers in the program, and educating them on Medicare's rules and regulations and billing procedures. The fiscal intermediaries and carriers also staff Medicare's provider toll-free lines across the country to answer a wide-range of provider questions. In addition, the fiscal intermediaries and carriers perform a variety of functions to ensure the financial integrity of the Medicare program. Currently, all fee-for-service contractors—the fiscal intermediaries and the carriers "are governed by cost reimbursement contracts. By broadening the type of contracts available for use in Medicare contracting and taking greater advantage of competition and other contracting principles in the Federal Acquisition Regulation, the Secretary would be allowed to maximize incentives to encourage more efficient, innovative, and cost-effective contractor operations.

MANAGING FOR RESULTS

CMS has taken a variety of steps over the last several years to improve oversight and management of Medicare's fee-for-service contractors. One of the first, and among the most important, steps we took was to restructure and consolidate CMS's management of the contractors. One individual, the Deputy Director for Medicare Contractor Management, now is directly responsible for all Medicare contractor management activities within the Agency. When the Agency restructuring plan I announced earlier this month is fully implemented, this position will be located in the Center for Medicare Management. We have created direct lines of communication between the contractors and the Deputy Director through our Consortium Contractor Management Officers. These groups are located in each of our four regional consortia and serve as the "eyes and ears" of the Agency for the contractors. Our goal is to be more consistent in our management of fee-for-service contractor per-

formance and to open the lines of communication between our Agency and our contractor partners.

The groups regularly monitor the contractors' performance; provide management and guidance; work with technical experts in the Agency to approve budgets, establish Corrective Action Plans; and help to eliminate Agency obstacles in obtaining answers, feedback, and guidance from CMS's central office and the regions. Furthermore, the Medicare Contractor Oversight Board provides executive leadership and establishes guiding principles for CMSs oversight of the Medicare fee-for-service contractor network.

We also have made substantial improvements to our contractor evaluation processes. In 1999, we revamped our Contractor Performance Evaluation process to ensure greater consistency and objectivity in our review of the contractors. We have incorporated specific, objective standards on a wide-range of contractor functions into our annual review plan. These standards help provide consistent guidance to contractors as to what is expected of them and what improvements are needed. Through accountability and leadership at the senior level of the Agency, we have developed nationally based review protocols and created national review teams for monitoring and reviewing contractor performance. These national review teams, which include experts in Agency business functions, come from every region and the central office. They help to ensure that performance reviews are consistent from region to region and contractor to contractor. In establishing our review of the contractors' performance, we use risk assessment tools to help focus our monitoring and target our resources most appropriately. In addition, in an effort to ensure consistency in our review process, we have increased our educational training and sponsored several national conferences for our reviewers. Our current evaluations are focused on the greatest risk—financial integrity. In the future, we plan to focus our reviews more on customer service. This will include feedback from providers and beneficiaries. Without contractor reform, however, our ability to provide strong incentives to reward improvements in performance is quite limited.

LOOKING TOWARDS THE FUTURE

In conjunction with this new approach to contractor management and oversight, we are developing a long-term business strategy for Medicare fee-for-service contractor operations, taking into account both our past experience and current factors, including the changing business environment. There are several key factors driving the need for this strategic business plan. Our primary concerns are the need to prepare the Medicare program for the future, to ensure that the Medicare fee-for-service program and its contractors are both responsive to providers and, above all, contribute to providing high-value services for beneficiaries; and to protect the trust funds from needless error and waste while also remaining accountable to taxpayers.

Our strategic business plan will provide us with a framework for decision-making and articulating our business vision to our contractors. It also will assist us in improving our management and oversight and stabilizing our business relationships with them. Our goal is to promote organizational learning and innovation within the Agency as well as with our contractors. We know, for example, that there is a growing need for flexibility in administering the fee-for-service program. And we have learned a great deal about the need to respond quickly and think in innovative ways to adapt to changes following the passage of the Balanced Budget Act, Balanced Budget Refinement Act, and subsequent legislation. Our business plan will help ensure that our contractor systems have the operational capacity to respond to these complex and multiple programmatic changes, such as modifications to Medicare coverage or the addition of new and complex payment systems, and to meet future programmatic challenges.

Our business plan also is focused on our continuing to meet the needs of our beneficiary, provider, and contractor stakeholders. This includes the transition of claims processing work from a contractor leaving the program to one assuming additional work with minimal disruption to providers and beneficiaries, improving educational services provided to beneficiaries and providers by our contractors, and compensating contractors appropriately for the work they do. At the same time, we must strive to improve the financial management of the Medicare program by minimizing the potential for abuse and errors, considering cost-effective ways to implement program and system changes, and improving the integrity of the provider enrollment process.

CONTRACTING REFORM

We must continue to manage the Medicare program efficiently and effectively and to fully implement our business strategy. To do that, we must fundamentally change

our relationship with the Medicare fee-for-service contractors. I firmly believe that the Medicare fee-for-service contracting work should be awarded competitively to the best-qualified entities, using performance-based service contracts that include appropriate payment methodologies. This is something that current law will not allow.

I believe these contracts should result in contractors receiving payment when they deliver something of value, and profit only when they perform at or above the satisfactory level. We must be able to maximize economies of scale and improve the level of service to our beneficiaries and providers. We would like to work cooperatively with our existing contractors to get to this goal, but these changes require legislative action. As I mentioned, today we are proposing legislation to address these differences and we want to work with this Committee and the Congress on a viable, sensible solution.

Through these legislative changes, CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to work together more effectively and better adapt to changes in the Medicare Program.
- Promote competition, leading to more efficiency and greater accountability.
- Establish better coordination and communication between CMS, contractors and providers.
- Promote CMS's ability to negotiate incentives to reward Medicare contractors that perform well.

These changes will enhance the Agency's ability to more effectively manage claims processing for the Medicare program in the future, and ensure that the future changes to the Medicare program's operating structure are free from unnecessary constraints.

We are continuing to proceed with the implementation of our long-range business strategy. To capture the benefits of integrated data processing, we have begun to consolidate our claims processing workload among our existing contractors, and are moving to consolidate and standardize contractor claims systems. Our goal is to have one system for intermediary claims, one for carrier claims, and one for durable medical equipment claims. And we will continue to establish more direct control of our data centers, which should reduce costs and improve efficiency. This consolidation will allow us to make changes efficiently and consistently, and help streamline our information technology infrastructure. Over time, based on the results of ongoing risk and cost benefit analysis, we anticipate expanding our current pool of contractors to include those who can perform specific functions, such as program integrity and coordination of benefits. In addition, we will continue to build the systems interfaces needed to ensure the full integration of Medicare's contractor operations with the new integrated general ledger accounting system initiative to enhance the contractors' financial management, and protect the Medicare trust funds for the future.

CONCLUSION

I appreciate the opportunity to appear before you today and share our vision for reforming the Centers for Medicare and Medicaid Services' administration of Medicare's fee-for-service claims processing contractors. Together, we can take aggressive action to reform Medicare's current contracting arrangement. We must build on the strengths of our current contracting relationships and foster a environment of accountability, innovation, and flexibility. We already have a strong business strategy in place. Through the implementation of this plan, and the realization of our contracting reform objectives as set forth in our legislative proposal, I am confident the Medicare program will be strengthened and better prepared to meet future challenges. I look forward to working with this Committee and the Congress on a bipartisan basis to enact this critical reform legislation. Thank you and I am happy to answer your questions.

Mr. GREENWOOD. Thank you, Mr. Scully. It is my understanding that you will stay with us.

Mr. SCULLY. Yes.

Mr. GREENWOOD. We will have the next two witnesses give their testimony. Then the three of you will take questions as a panel. So we call forward Mr. Michael Mangano, who the Acting Inspector General, Department of Health and Human Services, and Ms. Leslie Aronovitz.

Did I say that right, Aronovitz?

Ms. ARONOVITZ. That's okay.

Mr. GREENWOOD. You are both aware that the Oversight and Investigations Subcommittee has the practice of having its witnesses give their testimony under oath. Do either of you object to testifying under oath? Under the rules of the committee and the House, you are entitled to counsel. Do either of you wish to be advised by counsel today? In that case, if you will raise your right hand.

[Witnesses sworn.]

You are both under oath. We will hear first from Mr. Mangano.

TESTIMONY OF MICHAEL F. MANGANO, ACTING INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND LESLIE G. ARONOVITZ, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. MANGANO. Thank you very much, Mr. Chairman, and members of the subcommittee. I really appreciate this opportunity to testify before you this morning on the Medicare program, and on the importance of the Medicare contractors who actually operate this particular program.

As we all know, these Medicare contractors function well when providers are promptly paid, beneficiaries receive the health care services that they are entitled to, and the trust funds are protected against wasteful spending. When they don't, the entire program is in jeopardy.

Since the inception of the Medicare program, numerous legislative changes have been made and amendments added to the Social Security Act, which have led to substantial changes.

Mr. BILIRAKIS. Why don't you pull that mike closer, please, sir?

Mr. MANGANO. Yet the way the Centers for Medicare and Medicaid Services, CMS, actually has decided to select its contractors and organize its contractors has really remained much the same over the years, primarily due to the laws.

CMS needs to be given greater flexibility in the methods it uses to select, organize, and supervise its Medicare contractors. With this, we believe that it needs to have authorities to use entities other than insurance companies, select them competitively, pay them on an other than cost basis, organize them according to the function and benefit areas, and hold them accountable for performance.

Over the years, we have identified numerous problems with contractor operations. Perhaps most troubling of all has involved lapses in the contractor's own integrity and involvement in such things as misusing government funds while concealing their actions, altering documents and falsifying statements of specific work that was performed, preparing bogus documents to falsely demonstrate superior performance, which then led to bonuses being paid by the Medicare program or additional contracts being given to that particular contractor, and adjusting their claims processing so that systems edits, designed to prevent inappropriate payments were turned off, thus resulting in misspent Medicare trust fund dollars. Since 1993, we have entered into civil settlements with 14 Medicare contractors, resulting in total settlements in excess of $350 million.

We have also encountered problems associated with financial management and accounting procedures. For several years, we have reported serious errors in contractor reporting of accounts receivable that resulted from weak financial controls. It is quite clear that the root cause of these problems has been the lack of an integrated dual entry accounting system, less than adequate oversight and internal controls that would have prevented these problems from occurring in the first place.

CMS also relies on extensive electronic data processing operations to administer the Medicare program and to process and account for Medicare expenditures. Here we found numerous general control weaknesses, primarily with Medicare contractors. About 80 percent of the 124 problems that we found in our review of the last financial statement of the Medicare program identified three general types of controls that we felt were insufficient, namely, access controls, entry-wide security programs and systems software controls.

The ability to prevent or correct the problems just described stem at least in part from the way that CMS is required to contract with its claims administrators. The Medicare statute places substantial limits on how CMS can obtain contractor assistance to administer the Medicare program, including limiting CMS to choosing only certain types of companies to process claims and restricting them to a cost-based reimbursement method.

Although most of government contracts require competitive bidding, using full and open competition with very few prohibitions on who can be awarded the government contract, CMS typically contracts with fiscal intermediaries and carriers without using full and open competition restricted to health care companies sometimes selected by health care providers, and is required to use cost reimbursed contracts where the government assumes all the risk.

To promote innovations and efficiencies from the private sector, legislation is needed that would increase their flexibility in how it contracts by allowing it to contract competitively and with entities that are not necessarily insurance companies, allow it to contract with one entity to perform both contractor and intermediary functions, permit the Secretary to follow normal government procurement regulations, and reimburse contractors on a fixed-fee basis when needed. These changes would provide CMS with greater flexibility, promote competition, increase CMS' ability to negotiate incentives, and improve their contractor performance evaluation process.

We believe these common sense approaches are long overdue and have consistently testified in their support. CMS needs to have sufficient flexibility in its authorities to contract with companies best able to carry out the needed functions, hold these companies accountable when they fall short, and reward them when they perform well. Beneficiaries and providers will be better served when that happens, and CMS will get a better value for the contracting dollar.

Thank you very much, Mr. Chairman. I will look forward to answering your questions at the appropriate time.

[The prepared statement of Michael F. Mangano follows:]

PREPARED STATEMENT OF MICHAEL F. MANGANO, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairmen and members of the Subcommittees. I appreciate the invitation to testify today on the important issue of improving Medicare contractor operations.

Medicare contractors are the heart of the Medicare program. When they function well, providers are paid promptly, beneficiaries receive the health care services they need, and the Trust Fund is protected against wasteful spending. When they don't function properly, the entire program is jeopardized—those who benefit from it, those who provide care, and those who pay for it all suffer the consequences.

Since the inception of Medicare, numerous legislative changes have been made and amendments added to the Social Security Act which have led to substantial changes in the Medicare program.

For example, the way Medicare pays for health care has changed through time, from primarily cost/charge based payment systems to new fee-schedule and prospective based arrangements. While the Medicare program as a whole has seen significant change, the way that the Centers for Medicare and Medicaid Services (CMS) is allowed to select and organize its contractors has remained much the same as it has since the inception of the program.

CMS needs to be given greater flexibility in the methods it uses to select, organize, and supervise the contractors who handle the day-to-day operations of the Medicare program. This includes authorities to use entities other than insurance companies, select them competitively, pay them on other than a cost basis, organize them according to functions or benefits areas, and hold them accountable for performance.

BACKGROUND

The Medicare program provides health insurance for 39.5 million elderly and disabled Americans at a cost of over $220 billion in fiscal year 2001. Although beneficiaries have a growing number of options under the Medicare+Choice program, the majority of beneficiaries are still covered by traditional fee-for-service Medicare. The fee-for-service program is administered by the CMS with the help of approximately 50 contractors that handle claims processing and administration.

Since the Medicare program was created, the government has contracted with private health insurance companies for claims processing and related administrative services. There are two primary types of contractors. Fiscal intermediaries (FIs) process claims filed under Part A of the Medicare program by institutions, such as hospitals and skilled nursing facilities. Carriers process claims under Part B of the program filed by other health care providers such as physicians and medical equipment suppliers. In addition to these two types, Durable Medical Equipment Regional Carriers (DMERCs) pay suppliers of durable medical equipment, prosthetics, and orthotics; and, Regional Home Health Intermediaries (RHHIs) process home health claims.

Contractor tasks for the Medicare program fall into 5 functional areas: 1) claims processing, 2) payment safeguards, 3) fiscal responsibility, 4) beneficiary services, and 5) administrative activities. Claims processing involves receiving claims, promptly paying those that are appropriate, taking necessary action to identify inappropriate or potentially fraudulent claims and either withholding payment or recovering overpayments. Payment safeguard activities require additional actions to further safeguard the integrity of the Medicare program and protect against fraudulent and abusive billing. Safeguard activities include medical review to determine the medical necessity of procedures and services, Medicare Secondary Payer (MSP) review [1], audits, and investigations by fraud units. Fiscal responsibilities by the contractors include all actions to ensure a full and accurate reporting of Medicare accounts receivable and financial reconciliations.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) enacted the Medicare Integrity Program, which provided CMS with new authorities to contract with entities beyond, but also including, current carriers and fiscal intermediaries to perform specific payment safeguard functions. Such contractors can take on some, all, or any subset of the work associated with current contractor payment safeguard functions including medical and utilization review, cost report audits and provider education.

[1] Medicare Secondary Payer activities identify other sources of payment, such as employer-sponsored insurance or other third-party payer that may cover health claims for Medicare beneficiaries. These payers are primary and Medicare is secondary with respect to responsibility for paying a claim.

Unfortunately, we have identified numerous problems in contractor operations over the last few years. I will highlight some of these problems for you now.

INTEGRITY PROBLEMS

Perhaps the most troubling of all the problems that the Office of the Inspector General (OIG) has observed has involved lapses in contractors' own integrity—misusing government funds and actively trying to conceal their actions, or altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars.

Since 1993, a number of criminal and civil actions have been taken against carriers and intermediaries in connection with their performance under CMS contracts, and we have entered into civil settlements with 14 Medicare contractors with total settlements exceeding $350 million. OIG has imposed 8 corporate integrity agreements in connection with these settlements. Corporate integrity agreements are mandatory compliance and reporting requirements agreed to by the contractor to avoid exclusion or debarment. In addition, two contractors have entered into guilty pleas to the charge of obstruction of a federal audit.

The following examples illustrate the egregiousness of the problems which can occur and the consequent exposure to financial losses. Unfortunately, they are not isolated cases. At any given time, several contractors may be under investigation by our office. Presently, we have 24 former or current contractors actively under investigation.

Health Care Service Corporation

In July of 1998, Health Care Service Corporation, the Medicare carrier for Illinois and Michigan, agreed to pay $140 million to resolve its civil liability under the Civil False Claims Act and the Civil Monetary Penalties Law. On an annual basis, CMS evaluates the performance of its carriers, relying, in large part, on information, data and certifications provided by the carriers. Carriers that demonstrate poor performance on these annual reviews are subject to contract termination or other adverse action by CMS. Between 1985 and 1997, Health Care Service Corporation altered documents and manipulated data in order to improve its score on these annual reviews. During our investigation, we found the following problems: improper processing of Medicare Secondary Payer claims, bypassing the system generated audits and edits during the processing of Part B claims, and improper deletion of claims from the system.

In addition to the civil settlement, the corporation pleaded guilty to obstructing a federal audit, conspiracy to obstruct a federal audit and six counts of making false statements to CMS. Health Care Service Corporation paid a $4 million criminal fine in connection with these charges. Two of the corporation's managers pleaded guilty and five others were indicted on various criminal charges related to this scheme. CMS terminated the Medicare contracts with Health Care Service Corporation as of September 30, 1998. This case resulted in the largest civil fraud settlement against a Medicare contractor to date.

XACT Medicare Services of Pennsylvania

In August of 1998, a Medicare carrier located in Pennsylvania agreed to pay $38.5 million to resolve its liability for misconduct in its performance as a carrier. A joint investigation by the OIG and other Federal agencies found that during the years 1988 through 1996, the carrier engaged in the following misconduct: failing to properly process or take appropriate action to recover improper payments related to Medicare secondary payer claims; obstructing the carrier performance evaluation program by rigging samples for CMS audits; failing to recover overpayments; failing to monitor End Stage Renal Disease laboratory claims; and overriding payment safeguards to by-pass electronic audits or edits when processing Part B claims. As part of the settlement, the carrier agreed to enter into an extensive corporate integrity program to ensure proper training for its employees and external reviews of its performance under its contract with Medicare.

Blue Cross/Blue Shield of Michigan

On January 10, 1995, Blue Cross/Blue Shield of Michigan, a Medicare carrier, agreed to pay $27.6 million to settle a qui tam suit under the False Claims Act initiated by a former employee. At the time that the suit was filed, in June 1993, Blue Cross/Blue Shield of Michigan was also the fiscal intermediary for the Medicare

Part A program in Michigan and was the carrier for the Medicare Part B program. As of September 30, 1994, CMS terminated both contracts and Blue Cross/Blue Shield of Michigan no longer serves as intermediary or carrier. As the intermediary, Blue Cross/Blue Shield of Michigan was responsible for auditing participating hospitals' cost reports to ensure accuracy. An Office of Inspector General (OIG) investigation showed that they performed inadequate, cursory audits in which they disregarded significant overpayments. They later gave CMS fraudulent work papers in an attempt to show that complete and accurate audits were performed. The precise amount of loss to the Government could not be determined because it would have required auditing more than 200 hospitals. As part of the settlement, the Blue Cross/Blue Shield of Michigan agreed to repay the entire amount CMS had paid to perform audits over a 4 year time period, approximately $13 million.

Blue Cross/Blue Shield of Michigan also agreed to pay an additional $24 million to settle charges of violating Medicare secondary payer laws. Under these laws, private insurers are required to act as the primary benefits payer under certain circumstances when an individual has medical insurance under both Medicare and an employer health plan. An OIG audit determined that in its capacity as the Medicare contractor in Michigan, Blue Cross/Blue Shield of Michigan paid thousands of dual coverage claims from Medicare trust funds rather than from its own funds in cases where there was overlapping coverage.

Anthem Blue Cross and Blue Shield of Connecticut

In December of 1999, Anthem Blue Cross and Blue Shield of Connecticut (Anthem), Connecticut's former Medicare fiscal intermediary, agreed to pay the Government $74.3 million to resolve allegations of wrongdoing by its predecessor corporation. The company allegedly falsified hospital cost reports to meet Government performance standards as a Medicare fiscal intermediary. The company's misconduct led several Connecticut hospitals to improperly receive Medicare overpayments and enabled the company to obtain a better performance evaluation from CMS than it would have otherwise received. This settlement represents the largest civil settlement in a health care fraud case in the State and the second largest Medicare contractor settlement nationwide. As part of the settlement, the company, which is no longer an intermediary, agreed to the imposition of a corporate integrity agreement for 5 years for its Medicare+Choice health maintenance organization contract, which it still operates.

FRAUD UNIT PERFORMANCE

As part of their payment safeguard activities, Medicare contractors are required to have Fraud Units which are designed to detect and deal with problems of fraud and abuse within the provider community. The types of problems detected range from individual cases of suspected fraud, to patterns of fraud or questionable activity which may represent a broader program vulnerability.

As we work closely with these units, we in the OIG are keenly interested in their operations and effectiveness. In 1996, we reviewed the functions of the carrier fraud units, and in 1998 we reviewed the fiscal intermediary fraud units. Overall, we found that their effectiveness varies considerably and often their performance is not directly related to the size of the unit or the total number of resources allocated. Total case loads among the Fraud Units varied considerably, from zero to over 600 for the intermediaries. In reviewing carrier case files, we also found that some allegations of fraud were being lost during the overpayment adjustment process and were not properly developed as potential fraud cases. In addition to complaints received, Fraud Units are encouraged to proactively develop their own cases for potential referral to our office. Unfortunately, we found that less than one-half were actively engaged in developing their own cases. Similarly, less than one-half of the fraud units were active in identifying program vulnerabilities.

A key factor is a contractor management's commitment and attention to fraud matters overall. The most successful Fraud Units are those given significant prominence in the contractor's organizational structure, reporting to the highest levels of corporate management. Overall, however, effectiveness of the Fraud Units has been hampered by staff turnover, lack of proper background and training, and an overall lack of uniformity and understanding of key fraud terms and definitions.

As mentioned earlier, HIPPA provided CMS with new authorities to contract with entities separate from current carriers and fiscal intermediaries to perform specific program integrity functions. These new Program Safeguard Contractors will supplement, and in some cases replace, the work of fiscal intermediary and carrier fraud units. It is too early to evaluate the performance of these safeguard contractors; however, as I will discuss in more detail later, their structure provides a model on which to base broader contractor reforms.

FINANCIAL MANAGEMENT PROBLEMS

We have also encountered problems associated with financial management and accounting procedures and longstanding weaknesses in internal controls, including deficiencies related to the receivable amounts reported in CMS' financial statements and electronic data processing.

Financial Systems and Processes

Along with its Medicare contractors, CMS is responsible for managing and collecting many billions of accounts receivable each year. Medicare accounts receivable are primarily overpayments made to health care providers by contractors that must be repaid to Medicare, and funds due from other entities when Medicare is the secondary payer. For FY 2000, the contractors reported about $30 billion in accounts receivable activity which resulted in an ending gross balance of approximately $7.1 billion—over 87 percent of CMS' total receivable balance.

For several years, we have reported serious errors in contractor reporting of accounts receivable that resulted from weak financial controls. Control weaknesses were noted again in our FY 2000 audit. Because the claim processing systems used by the contractors lacked general ledger capabilities, obtaining and analyzing financial data was a labor-intensive exercise requiring significant manual input and reconciliations between various systems and ad hoc spreadsheet applications. This situation increases the risk that contractors could report inconsistent, incomplete, or erroneous information.

To address previously identified problems in documenting and reporting accounts receivable and to accurately determine receivable balances, CMS began contracting with independent public accountants in FY 1999. This year, the accountants noted significant improvement in the CMS central office's analysis of information included in its financial statements, along with the improvement in contractors' processing and reporting of receivables. Over the 2-year period, however, the independent public accountants identified about $590 million in non-Medicare Secondary Payer recorded debt that the Medicare contractors could not document. While all of these receivables were written off because of the lack of documentation, some may have represented actually debt due to Medicare that should have been collected.

Although it is quite clear that the root cause of the accounts receivable problem is the lack of an integrated, dual-entry accounting system, better oversight or implementation of compensating internal controls could ensure that the receivables will be properly accounted for and reflected in their future financial reports. For instance, had CMS regional offices been required to conduct reviews similar to those conducted by the independent public accountants, many problems could have been detected earlier or prevented and the need to hire outside accountants would have been obviated. Similarly, stronger regional office oversight of the contractors would have helped to ensure that essential controls, such as reconciliations, were in place to prepare accurate and complete financial reports. Of the 10 contractors in our sample, 9 did not reconcile the monthly expenditures reported to CMS to the actual paid claims tape as CMS requires. Failing to conduct this reconciliation increases the risk of material misstatements in the financial statements.

To address its systems problem, CMS plans to develop a state-of-the-art Integrated General Ledger Accounting System. However, the system will not be fully operational until 2007. Until then, stronger internal controls and oversight of the Medicare contractors are critically needed.

Electronic Data Processing

The CMS relies on extensive electronic data processing (EDP) operations at both its central office and Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data and sensitive information while reducing the risk of improper Medicare payments disruption of critical operations, and malicious changes that could interrupt data processing or destroy data files.

However, we again found numerous EDP general control weaknesses, primarily at the Medicare contractors. About 80 percent of the 124 weaknesses that we noted involved three types of controls:

- **Access controls** ensure that critical systems assets are physically safeguarded, that logical (e.g. electronic) access to sensitive computer programs and data is granted only when authorized and appropriate, and that only authorized staff and computer processes access sensitive data in an appropriate manner. Weaknesses in these controls represented the largest problem area. At several con-

tractors, for example, programmers had inappropriate access to beneficiary history files, and passwords were not properly administered.

- **Entry-wide security programs** ensure that security threats are identified, risks are assessed, control techniques are developed, and management oversight is applied to ensure the overall effectiveness of security measures. At several sites, we found that contractors lacked fully documented, comprehensive entity-wide security plans.
- **Systems software controls** help to prevent unauthorized individuals from using software to read, modify, or delete critical information and programs. We noted problems in managing routine changes to systems software to ensure their appropriate implementation and in configuring operating system controls to ensure their effectiveness.

In addition, the prior control weaknesses concerning the Medicare data centers' access to the software program coding of the "shared" system used by certain Medicare contractors remains unresolved. This weakness has been expanded to include the Common Working File system, which all shared systems use to obtain authorization to pay claims and to coordinate Medicare Parts A and B. Access to source code renders the Medicare claim processing system vulnerable to abuse, such as the implementation of unauthorized programs.

CURRENT STRUCTURAL BASIS FOR MEDICARE CONTRACTING

The ability to prevent or correct the problems just described stem in part from the way CMS is required to contract with its claims administrators. The Medicare statute places substantial limits on how CMS may obtain contractor assistance to administer the Medicare program, including limiting CMS to choosing only certain types of companies to process claims and restricting them to a cost-based reimbursement method.

I will describe how Medicare currently contracts with its carriers and fiscal intermediaries and contrast that with the flexibility in contracting authority already available to most other government agencies.

Medicare Contracting Entities

Carrier, Fiscal Intermediary, DMERC and RHHI Contracts. The legislative authorities under which CMS contracts with carriers and fiscal intermediaries are found in Title 42 of the United States Code (U.S.C.).[2] Currently, these contracts are governed by laws that are more restrictive than general federal contract laws. These contracts are not subject to the general government contracting authorities which are found in Title 41 of the United States Code, nor are they subject to the Federal Acquisition Regulation (FAR).

Program Safeguard Contracts. Contracts with program safeguard contractors are subject to FAR and Title 41 of the U.S.C.[3] The contracts must be awarded using full and open competition with few prohibitions on who can hold these contracts. These contracts can be entered into for up to 5 years and can be reimbursed using either fixed price or cost-reimbursement methodologies. In addition, the program safeguard contracts can be terminated at the Government's "convenience."

Awarding the Contract

Although most government contracts require competitive bidding using full and open competition with very few prohibitions on who can be awarded a government contract, CMS is limited as to which entities it may contract with. Under Part A, the statute allows for a process under which hospitals and certain other institutional providers nominate an organization to serve as a representative for its members. Currently, the National Blue Cross/Blue Shield Association, designated by the providers, serves as the prime contractor with CMS. As such, it subcontracts with its local member plans to perform as fiscal intermediaries. Presently, all fiscal intermediaries are insurance companies. For home health and hospice providers, CMS has designated a small number of FIs to serve as Regional Home Health Intermediaries (RHHIs), based on its current authority to designate an intermediary to serve a class of providers.

Carriers are defined by statute to be non-governmental organizations engaged in "providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts," or other such group arrangements. This requirement has effectively limited such contracts to insurance companies. By statute, carrier contracts may be entered into without competition. CMS contracts with DMERCs under a separate authority and uses a competitive bidding process to award these con-

[2] Social Security Act, Sections 1842 (42 U.S.C. 1395u) and 1816 (42 U.S.C. 1395h).
[3] Social Security Act, Section 1893, 42 U.S.C.1395ddd.

tracts. (See Table 1 for a comparison of how and to whom contracts are normally awarded.)

Table 1—Contract Award

Type of Contract	Competitive or non-competitive	Contractor
General Government Contracts	Competitive	Any organization
Program Safeguard Contractors	Competitive	Any organization
Fiscal Intermediaries	Non-competitive	Insurance co. nominated by a provider group
RHHI	Non-competitive	Fiscal intermediary designated by CMS
Carriers	Non-competitive	Company with health insurance experience
DMERC	Competitive	Company with health insurance experience

Contract Type

Generally, government contracts can be either fixed-price contracts or cost-reimbursement contracts. In a fixed-price contract, the contractor has the full responsibility for the performance costs and resulting profit or loss. Fixed-price contracts are preferred since the contractor guarantees performance of the work as a condition of getting paid. In a cost-based contract, the government assumes the risk for all allowable costs. The contractor is liable for delivering only its best effort, not successful performance. General government contracts can be up to 5 years.

On the other hand, Medicare's fiscal intermediary, carrier, RHHI and DMERC contracts are generally limited to cost-reimbursement contracts. For these contracts, CMS and the contractor negotiate an overall amount for the contract based on standards established by CMS. These contracts are only made for a year.

Table 2—Contract Types

Type of Contract	Fixed-price or cost-reimbursement	Length
General Government Contract	Fixed-price or cost-reimbursement	Up to 5 years
Program Safeguard Contractors	Fixed-price or cost-reimbursement	Up to 5 years
Fiscal Intermediaries	Cost-reimbursement	1 year
RHHI	Cost-reimbursement	1 year
Carriers	Cost-reimbursement	1 year
DMERC	Cost-reimbursement	1 year

Contract Renewal and Termination

In general, government contracts can be renewed as long as the contractor meets or exceeds the performance requirements established in the current contract. Most contracts may be terminated by the government at any time for default of the contract or for the convenience of the government. If the government terminates the contract for its convenience, then the government must compensate the contractor for any preparations and for any completed and accepted work.

The CMS contracts with carriers and fiscal intermediaries, including RHHI and DMERC contracts, have automatic renewal clauses. As long as the contractors meet or exceed the standards that CMS publishes annually, the contracts are renewed. If CMS terminates the contract upon a determination that the contractor has failed to properly carry out its contracted duties or is not operating in an efficient and effective manner, the contractor has a right to a hearing. Because contracts with fiscal intermediaries and carriers are generally only one year in duration, these contracts are rarely terminated. Instead, CMS simply does not renew the contract at the end of the one year period. The contractor, on the other hand, can terminate at any time upon written notice to the government. Under CMS' prime contract with the National Blue Cross Association, when one of the local Blue plans does not renew its contract, the Association may choose the replacement contractor, thus further limiting CMS' choice of future contractors.

Table 3—Contract Renewal and Termination

Type of Contract	Renewal	Termination
General Government Contract	May renew	No hearing
Program Safeguard Contractors	May renew	No hearing
Fiscal Intermediaries	Automatic renewal	Hearing
RHHI	Automatic renewal	Hearing

Table 3—Contract Renewal and Termination—Continued

Type of Contract	Renewal	Termination
Carriers	Automatic renewal	Hearing
DMERC	Automatic renewal	Hearing

MODELS FOR CONTRACTOR REFORM

As noted earlier, under the Health Insurance Portability and Accountability Act of 1996, CMS was granted new authority and flexibility in contracting separately for program integrity functions. It may enter into contracts or work orders for specific program safeguard functions, such as medical review, fraud detection, cost report audits, and reviews to identify primary payers to whom Medicare is the secondary payer.

To date, CMS has awarded 19 contracts to Program Safeguard Contractors (PSCs) to carry out a wide range of activities. These tasks include supplemental activities, such as an analysis of Y2K issues, which have not replaced regular contractor functions. Other tasks in part or in whole replace safeguard functions currently being done by contractors. For example one PSC is performing program integrity activities to target vulnerabilities in therapy services. Another PSC is tasked with conducting postpayment medical review fraud detection and data analysis for 12 Western states.

It is too soon to fully evaluate the success of this model; however, preliminary results are encouraging. We support this new authority and look forward to continued improvements in program operation and oversight that are taking place under the Medicare Integrity Program.

Another promising development is the designation of specialty contractors such as the Durable Medical Equipment Regional Carriers. They review and pay all claims for medical equipment and supplies. There are only four of them, which appropriately concentrates their expertise in this complex area. They are bolstered by a data analysis unit, staffed by one of these carriers but supporting all four. This enables them to analyze payment and usage patterns which may suggest possible improper or questionable conduct. They are also able to effectively collaborate on the formulation of national coverage policies and payment control systems.

A recent OIG evaluation found that these entities are effective. We believe that specialty contractors, with a supporting analytic unit, would make sense for problematic areas and recommend that they be more widely used.

PROPOSED LEGISLATION

To promote innovations and efficiencies from the private sector, legislation is currently being developed that would increase CMS' flexibility in how it contracts with Medicare fiscal intermediaries and carriers by allowing it to award work competitively and use performance based contracts. Through this legislation, CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to better adapt to changes in the Medicare program.
- Promote competition, leading to more flexible efficiency and accountability.
- Establish better coordination and communication between CMS, its contractors and health care providers.
- Promote CMS' ability to negotiate incentives for Medicare contractors to perform well.
- Improve CMS' contractor performance evaluation processes, while maximizing objectivity in contractor evaluation.
- Stabilize and guide CMS' business relationship with its contractors.

CMS has proposed such broad and more flexible contracting authority in the past, and we have consistently testified in support. For instance, we have supported past proposals to allow CMS to enter into contracts with one entity to perform both carrier and intermediary functions, allow the Secretary to follow Federal Acquisition Regulations, and to reimburse contractors on a fixed price basis when needed. We believe such common sense approaches are long overdue. In fact, in recent work we found that Medicare's claims processing system did not prevent duplicate payments by multiple carriers for any of the 242 services in our audit sample. An ability to consolidate the number of contractors would help to prevent such types of duplicate payments from occurring.

More flexibility and specialization will, we believe, bring greater expertise and efficiency to contractor operations. This will, in turn, improve their relations with pro-

viders and facilitate provider education and understanding of Medicare rules and regulations. Further, the ability to pay contractors on a fixed-cost basis would offer the flexibility to award contracts for the best possible value.

CONCLUSION

Through our investigations, financial audits, and evaluations of management practices, we continue to identify problems at the Medicare contractors which run the gamut from operational inefficiencies to deliberate defrauding of the Medicare program. Taken as a whole, these problems underscore the critical need for immediate contracting reforms.

CMS needs to have sufficient flexibility in its authorities to contract with the companies best able to carry out the needed functions, to hold these companies accountable when they fall short, and to reward them when they perform well. Beneficiaries and providers will be better served, and CMS will get better value for its contracting dollars.

We fully support the need for Medicare contracting reform legislation. We also support a reduction in the number of private health insurance companies that process claims to a more manageable number. We look forward to the changes in Medicare contracting that are already taking place under the new Medicare Integrity Program and look forward to changes brought about by more global contracting reforms as well.

Mr. GREENWOOD. Thank you for your testimony.

Ms. Aronovitz, you are recognized for 5 minutes.

TESTIMONY OF LESLIE G. ARONOVITZ

Ms. ARONOVITZ. Thank you, Chairman Bilirakis, Chairman Greenwood, and members of the subcommittees. I am pleased to be here today as you consider how Medicare might be improved through contracting reform. What you will hear from us is a lot of agreement about the need for new contract authorities. How CMS ultimately plans and implements their use will be key. That is what we really want to talk about.

The original Medicare statute, along with subsequent regulations and practices, limits how the program contracts for claims administration services. As Mr. Scully and Mr. Mangano have already indicated, there is no full and open competition for these contracts. The agency is limited to choosing from a small pool of health insurers. Contracts generally cover all claims-related activities. Contractors are paid for costs, but do not earn profits. The agency is limited in its ability to terminate contracts. Most Federal programs do not face these restrictions. There has been concern that these policies may impede effective program management.

Today, I am focusing on how contracting reform might help to address these concerns, but especially on the challenges CMS faces in implementing contractor reform. First, Medicare could benefit from contracting reform legislation that authorized full and open competition for claims administration contracts, and provided greater flexibility in how contracts are structured. Full and open competition would allow CMS to select contractors on a competitive basis, which could help promote better performance and greater accountability, as you have heard from the other witnesses.

We also agree that it would allow CMS to select from a broader array of entities, capable of performing needed tasks and not just from among the dwindling number of health insurers interested in obtaining these contracts. Providing greater flexibility in how contracts are structured could also have benefits. It would allow CMS to issue contracts for discrete program functions, and that could improve performance through specialization. Although CMS has

not stated what functions it might separately contract for, we know that there is wide variation in how different contractors inform providers about program policy changes and respond to provider concerns. So, for example, having special contractors handle those responsibilities could lead to more consistency and better relations between the program and providers.

Allowing contractors to earn a profit would let CMS craft incentives to reward contractors for high quality performance. Bringing contractor termination procedures into line with those of other Federal programs could make it easier for CMS to terminate poor performers.

While Medicare could benefit from contracting reforms, freeing the program from current contracting restrictions would only be a first step in realizing the potential benefits. For example, CMS would need to carefully define the scope of work in any new contract—that is not an easy thing to do—and develop sound contractor selection criteria. Transition to full and open competition for all contractors would need to be phased in to ensure effective coordination among all contractors, and avoid disruption in service to beneficiaries and providers, especially in the claims processing stream.

Adequate performance goals and measures would need to be developed to evaluate how well contract specifications were met, and whether any financial incentives had been earned. The recent experience in hiring special contractors for program safeguard activities provides useful lessons about the challenges that would need to be addressed. It took CMS officials about 3 years to determine how best to implement the authority to hire program safeguard contractors, develop the contract specifications, issue proposed regulations governing those contractors, develop selection criteria, review proposals, and select contractors. It then took additional time for these contractors to hire staff, develop systems, and to begin performing their duties.

We expect it will also take time to fully utilize these new authorities. We think it would be prudent for CMS to take an incremental approach as it proceeds.

Accordingly, removing Medicare's contracting limitations to promote full and open competition and increase flexibility, could lead to more efficient and effective management. However, reform will not yield immediate results. We believe that there is a need for careful and deliberate implementation of any reforms that may be enacted.

This concludes my oral comments. I would be happy to answer any questions you may have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, DIRECTOR, HEALTH CARE—PROGRAM, ADMINISTRATION AND INTEGRITY ISSUES, GAO

Messrs. Chairmen and Members of the Subcommittees: I am pleased to be here today as you continue to consider how the Medicare program might be modified. Discussions about how to reform and modernize Medicare have, in part, focused on whether the structure that was adopted in 1965 is optimal today. In that context, questions have been raised about whether the program could benefit from changes to the way Medicare's claims processing contractors are selected and the functions they perform.

The original Medicare statute, along with subsequent regulations and practices, limits how the program may contract for these services in ways that differ from most federal contracts. There is no full and open competition for the contracts; the agency is limited to choosing among health insurers; contracts generally must cover the full range of claims processing and related activities; and the agency is limited in its ability to terminate contracts. The Health Care Financing Administration (HCFA), recently renamed the Centers for Medicare and Medicaid Services (CMS), has, since 1993, repeatedly proposed legislation to lift current contracting restrictions in order to increase competition for these contracts and provide more flexibility in how they are structured.[1] This year, the agency again plans to seek such changes in order to improve program management.

To assist the Subcommittees as they consider ways to strengthen Medicare's program administration, my remarks today focus on our analysis of contracting reform issues. Specifically, I will discuss (1) how reform might help to address concerns that current contracting policy may impede effective program management, and (2) challenges in implementing reform. My comments are based on our prior and ongoing work related to strengthening Medicare operations.

In summary, Medicare could benefit from full and open competition and its relative flexibility to promote better performance and accountability. If legislation removes the current limits on Medicare contracting authority, CMS could (1) select contractors on a competitive basis from a broader array of entities capable of performing needed program activities; (2) issue contracts for discrete program functions to improve contractor performance through specialization; (3) pay contractors based on how well they perform rather than simply reimbursing them for their costs; and (4) terminate poor performers more efficiently.

Freeing Medicare from current contracting limitations is only the first step in realizing potential benefits. Recent experiences with special contractors for Medicare program safeguard activities provide useful lessons that the agency could draw upon if it were free to use full and open competition. These experiences also presage the challenges in achieving the potential benefits of more flexible contracting authority. For example, CMS would need to marshal its expertise to effectively use competitive bidding authority and increased flexibility. It would need to carefully define the scope of work in any new contracts and develop sound contractor selection criteria. Transition to full and open competition for all contractors would need to be phased in to ensure effective coordination of functions among all contractors and to avoid disruption in service to beneficiaries and providers. And, if contracts with financial incentives for high-quality performance were used, CMS would need to develop adequate performance goals and reliable measures to monitor and evaluate the extent to which contract specifications were being met and awards earned.

BACKGROUND

Medicare is a federal health insurance program designed to assist elderly and disabled beneficiaries. Hospital insurance, or part A, covers inpatient hospital, skilled nursing facility, hospice care, and certain home health services. Supplemental medical insurance, or part B, covers physician and outpatient hospital services, laboratory and other services. Claims are paid by a network of 49 claims administration contractors called intermediaries and carriers. Intermediaries process claims from hospitals and other institutional providers under part A while carriers process part B claims. The intermediaries' and carriers' responsibilities include: reviewing and paying claims; maintaining program safeguards to prevent inappropriate payment; and educating and responding to provider and beneficiary concerns.

Medicare contracting for intermediaries and carriers differs from that of most federal programs. Most federal agencies, under the Competition in Contracting Act and its implementing regulations known as the Federal Acquisition Regulation (FAR),[2] generally may contract with any qualified entity for any authorized purpose so long as that entity is not debarred from government contracting and the contract is not for what is essentially a government function. Agencies are to use contractors that have a track record of successful past performance or that demonstrate a current superior ability to perform. The FAR generally requires agencies to conduct full and open competition for contracts and allows contractors to earn profits.

Medicare, however, is authorized to deviate from the FAR under provisions of the Social Security Act enacted in 1965.[3] For example, there is no full and open competi-

[1] Our statement will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

[2] 48 CFR, Chapter 1.

[3] Section 1816 addresses fiscal intermediaries and section 1842 addresses carriers.

tion for intermediary or carrier contracts. Rather, intermediaries are selected in a process called nomination by provider associations, such as the American Hospital Association. This provision was intended at the time of Medicare's creation to encourage hospitals to participate by giving them some choice in their claims processor. Currently, there are three intermediary contracts, including the national Blue Cross Blue Shield Association, which serves as the prime contractor for 26 local member plan subcontractors. When one of the local Blue plans declines to renew its subcontract, the Association nominates the replacement contractor. Carriers are chosen by the Secretary of Health and Human Services from a small pool of health insurers, and the number of such companies seeking Medicare claims-processing work has been dwindling in recent years.

The Social Security Act also generally calls for the use of cost-based reimbursement contracts under which contractors are reimbursed for necessary and proper costs of carrying out Medicare activities but does not expressly provide for profit.[4] Further, Medicare contractors cannot be terminated from the program unless they are first provided with an opportunity for a public hearing—a process not afforded under the FAR.

MEDICARE COULD BENEFIT FROM OPEN COMPETITION AND INCREASED FLEXIBILITY

Medicare could benefit from various contracting reforms. Freeing the program to directly choose contractors on a competitive basis from a broader array of entities able to perform needed tasks would enable Medicare to benefit from efficiency and performance improvements related to competition. It also could address concerns about the dwindling number of insurers with which the program now contracts. Allowing Medicare to have contractors specialize in specific functions rather than assume virtually all claims-related activities, as is the case now, also could lead to greater efficiency and better performance. Authorizing Medicare to pay contractors based on how well they perform rather than simply reimbursing them for their costs, as well as allowing the program to terminate contracts more efficiently when program needs change or performance is inadequate, could also result in better program management.

Ability to Contract With a Broader Array of Entities Would Expand CMS Options

Since Medicare was implemented in 1966, the program has used health insurers to process and pay claims. Before Medicare's enactment, providers feared that the program would give the government too much control over health care. To win acceptance, the program was designed to be administered by health insurers like Blue Cross and Blue Shield. Subsequent regulations and decades of the agency's own practices have further limited how the program contracts for claims administration services. The result is that agency officials believe they must contract with health insurers to handle all aspects of administering Medicare claims, even though the number of such companies willing to serve as Medicare contractors has declined and the number of other entities capable of doing the work has increased.

While using only health insurers for claims administration may have made sense when Medicare was created, that may be much less so today. The explosion in information technology has increased the potential for Medicare to use new types of business entities to administer its claims processing and related functions. Additionally, the need to broaden the pool of entities allowed to be contractors also has increased in light of contractor attrition. Since 1980, the number of contractors has dropped by more than half, as many have decided to concentrate on other lines of business. This has left the program with fewer choices when one contractor withdraws, or is terminated, and another must be chosen to replace it.

Since 1993, the agency has repeatedly submitted legislative proposals to repeal the provider nomination authority and make explicit its authority to contract for claims administration with entities other than health insurers. Just this month, the Secretary of Health and Human Services told the Senate Finance Committee that CMS should be able to competitively award contracts to the entities best qualified to perform these functions and stated that such changes would require legislative action. With such changes, when a contractor leaves the program, CMS could award its workload on a competitive basis to any qualified company or combination of companies—including those outside the existing contractor pool, such as data processing firms.

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[4] CMS has some limited authority to build financial incentives into intermediary and carrier contracts. This authority was granted under section 2326(a) of the Deficit Reduction Act of 1984 and made permanent by section 159 of the Social Security Act Amendments of 1994.

Contracting for Specific Functions Could Strengthen Service to Beneficiaries and Providers

Allowing Medicare to have separate contractors for specific claims administration activities—also called functional contracting—could further improve program management. Functional contracting would enable CMS to select contractors that are more skilled at certain tasks and allow these contractors to concentrate on those tasks, potentially resulting in better program service. For example, the agency could establish specific contractors to improve and bring uniformity to efforts to educate and respond to providers and beneficiaries, efforts that now vary widely among existing contractors.

Currently, CMS interprets the Social Security Act and the regulations implementing it as constraining the agency from awarding separate contracts for individual claims administration activities, such as handling beneficiary inquiries or educating providers about program policies. Current regulations stipulate that, to qualify as an intermediary or carrier, the contracting organization must perform all of the Medicare claims administration functions. Thus, agency officials feel precluded from consolidating one or more functions into a single contract or a few regional contracts to achieve economies of scale and allow specialization to enhance performance.

CMS has had some experience with functional contracting under authority granted in 1996 to hire entities other than health insurers to focus on program safeguards.[5] CMS has contracted with 12 program safeguard contractors (PSC) who compete among themselves to perform task-specific contracts called task orders. These entities represent a mix of health insurers, including some with prior experience as Medicare contractors, along with consulting organizations, and other types of firms. The experience with PSCs, however, makes clear that functional contracting has challenges of its own, which are discussed later in this testimony.

Offering Contractors Payment Incentives Could Result in Greater Efficiencies

Allowing Medicare to offer financial incentives to contractors for high-quality performance also may have benefits. According to CMS, the Social Security Act now precludes the program from offering such incentives because it generally stipulates that payments be based on costs. Contractors are paid for necessary and proper costs of carrying out Medicare activities but do not make a profit. Repeal of cost-based restrictions would free CMS to award different types of contracts—including those that provide contractors with financial incentives and permit them to earn profits. CMS could test different payment options to determine which work best. If effective in encouraging contractor performance, such contracts could lead to improved program operations and, potentially, to lower administrative costs. Again, implementing performance-based contracting will not be without significant challenges.

CMS Needs to be Able to Terminate Poor Performers More Efficiently

Allowing Medicare to terminate contractors more efficiently may also promote better program management. The Social Security Act now limits Medicare's ability to terminate intermediaries and carriers, and the provisions are one-sided. Intermediaries and carriers may terminate their contracts without cause simply by providing CMS with 180 days notice. CMS, on the other hand, must demonstrate, that (1) the contractor has failed substantially to carry out its contract or that (2) continuation of the contract is disadvantageous or inconsistent with the effective administration of Medicare. CMS must provide the contractor with an opportunity for a public hearing prior to termination. Furthermore, CMS may not terminate a contractor without cause as can most federal agencies under the FAR.

In past years, the agency has requested statutory authority to eliminate the public hearing requirement and the ability of contractors to unilaterally initiate contract termination. Such changes would bring Medicare claims administration contractors under the same legal framework as other government contractors and provide greater flexibility to more quickly terminate poor performers. Eliminating contractors' ability to unilaterally terminate contracts also may help address challenges the agency faces in finding replacement contractors on short notice.

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[5] This authority was granted under section 1893 of the Social Security Act as amended. Program safeguard activities are intended to prevent and detect fraudulent and abusive activities of providers and beneficiaries. These activities include (1) medical review of claims to determine if they are for covered, medically necessary and reasonable services, (2) reviews to identify other primary sources of payment, (3) audits of cost reports submitted by institutional providers to determine if costs are allowable and reasonable, (4) identification and investigation of possible fraud cases, and (5) provider education and training related to Medicare coverage policies and appropriate billing practices.

CONTRACTING REFORM POSES MANY IMPLEMENTATION ISSUES

While Medicare could benefit from greater contracting flexibility, time and care would be needed to implement changes to effectively promote better performance and accountability and avoid disrupting program services. Competitive contracting with new entities for specific claims administration services in particular will pose new challenges to CMS—challenges that will likely take significant time to fully address. These include preparing clear statements of work and contractor selection criteria, efficiently integrating the new contractors into Medicare's claims processing operations, and developing sound evaluation criteria for assessing performance. Because these challenges are so significant, CMS would be wise to adopt an experimental, incremental approach. The experience with authority granted in 1996 to hire special contractors for specific tasks related to program integrity can provide valuable lessons for CMS officials if new contracting authorities are granted.

Contracting With New Entities Will Take Time and Require Careful Planning

If given authority to contract competitively with new entities, CMS would need time to accomplish several tasks. First among these would be development of clear statements of work and associated requests for proposals detailing work to be performed and how performance will be assessed. CMS has relatively little experience in this area for Medicare claims administration because current contracts instead incorporate by reference all regulations and general instructions issued by the Secretary of Health and Human Services to define contractor responsibilities. CMS has experience with competitive contracting from hiring PSCs. It did take 3 years to determine how best to implement the new authority through its broad umbrella contract, develop the statement of work, issue the proposed regulations governing the PSCs, develop selection criteria, review proposals, and select contractors.[6] Program officials have told us they are optimistic about their ability to act more quickly if contracting reform legislation were enacted, given the lessons they have learned. However, we expect that it would take CMS a significant amount of time to develop its implementation strategy and undertake all the necessary steps to take full advantage of any changes in its contracting authority. CMS took an incremental approach to awarding its PSC task orders, and the same would be prudent for implementing any changes in Medicare's claims administration contracting authorities.

Even after new contractors are hired, CMS should not expect immediate results. The PSC experience demonstrates that it will take time for them to begin performing their duties. PSCs had to hire staff, obtain operating space and equipment, and develop the systems needed to ultimately fulfill contract requirements—activities that often took many months to complete. Without sufficient start-up time, new contractors might not operate effectively and services to beneficiaries or providers could be disrupted.

Coordination Is Critical for Functional Contractors

Developing a strategy for how to incorporate functional contractors into the program and coordinate their activities is key. While there may be benefits from specialization, having multiple companies performing different claims administration tasks could easily create coordination difficulties for the contractors, providers, and CMS staff. For example, between 1997 and 2000, HCFA contracted with a claims administration contractor that subcontracted with another company for the review of the medical necessity of claims before they were paid.[7] The agency found that having two different contractors perform these functions posed logistical challenges that could make it difficult to complete prepayment reviews without creating a backlog of unprocessed claims.

The need for effective coordination was also seen in the PSC experience. PSCs and the claims administration contractors need to coordinate their activities in cases where the PSCs assumed responsibility for some or all of the program safeguard functions previously performed by the contractors. In these situations, HCFA officials had to ensure that active claims did not get lost or ignored while in the processing stream.

Coordination is also necessary to ensure that new efficiencies in one program area do not adversely affect another area. For example, better review of the medical ne-

[6] CMS developed an indefinite-delivery/indefinite-quantity contract that allowed it to select contractors and outline in broad terms the activities to be performed. Each task order identifies a specific function to be performed. For example, one task order involves conducting unannounced site visits to selected community mental health centers to determine whether they are complying with Medicare regulations.

[7] According to a CMS contracting official, a claims administration contractor has the flexibility to subcontract under section 1842 of the Social Security Act.

cessity of claims before they are paid could lead to more accurate payment. This would clearly be beneficial, but could also lead to an increase in the number of appeals for claims denials. Careful planning would be required to ensure adequate resources were in place to adjudicate those appeals and prevent a backlog.

CMS has not stated how claims administration activities might be divided if the agency could do functional contracting. It would be wise for CMS to develop a strategy for testing different options on a limited scale. In our report on CMS' contracting for PSC services, we recommended, and the agency generally agreed, that it should adopt such a plan because CMS was not in a position to identify how best to use the PSCs to promote program integrity in the long term.[8]

Experience Is Needed to Develop Effective Evaluation Criteria

Taking advantage of benefits from competition and performance-based contracting hinges on being able to identify goals and objectives and to measure progress in achieving them. Specific and appropriate evaluation criteria would be needed to effectively manage any new arrangements under contracting reform. Effective evaluations are dependent, in part, upon clear statements of expected outcomes tied to quantifiable measures and standards. Because it has not developed such criteria for most of its PSC task orders, we reported[9] that CMS is not in a position to effectively evaluate its PSCs' performance even though 8 of the 15 task orders had been ongoing for at least a year as of April 2001. If CMS begins using full and open competition to hire new entities for other specific functions, it should attempt to move quickly to develop effective outcomes, measures, and standards for evaluating such entities.

Effective criteria are also critical if financial incentives are to be offered to contractors. Prior experiments with financial incentives for Medicare claims administration contractors generally have not been successful. This experience raises concerns about the possibility for success of any immediate implementation of such authority without further testing. For example, between 1977 and 1986, HCFA established eight competitive fixed-price-plus-incentive-fee contracts designed to consolidate the workload of two or more small contractors on an experimental basis. Contractors could benefit financially by achieving performance goals in certain areas at the potential detriment of performance in other activities. In 1986, we reported that two of the contracts generated administrative savings estimated at $48 million to $50 million.[10] However, the two contractors' activities also resulted in $130 million in benefit payment errors (both overpayments and underpayments) that may have offset the estimated savings. One of these contractors subsequently agreed to pay over $140 million in civil and criminal fines for its failure to safeguard Medicare funds.

CONCLUDING OBSERVATIONS

Removing the contracting limitations imposed at Medicare's inception to promote full and open competition and increase flexibility could help to modernize the program and lead to more efficient and effective management. However, change will not yield immediate results, and lessons learned from the experience with PSC contractors underscore the need for careful and deliberate implementation of any reforms that may be enacted.

This concludes my statement. I would be happy to answer any questions that either Subcommittee chairman or Members may have.

GAO Contact and Staff Acknowledgments

For further information regarding this testimony, please contact me at (312) 220-7600. Sheila Avruch, Bonnie Brown, Paul Cotton, and Robert Dee also made key contributions to this statement.

Related GAO Products

Medicare Management: Current and Future Challenges (GAO-01-878T, June 19, 2001).

Medicare: Opportunities and Challenges in Contracting for Program Safeguards (GAO-01-616, May 18, 2001).

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO-01-247, Jan. 2001).

High Risk: An Update (GAO-01-263, Jan. 2001).

[8] Medicare: Opportunities and Challenges in Contracting for Program Safeguards (GAO-01-616, May 18, 2001).

[9] GAO-01-616, May 18, 2001.

[10] Medicare: Existing Contracting Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 22, 1986).

Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure (GAO/T-HEHS-00-108, May 4, 2000).

Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight (GAO/HEHS-00-46, Mar. 23, 2000).

Medicare: Program Safeguard Activities Expand, but Results Difficult to Measure (GAO/HEHS-99-165, Aug. 4, 1999).

Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century (GAO/T-HEHS-99-58, Feb. 11, 1999).

Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85, Jan. 29, 1998).

Mr. GREENWOOD. Thank you for your testimony.

Mr. Scully, if you will return.

The Chair recognizes himself for 5 minutes for questions.

I would like to ask each of you how you see these proposed contract reforms affecting the average Medicare beneficiary, my mother, my father, other beneficiaries? How would they, if they would, notice or benefit from these changes?

Let me start with you, Mr. Scully.

Mr. SCULLY. I think hopefully, I mean we have some great contractors who do a terrific job. I used to represent a couple of them when I was a lawyer. We also have some that have not done such a great job, and our ability to identify the ones that have done the best job and been the most responsive to providers and beneficiaries is limited. To our ability to switch work flows from one place to another is very limited. So when we have a contractor who is the lowest rated and is the least responsive to providers and beneficiaries, it's tough to make a change. Our ability to switch work flows to another FI is very limited. It has to go through the Blue Cross Blue Shield Association.

I represented Blue Cross of California when they were being pushed out of the program in the early 1990's. They fixed their problems and stayed in for a few more years. But I have been on the other side of it. I think there is a pretty substantial difference in the quality of contractors. But our ability to adjust our work flows, depending on who the best contractors are, is pretty limited. I don't think that is really good policy.

I think if we could identify instead of 49 FIs and carriers, a more limited number of people who we could move the work flows around to, depending on their performance, we would have a much better situation.

I also think some of the things that were referred to as far as local medical decisions and things like that with a more consolidated group of contractors, that we had probably a better, more rationally motivated relationship with, you would probably find more consistent decisionmaking as well.

Mr. GREENWOOD. Mr. Mangano?

Mr. MANGANO. I think in this country we expect high quality. We expect high quality out of our health care system, out of our automobiles, and every other part of the economy that we deal with.

If we have a system that allows CMS to find the best contractors that can operate most efficiently, and that efficiency enhances the effectiveness of their services to the beneficiaries, that is, when beneficiaries have problems and they want to call their Medicare contractor, if we have the contractors that perform best at doing those functions, then I think people are going to feel that they have

responsive government on their hands, and they are going to be able to get their questions answered, and they are going to be able to get the services they are entitled to under the Medicare program.

Ms. ARONOVITZ. We talk about full and open competition. One of the underpinnings for full and open competition is the principle of getting the best value for your product or service. That involves cost, but it also involves performance or quality and timeliness. I think what Mr. Scully and Mr. Mangano said is that CMS should be in a position to be able to have the flexibility to assure that its contractors are performing well and according to whatever measures have been set out.

But an even more direct result of new authority could be in the area of functional contracting. I'm not sure that this would be the most feasible, but it is something CMS needs to consider. We know that there are some direct interactions that occur between contractors and the providers and the beneficiaries right now in terms of answering questions on the telephone, sending newsletters to the providers, and developing carrier and intermediary websites.

In the process of looking at those mechanisms that create an environment for good provider and beneficiary relations, it is possible that a functional contract, where experts understanding how to communicate with beneficiaries and providers, might turn out to be a very good thing. So there are ways to immediately get some of the benefits from authorities if you could find a functional contract that could address some of the immediate problems that you have.

Mr. GREENWOOD. The contractors sort of seems to need to serve three masters, at least. You have the obligation to the taxpayers to provide the service at a cost-efficient way. You have the obligation to interact with the beneficiaries in a way that is appropriate. Then you have the obligation to interrelate with the providers, who are often frustrated in their interactions with the providers.

How, with the latitude of these reforms, how does CMS manage to weigh these three competing demands and make sure that in the interests of serving one of those masters, we don't begin to do a lesser job with the others? Any one of you want to try that? Tom?

Mr. SCULLY. It is always a tough balance. Again, I don't want to complain about contractors. There are some very good ones. It is just our limited ability to find the ones who get that balance right the most. I think there's some like United Wisconsin, I guess is the United Government Services, which is Blue Cross Wisconsin, there are some Blues that have made a fundamental decision this is something they are in for the long haul and are very focused on. Pal Meadow in South Carolina is one. Wisconsin is another. There are others that do a pretty good job. I don't want to evaluate all of them right here. There are others that aren't as interested in it. Blue Cross of North Carolina, Mr. Burno dropped out about 2 weeks ago. They just made a decision this was not a core business strategy of theirs. I respect that, but some people are more focused on it than others, and some are more interested in this business. We want to identify with those people and become tighter, better partners, and make sure we get that balance right.

Another point which I didn't make earlier is that right now, you have to be an insurance carrier. So for instance, EDS, which I

would argue is one of the better information transfer agents, wanted to get into this business. They had to go out and buy a shell insurance company to do it. Other people we have looked at that are trying to get in this business, to maybe potentially be additional good contractors, credit card companies and others, can't do it under the existing statute.

So our flexibility to find people that want to be in this business and want to establish long-term partnerships is limited by the statute that says you have to be an insurance carrier.

Mr. GREENWOOD. Do either of the other of you wish to testify? My time is up, so please be brief.

Mr. MANGANO. Not really. It is just a question of, I think, making expectations clear, having contracts that are written clearly enough in terms of explaining what the requirements are in the provision of services to beneficiaries as well as to provide services to suppliers who are going to be billing the Medicare program.

To the degree to which those specifications can be clear and that the contractors can be held responsible for delivering services on a performance basis, I think you are going to increase the opportunity to having more success with contractor operations.

Mr. GREENWOOD. Okay. My time is expired.

The Chair recognizes the gentleman from Ohio, Mr. Brown, for 5 minutes.

Mr. BROWN. Thank you, Mr. Greenwood, Mr. Chairman.

Mr. Scully, I have regular Medicare meetings in my district, which many Members have, just to familiarize beneficiaries with various Medicare services and answer questions, all that. We may have 50 people there. We may have 200 people there. We also have all these meetings. One of the presenters is from the Ohio State Health Insurance Counseling Assistance Program, OSHIP and Ohio SHIP, whatever, and in other States.

They are important because they translate education outreach efforts to the State and local level. They also, as you know, are heavily reliant on volunteers. The SHIP programs, I believe, get about $15 million spread across the country, the 50 State agencies. How will CMS ensure, as it is getting more and more difficult for them with this pretty small amount of money to do what they need to do? The services they give are obviously very important. How do you plan to ensure that these agencies have the sufficient resources and staff to respond to an increase in referrals generated by the 1-800 number and all that that entails?

Mr. SCULLY. Well, I think the SHIPs do a great job. I think it's $13 million. It might be $15, but it is in that range, which is obviously a limited amount of money. Probably my No. 1 priority tied with contractor reform is beneficiary education. As you may have seen, we have already announced that we are planning to spend $35 million this fall on I think an unprecedented level of beneficiary education.

One of the biggest efforts in that, I think it's about $17, $18 million is substantially enhancing the 1-800 number. What happens now, if you call 1-800-MEDICARE from Ohio or from Philadelphia, is you generally get a very basic level of information and then you get transferred off to a SHIP, which are generally volunteers. They get an increasingly intense level of call-ins to our 1-800 number.

One of the things that is going to happen starting October 1, is when you call in, you are going to have an entire new tier of the Medicare 1-800 number that you will get a person on the phone who is familiar with your Ohio district or Philadelphia or Florida, whatever, that will give you a whole level of information about your Medicare, Medigap benefits, your Medicare benefits, your out-of-pocket costs. They won't pick a whole package for you, but they will give you a whole level of assistance parallel with what the SHIPs are doing.

So I think one of the things that you are going to get, and it's also going to be 24 hours a day, 7 days a week, instead of the current 8 hours a day, 5 days a week. So one of the things that this will do is I think substantially reduce the referrals to the SHIPs. SHIPs do a great job. They do such a good job that we are basically trying to turn our 1-800 MEDICARE numbers into basically a massive SHIP service. The SHIPs are basically through the State insurance commissioners.

Mr. BROWN. Do you see placing, as some have suggested, a Medicare representative in every Social Security Office so people can have that one-on-one contact?

Mr. SCULLY. You know, that used to be—that is a very complicated issue, because obviously CMS/the old name evolved out of Social Security. So for years, there was a Medicare person in each Social Security Office, which was helpful. As the budgets were squeezed at various departments over the years, the Social Security obviously—their No. 1 priority was not Medicare. Medicare people disappeared from that.

We are intensely focused on beneficiary education. Whether the best way to do that is to put people back in Social Security offices or to do it through senior centers, or to do it through others ways are things that I am very open to and I have been looking at it. But we are very focused on beneficiary education. I think it is going to be pretty hard this fall for anybody in the United States to miss our beneficiary education campaign, hopefully.

Mr. BROWN. The last question, Mr. Chairman, along these lines, Medicare plus choice or its predecessor used to—managed care generally used to provide more money for various kinds of agency information. That has been cut over the years, what managed care has provided. Sort of two parts to the question. As you strive to increase the involvement of managed care in Medicare, whether you are successful in that or just the fact that we have provided managed care a good bit more money in this $11 billion last year and lots of dollars before that, do you plan to call on managed care, on Medicare plus choice participants to provide more education resources so that OSHIP and others complementarily, if you will, can provide better kind of service?

Mr. SCULLY. Through the user fee package?

Mr. BROWN. Well, however you would use the power of this office to encourage managed care companies, to encourage Medicare plus choice to provide more agency information.

Mr. SCULLY. Yes. We are clearly going to do that. How it's funded, I think the user fee was reduced last year in legislation, so there is some limited discretion over that.

We are clearly going to put out a lot more information on our website and various other places about plans. Just to clarify, by the way, I am trying to knock the word managed care out of my vocabulary. Private health plans—I have been misquoted frequently as wanting to double managed care. My point, which was widely reported about the Medicare+Choice plan was that in 1997 when the bill passed, CBO had anticipated by 2002 that you would have about 30 percent of people in Medicare+Choice. That number has now dropped to 15 percent. I have every indication more people are going to drop out this summer.

What I have been saying is that I think a lot of seniors who have private health plan choices like the drug coverage, we tend to keep those people in, and then try to get back to what most people anticipated was the growth curve. But it is not that I am out there trying to pump managed care. We are very interested in making seniors know about other options, whether it's Medicare+Choice, Medicare Select, Medigap.

One of the things when I came into this job I found was that our data and our polling show seniors really do not understand the benefits at all, even the base benefit. They don't understand the copayments and the deductibles. So I am interested in educating them as thoroughly as we can, and whatever option they decide to pick is great, as long as they know what they are doing.

Mr. GREENWOOD. The time of the gentleman has expired. The Chair recognizes the chairman of the Health Subcommittee, Mr. Bilirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Last week we had a hearing, a young lady from HHS—I don't remember whether she was from CMS or not, C-M squared S, but she stayed in the audience. That was very impressive, that you had someone doing that. I would hope that you would have someone sitting in here taking notes when the next panel comes up. I think it is so very important. It makes people feel good too, that someone cares.

Mr. SCULLY. It would probably be me, Mr. Chairman. I am still a staff person.

Mr. BILIRAKIS. There is a June 28 letter from Secretary Thompson to Speaker Hastert regarding your recommendations on needed legislative changes to the law. Are you, Mr. Mangano or Ms. Aronovitz, familiar with that? Have you had a chance to look at it?

Ms. ARONOVITZ. I think we received it this morning. But I think in some ways it is very similar to prior year proposals.

Mr. SCULLY. Yes.

Mr. BILIRAKIS. We have two mikes there. We ought to be able to use them.

So you are familiar with it?

Mr. MANGANO. Yes. I had seen the bill a couple of days ago.

Mr. BILIRAKIS. Okay. You have seen it before we have this morning.

I am not asking about it now, but I would hope that you would submit to us any thoughts you have on these recommendations and your recommendations regarding them. That could be very, very helpful.

Mr. MANGANO. I would be happy to.

Mr. BILIRAKIS. We would appreciate that very much.

Mr. Scully, in your written testimony you state that "Many contractors serve multiple and sometimes non-contiguous States, resulting in a patchwork"—underlined—"Patchwork of coverage in service across the country." We found out that that is one of the problems, that there is a patchwork, lack of consistency, if you will, a lack of contract authority, and what CMS aimed with expanded contract authority, would CMS aim to minimize this current patchwork? What benefits do you believe could be achieved from more regional contracts or single contracts?

Look at the charts. There you see fiscal intermediaries, carriers. Is there a need to have separate fiscal intermediaries from carriers? If there is no need, would that be more efficient, result in better efficiency and less costs?

Mr. SCULLY. I think eventually it would. I am not sure right now, as many people stated, I don't think you can do this over night. I think this is a multi-year phase in. I mean you definitely have completely different Part B and Part A deductibles and systems. In some of the States that overlap, like Blue Cross of Florida I think or Trail Blazer, as both contracts, which I think is actually I didn't realize until last night when I was reading, that that is actually part of Blue Cross of South Carolina as well.

Mr. BILIRAKIS. But they are separate contracts.

Mr. SCULLY. They have two contracts, but they have two different systems, two different groups of people.

Mr. BILIRAKIS. Right.

Mr. SCULLY. Arguably, if Trail Blazer is doing Texas in Part A and Part B, those functions could be merged. There has also been a lot of discussion, whether it happens or not, in Congress about eventually merging Part A and Part B in some form anyway. So I don't think whether that ever happens or not, the merging of the contractor systems to me intuitively makes a lot of sense. That there's not a great ability——

Mr. BILIRAKIS. Even if Parts A and B are merged, so you would only have one carrier that would handle the fiscal as well as the rest of it, makes sense. Does it not?

Mr. SCULLY. Yes.

Mr. BILIRAKIS. It certainly sounds more efficient. It sounds like probably less costly.

Mr. SCULLY. Well, I would hope so. At some point it should be. I also think fundamentally I am not a believer in cost-based systems any place in Medicare. Whether you look at it for hospitals or any of our old cost-based systems, there is not immediate overnight savings. With the DRGs, there probably won't be immediate overnight savings when we go from rehab hospitals to PPS this year. But I think all the prospective payments systems show that if you incentivize people correctly, eventually there are cost savings and there are efficiencies. I think most of these companies will tell you that they would rather do rather than a cost-based contract is just the tradition. That they would much rather be incentivized.

Mr. BILIRAKIS. You don't feel that you have the legal authority to make these changes now though? You would need changes made in the law?

Mr. SCULLY. We believe we clearly don't.

Mr. BILIRAKIS. Okay. If we go ahead and incorporate these as we contemplate doing in our "Medicare Reform Modernizing" or whatever we want to call it, prescription drug legislation, you would go right into trying to make some of these changes as rapidly as you reasonably can?

Mr. SCULLY. Yes. I would not expect that we are going to get to 18 and 20 overnight, but I do think that we could identify in those charts the people who are our best partners, and generally start to move work toward them and start to find the best people who are doing the best services, and give them more work, and gradually phaseout the people that——

Mr. BILIRAKIS. You know for years we have heard about problems like this. I can't recall any emphasis made on the part of the old HCFA people over the years. I am not referring to any particular administration coming up here and placing emphasis on these things. In fact, Mr. Brown keeps talking about additional resources. He means money, I guess. The point is, yes, if that is needed, there should be requests for it. But that certainly in and by itself never gives us the answer in and by itself. Nor do I recall much emphasis being placed on people coming up here basically demanding, at least explaining the need for that money.

Mr. SCULLY. I think some form of this bill, I know all 4 years of the first Bush Administration I was in, we set something up. But there always seemed to be other controversies, whether it was RBRBS back then or whatever. But in Nancy Eon's case, who is a good friend of mine or the most recent administrator, she had Y2K, BBA, lots of other things going on. I think this just fell down the priority list. But for whatever reason right now, it is a big priority for us and a huge one for the Secretary. So we are happy to explain what I think is a long overdue need.

Mr. BILIRAKIS. Mr. Chairman, may I continue on? I realize I have gone past my time.

Mr. GREENWOOD. Just this once.

Mr. BILIRAKIS. Just this once. He's paying me back, is what he is doing.

Mr. Mangano, we have talked before. The fraud provisions and what not, we have all placed emphasis on that. How much of the fraud claims that are taking place out there would you say is the result of lack of communication, lack of education? I would say on the part of providers as well on the part of the contractors in the old HCFA. It is a big problem, certainly in my congressional district, as you know. I am trying to get to the meat of that. I mean, you know, I just can't believe that all of these providers are bad guys. I just wonder how much of it might be due to lack of communication and what not. If that is much of the case, I would hope that Mr. Scully will be aware of it so that again, we can have uniformity of communications and adequate communications and that sort of thing. Not much of a question, but if you have any quick comment.

Mr. MANGANO. Well, each year that we have done our review of the payment claims, the improper payment report we call it in our office, we have seen dramatic improvements in terms of the reduction in improper payments. From the first year we did it, 1996, it

was running at 14 percent or $23 billion, to the last year that we did it, where it was down to just under 7 percent, at $11.9 billion.

Each year we have done this review, we have made recommendations. HCFA has basically agreed that we have to increase the education component of the Medicare program. Providers have every right to know how to bill properly. When they bill properly, everybody succeeds.

There have been efforts across the country and conferences have been held in local areas. Our staff goes out many, many times during the year to meet with local groups as well as professional groups to help explain the compliance rules from our perspective and the CMS perspective, et cetera.

But we still need to do more of it. It is clear to us there is not the level of clarity that needs to be existing out there for everybody to be able to understand the rules and to bill properly.

Mr. BILIRAKIS. Yes. From an image standpoint, they are guilty. They are guilty even if found innocent later on. It gets around the community and there goes their reputation and all of their hard work and education down the drain. So it is something we have got to emphasize.

Thank you very much, Mr. Chairman. I appreciate your indulgence.

Mr. GREENWOOD. The Chair recognizes the gentlelady from Colorado, Ms. DeGette, for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

In the next panel, Mr. Chiplin is going to testify, and we talked about this a few minutes ago, that the beneficiaries require a lot of information so that they can make an informed decision about their health care decisions. I guess I would ask you, Mr. Scully, how well CMS ensure that beneficiaries can get this information if the contractor functions are parceled out to two, three, or four different entities?

I can see the rationale for that in a lot of contexts, but in the context of beneficiary information, won't they get confused trying to call one contractor to get benefit information, another to get eligibility information, and someone else to get the status of their claim?

You testified earlier that it used to be that before the budget cuts, there would be more people in the Social Security offices and so on to give this information. How are we going to get that education to the beneficiaries?

Mr. SCULLY. As far as I think the GAO testimony was that there is some merit in contracting our more and splintering our contracts further, which we are looking at. I have not quite reached that decision yet, for some of the reasons you suggested, which is I am worried about becoming too splintered. But we are in the process of evaluating that.

I can tell you since the day I walked in the door, my No. 1 focus, and I think the staff will tell you this, has been beneficiary education and putting together this major campaign to educate seniors and beneficiaries.

I think a lot of that is done more through us than through the contractors. I think, for instance, if you look at our website, which doesn't get many hits. If you are a dialysis patient, there is no

question in my mind if you go into Denver and pull up dialysis centers, there is very detailed information on quality on dialysis centers. People don't use it. They go when the nephrologist tells them to go.

Similarly, the information on nursing homes is not I don't think quite objective enough, and we are working on that. But my goal is to basically provide a lot more quality, objective, fair information for people to make better decisions. That is going to be probably my No. 1 push, as long as I survive 3½ years.

Ms. DEGETTE. I think that is an admirable goal. But don't you think that that particular component of beneficiary education would be made more difficult if contractor functions are parcelled out?

Mr. SCULLY. Well, I think that is the balance to weigh. But I think what we are talking about here fundamentally to begin with is probably contraction of contractors, where you have more consistent contracting. Whether it is also a good idea, as we have done in some of the fraud abuse efforts, to subcontract out specific issues to subcontractors who are more focused on particular beneficiary education areas, we have not made that decision yet. I think it is being discussed. That is one of the recommendations GAO had, but I think the balance there is splintering it too much.

Ms. DEGETTE. Ms. Aronovitz, would you comment on that?

Ms. ARONOVITZ. I think there is a difference between having fewer contractors, but still having an interface and having oversight in management so that you would still have local connections. If somebody calls an 800 number, they don't necessarily know that they are getting a Blue Cross Blue Shield company in Alabama versus in North Dakota. There are a lot of ways to still maintain the local relationship between beneficiaries. We would not want CMS to ever consider any kind of functional contract that would break the relationship in that way. So it is a matter of figuring out how to be very specific about what you are asking for and then finding experts who could bid on these contracts that could provide that kind of quality.

Ms. DEGETTE. I think that that is an important concept to keep in mind as you go through this.

Let me follow up, Ms. Aronovitz, just about functional contracting. It seems to me that if it is going to work well, CMS is going to need to clearly lay out the scope of responsibilities and expectations for each contractor, and make sure that the contractors are not duplicating work or letting responsibilities fall through the cracks, some of the same problems that you are suggesting this to remedy.

What steps will CMS need to take to administer Medicare properly if they use functional contracting?

Ms. ARONOVITZ. I think functional contracting is a very, very good concept theoretically. But I think implementation-wise, there are a lot of challenges. I think CMS is learning a lot from its contracting for program safeguard contracts. A lot of those are functional contracts. They are very specific.

We issued a report about 2 or 3 months ago on the status of CMS' efforts to implement its PSC or MIP authority on these functional contracts. Basically there are two issues that CMS really has

to be careful about. The first one is being very specific about defining or putting your arms around what that function would be. It is not that easy to do, but if you don't do a good job, then you are going to get somebody to bid on something less than what you are actually expecting.

The second thing is that you have to have performance measures and standards in place because if you don't have performance measures articulated well upfront, you are not going to know whether you are getting what you are paying for. Those are the types of activities that become critical in any type of contracting, whether it is an invitation for bid or a request for proposal. In either case, you really need to understand what type of performance you are expecting. It's not easy.

Ms. DEGETTE. Thank you.

Mr. GREENWOOD. The time of the gentlelady has expired. The Chair recognizes for 5 minutes Dr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. Mangano, you have been with HHS a long time. You have been working in the area of Medicare a long time. You have been involved in subcontracting area a long time. I think we all would agree that systems developed over 35 years ago probably at least need to be changed. If we were starting from scratch, they might not even recognize each other.

Now do you ever sit around fantasizing what this really ought to be? How this system really should deal with subcontractors? Because you have a lot of experience and I value your thought.

Mr. MANGANO. Well, I would like to answer it this way. The Congress and the American people have every right to expect that the Medicare system be run efficiently and effectively.

I would like to maybe use a little bit of imagination now and think that we have all just started up a new company. This company is going to do about $200 billion worth of business each year. We are going to have 40 million customers. We are going to have over a million different providers of service here. You are the board of directors, and you are interviewing potential candidates that are applying to be your chief executive officer. A young chap comes walking in the door and he says, "I have got a great new business plan for you. Here is how we are going to run our company. First, we are not going to do any open or full competition for any of the contracts for the people who are actually going to manage our program on an every day basis . . ."

Mr. NORWOOD. Mr. Mangano?

Mr. MANGANO. Yes, sir.

Mr. NORWOOD. Forgive me. I did ask our witness the question. I want it in writing. You are in charge. You are king for the day. You start from scratch. Tell me how you would do the subcontractors. Give me your opinion at the same time on the changes that Mr. Scully brings to us today from the Administration that they would like to see in a bill.

I would absolutely love to sit here and hear the answer, but we don't have time. So I take my question to you very seriously. I think you could bring a lot to the table for us to look at as this subcommittee tries to accommodate Mr. Scully, the Administration, and make some finally changes in Medicare.

Mr. Serato states in his written testimony that at last count, Medicare contractors receive on average a new instruction from CMS every 5 hours of every day of the year. What happens, Tom, talk to me in terms of being a hospital man, not head of this agency. What happens when CMS sends these instructions down to the subcontractors? What do they do with those instructions? Do they send them to your hospital?

Mr. SCULLY. I think they send them everywhere. That is part of the problem with the whole system. There are a lot of great people in CMS. I think the Secretary found that, and I have found that too. But there has been a mode over the years of just sending out random strafing runs from everybody. I am trying to change that.

Mr. NORWOOD. Did you receive those in your hospitals? In other words, it isn't just the subcontractor who receives the new document or change order every 5 hours, it is also those on the other end that are providing the care?

Mr. SCULLY. I think the change orders he is talking about are the ones that actually go to the FIs and the carriers. But separate and apart from that, HCFA puts out a lot of regulations and program memorandums that go directly to the providers outside of that everyday. One of the first steps—I am not sure you have seen our response yet to the committee, but the Secretary announced the regulatory reform effort last week which is a first step, and this is the regulatory side. Starting October 1, CMS is going to put out a compendium of all its regulations each quarter. There will be a menu of everything coming out that quarter. If it is not on there, it won't come out.

Second, we are going to put out regulations and program memorandums 1 day a month. So that if you are a hospital or a physician or a provider, you will only have to look at the Federal Register 1 day a month. Now it is a self-imposed regulation. We are trying to simplify the process.

Mr. NORWOOD. What you are saying is you are going to have less than one every 5 hours under your regime?

Mr. SCULLY. I think that is to the carriers, what he is talking about. But the first step——

Mr. NORWOOD. But the carrier passes it on down the line.

Mr. SCULLY. Yes. No question. Well indirectly.

Mr. NORWOOD. Not maybe every time, but frequently.

Mr. Mangano, I wondered if you knew there was a change order every 5 hours? Did you know that before coming in here?

Mr. MANGANO. I did not know it was once every 5 hours, but I do know there are a lot of them.

Mr. NORWOOD. Now could you somehow logically put together a relationship that that might have a lot to do with some of your investigations into what is called waste, fraud, and abuse, and there is where we save all our money?

Mr. SCULLY. One thing I would argue, one argument for reform is that in a cost-based system, you send out a change order. They may be upset about it, but they just build it into their cost. If we went to a more rational contracting system, there would be a lot more push back all——

Mr. NORWOOD. That hospital can't build it into its costs very readily.

Mr. SCULLY. This is to the carriers.

Mr. NORWOOD. I know. But they come from the carrier. I promise you, the carrier doesn't sit there with it. They tell us what to do because of what CMS told them what to do. I am asking for somebody to say they understand that perhaps some of this so-called waste, fraud, and abuse is being stimulated out of Baltimore, out of people who are honestly trying to do right in the system, who can't keep up with the change order every 5 hours or even if there is one a week.

Mr. SCULLY. I totally agree with you. One thing I have tried to bring, sometimes to the great pain of my staff in the 3 weeks I have been there, is to have them view it from the local provider side, because in a lot of cases, they have the best of intentions, and they don't understand what happens to the docs and the hospitals at the other end of what they are doing. I think I have made a pretty big push already to make them understand that.

Mr. NORWOOD. Thank you. I see the red light, Mr. Chairman. I'm sorry about it, but I see it.

Mr. GREENWOOD. We noticed you care about this issue, Mr. Norwood.

The gentlelady from California is recognized for 5 minutes.

Ms. CAPPS. Thank you, Mr. Chairman. Thank you very much for the testimony of each of the three of you. I was sitting here thinking of a kind of theoretical, sort of sophisticated question, set of questions I could pose to you. Then I thought of a rural county that I represent in central California, San Luis Obispo.

I am thinking of a provider, one in particular, who wrote me such a painful letter. I had a conversation with him it was so troubling to read his letter. The reimbursement rate is third lowest in the State, in that particular county, although I have worked hard, we got it raised 12 percent. It is because the cost of living doesn't match it in any way. It is an area where Medicare+Choice is pretty much vacated.

But I am talking now about the provider, who when we had a change of carriers about a year ago, all of a sudden there was a delay in payment. Many of the providers took liens on their practices and mortgages on their houses and went into debt. Rural areas have their own peculiar challenges.

This one, this doctor is—I hope he is still in practice, just a couple years from retirement, really not equipped to do anything else—so far in debt, not able to have enough other kinds of insurance patients and Medicare reimbursing so little anyway for the cost of service to provide, feeling a responsibility toward providing for his patients as providers leave. Then patients have to drive even further distances, and Medicare patients have challenges. Many of them are elderly.

I was hard pressed to know how to respond to him. He said can't the system—the margin is so small anyway. When the carrier changes and all of a sudden there is a delay, we get really involved in our congressional office because they call us right away. "What's wrong? I am not able to meet my expenses."

I just, I don't know how to pose the questions to you, but I don't know how to deal with this troubling, troubling situation in my community.

Mr. SCULLY. Well, I am sorry to hear that. I hope you will call me if you have——

Ms. CAPPS. I have called. Well, it was your predecessor.

Mr. SCULLY. You have called me already?

Ms. CAPPS. No, I haven't called you yet, but thank you for the offer.

Mr. SCULLY. Because I already have to go to about seven, there are eight different States, and I would love to visit Santa Barbara as opposed to North Dakota.

Ms. CAPPS. No, this is San Luis Obispo.

Mr. SCULLY. I'm know. I'm kidding. And San Luis Obispo.

Ms. CAPPS. Santa Barbara though is No. 4 lowest in reimbursement. That is considerably lower than next door neighbor county to the south.

Mr. SCULLY. Yes. I am pretty familiar with your district. I obviously will try to help. I was not familiar with that change, and that there was a slowdown.

As a general matter, I think it is United Government Services, my general experience with them is that they are one of the better contractors. So I am sorry to hear that. I think they have the whole State.

Ms. CAPPS. I thought this one was Heritage, but I looked at your list and I didn't see that particular one.

Mr. SCULLY. Heritage is EDS, I believe. Yes, Heritage is EDS. Must be HI, I guess.

Ms. CAPPS. I am not trying to lay the finger on a particular carrier. But if this is what happens as changes are made, you just have to know that there are real-life consequences that are very, very painful.

Now in terms of our beneficiaries, we have a wonderful program, pretty much volunteer, a voluntary program called HICAP. I think it is throughout the State of California, which they do a marvelous job of interpreting regulations and answering questions and referring patients, and explaining the services. But I have had tremendous challenges in meeting the requests for "help us" from both providers and also hospitals. So many are so close to going under, been in the red so long, and it is really troubling. Medicaid and Medicare, we call it Medi-Cal, are really their main sources of income.

Mr. SCULLY. Well, in fairness to defend Medicare to some degree since I used to be in the hospital business until 3 weeks ago, Medicare believe it or not, is generally the best and fastest, the fastest payer, far faster than most of the private because under statute we have to be.

But if you have problems with your carriers—it is EDS, Heritage is their insurance company—if you have problems with them, I would be happy to get the men to sit down with you in our regional office in San Francisco, and try to make sure that we incentivize them to better performance.

Ms. CAPPS. Is this part of what I guess, my question then to you and your testimony or I will take a response from anyone else. I don't want this to be a complaining session. But is the goal then of this time of organization to prevent these kinds of things from happening? I guess I am not quite——

Mr. SCULLY. I guess I am surprised, because generally EDS, I thought was pretty good. I hope this is a unique problem. But my goal is basically to find the best contractors, exactly in your situation, find the 18 to 20 best Part A, Part B contractors together and gradually evolve to a system where we have got the best people who perform the best to pick up more and more volume so that the people who end up providing services in your county are our best contractors.

Right now, our ability to shift workload to the best people is not very good. It is very limited. So my hope is in 5 or 6 years, we can sit down as CMS and say everybody has got one of our top 20 performing contractors, and that they are incentivized. I personally just think cost-based contracting is crazy. Get into appropriate incentivized contracts, incentivized to perform better.

Ms. CAPPS. I wondered when I first began hearing your testimony what is the incentive for anyone to want to volunteer to work with you. Then I am also of course very aware of your 2 percent administrative costs. I mean who else does business like that?

Ms. ARONOVITZ. I just want to add one thing. That is, that what I hear you saying does not have to do with ongoing performance of the contractor.

Ms. CAPPS. No.

Ms. ARONOVITZ. But when a contractor leaves.

Ms. CAPPS. Changing.

Ms. ARONOVITZ. Right. Transitions in HCFA have been notoriously challenging. It is a difficult thing to try to get a whole new contractor in place.

Ms. CAPPS. I appreciate that.

Ms. ARONOVITZ. I think that is a really important lesson. I think CMS has gotten much, much better in transition, in doing transitions than it did several years ago, where we were very concerned. But it is a lesson to keep in mind when you are going to be consolidating or using new authorities to consolidate your contractors because if you are not careful and you don't do it slow enough and do a lot of planing, then you might have these disruptions in service. One of the really critical challenges that the agency faces is to avoid those kinds of disruptions.

Ms. CAPPS. I appreciate that. Thank you.

Mr. GREENWOOD. The time of the gentlelady has expired. The Chair recognizes the gentleman, Mr. Ganske, for 5 minutes.

Mr. GANSKE. Thank you, Mr. Chairman.

On June 6, I gave special orders on Medicare reform. I have a copy here which I will provide to you, Mr. Scully. I have 26 recommendations for Medicare CMS reform. It is not meant to be exclusive. I am sure there are many other suggestions. Number 26 says the efficient organization, performance, and oversight of Medicare fiscal intermediaries and carriers is hampered by legislative prohibitions against competition and financial incentives for good performance which should improve contractor performance by modernizing the legislative authorities, including the authority to compete for contracts and to financially reward good performance.

I think those are principles that we need to look at, consistent with what this hearing is about. But the details are very important on this. So I guess I have a question in terms of how do you define

or what are you thinking about when you are talking about functional contracting?

Mr. SCULLY. Functional contracting, and it is something that has been debated in CMS since I got there, which is how good an idea it is. I mean the basic issue is do you want to take some of the functions that our carriers and FIs have done, such as reviewing claims patterns for upcoding, fraud and abuse, things like that, and break them out of existing contracts and give them to a separate subcontractor who is focused just on that as a functional contract. I think their argument is to have both ways. As Ms. DeGette suggested, I think finding people who are most effective at their subset of the world is a great idea. But to the point where we balkanize the system so that we have got too many overlapping contractors, I think that is a tension that we need to resolve in CMS, to what works best.

We have broken some of it out already in the MIP program, the Medicare Integrity Program for subcontracting. Some of the contracts have come back and said look, we can do the same thing. You are reinventing the wheel, and you are wasting your time. I think that is just something we need to look further into and find the right balance as to what the carriers and FIs, hopefully consolidated together, can do best and can we really go out and find people who are focused on specific claims review can do for us a little better. But I am concerned about just balkanizing the whole program and having contractors crawling over each other, which is the worst of all worlds.

Mr. GANSKE. I share your concern on that. I think there are some elements in this proposal that tend to be both centripetal and centrifugal. In other words, there are some parts of the proposal I think tend to go toward fragmentation, parts tend to pull back in. For instance, the issue of executing combined Part A and Part B contracts. Tell me how you think that would work.

Mr. SCULLY. I think it is a complex transition, but I think right now, my understanding, and I have only been there 3 weeks so I am still learning, is that we have totally separate Part B and Part A systems. So even if you are Trail Blazer or Blue Cross of Georgia, I think, or some of the others that have both halves of the contract, both parts of the contract, they really operate in separate worlds. There is a common working file that ties them together to some degree, but there is a limited amount of discussion between those two sides.

I think to some degree a phasing in where you had overlap would be helpful in a whole variety of ways, including the fact even when you get to things like lifetime deductibles and outlays for Medicare, it is hard to track. So running a coordinated program, it seems for a variety of policy reasons as well as just functionally running the carriers better, in the long run, I don't think it can happen overnight, trying to develop our new systems toward an integrated Part A and B system. Whether Part A and B are together or separate, it just seems to me it would be a more rational way to deliver the services.

Mr. GANSKE. I think before heading in that direction, you need to answer the question. There are many reasons why Part A and Part B have been separate traditionally over the years. You need

to decide whether in fact that is a way to go in the first place, and then if you decide that it would be, how well you could make it functionally work. I think Mr. Serota has some testimony that he will give us today on how complicated that actually could be.

I don't think that we as a committee have come to any consensus on that issue over the combination of Part A and B. I certainly have not.

Mr. SCULLY. I would hope that I could work with you. One of my ideas this fall is to find some of the places where Part A and B overlap, and there are a number of States, and to try to do some pilots and demos that are incentive-based, where you have an overlapping contract to see how well it works, and see what the problems are. Because clearly, we do not want to dive into this head first without knowing where we are going.

Mr. GANSKE. I would tend to agree with that because I think that rather than instituting a broad, overall change without first realizing what some of the consequences could be would be foolhardy.

So anyway, I will get a copy of this to you. I would very much appreciate it if in some way, you could respond to each of these points that I make in my speech so I get some idea of what you are thinking about these issues.

Mr. SCULLY. We have a new hopefully implemented policy responding to all congressional inquiries in 14 days. Twenty six questions might take a little longer, but hopefully we will be pretty quick.

Mr. GANSKE. Thank you. I yield.

Mr. GREENWOOD. The time of the gentleman has expired. All of the members of the panel have had the opportunity to inquire of these witnesses. So there is a floor vote being called now. In fact, there are a series of them. So this panel is excused. We thank you for your testimony. I look forward to working with you in the future.

We will recess until 12:30.

[Brief recess.]

Mr. GREENWOOD. The committee will come to order. The Chair would ask the third panel, consisting of Mr. Scott Serota, President and CEO of Blue Cross and Blue Shield Association, and Mr. Timothy Cullen, Chairman of United Government Services, Mr. Alfred Chiplin, Managing Attorney, Health Care Rights Project, Center for Medicare Advocacy, Inc. to come forward.

Welcome, gentlemen. Thank you for indulging us while we had the series of votes. Appreciate your presence.

You gentlemen are aware that this is a hearing, a joint hearing between the Health and the Oversight and Investigations Subcommittees. It is the practice of the Oversight and Investigations Subcommittee to take testimony under oath. Do any of you have any objections to giving your testimony under oath?

Mr. SEROTA. No, sir.

Mr. GREENWOOD. Pursuant to the rules of the committee and the House, you then have the right to be represented by counsel. Do any of you wish to be represented by counsel during your testimony?

Mr. SEROTA. No, sir.

Mr. GREENWOOD. Okay. In that case, if you will rise and raise your right hand I will give you the oath.

[Witnesses sworn.]

Mr. GREENWOOD. You are under oath.

Mr. Serota, if you would begin by giving your testimony, you will be recognized for 5 minutes.

TESTIMONY OF SCOTT P. SEROTA, ACTING PRESIDENT AND CEO, BLUE CROSS AND BLUE SHIELD ASSOCIATION; TIMOTHY F. CULLEN, CHAIRMAN, UNITED GOVERNMENT SERVICES, LLC; AND ALFRED J. CHIPLIN, JR., MANAGING ATTORNEY, HEALTH CARE RIGHTS PROJECT, CENTER FOR MEDICARE ADVOCACY, INC.

Mr. SEROTA. Thank you, Mr. Chairman, and members of the subcommittees. I am Scott Serota, President and Chief Executive Officer of Blue Cross Blue Shield Association. I appreciate the opportunity to testify today. I also appreciate your interest and leadership in identifying ways to improve the Medicare contractor program to enhance services for beneficiaries and providers.

Many of our plans contract with the government to handle much of the day-to-day Medicare administrative activities. We pay claims, provide customer service, educate providers, and fight waste, fraud, and abuse. Our contractors are committed to achieving outstanding performance. Blue Cross Blue Shield plans are proud of their role as Medicare administrators. Even with soaring workloads we have remained cost-effective, keeping administrative costs to less than 1 percent of the total Medicare benefits.

We also protect the trust fund by saving the government $17 for every dollar invested in program safeguard activities. We support efforts to improve the ability of both contractors and the CMS to provide the highest level of service to Medicare beneficiaries.

Before discussing our specific recommendations on contractor reform, I would like to provide you with a perspective on the challenges we face as contractors. First, inadequate funding, coupled with rising workloads impede contractors' ability to provide service levels beneficiaries and providers expect and frankly, deserve. Our contractors have been severely under-funded since the early 1990's, while claims volume have risen almost 70 percent.

While the additional funding provided through a permanent appropriation in 1996 for dedicated fraud and abuse activities has helped, it has not solved the budget problems for the rest of the contractor budget, which are needed to pay claims, provide customer service, and educate providers. This is still subject to the annual appropriations process. We are pleased the Administration and many members of this committee have recognized the need for additional administrative resources. We would like to work with you to make this happen.

Second, the Medicare program has grown more and more complex in recent years. Over the past few years, several new payment mechanisms were implemented and benefits added. In addition, HIPAA administrative simplification provisions and privacy rules must be implemented. Just as each of you have heard from providers about Medicare complexities, so do we as contractors hear these same complaints from the providers.

Third, frequent changes in program direction challenges our contractors. At last count, Medicare contractors received an average of a new instruction from CMS every 5 hours of every day of the year. Finally, many legislative changes to Medicare are rarely accompanied by administrative funding or appropriate transition time for proper implementation.

I will turn to our specific recommendations for contractor reform. These recommendations are based on the broad outline of CMS' proposal since we just this morning received specifics. In general, we agree with most of CMS' proposal. We agree that competition can be strengthened in the program. CMS should be able to contract with any qualified entity, not just health insurers. In doing this, CMS should focus on competitively bidding those contracts with those contractors which are voluntarily exiting the program or those contractors which perform poorly. This would allow the government to maintain those contractors that are providing quality service and meeting CMS' performance expectations.

We also would support the elimination of provider nominations, so long as the provider community is in agreement. We strongly support modernizing current cost-based contracts. Currently, most contractors are paid cost up to a cap set by CMS. There is no opportunity for profit. We believe CMS should be allowed to use other payment options, such as cost-plus contracting.

Our bottom line objective with any reform effort is to ensure that the services to beneficiaries and providers are not disrupted or made more complicated. We must improve the program, not make it more difficult. It is for this reason we would encourage the committee to establish a more businesslike contracting environment, with a clear and definitive statement of work, disciplined and controlled change orders, sufficient funding to accomplish the work in a timely and professional manner, with prompt responses to contractors' budget requests, and contracting officers that are fully empowered within CMS to manage the contractual relationship.

There are two areas in which we differ with CMS. We do not agree that CMS should further fragment the program through functional contracting. Our understanding is that CMS wants to separately contract each function. For example, have one contractor pay claims, one provide beneficiary services, another for education. We just don't think this makes any sense.

When a provider or beneficiary calls, they don't want answers, they want action. They want a problem solved. Functional contracting would diminish the current single point of accountability that our contractors represent. In addition, it disrupts effective management of the program, and has the potential to increase, not decrease costs, because each entity will have its own budget and coordination costs.

We do not believe that A and B contractor operations should be merged. We believe the objective of approved care for beneficiaries and more uniform medical policies can easily be accomplished without having to change contractor operations. Data can be shared and combined, and local medical policies can be brought into agreement.

I do have one final recommendation not included in the CMS proposal. That is, to provide stable and adequate funding. It is simply

unrealistic to expect contractors to meet expectations without appropriate resources. To achieve this goal, we recommend a new funding methodology be developed for Medicare contractors. Congress should explore employing mechanisms similar to those used to fund Social Security administrative costs and Medicare peer review organizations.

I urge the committee to increase the permanent MIP appropriation that is capped at $720 million in fiscal year 2003 and beyond, despite the continued increase in claims volume. If fraud and abuse efforts are to be effective, MIP funding must keep pace with the increasing workloads.

In summary, we are committed to achieving outstanding performance by providing high quality service to beneficiaries and providers. We believe more can and should be done to improve contractor operations and oversight. We look forward to working with the committee on these recommendations to improve the program. Thank you.

[The prepared statement of Scott Serota follows:]

PREPARED STATEMENT OF SCOTT SEROTA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairmen and members of the Oversight and Investigations and Health Subcommittees, I am Scott Serota, President and Chief Executive Officer of the Blue Cross and Blue Shield Association. We represent 45 independent, locally operated Blue Cross and Blue Shield Plans throughout the nation. I appreciate the opportunity to testify before the Subcommittees on Medicare contractor reform.

Since 1965, Blue Cross and Blue Shield Plans have played a leading role in administering the Medicare program. They have contracted with the federal government to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner. Nationally, Blue Cross and Blue Shield Plans serve as Part A Fiscal Intermediaries (FIs) and/or Part B carriers and collectively process most Medicare claims.

Medicare contractors have four major areas of responsibility:

1. **Paying Claims:** Medicare contractors process all the bills for the traditional Medicare fee-for-service program. In FY 2001, it is estimated that contractors will process over 900 million claims, more than 3.5 million every working day.
2. **Providing Beneficiary and Provider Customer Services:** Contractors are the main points of routine contact with the Medicare program for both beneficiaries and providers. Contractors educate beneficiaries and providers about Medicare and respond to about 40 million inquiries annually.
3. **Handling Hearings and Appeals:** Beneficiaries and providers are entitled by law to appeal the initial payment determination made by carriers and FIs. These contractors handle over 7.4 million annual hearings and appeals.
4. **Special Initiatives to Fight Medicare Fraud, Waste, and Abuse:** All contractors have separate fraud and abuse departments dedicated to assuring that Medicare payments are made properly. According to the Department of Health and Human Services (HHS), these activities saved the government $9 billion in 1998.

Medicare contractors operate under detailed instructions from the Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration. As government contractors, Medicare contractors must comply with numerous federal statutes, regulations, and Executive Orders. In addition, contractors must follow extensive CMS-issued program guidelines and manual instructions. To monitor compliance with these guidelines, contractors are visited several times each year by their local CMS regional office staff for an assessment of their performance against CMS' requirements. These reviews, termed Contractor Performance Evaluations, are conducted across all aspects of contractor operations—claims processing timeliness and accuracy, customer service, fraud and abuse detection efforts—and culminate in a formal annual report called the Report of Contractor Performance. Also, CMS routinely contracts with private companies to review various critical aspects of contractors operations.

Blue Cross and Blue Shield Medicare contractors are proud of their role as Medicare administrators. While workloads have soared, operating costs—on a unit cost basis—have declined about two-thirds from 1975 to 2001. In fact, contractors' administrative costs represent less than 1 percent of total Medicare benefits. Few government expenditures produce the documented, tangible savings of taxpayers' dollars generated by Medicare anti-fraud and abuse activities. **For every $1 spent fighting fraud and abuse, Medicare contractors save the government $17.**

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We support efforts to improve the ability of both contractors and the CMS to cost-effectively provide the highest service levels to Medicare beneficiaries.

With this as background, I would like to focus my testimony on the following two areas:

I. Current challenges facing Medicare contractors; and
II. BCBSA recommendations for contractor reform.

I. CHALLENGES FACING CONTRACTORS

There are four key challenges currently facing Medicare contractors:

1. Inadequate funding levels with rising workloads;
2. Increased complexity of Medicare rules;
3. Frequent changes in program direction; and
4. Legislative mandates not accompanied by additional funding.

Inadequate funding levels: Of utmost importance to attaining outstanding performance is an adequate budget.

However, Medicare contractors have been severely underfunded since the early 1990's and are facing poor prospects of receiving adequate funding next year. During the early to mid-1990's, reductions in funding concurrent with increases in workload seriously eroded contractors' ability to fight fraud and abuse. Between 1989 and 2000, the number of Medicare claims climbed almost 70 percent to over 800 million, while payment review resources grew less than 11 percent. As a result, the amount allocated to contractors to review claims shrank from 74 cents to 48 cents per claim. Because of the significant cost of reviewing claims, **this decline in funding resulted in CMS' directions to contractors to reduce the percentage of claims that were scrutinized and investigated.** Similarly, the percentage of cost reports audited declined—between 1991 and 1996, the chances that any institutional provider's cost report would be reviewed in detail fell from about 1 in 6 to about 1 in 13.

Throughout this period, contractors identified to CMS additional anti-fraud efforts they could undertake if awarded additional resources. BCBSA and Blue Plans urged both Congress and the Administration to allocate significantly more funds for critical anti-fraud and abuse efforts. Finally, in 1996, Congress created the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act. MIP provided a permanent, stable funding authority for the portion of the Medicare contractor budget that is explicitly designated as fraud and abuse detection activities. MIP funding was set at $500 million in 1998 and is authorized to rise to $720 million in 2002. After 2002, the permanent authorization is capped at $720 million despite continuing estimated increases in claims volumes.

Thanks to this new funding mechanism, Medicare contractors have been able to improve their efforts to reduce the amount of fraud, waste, and abuse in the Medicare program. Contractors' enhanced anti-fraud and abuse efforts due to MIP funding contributed to the significant decline in improper claims and documentation submission by providers. The OIG audit of FY 2000 claims estimated that improper Medicare payments had dropped to $11.9 billion, or about 6.8% of the $173.6 billion in Medicare payments. The improper payment rate declined by over 50% or $11 billion in five years.

But, the creation of MIP did not solve the budget problems for the remainder of the contractor budget. The largest portion of the contractor budget—program management—is subject to the annual appropriations process and continues to face severe funding pressures. Program management activities include claims processing , beneficiary and provider communications, and hearings and appeals of claims initially denied. Under the appropriations process, contractors must compete for funding with high priority programs such as the National Institutes of Health and education.

For example, between 1989 and 1998, funding for program management activities (adjusted for inflation) declined by 18 percent. During this period, the volume of Medicare claims increased by 84 percent; Medicare outlays (in real dollars), by 65 percent. Whenever possible, contractors responded to reduced funding by achieving

significant efficiencies in claims processing, lowering program management costs per claim by 56 percent in real dollars over this period. But even these efficiencies have not been enough to keep pace with rising Medicare claims volume and diminishing funding levels. For example, this year, contractors have been instructed to cut back on customer service plans, responding to inquiries, provider training and other provider services in order to live within the 2001 budget.

Inadequate budgets for program management also impact Medicare's fight against fraud and abuse. While many think of program management activities as simply paying claims, these activities are Medicare's first line of defense and are critically linked to MIP anti-fraud and abuse activities. As an example, many of the front-end computer edits (e.g., preventing duplicate payments and detecting suspicious claims) are funded through program management. Inadequate funding impacts different functions at different times, but always disrupts the integration of all the functional components needed to "get things right the first time." It thus results in inefficiency and higher costs.

We are pleased that Secretary Thompson and many Members of this Committee have recognized the need for additional administrative resources at CMS. However, we are concerned that the Administration's FY 2002 budget relies on $115 million in new user fees from doctors, hospitals, and other providers. Congress has consistently rejected user fees and BCBSA would recommend they be rejected again. We also strongly recommend Medicare contractor funding be increased to $1.567 billion in FY 2002 to ensure adequate resources are available to provide the high quality services beneficiaries and providers deserve.

Increased Complexity of Medicare Rules: The Medicare program continues to grow more and more complex. It takes a great deal of time and resources to educate providers and beneficiaries about new laws and rules as well as answer questions. Contractors have been challenged over the years with enormous program changes such as:

- New payment mechanisms for outpatient departments, home health agencies, and skilled nursing facilities.
- Changes to Medicare coverage rules: Balanced Budget Act (BBA), Balanced Budget Refinement Act (BBRA), and the Beneficiary Improvement and Protection Act (BIPA).
- Implementation of the administrative simplification provisions of HIPAA.

Just as Members of Congress are hearing from providers on the program's complexities, so too are contractors who must answer their questions and concerns.

Frequent Changes in Direction: Medicare contractors are challenged by the very nature of the business. At last count, Medicare contractors, received on average a new instruction from CMS every five hours of every day of the year. This constant state of change requires contractors to be extremely flexible—both in terms of operations and budget. It has not been uncommon in the past for contractors to be forced to abandon projects or reallocate staff mid-year in order to adapt to CMS' suddenly revised priorities or modified funding levels.

Medicare contractors operate under cost contracts, and CMS places budget caps, or limits, on the unit costs paid to contractors to process claims. By law, Medicare contractors are not allowed any profit. Under these contracts, Medicare contractors essentially do whatever work CMS requests, without "change orders." There is not a clear statement of work at the beginning of the year, and contractors generally must comply with constant change orders from CMS without additional reimbursement. These demands make the Medicare contractor business extremely challenging.

Legislative Mandates Without Funding: Legislative changes to Medicare are rarely accompanied by administrative funding or appropriate transition time for proper implementation. This is extremely cumbersome for contractors that are already strapped for resources.

BCBSA RECOMMENDATIONS TO IMPROVE THE MEDICARE CONTRACTOR PROGRAM

BCBSA agrees that revisions to the Medicare contractor program could strengthen contractors' ability to effectively and efficiently handle day-to-day administration of the Medicare program. Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance levels and providing superior service to Medicare beneficiaries and providers. We want to work with the Congress and CMS to attain this objective. While CMS has outlined a number of changes, we understand the specific proposal is still under development. Therefore, our comments reflect our best understanding of their proposal at this time.

Competitive Contracting: We believe that Congress should explore revising Medicare contracts to allow qualified companies to compete based on a modified

Federal Acquisition Rule (FAR)—the federal government's rules on competitive contracting. The FAR would instill at least two disciplines now missing in the program: a clear scope of work, and a professional contracting officer for each contract, through whom contract changes are made. Conducting such competitions under the FAR would ensure that contracts are awarded on the basis of fair competition, and it would give all contractors appropriate appeal rights and due process.

HHS has indicated its intent to reduce the number of contractors to fewer than 20 by 2006. We would point out that such consolidation is already occurring without legislation. In fact, the number of FFS contractors has declined from nearly 50 in 1985 to 32 at the present time. We would caution the Congress and the Administration against moving precipitously with additional consolidation. It could have the potential of seriously disrupting program operations, which in turn could hinder provider services and beneficiary care. To ensure stability of the Medicare program, BCBSA recommends that CMS only put to competitive bid poor performing contractors or those that occur when a contractor is voluntarily exiting the program, rather than using an artificial and mandated timetable for consolidation. This would allow the government to maintain those contractors that are providing quality services and meeting CMS' performance expectations.

Allowing Non-Health Insurers: BCBSA does not oppose the CMS proposal to allow non-health insurance entities as FFS contractors. In fact, we believe CMS already has this authority under current statute and would question whether CMS actually needs additional legislative authority to accomplish this. However, we strongly support the development of criteria to ensure that entities allowed to compete are well qualified to provide the full range of Medicare administrative services.

Functional Contracting: We understand that CMS would like additional authority to further fragment current contractor functions. CMS already has considerable authority to contract separately for Medicare processing functions. For example, the MIP authority under HIPAA permits HHS to separately contract for payment safeguard functions and last year's Medicare legislation requires separate contracting for second level appeals.

We believe it is unwise for CMS to further fragment Medicare functions because it would diminish the current single point of accountability that fiscal intermediaries and carriers represent to providers and beneficiaries. By breaking up contracting functions and spreading them among a large pool of new entities—many of whom would be inexperienced in Medicare—the claims payment process could be impaired, which is likely to disrupt effective management of the program. Costs would invariably increase because claims processing, customer service, and fraud and abuse activities are interconnected; for example, claims processing and fraud control efforts would still require coordination and extensive data sharing after these responsibilities are divided. At the very least, a comprehensive plan to ensure efficient coordination among the functional contractors and an infrastructure to support the coordination must be developed and implemented prior to adopting any provisions to further fragment program operations.

Moreover, separating key functions to different contractors could hinder efforts to fight fraud and abuse and disrupt services to beneficiaries and providers for several reasons:

1. Fragmentation is likely to create competing, counterproductive incentives.
2. Staffing resources required to implement and manage this type of new contracting authority are so immense that they would undermine CMS' efforts to administer its other initiatives effectively.
3. Contracts could be awarded to entities that have no experience working with the Medicare program (a current program requirement), or even entities that have no familiarity with health claims processing.
4. Functional contracts are likely to increase, not decrease costs.

Above all else, fragmenting the claims payment process would destroy the current single point of accountability now available to CMS, providers, and beneficiaries. I cannot emphasize enough the potential confusion and difficulty that may arise from managing a multitude of independent specialty contractors who share work but do not share accountability for the outcome (e.g., for a correctly and efficiently processed claim), and may even consider themselves competitors to each other. It is conceivable that under CMS's proposal an individual claim could be handled by three or more individual contractors before it is finally processed. This fragmentation could remove any accountability for processing a single claim properly—from beginning to end.

Combine Part A and B Contractor Operations: The Medicare program is unique in that two distinct operations exist for Parts A and B, each having been designed separately. We do not believe that merging contractor operations would improve the program for beneficiaries. In fact, it could have the opposite effect, hin-

dering operations and causing disruptions in services. Part A is geared toward interactions with hospitals and the provider community while Part B contractor operations are targeted toward interactions with beneficiaries.

Because of the differing benefit structures, which led to separate Part A and Part B contractors, Medicare's information systems have not advanced the techniques for consolidated processing. In fact, since CMS's aborted attempt to construct a single processing platform in the early 1990s (the Medicare Transaction System or MTS), CMS has pursued a strategy of separate automated systems for Part A and Part B, and an additional automated claims processing system for its Durable Medical Equipment Regional Contractors. As the General Accounting Office testified recently before your Committee: "HCFA lacks [the capacity to collect comprehensive information on services and payments in the aggregate and for individual beneficiaries] today, not because it has separate contractors for parts A and B, but because of deficiencies in its information systems."

We can appreciate the advantages of having a common database of beneficiary and claims information to promote customer service and medical review. Similarly, local medical policies should not differ between Part A and Part B in the same states or major metropolitan areas. These two concerns, however, are easily dealt with without having to change contractor operations: data can be shared and combined, and local medical policies can be brought into agreement.

Eliminate Provider Nominations: Provider nomination was originally implemented to offer greater ease and simplicity of claims payment for institutional providers. This process has been important for provider chains that are able to choose one contractor to handle claims from their providers on a nationwide basis. As you consider this recommendation, we suggest consulting with the provider community on the impact of such a change. BCBSA would not oppose this, which would include elimination of our Prime Contract, so long as the provider community is in agreement.

Drop special contractor termination provisions: CMS clearly has the authority to terminate current contractors if they are not meeting performance expectations. We understand that CMS is considering a proposal that would eliminate contractor's current termination rights, primarily the payment of phase-out costs. Continuing contractors should retain their existing termination rights.

The original construction of Title XVIII intended contractors to be reimbursed at neither profit nor loss and permitted contractors termination rights and payment for phase-out costs. Had the statute envisioned today's typical FAR contracting rules, termination rights and reimbursements would be handled differently. If, in the future, Medicare FFS contracts are procured under the FAR, then interested parties will be able to consider those termination provisions in their bid proposals. Contractors that are not given the opportunity to rebid under different termination rules, should retain the current contractual rights.

CMS authority to award other than cost reimbursement contracts: We agree with CMS that the current cost based contracting system should be modernized. Currently, most contractors are paid costs up to a cap set by CMS; there is virtually no opportunity for profit. We believe CMS should be allowed to use other payment options, such as cost plus contracts.

We would like to again highlight that contractors have been extremely efficient. Unit costs have dropped two-thirds over the last 25 years; administrative costs represent less than 1 percent of benefit payments. This has been achieved by the many technological advances employed by contractors.

As previously stated, a major challenge over the past 10 years has been inadequate funding, coupled with rising workloads and legislative changes necessitating major payment systems revisions. The prospects for adequate funding for next year do not appear promising. Any change to how contractors are paid must be accompanied by sufficient overall funding.

Stable and Adequate Funding is Necessary. While Blue Cross and Blue Shield Medicare contractors are committed to continually achieving greater efficiencies, it is simply not realistic to expect contractors to attain outstanding performance levels with greater workloads and tighter budgets.

We urge Congress to provide adequate funding levels to assure that contractors can perform the range of functions necessary to safeguard program funds and support high quality service levels to beneficiaries and providers. As highlighted earlier, funding has not kept pace with programmatic needs—important functions are not being funded. We have two specific recommendations that are not included in the CMS package:

- First, we urge Congress and the Administration to assure Medicare administrative funds keep pace with workload increases and new legislative/regulatory requirements. Congress also may wish to explore using a new methodology to de-

velop Medicare contractor budgets, such as those mechanisms used to fund Social Security Administration administrative costs and Medicare Peer Review Organizations.

- Second, we urge the Committee to increase the permanent MIP appropriation, which is currently capped at $720 million in 2002 and beyond. If fraud and abuse efforts are to be effective, MIP funding must keep pace with workload increases. MIP has also had a positive effect on Medicare's financial situation, lowering FFS inflation and extending Part A Trust Fund solvency, according to the OIG and Medicare Trustees. Therefore, it is critical this program be continued.

BCBSA would like to work with Congress to assure adequate funding is available each year for high quality provider and beneficiary services.

CONCLUSION

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We believe more can and should be done to improve Medicare contractor operations and CMS oversight. Success in Medicare claims administration requires that CMS and the contractors work together toward their mutual goal of providing high quality services to beneficiaries and providers, including accurate and timely claims payment.

BCBSA look forward to working with this Committee and CMS to make these needed improvements.

Mr. GREENWOOD. Thank you for your testimony.

Mr. Cullen, you are recognized for 5 minutes.

TESTIMONY OF TIMOTHY F. CULLEN

Mr. CULLEN. Thank you, Mr. Chairman, and members of the subcommittees. My name is Tim Cullen. I am Chairman of the Board of United Government Services. We are the largest Medicare Part A intermediary. We process about 20 percent of all Part A claims. We employ 1,300 people in eight different States.

We support the Medicare Contractor Reform proposals of the Secretary and CMS. We welcome and support more competition in Medicare contracting. We have competed for and won contracts in the Medicare program. In our private business side at Wisconsin Blue Cross, we compete for business every day.

The Medicare contractor program needs to change and be administered within the context of free market competition. This is the clear and obvious direction of nearly every segment of our society. The program needs competition. It needs incentives. It needs reasonable limits on contractor liability.

The current program of cost contracts, with no incentives to excel and unlimited liability, is essentially a program of all stick and no carrot. The current system of throwing out non-compliant contractors, but not rewarding good ones simply encourages mediocrity. That does not serve the senior citizens of America well.

We support moving away from cost contracts. Cost contracts do not reward excellence. Cost contracts require CMS to micromanage contractors. We need to move to incentive-based contracts through the competitive bid process. I have no doubt that CMS can successfully manage the changes proposed by the Secretary and the administrator.

Transitions of business to new contractors would occur with reform. There would be this movement of business to different contractors. This does not need to be disruptive to senior citizens or providers. Working closely with CMS, we at United Government Services have successfully completed large transitions in Michigan, Virginia, West Virginia, and California, all in the past 4 years. In

addition to these States for the Part A side, we also assumed workloads for the federally qualified health centers in all 50 States, as well as regional home health intermediary for eight more western States.

If you address the issues involving the employees currently doing the work, it is a key factor in that success. We also go out and meet with provider groups, meet with beneficiary groups in advance of the transition date so they know who the contractor and intermediary is going to be, and know how to get a hold of us. You can mitigate a lot of those transitional issues if you meet with people in advance.

The Medicare contractor budget of over $1 billion does not go out for bid today really unless the contractor leaves voluntarily or involuntarily. As a matter of public policy, we do not think this is defensible, particularly for large contractors and intermediaries.

We support the elimination of the provider nomination process, and therefore, the Blue Cross Association master contract with CMS. As a practical matter, on a day-to-day basis, we intermediaries interact with CMS daily, hourly, and not that often involving the association. So as a practical matter, the relationship is between us as intermediaries and with CMS.

Regarding changes to termination agreements and costs, we must recognize and protect existing contracts with employees, such as our unionized employees in downtown Milwaukee. We are proud of our employment record on the new contracts we have been awarded, and are well aware that both the committee and CMS value continuity of services when intermediaries change.

Contract incentives can be structured to be very beneficial to a senior citizen. Incentives can reward contractors for speed and accuracy, for example, in handling customer service phone calls. Have the incentives reward the kind of behavior that benefits the senior citizen.

Competition and properly structured incentives will encourage excellence in Medicare contracting. This serves the senior citizens of America.

I thank you for this opportunity to testify. I will be pleased to try to answer any questions of the subcommittees. Thank you.

[The prepared statement of Timothy F. Cullen follows:]

PREPARED STATEMENT OF TIMOTHY F. CULLEN, CHAIRMAN, UNITED GOVERNMENT SERVICES, LLC

Mr. Chairman and members of the Committee I am pleased to testify before you today. I am Chairman of the Board of United Government Services (UGS). As the largest Medicare Part A intermediary we process 20% of all Part A claims. We employ 1,300 people in eight states.

We support the Medicare Contractor Reform proposals of the Secretary and CMS.

We welcome and support more competition in Medicare contracting. We have competed for and won contracts in the Medicare program and on our private business side, at Wisconsin Blue Cross, we compete for business everyday.

The Medicare contractor program needs to change and be administered within the context of free market competition. This is the clear and obvious direction of nearly every segment of our society.

The program needs competition, incentives and reasonable limits on contractor liability.

The current program of cost contracts, with no incentives to excel and unlimited liability, is essentially a program of no carrot and all stick.

The current system of throwing out non-compliant contractors but not rewarding the good ones encourages mediocrity and that does not serve the senior citizens of America well.

We support moving away from cost contracts. Cost contracts do not reward excellence. Cost contracts require CMS to micromanage contractors. We need to move to incentive-based contracts through the competitive bid process.

I have no doubt that CMS can successfully manage the changes proposed by the Secretary.

Transitions of business to new contractors would occur with reform. This does not need to be disruptive to senior citizens or providers. Working closely with CMS, we at UGS have successfully completed large transitions in Michigan, Virginia, West Virginia and California all in the past four years. Addressing issues involving the employees currently doing the work is a key factor in this success.

The Medicare contractor budget of over one billion dollars does not go out for bid unless a contractor leaves voluntarily or involuntarily. As a matter of public policy we do not think this is defensible for large contractors and intermediaries.

We support the elimination of the provider nomination process and therefore the Blue Cross Association Master Contract with CMS. As a practical matter, on a day to day basis we intermediaries interact directly with CMS and only on a rare basis involve the Association.

Regarding changes to termination agreements, we must recognize and protect existing contracts with employees such as our unionized employees in downtown Milwaukee. We are proud of our employment record on the new contracts we have been awarded and are well aware that both the Committee and CMS value continuity of services when intermediaries change.

Contract incentives can be structured to be very beneficial to senior citizens. For example, incentives can reward contractors for speed and accuracy in handling customer service phone calls. Incentives can reward contractors for answering a high percentage of phone calls in a short period of time.

Competition and properly structured incentives will encourage excellence in Medicare contracting and this serves well the senior citizens of America.

Thank you for this opportunity to testimony and I will try to answer any questions from the Committee.

Mr. BILIRAKIS. Thank you very much, Mr. Cullen. I apologize for this shifting around up here, but you have been up here enough to know what it is like.

Mr. Chiplin, who is the Managing Attorney for the Health Care Rights Project, Center for Medicare Advocacy. Welcome, sir. Please proceed.

TESTIMONY OF ALFRED J. CHIPLIN, JR.

Mr. CHIPLIN. Thank you, Mr. Chairman, and subcommittee members. My name is Alfred Chiplin. I am the Managing Attorney in the Washington, DC based Health Care Rights Project at the Center for Medicare Advocacy.

Thank you for this opportunity to testify on Medicare contractor issues affecting older and disabled Americans, particularly as the Center for Medicare and Medicaid Services, CMS, takes on new leadership and is in the midst of another of its all too frequent reorganizations.

Beneficiaries need good information from carriers and intermediaries. One of the more critical functions of carriers and intermediaries is to educate people about Medicare options and about how to get medically necessary services. From our experience, we have learned that people with Medicare need to hear about their Medicare options from multiple sources multiple times. Unfortunately, CMS has cut carrier and intermediary funding to provide these important educational services. Other than the State health insurance assistance programs, which are substantially under-

funded to meet community needs, the elderly and people with disabilities have few places to turn for good information.

Beneficiaries need timely information about the Medicare+Choice program and its plans. Recent actions by the Secretary of HHS are likely to undercut significantly any legitimate CMS efforts to provide reliable and timely beneficiary information necessary to make decisions about choosing a Medicare+Choice plan.

On May 25 of this year, the Secretary sent a letter to the American Association of Health Plans, summarily giving HMOs additional time in which to inform CMS of their proposed benefits and premiums for their 2002 Medicare plans, and whether they plan to participate in the Medicare program. A number of beneficiary organizations and individual beneficiaries have recently filed suit against the Secretary, complaining that this action is illegal. They allege that the delay in this important information deadline from July 1, 2001, to September 17, 2001, will prevent older and disabled Americans from receiving Medicare and You, the annual government mailing with comparative health plan information, in time to make an informed choice about services.

The Secretary's decision also allows HMOs to mail out marketing materials with unapproved information as long as it includes a disclaimer explaining that the information is subject to final approval.

We also note that the Secretary is doing a few things that we think are useful in this regard. He is taking the Medicare hotline, the 1-800 number, and moving that to a 24 hour a day, 7 day a week service, which we think will be helpful. We also are pleased that in this whole movement, they are moving to extending the special enrollment period through the month of December. These actions we think will be helpful. But overall, it puts beneficiaries in a bad position with respect to being able to have good information both for the plans, for carriers, for intermediaries about making health plan choices. We think this will redown to much confusion, and will have a number of negative repercussions at all levels with respect to decisionmaking.

In addition, beneficiaries need all types of information from their carriers and intermediaries. We also note that Medicare continues to be a program full of what I call bifurcations. What I mean by that is that intermediaries and carriers, carriers and their staff, generally rely on various Medicare manuals, program instructions, and other kinds of interpretations in making decisions about Medicare claims. In many instances, these instructions and interpretations are in fact inconsistent with the Medicare statute and implementing regulations. Much attention needs to be given to that.

We are also concerned about issues of contractor oversight. We note that CMS responded to a letter of proposals by Congressman Stark and Congresswoman Johnson on June 14, saying that it is exploring incorporating the use of best practice standards from the private industry. We have no basic problem with this, although we caution that the adaptation and use of such practices is not a substitute for good statutory and regulatory enforcement and contract enforcement.

Similarly, we have just learned of a durable medical equipment carrier making coverage decisions on the basis of a publication called Home Medical Equipment Answer Book. This of course is not

an official Medicare manual, nor regulation, but rather an industry synthesis of Medicare law and practice. CMS should assure that carriers and intermediaries use such non-Medicare tools in a fashion that does not compromise Medicare law. It is illegal to use screens in norms of treatment and treatment rules of thumbs to deny Medicare coverage without first providing a Medicare beneficiary with an opportunity for an individualized evaluation of his or her medical factual situation.

We are also concerned that beneficiaries and carriers and intermediaries need to look at and address the whole question of managing the local coverage determination process known as LMRPs. In this system, carriers and intermediary functions to make, review and approve local coverage determinations about Medicare. In fact, 95 percent of all coverage policies are made on the local level, with 5 percent being made and developed on the national level. Currently there are some 8,000 LMRPs. The local carrier advisory committee develops these with input from State medical societies, medical directors, and advocacy groups.

Mr. BILIRAKIS. Please summarize, Mr. Chiplin, if you would, please.

Mr. CHIPLIN. The concern here is that you have all these carriers, all this information being developed by different people. There is no commonality of information. One intermediary in one area gives coverage for certain things, and one the next day doesn't give it. People are all over the place. There is no way to get these processes harmonized. It means beneficiaries go without coverage. That is the basic summary of that.

The main thing that we would say in summary about this whole set of issues of carrier and intermediary contracting concerns is that they need to be adequately funded. They need to be funded specifically to address the question of beneficiary information in all of its forms.

We also need to have them to address ways of getting at information. There is a lot of concern about whether the Internet is in fact a vehicle useful for older people. The geriatological research on that is rather mixed.

So we strongly encourage more funding, careful analysis, and if you move to a different system of contractors, that there is ample experimentation and transition planning so that we don't have the kinds of problems that Congresswoman Capps identified in her comments earlier this morning.

Thank you.

[The prepared statement of Alfred J. Chiplin, Jr. follows:]

PREPARED STATEMENT OF ALFRED J. CHIPLIN, JR., CENTER FOR MEDICARE ADVOCACY, INC., HEALTHCARE RIGHTS PROJECT

Good morning, ladies and gentlemen. My name is Alfred J. Chiplin, Jr. I am the managing attorney in the Washington, DC-based Healthcare Rights Project of the Center for Medicare Advocacy, Inc., (the Center). The Center represents elders and people with disabilities who are unfairly denied Medicare and/or access to necessary healthcare.

Thank you for this opportunity to testify on Medicare contractor issues affecting older and disabled Americans. This is an important and highly relevant topic, particularly as the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), takes on new leadership and is in the midst of another of its all too frequent reorganizations.

About the Center for Medicare Advocacy, Inc.

In addition to the Healthcare Rights Project, located here in Washington, DC., the Center for Medicare Advocacy has its headquarters in Connecticut, a data unit in Maine, and a consulting attorney in Tucson, AZ. The Center celebrated its 15th anniversary on March 1, 2001.

The Center for Medicare Advocacy, Inc., (the Center) is staffed by attorneys, paralegals, nurses, and technical assistants who provide legal advice, self-help materials, and representation to elders and people with disabilities. The Center operates a Medicare toll-free telephone hotline for Connecticut residents. This line responds to over a 1,500 calls per calendar quarter from persons seeking information about Medicare coverage and related issues.

In addition to this state specific work, the Center is involved in national advocacy on behalf of improvements in Medicare coverage and appeals processes. Attorneys for the Center have participated in most of the major beneficiary-focused Medicare litigation that has been brought over the years—including issues of access to Medicare covered services for persons with chronic conditions, the lack of notice that comports with due process when skilled nursing facilities decide to terminate services for beneficiaries, and the problem of lack of notice or inadequate notice when managed care organizations decide to deny, reduce or terminate Medicare covered services. Similar litigation has been brought in the context of the home health benefit.

The Center is called upon frequently to provide training for attorneys and other advocates who seek to represent Medicare beneficiaries. Center staff regularly provide Medicare training at national conferences and at state and local events. The Center has assisted organizations in establishing local Medicare education efforts, including brochures, pamphlets, and other writings of interest to those who represent beneficiaries. Our most recent effort in this regard is our *Medicare Handbook,* published in July 2000. An updated version of this text is at the printers for a re-issue date of August 2001. In addition, we maintain an informational website at www.medicareadvocacy.org. The site was visited 28,000 times last quarter.

Beneficiaries need good information from carriers and intermediaries.

Older and disabled Americans need access to meaningful and accurate information to make informed health care choices, to gain access to health care that is medically necessary, and to assure access to a health care system that responds to their needs and the needs of their community. Any changes to the Medicare carrier and intermediary contracting system should strive to realize these needs.

One of the carriers' most critical functions is to educate people about Medicare options and how to get medically necessary services. I am sure you know from personal experience and experiences your constituents have shared with you how very difficult it is to make good health care choices. For the elderly and people with disabilities, these decisions are particularly hard because they tend to have low fixed incomes and a high likelihood of needing substantial health care services.

From our experiences, we have learned that people with Medicare need to hear about their Medicare options from multiple sources, multiple times. Carriers, which have local offices throughout communities, provide education through face-to-face meetings, and are viewed as a trusted source by people with Medicare. Carriers have also instituted toll-free hotlines for consumers, have begun to provide more free information to providers, and have expanded their educational reach through their web sites.

Unfortunately, CMS has cut carrier funding to provide these important educational services and, other than the State Health Insurance Assistance Programs which are substantially underfunded to meet community needs, the elderly and people with disabilities have few places to turn for good information.

Timely information about Medicare+Choice Plans.

In addition to the lack of funding questions raised above, there is the problem of providing timely and accurate information necessary to make Medicare+Choice plan choices. Recent actions by the Secretary of the Department of Health and Human Services are likely to undercut significantly any legitimate CMS effort to provide reliable and timely beneficiary information necessary to make decisions about choosing a Medicare+Choice plan. In a May 25, 2001 letter to the American Association of Health Plans, Secretary Thompson summarily gives HMOs additional time in which to inform CMS of their proposed benefits and premiums for their 2002 Medicare plans and whether they plan to participate in the Medicare program.

A number of beneficiary organizations and an individual Medicare beneficiary have recently filed suit in federal district court for the District of Columbia alleging

that the Secretary's action is illegal.[1] They allege that the delay in the deadline from July 1, 2001 to September 17, 2001 will prevent older and disabled Americans from receiving Medicare and You, the annual government mailing with comparative health plan information, in time to make an informed choice about their health care options.

Since Medicare+Choice was enacted in 1997, HMOs have been required by law to submit their Medicare plan information to HCFA, now CMS, which is responsible for reviewing and analyzing the data, putting it in a comparative format and sending it to the nearly 40 million peoplw with mMedicare 15 days before November 1, in time for Medicare's open enrollment period. This year, however, the Secretary authorized CMS to mail out Medicare and You 2002 without the comparative information on premiums, benefits, and cost-sharing for every Medicare HMO in the community.

The Secretary's decision also allows HMOs to mail out marketing materials with unapproved information as long as it includes a disclaimer explaining that the information is subject to final approval. And, he is extending the time frame for the HMOs to mail out their own marketing materials, including information on benefit and premium changes.

Consumer advocates are also concerned because beginning January 2002, those enrolled in Medicare HMOs will be "locked-in" to their healthcare choices. They will only be permitted to make one change during the first six months of the year and later during the open enrollment period in the fall of the year.

People who lose their HMO coverage can enroll in Original Medicare (fee-for-service) and may purchase a supplemental (Medigap) policy if they do so during a special time period that begins October 2, 2001 and ends March 4, 2002. About 27 percent of people with Medicare have one of the 10 different Medigap plans, the price for which varies depending on the amount of coverage one buys. Those interested in choosing another HMO option, if one exists in their community, are advised to research the cost of premiums, benefits and co-payments, what doctors and hospitals participate in a given plan, and prescription drug coverage available. Over the last three years, about 1.7 million older and disabled Americans had to find new healthcare coverage when their HMOs dropped out of the Medicare program.

The results of this approach to information dissemination is likely to include many negative repercussions for carriers and intermediaries as they try to help people with questions and options in this uncertain environment. The law of unintended consequences, particularly of the "negative kind," is likely to be monstrously evident throughout this up-coming M+C plan election process.

Carrier and Intermediary Education about Medicare coverage.

Medicare continues to be a program filled with unfortunate bifurcations. Intermediaries and carriers and their staffs generally rely on the various Medicare manuals and program instructions comprising the agency's interpretation of the statute they administer. In many instances these instructions and interpretations are in fact inconsistent with the Medicare statute and implementing regulations. Beneficiaries often have to continue through the administrative review process until they reach the Administrative Law Judge (ALJ) level of review before the applicable Medicare law and regulation is applied. This is wasteful and time-consuming for all parties concerned. More attention should be given to assuring that carrier and intermediary policies and practices conform to the law. In this regard, we caution that Congress not take the easy way out and simply ratchet down the ability of ALJs to go beyond carrier and intermediary interpretations of the law, but rather strive to assure that carrier and intermediary policy is in conformance with the Medicare statute and regulations.

Reforms in this area should include a focus on assuring that carriers and intermediaries have been advised that their practices and pronouncements on a given issue are outside the statute and regulations. Moreover, carriers and intermediaries must be monitored to assure that once advised, corrective actions are taken. We have, for example, encountered many situations where carriers and intermediaries consistently misapply Medicare law and regulation with respect to granting Medicare coverage of services and procedures for persons with chronic conditions where skilled maintenance therapies are reasonable and necessary and have been prescribed by the patient's physician. This is particularly a problem in the area of Medicare covered home health services. It is long-settled that such coverage is appropriate under the Medicare program

[1] See, *The Gray Panthers Project Fund, et al., v. Thompson, Secretary of Health and Human Services,* Civil Action No. 1:01CV01374 (HHK)(D. DC, filed June 22, 2001).

Assuring contractor oversight.

We note in CMS' June 14, 2001, response to Congressman Stark's and Congresswoman Johnson's proposals for administrative reform, that it is exploring incorporating the use of best-practice standards from the private industry. While we have no problem with this in the main, we caution that the adaptation and use of such practices is no substitute for statutory and regulatory enforcement or contract enforcement.

We have just learned of a Durable Medical Equipment Review Contractor (DMERC) making coverage decisions on the basis of a publication called a *Home Medical Equipment Answer Book.* This, of course, is not an official Medicare manual or regulation, but rather an industry synthesis of Medicare law and practice. CMS should assure that carriers and intermediaries use such non-Medicare tools in a fashion that does not compromise Medicare law. It is illegal to use screens and norms of treatment, and treatment "rules of thumb" to deny Medicare coverage, without first providing a Medicare beneficiary with an opportunity for an individualized evaluation of his or her medical-factual situation.

Similarly, our experience is that CMS, formerly HCFA, rarely takes serious and significant enforcement steps against recalcitrant carriers and intermediaries. Best practice and continuous quality improvement approaches to quality must not be allowed to become an impediment to the use of more forceful sanctions where appropriate. We are not suggesting that only the severest of penalties be considered in all circumstances, but rather that there is established a culture and practice of the use of the full range of the agency's tools and resources to assure statutory, regulatory, and contractual compliance.

Managing the local coverage determinations process.

Another important carrier and intermediary function is to make and/or review and approve local coverage determinations, also called Local Medical Review Policies or LMRPs. Ninety-five percent of all coverage policies are made on the local level, with 5% being developed on a national level. Currently, there are approximately 8,000 LMRPs The local carrier advisory committee (CAC) develops these LMRPs, with input from state medical societies, medical director groups, and advocacy groups responding to consumers, and uses carrier data that indicates high utilization of a particular treatment or procedure.

LMRPs in Medicare, until recently, have been a relatively hidden element of the Medicare coverage process. They reflect differences in local community medical practices and norms of treatment which in many ways belie the over all notion of Medicare as a uniform system of coverage and procedural rules for the operation of the federal Medicare program.

Given the lengthy time it often takes for a national coverage decision to be approved, from six months to several years, local coverage determinations are in many cases viewed as practical or expedient. In many instances, LMRPs can be and are the first step in developing new national coverage determinations by proving the success of the treatment or procedure on a local level, which can then be subject to more stringent national review when national coverage determinations are made. Nonetheless, their proliferation, without uniform oversight and without notice and opportunity for beneficiary involvement, leads to program fragmentation and inconsistencies in coverage and to litigation in some instances.

We note in CMS' June 14th letter of response to Representatives Pete Stark and Nancy Johnson's proposal of CMS administrative reforms, hat on the issues of LMRPs, that the agency acknowledges the problems of inconsistent policies and that standardization is necessary. We strongly encourage the agency to follow through on standardizing these policies. This is essential if the Medicare program is to be a national and uniform and reliable program of services and benefits.

Balancing local and national coverage determinations.

Medicare needs to strike a good balance between national and local coverage determinations, as both have advantages. National determinations ensure that everyone with Medicare is given access to a particular service, no matter where they live. Local determinations ensure that people with Medicare can get access to serious, life-saving treatments in their community, even when no national coverage decision has been made. LMRPs have also proved helpful in extending coverage to people with Medicare for life-changing services outside of the area in which the LMRPs were implemented.

For example, a Medicare HMO beneficiary in Pennsylvania was denied a treatment for severe back pain. She was wheelchair-bound because of her back problems. Over the years she had numerous back surgeries and underwent treatment at several pain management clinics. Her doctor requested that the HMO authorize a con-

sultation with an out-of-network doctor in New York to see if she would be a candidate for Percutaneous Laser Disc Decompression (PLDD), a procedure that was covered by the Medicare carrier in New York, but not by the carrier in Pennsylvania.

The HMO denied pre-authorization claiming that PLDD was without proven clinical efficacy, and that the HMO did not have to cover the procedure because it was not available in Pennsylvania. With the recommendation of her doctor who claimed that the HMO would cover the service, the beneficiary borrowed money from the bank, had the consultation and eventually the procedure. The surgery allowed her to dispense with her wheelchair, and resume many of her daily activities. After receiving multiple denials for coverage by the HMO, an administrative law judge overruled arguments that since PLDD was not covered in Pennsylvania, the carrier in Pennsylvania did not have to cover it and required the HMO to reimburse the beneficiary for the procedure.

While there may be good reason to change the Medicare contracting system, any reforms should bear in mind the risk of losing the expertise of local carriers, making Medicare education less available, and possibly jeopardizing local coverage determinations. Carriers today are generally the only source for information about local coverage rules, although CMS has now contracted-out the cataloging and compiling of LMRPs on a website .

We have found that even Medicare managed care plans, although required to cover the same services as original Medicare in their geographical area, often do not know what Medicare covers . A carrier responsible for a broader area such as an entire region would face the challenge of keeping updated information regarding the various local coverage determinations throughout the states under its jurisdiction.

Carriers also serve as the critical link between CMS policymakers and local providers by sharing information about providers' experiences with the government, and educating providers about new government regulations or administrative directives. The local nature of the carriers also allows them to better represent to CMS the concerns of people with Medicare in their state.

The Centers for Medicare and Medicaid Services (CMS) have announced a $35 million national Medicare education campaign to inform people about their Medicare options. A portion of this money should be allocated to carriers to reinforce their role as Medicare educators and to allow them to expand their hotline and counseling services. In short any contractor reform initiatives must appreciate that access to good information and good health care are the foundation of a strong Medicare program.

Conclusion.

We appreciate the opportunity to testify on these important issues. We recognize the large and important task that confronting CMS as an agency and as a community of concerned and dedicated staff. Further, we recognize that CMS can not meet its many responsibilities to provide meaningful beneficiary education and services to Medicare beneficiaries through its carriers and intermediaries without adequate staffing and funding. We feel the agency has all too often been cobbled by the combined curse of under-funding, under-staffing, and seemingly rudderless change and reorganization. In this regard, CMS staff need the assurance of sound and reliable direction and authority so that they can work with carrier and intermediary staff with confidence in the laws, regulations, and instructions that govern the Medicare program and with confidence in the tools of oversight and enforcement extended them by the agency itself.

Thank you very much.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chiplin. I might add that particularly the areas that you mentioned are the same areas that we are concerned with.

Mr. Greenwood, to inquire.

Mr. GREENWOOD. Thank you, Mr. Chairman. Address a question to Mr. Serota, if I might.

A for-profit private contractor is going to obviously have an obligation toward its bottomline, toward its profit, toward its stockholders if there are stockholders. It also has an obligation to the taxpayers, obviously. CMS will want to make sure that it gets the most efficient use of taxpayers dollars. It also has an obligation to the beneficiary to provide prompt, clear, usable information and so

forth. Then finally, a very important obligation to the providers to make their life as manageable as possible.

What are the ways that we can construct, that CMS can construct contracts so that the private for-profit contractor doesn't skimp on any of its other obligations in the name of maximizing its profit?

Mr. SEROTA. Well, I think there are a number of ways. I think the first probably is to reform the methodology for reimbursement for contractors so that there is an opportunity for them to earn a margin on the business. I think if the statement of work is clearly statement, the accountability is clearly stated, and there are clear indications of the expectations, our contractors, our Blue contractors as well as others will be able to evaluate whether they can in fact meet all those obligations in a cost-effective fashion.

That kind of statement of work put out to competitive bid would allow plans to make an assessment and participate in the program when they can meet all those obligations. They should be held to very high performance standards to ensure that they meet those obligations, principally to the beneficiaries and the providers. I think with a reasonable opportunity to earn a return, they will be able to satisfy their shareholders as well.

Mr. GREENWOOD. Let me be more specific. If I am an optomologist and I have a patient, and I want to do a surgical procedure that has to do with lifting an eyelid for instance, and because that provides better eyesight. So it is covered—I am making this up, but it is covered if it is to improve the eyesight. It is not covered if it is cosmetic. So the physician makes whatever the term is, an application to have that procedure reimbursed. Do you have an obligation as a private contractor to try to make extra certain that you don't pay for something you shouldn't? You owe that to the taxpayers, you owe that to your bottomline. But the patient and the provider out there are frustrated because they are going through whatever paperwork, hoops you make them go through.

So the question is how do we end up rewarding the contractor who manages to fulfill the obligations in terms of cost, but do it in a way that makes the providers stand up and cheer, and say that is what we have been waiting for, that kind of responsiveness, that kind of effectiveness.

Mr. SEROTA. Well, I think by putting performance standards into the contract, which requires decisions to be made in a timely fashion upon receipt of information, I think is certainly one way to hold contractors accountable. I also think with a clear statement of expectation, that this is what is expected so that the providers, the beneficiaries, and the contractors all understand their expectations and their responsibilities on the front end, will also allow those kinds of things.

Mr. GREENWOOD. How would you feel about a mechanism that allowed the providers to provide, to offer some input into how well those expectations are being met?

Mr. SEROTA. I think that that is the best way to get feedback on whether you are satisfying your customers. Just ask them. Clearly providers and beneficiaries are our customers in this regard. We survey in our private business, providers and consumers all the time to be certain we are meeting their expectations. I think that

that would be a reasonable way to ensure that we were meeting our expectations in the provider contracting area as well.

Mr. GREENWOOD. Mr. Cullen, could you comment on those questions, please? You will need to pull one of the microphones toward you.

Mr. CULLEN. Well, I think that you would set standards for the contract that we would have to perform, if there was incentives in it. Then the marketplace will decide it. Businesses that don't want to get into this business, will look at the return, the risk and so on, and decide whether to get in or not. I think that can work.

I also think that we as contractors or intermediaries have a function like most insurance companies, which is if you will, we are sort of the heavy. We are the one responsible for delivering the bad news, talking about costs on the commercial side, and here denying care based on regulations that we are meant to enforce. I think that is our job. I think to the extent this morning that Congresswoman Capps thought it was the Part B carrier's problem in California and her constituent thought it was the Part B carrier's problem, not Congresswoman Capps'. To this extent, I think the way the system is supposed to work. It is our job to please these customers. We would be incentivized to do it if we got past the cost contract environment.

Mr. GREENWOOD. My time has expired. I thank the chairman.

Mr. BILIRAKIS. Mr. Brown, to inquire.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Chiplin, there is a study by Judith Hipper or Hibbard for AARP on the information that older consumers use to make health plan choices. I have looked at those materials sent out. I am pretty confused. I do health care a lot here. I have got to think that seniors are at least as confused by this sort of cascading of information that they receive.

It is pretty clear from this study that seniors prefer one-on-one support assistance, as I guess probably we all do. Sometimes it is not especially available. I am concerned that CMS' new education initiative doesn't place enough emphasis on getting seniors that one-on-one assistance. Do you tend to think that way also?

Mr. CHIPLIN. Well, I do. The big concern right now and the primary vehicle for getting the one-on-one assistance is through the State health insurance counseling system, they call them SHIPs. In California, they call them HICAPs. They have different names. But they are very under-funded. Carriers and intermediaries also play a role in the beneficiary education side of it. But getting good information out through lots of venues is very important. Medicare information is inherently complicated. So I think the more vehicles you can use, the better, and that you keep the information in small bite-sized pieces, and have lots of different writings that target particular coverage issues.

Mr. BROWN. So funding SHIP is one we talked about that is funding I thought $15 million. The administrator earlier, Mr. Scully, said $13 million. Whatever it is, it is clearly—I know it is with Nationwide in Ohio, the carrier there, it is pretty clearly under-funded even with the reliance on volunteers the way that they do.

What about the proposal to put a Medicare person in the Social Security offices? Does that make sense?

Mr. CHIPLIN. I think it does. That would really be helpful because we often get questions about Medicare coverage and people say I have gone to my Social Security office and there wasn't anybody there that really could answer the question. So that would help.

I think also with that you would probably need to have a number of people at the Social Security office who could act as what you might call an ombudsman or some other kind of person who could sit down and spend a little bit more time with an individual to look at coverage, both coverage issues, eligibility issues, access to service issues.

Mr. BROWN. Any other thoughts on what we should direct HCFA or direct CMS to do, what ways through which education program other than better funding for SHIPs, other than potentially putting a Medicare person in the Social Security offices?

Mr. CHIPLIN. One other thing that comes to mind is to look intergenerationally. Older people rely often on their children and other young people or younger people in their lives and community. We find that when we do some pairing of older and younger around, understanding information, that that is also another and positive avenue of getting information out to people.

Mr. BROWN. Let me in my remaining time, Mr. Chairman, let me ask a different question, Mr. Chiplin. There was testimony earlier that we should consider consolidating the number of contractors. Our experience has been that contractors will make local coverage determinations, obviously based on local interests, local needs, local circumstances. Is there a contradiction there if we do more of this contractor kinds of consolidation that the uniqueness or the sort of home rule, if you will, or decisionmaking, local decisionmaking will suffer and that patients will not and Medicare beneficiaries will not have the kind of service that they might have otherwise?

Mr. CHIPLIN. That is one of the most tangled area of Medicare practice I know of, of this whole business of local medical coverage, local medical practices, and you have national ones, and how all those things integrate. I think Medicare needs to re-look at that from beginning to end.

I do think that under the current system, having some ability for coverage issues to bubble up, if you will, from the local area and local practice has some merit. But you do end up with a very bifurcated national program. That, as you see in my testimony, is a major problem where you have carrier A covering something and carrier B not covering it. This is supposedly a national program.

So I think that you could put money into it and you could do some specialization with various carriers around coverage and coverage policy questions, but you still don't deal with the larger question of a uniform program.

Mr. BROWN. Mr. Serota, do you want to respond to that?

Mr. SEROTA. Well, I think that it is important to recognize that healthcare is a local phenomenon. It is delivered locally. It is delivered in every community, and that we are trying in this environment to deliver a national program Medicare on a local basis. There needs to be some ability, and we have that through the—I

will give you the wrong name, but the medical advisory groups and the Part B local medical groups to modify the practice to fit more appropriately with what is available in a local community. I think that that's important. That is the flavor of American health care. Frankly, that is one of the reasons the Blues have been as successful as they have been, because we are on the ground in every market.

So I think you need to ensure that we don't get too uniform in an administration so that we can't take advantage of innovation and creativity, which happens in a local market, so we need to allow that flavor to continue to exist.

Mr. BILIRAKIS. Do you agree with that, Mr. Cullen?

Do you agree with that too, Mr. Chiplin?

Mr. CULLEN. This issue is already here, if nothing else that's been talked about today ever occurs. We are the Part A all the way in seven States from Virginia to Hawaii. So we are trying to be consistent across in several territories. We process claims through 12 time zones, way out into the Pacific. I think in the end, because it is a national program, Mr. Chiplin in any case, that a lot of these decisions have to be decided nationally because health care is delivered locally as Mr. Serota says, but local, is that all just all of Virginia, is that local? Or an area of Virginia or all of Wisconsin? It gets pretty broad right away, just with all the contractors, intermediaries we have today. I think it has to be decided nationally.

I also would say that—I wasn't asked, but on the customer service, that putting somebody in every Social Security office would certainly be helpful, but of course there is not a Social Security office in every community. In my home county, there is one. But there are lots of people who wouldn't have access easily.

The 1-800 number which you have funded, which is now toll-free, has tremendously increased the number of phone calls we get because now senior citizens can call not on their own nickel. They can call an 800 number toll free and get questions answered. That, as you look to what needs to be funded, to fund the customer service area of our work so we can handle all those phone calls is one of the better ways in 2001 probably to serve senior citizens in terms of answering their questions.

Mr. BILIRAKIS. Mr. Chiplin, do you have anything more you wanted to offer or have you explored that pretty deeply?

Mr. CHIPLIN. I agree in part with Mr. Serota. I do think it is a lot of value of having coverage issues worked through locally, but I think we end up in the situation where we don't have any uniformity of standards, no dependability in the program with respect to coverage policy. That really hurts beneficiaries, especially since it takes so long to get things through the approval process.

Mr. BILIRAKIS. We get a lot of complaints toward that end.

When we first started on this path of patients first, taking a look at what was in HCFA, and taking a look at the need to make some changes, and to do it with them and not to basically shove it down their throats, we made the comments a number of times that we weren't attacking HCFA. This wasn't a witch hunt. But they don't have a very good image out there. I dare say that if the beneficiaries had a better knowledge of HCFA's performance over the last number of years, that image would probably be even worse.

But certainly with the providers, I think you all have to agree the image is not a very good one.

I guess the biggest complaint we ever get from any of these people over the years has been about HCFA. It hasn't been so much reimbursements or low reimbursements or anything of that nature. I have had doctors say all I have to do is tell me what I can charge and stick with it for a while and I'll charge it, whatever it is. I won't question it. But to not know, to not know and to basically be in fear of getting into trouble is just a terrible thing.

We are looking at ways to try to make things a little more efficient, but we are an ivory tower. We don't really know it as well as we sometimes think we do.

I guess I do not quite understand, now Trail Blazer in Texas is the carrier. Trail Blazer in Texas is also a fiscal intermediary, for the most part. Mutual of Omaha is in there. Are there any other smaller ones or any others?

Mr. SEROTA. There may be. I am not sure.

Mr. BILIRAKIS. There may be, but it would be a small percentage if there were, right?

Trail Blazer is able to conduct both functions. But we are talking about two separate contracts, two separate groups of people? Take me through that. Why can't Trail Blazer under one contract do—they do both jobs in Texas. Whether it's the same people, who do it or not, I don't know. Can someone take me through that to try to explain that to me?

Mr. SEROTA. I don't think I can take you in depth through the Trail Blazer. I can give it conceptually.

Mr. BILIRAKIS. I am sure we can pick at Blue Cross.

Mr. SEROTA. Well, Trail Blazer is Blue Cross. It is owned by Blue Cross of South Carolina.

Mr. BILIRAKIS. Oh it is? See, that's what we know up here.

Mr. SEROTA. There are functions in A and B that are designed differently. The Part A is primarily focused on dealing with the hospitals, and the providers to Part B, is primarily focused on dealing with beneficiaries.

However, there are functions that overlap. In those instances where the functions overlap, they are combined when a single FI and carrier hold the contract. They are combined, and they do work together. But it is a small piece of the administrative function. Predominantly the functions are different. The two contracts are serving different purposes and different masters. But where those functions do overlap, they do combine and consolidate and take advantage of the efficiencies.

Mr. BILIRAKIS. But even if the functions don't overlap, and I appreciate the distinction between Part A and Part B, although there is an awful lot of combining the two, as you know. But even if they weren't combined, why couldn't Trail Blazers under one contract basically handle both?

Mr. SEROTA. Well, if they were in a competitively bid situation, the best to do both, then I think there isn't a reason why they couldn't. The issue that concerns us is to force contractors, which may not be the best in both to do both, rather than competitively bid them both.

I think over time, you might get to a point where that makes sense, but given the current systems and structures that exist between A and B, you might end up with an inferior contractor in one A or B.

Mr. BILIRAKIS. If we gave CMS the additional authority, the flexibility, they would be able to go in from a bidding standpoint to determine, right? Whereas now, we basically tell them what they have to do.

Mr. SEROTA. But we don't think it should be forced. If the competitive marketplace causes it to happen, then certainly we are supportive of it. But what we don't think should happen is a forced scenario where A and B are forced together and bid together. We think that they are different enough that they should be bid separately and the best provider should be selected.

Mr. BILIRAKIS. But if they are blended together, if A and B, it's based on what we are thinking up here—I still haven't decided in my own mind whether it is a good idea or not—then you are going to have to be forced, I guess.

Mr. SEROTA. I guess my point is at this moment in time, I don't think that is the right course to take. I think that the programs are different enough today and the infrastructure doesn't exist yet at CMS to bring those two functions together. That would be my advice.

Mr. BILIRAKIS. Yes. You have testified to that.

Well, all right. Anything further?

Mr. BROWN. No.

Mr. BILIRAKIS. Well, this is a tough subject. I don't really know what our timeline is up here. To be honest with you, we should know but we aren't sure. We may go back into contracting in a subsequent hearing and we may not. I don't know. But we definitely are intent, both sides, and the staffs have been working together on this issue of repairs, improvements to help the agency to do a better job for the people.

We would always welcome, and we do welcome, suggestions from you toward that end. Please don't hesitate. I mean you only testified for a few minutes here. You waited a long time to do that. We apologize for the delays. But again, feel free. We will have questions to you, and we are requesting that you respond to those questions in a timely fashion. But again, we ask you to submit additional ideas and suggestions to us. You have an opportunity now. We are intent on making the changes.

Mr. BROWN. Mr. Chairman?

Mr. BILIRAKIS. Yes, sir.

Mr. BROWN. I have a question from Mr. Strickland, if he could submit it in writing, actually to Mr. Scully, but any other questions that any members have for any of the panelists.

Mr. BILIRAKIS. Well we are going to do that. I am not sure whether we have had unanimous consent. All members of the subcommittee, their opening statements will be made a part of the record. I don't know whether we have done that or not.

We appreciate your being here. And HHS is represented? Is somebody here taking notes? A couple, two or three hands up there. So they are represented, and they are taking notes, and they have heard your concerns.

Thank you very much.

Mr. SEROTA. You're welcome. Thank you. We wish you good luck.

Mr. BILIRAKIS. Thank you.

[Whereupon, at 1:20 p.m. the subcommittees were adjourned, subject to the call of the Chair.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association (ADA) believes Medicare modernization and improvements are critical to the future stability and success of the program. The ADA is a professional organization that represents more that 144,000 licensed dentists in the United States. The ADA seeks to advance the art and science of dentistry, and to promote high-quality dental care and the oral health of the American public.

Medicare does not cover most dental services. But the program affects thousands of small employer dentists and their Medicare-covered patients. For example, due to inconsistencies in Medicare regulations, some dentists can be required to file claims for clearly non-covered services. In addition, many dentists who provide covered services to Medicare beneficiaries on a regular basis must grapple with redundant notices and other unnecessary paperwork problems that can and should be ameliorated.

The dental delivery system is very different from the medical model. Most private sector dentists are solo practitioners with fewer than four employees. Very few dental offices employ more than one administrative staff person, who often also serves as the receptionist. This structure is sufficient to handle private insurer rules and regulations and process *reasonable* administrative demands of public programs. However, the staff resources necessary to address the enhanced administrative burdens caused by contradictory regulations and outdated rules can easily outstrip the dental office administrative staff's capabilities. Unnecessary requirements increase the cost of providing dental services to Medicare beneficiaries in a price sensitive dental market, which could adversely affect access.

MEDICARE REQUIREMENTS THAT NEED MODERNIZATION AND REFORM

Claims Submission for "Non-covered" Medicare Services

As stated above, Medicare generally does not cover dental care, except in limited situations. While non-covered services are exempt from Medicare policies, any Medicare beneficiary that receives a dental service may require a dentist to submit a Medicare claim. This requirement can occur because a Health Care Financing Administration (HCFA) rule, which has been interpreted by the agency and its fiscal intermediaries as giving the beneficiary a right to file a Medicare claim for virtually any dental service, has taken precedent over the Medicare statute excluding the vast majority of dental services.

If a Medicare beneficiary receives non-covered, categorically excluded dental services and requests that the dentist file a Medicare claim, despite the fact that Medicare does not cover the services provided, the dentist must comply. The dentist must honor this request and all parties affected (the patient and HCFA, as well as the dentist) must absorb the financial burden of filing an unnecessary claim.

There are additional costs for HCFA and dentists related to the filing of a Medicare claim for non-covered services. Because the program does not reimburse for most dental services the majority of dentists are not Medicare providers and, therefore have not filled out the lengthy application form in order to receive a provider number. Provider enrollment is an administratively complex process that can take numerous hours for the provider to complete and the agency to process. This process adds unnecessary costs to the health care system and could be easily remedied by HCFA. The ADA believes HCFA should bring its regulation into conformance with the Medicare statute and make it clear to carriers, dentists, and Medicare beneficiaries that there is no obligation to submit a claim for categorically excluded dental services. The Association would be willing to work with the Committee to provide language to accomplish this change.

The Association also believes it is necessary to include dentists in the private contracting law. This is important not only because it is fundamentally fair to allow any practitioner the ability to decide whether the practitioner wants to participate in a federal program, but also because opting out eliminates unnecessary paperwork affecting all of those associated with the Medicare system. However, dentists, unlike many other providers, are unable to decline or withdraw participation in Medicare. Section 1802 of the Social Security Act, as amended by Section 4507 of the Balanced

Budget Act of 1997, permits a physician or practitioner to enter into private contracts and effectively withdraw their Medicare participation with Medicare beneficiaries, if specific requirements are met. The ADA supports an amendment to section 1802 to include dentists.

Advance Beneficiary Notices

An Advanced Beneficiary Notice (ABN) must be completed on behalf of a Medicare beneficiary when there is uncertainty as to whether a given health care service is covered by the program. The form notifies the patient that Medicare may not pay for the services rendered by the provider, thus the patient may be responsible for any and all charges. This form must be completed and filed for each visit, even if the purpose of the visit is for the continuation of care in a series of treatments for a specified illness. As a result, at times redundant ABNs are filed, which provide no new notice to the patient. HCFA, participating dentists and their patients would all benefit from a change in policy on this matter to permit the filing of a single ABN that would be valid for all procedures intended to address a single illness.

Provider Enrollment Forms

Medicare's provider enrollment form is the source of quandary for many dentists who participate in the Medicare program. When they apply for a Medicare provider number, all dentists, regardless of whether they are generalists or specialists, must use the same provider category, which is category 19 (Dentist-Oral Surgeon). This is, at best, misleading because oral surgeons are a specialty within dentistry, representing a relatively small segment of all practicing dentists. HCFA should offer provider categories for all dental specialties as well as general dentists. This would avoid confusion and help alleviate problems encountered by oral surgeons, who too frequently are denied reimbursement for medical procedures for which they are qualified to perform because the carrier incorrectly assumes all procures performed by an oral surgeon are dental services, which are generally not covered by Medicare. The current system unnecessarily expends HCFA and dental office resources and delays proper payment on behalf of Medicare beneficiaries.

Mr. Chairman and members of the committee, thank you for providing the ADA with this opportunity to discuss our concerns about the need to modernize Medicare and modify the program's regulations in a manner that will save scarce HCFA resources and reduce burdens placed on dentists and many of their patients. The Association looks forward to working with you on this issue.

PREPARED STATEMENT OF THE MEDICAL DEVICE MANUFACTURERS ASSOCIATION

The Medical Device Manufacturers Association (MDMA), the national voice for the entrepreneurial sector of the medical device industry, appreciates the interest displayed by the Subcommittee on Health and the Subcommittee on Oversight and Investigations on reforming the systems that the Medicare program uses to contract for the processing of claims.

Our statement focuses on the role that Medicare's contractors play in developing local Medicare coverage decisions, also known as local medical review policies (LMRP). While MDMA believes there are certainly areas of Medicare contracting for which close scrutiny is long overdue, we do support the concept of local Medicare coverage policymaking, and we believe that technological innovation would suffer if Medicare carriers did not have the discretion to develop a local coverage policy in the absence of a national policy. Nevertheless, we need to instill in the local policymaking process much of the same openness, transparency, and accountability that the Centers for Medicare and Medicaid Services (CMS) are attempting to bring to the national process.

MDMA welcomed CMS's November 24, 2000 program memorandum (Transmittal AB-00-116) to its contractors on the development of local medical review policies in the Medicare program. The memorandum mandated new open LMRP development requirements and new draft LMRP publication requirements. We saw the program memorandum as a long-awaited first step toward modernization of the local processes for determining Medicare coverage of medical procedures and technologies where no national policy exists.

However, MDMA and its members remain concerned with the contractor medical director (CMD) workgroups and the role they play in developing local coverage policy; both are subjects that the program memorandum did not address. These CMD workgroups are not specifically authorized by law or regulation, do not meet publicly, and are not required to disclose the nature of their deliberations or to justify their decisions. Nevertheless, the work of these CMD workgroups is the basis for

hundreds of local medical review policies that determine what medical procedures and technologies are available to Medicare beneficiaries.

These CMD workgroups wield significant power in determining how federal entitlement benefits will be administered, yet they effectively are accountable to no one. MDMA believes that as CMS modernizes its national and local processes, CMS should do away with the CMD workgroups, one of the last vestiges of "behind-closed-doors" Medicare policymaking.

BACKGROUND

CMS contracts with private insurance companies to carry out various duties under the Medicare program, such as processing claims, investigating fraud and abuse, and determining coverage policies for medical procedures. Local "carriers" administer the Medicare Part B benefit (physician services, laboratory and diagnostic tests, certain medical equipment and supplies, and other related services).

For most Part B services, CMS has not issued national Medicare coverage policies. The carriers develop the vast majority of Medicare coverage determinations. Local coverage policies, also known as local medical review policies (LMRP), are supposed to be developed according to procedures set forth in CMS's *Medicare Program Integrity Manual* and are supposed to be published in periodic newsletters or similar documents issued by each carrier. According to CMS, 300 national coverage policies have been developed over the last 35 years, while more than 6,000 LMRP have been developed over just the past ten years.

According to Chapter 1, Section 2.7 of the *Medicare Program Integrity Manual,* each carrier must establish one Carrier Advisory Committee (CAC) per state in which the carrier operates. The purpose of a CAC is to provide:

- a formal mechanism for physicians to be informed of and to participate as advisors in the development of LMRP,
- a mechanism to discuss and improve administrative policies, and
- a forum for the exchange of information between carriers and physicians.

CMS also instructs its carriers to release proposed LMRP to the public for comment prior to implementation.

In addition, Medicare Part B carriers have also formed a number of contractor medical director (CMD) workgroups to develop templates for future LMRP development. These CMD workgroups do not meet publicly, yet the templates they develop are circulated among all carriers and often are used as the basis for the development of LMRP by other carriers.

CMS's November 24, 2000 program memorandum mandates new open LMRP development requirements and new draft LMRP publication requirements. According to the program memorandum, Medicare contractors now must allow for the submission and presentation of information from members of the general public in the LMRP development process. Medicare contractors also must provide open meetings for the purpose of discussing draft LMRP, and these meetings must be held prior to the presentation of these policies at CAC meetings.

The program memorandum, however, is silent on the role of the contractor medical director workgroups.

PROBLEM

Contractor medical director (CMD) workgroups play a significant role in the development of local Medicare medical review policies, yet these workgroups, unlike the CACs, are not specifically authorized under Medicare law, regulation, or administrative procedures. The *Medicare Program Integrity Manual* only mentions these workgroups in passing in Chapter 1, Section 6, when it lists "(p)articipating in CMD clinical workgroups" as one of the "other duties" of contractor medical directors.

These CMD workgroups apparently meet periodically, yet neither the agenda nor the minutes of these meetings are published publicly, nor do we know whether CMS even requires that the CMD workgroups file such documents with the agency. Moreover, their membership is not published in any official CMS document immediately available to the public, nor do we know how their membership is determined.

MDMA understands that during these CMD workgroup meetings, the Medicare contractor medical directors discuss whether new technologies or procedures are worthy of being covered under the broad discretion granted by CMS to Medicare carriers. Although there is no instruction or discussion in the *Medicare Program Integrity Manual* of a process for the development of "model" or "template" LMRP by these CMD workgroups, a cursory review of LMRP shows that such models or templates are cited frequently by contractors as the basis for their own local policies. We understand that most of these model or template LMRP are developed by CMD workgroups.

Even more curiously, we hear that Medicare carriers often adopt as "informal" LMRP the results of the discussions at these workgroup meetings, which completely circumvents and negates the LMRP development process. Finally, we understand that CMS staff attends many of these CMD workgroup meetings, which certainly lends the CMS imprimatur to these workgroups' decisions and actions.

MDMA and its members are not the only CMS "stakeholders" concerned with the actions of these CMD workgroups. For example, the American College of Surgeons raised detailed concerns similar to ours in response to CMS's 1998 "town hall" meeting on modernizing the Medicare coverage process:

> At the present time, some carriers are developing and announcing policy without CAC input while other carriers obtain input from the CAC but ignore it and issue final policies without any apparent response to the comments it received. Of particular concern to the College is the dissemination of "model" policy, which some carriers seem to view as a form of national policy that must be followed without question . . .
>
> . . . the College has significant concerns about the current model (recently renamed "template") policy development process. Under this process, a small number of contractor medical directors develop policy without providing physician organizations or other stakeholders an opportunity to provide input or to review early drafts. Once the contractor medical directors have completed their work on so-called templates, these materials are sent to all the carriers for their consideration. Generally speaking, carriers then proceed to adopt the templates as model policy. However, even when a carrier provides its carrier advisory committee with a chance to comment on the model policy, our impression is that the offer comes too late in the policy development process. The label "model" appears to signal that the issue has already been subject to a rigorous review, that further analysis and comment is unnecessary or unwanted, and that the policy should be accepted "as is." In fact, we consider the template process to be a CMS-sanctioned attempt to bypass the usual, albeit limited, due process safeguards associated with national coverage policy making. [October 19, 1998 letter from ACS to Jeffrey L. Kang, M.D., M.P.H., Director, Office of Clinical Standards and Quality, CMS re September 25, 1998, Open Town Hall Meeting To Discuss the Medicare Coverage Process]

SOLUTION

Again, MDMA appreciates CMS's ongoing efforts to modernize the local Medicare coverage policymaking process. The ability to participate in a transparent and predictable process, as well as to understand the criteria by which their technologies will be evaluated during that process, will help medical technology entrepreneurs develop innovative new products that meet the needs of the Medicare program and its beneficiaries.

However, CMS needs to take the next step toward true reform of the LMRP development process by disbanding the contractor medical director workgroups. Under the new open local process, CMS should not permit the development of model or template policies, including de facto national coverage (and non-coverage) policies and "informal" policies, by contractor medical directors absent public scrutiny and accountability. The early stages of LMRP development should be equally as open, if not more so, as the later stages.

Furthermore, we believe there simply is no need for CMD workgroups to develop model or template policies. Local medical review policy was intended by CMS to be an administrative and educational tool that describes how contractors will review claims to ensure that they meet Medicare coverage requirements. Local Medicare contractors are supposed to develop LMRP based on a perceived need for clarification, and they are supposed to develop these policies locally.

The model or template policies developed by CMD workgroups become de facto national policies as local contractors adopt them. If there is a need for clarity across the nation, then CMS should initiate the process of making a national coverage decision. Simply put, there should only be one national Medicare coverage process, and that process should be conducted by CMS.

We thank the subcommittees for your consideration of our perspective.

United States General Accounting Office
Washington, DC 20548

August 17, 2001

The Honorable Michael Bilirakis
Chairman
The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Jim Greenwood
Chairman
The Honorable Peter Deutsch
Ranking Minority Member
Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
House of Representatives

Subject: Medicare: Comments on HHS' Claims Administration Contracting Reform Proposal

On June 28, 2001, I testified before your subcommittees that the Medicare program could benefit from reformed claims administration contracting authority and practice.[1] On the same day, the Secretary of Health and Human Services (HHS) submitted a legislative proposal that would modify Medicare's contracting authority. You asked us to comment on whether the proposal gives the Centers for Medicare and Medicaid Services (CMS)[2]—the agency within HHS that manages Medicare—the flexibility to promote better performance and accountability in its contracting activities.[3] Accordingly, this correspondence discusses (1) current law and practice in Medicare claims administration contracting, (2) provisions in the proposal that would increase CMS' contracting flexibility, and (3) provisions that deviate from standard federal contracting requirements for full and open competition and indemnification of contractors.

In brief, due to statute and long-standing practice, Medicare claims administration contracting does not follow standard federal contracting rules in a number of ways.

[1] *Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services* (GAO-01-918T, June 28, 2001).
[2] CMS was known until recently as the Health Care Financing Administration.
[3] The Secretary has delegated authority to administer the Medicare program, including managing claims administration contractors, to CMS.

Medicare contractors are chosen from among health insurers without full and open competition—not from among all potentially qualified vendors. In addition, CMS almost always uses cost-only contracts and is limited in its ability to terminate contractors short of the full contract term, while the contractors have greater rights to terminate during the contract year than other federal contractors. The proposed legislation would modify Medicare law by providing CMS with explicit authority to contract with any qualified entities to perform any claims administration functions, reimbursing them through any payment method permitted under federal contracting rules. It would also give CMS the same authority as other federal agencies to retain or terminate contractors. We believe these provisions would benefit the Medicare program by increasing the agency's flexibility to promote contractor performance and accountability. However, we are concerned that certain provisions in this legislative proposal would allow CMS to continue to bypass federal contracting rules for Medicare claims administration in two ways. The proposal would permit, but not require, the selection or renewal of claims administration contractors through full and open competition. In addition, the proposal includes a provision that would require CMS to indemnify claims administration contractors from certain liabilities in a way that creates a potential open-ended liability for the government while reducing contractor accountability.

In commenting on a draft of this correspondence, CMS generally agreed with us on the benefits of the proposal, but was concerned that requiring full and open competition for these contracts on a regular schedule—such as every 5 years– might be too burdensome. In addition, CMS did not agree that the provisions on indemnification in the Secretary's proposal created an open-ended liability and pointed to existing statutory provisions as precedence for providing the type of indemnification proposed.

BACKGROUND

Medicare is a health insurance program for about 40 million beneficiaries—people aged 65 years and older, some disabled people under 65 years of age, and people with end-stage renal disease, which is permanent kidney failure treated with dialysis or a transplant. About 85 percent of beneficiaries are enrolled in the traditional program and receive their health care on a fee-for-service basis, while the rest are enrolled in prepaid health plans that contract with the government to receive monthly payments in exchange for providing needed Medicare services to enrollees. Medicare part A services include inpatient hospital, skilled nursing facility, and certain home health and hospice care, while part B services include physician and outpatient hospital services, and certain other medical services, such as clinical laboratory, outpatient physical and occupational therapy services, and durable medical equipment and supplies.

To process and pay claims for services in the traditional program, CMS has 49 contracts with insurance companies called fiscal intermediaries and carriers. Fiscal intermediaries process claims from hospitals and other institutional providers under

part A while carriers process claims for physicians and other health care providers under part B.

CLAIMS ADMINISTRATION CONTRACTING DEVIATES FROM STANDARD FEDERAL CONTRACTING IN SEVERAL WAYS

Contracting for Medicare claims administration services by fiscal intermediaries and carriers differs from that of most federal programs. Under the Competition in Contracting Act of 1984 (CICA) and its implementing regulations, known as the Federal Acquisition Regulation (FAR),[4] federal agencies generally may contract with any qualified entity for any authorized purpose, so long as that entity is not debarred from government contracting and the contract is not for what is essentially a government function. Agencies are to use contractors that have a track record of successful past performance or that demonstrate a current superior ability to perform. The CICA, as implemented by the FAR, generally requires agencies to conduct full and open competitions, because the Congress recognized that such competition generally resulted in the government receiving the best value for products or services it acquires. The FAR also allows contractors to earn profits and requires that contractors perform until the end of the contract term.

In contrast, since Medicare's establishment in 1965, the Secretary of Health and Human Services has been authorized by statute to select contractors to process Medicare claims under parts A and B without competition. When Medicare was established, there was concern about whether the federal government should be involved in medical decision- making and had the expertise to process large numbers of what would essentially be health insurance claims. The Medicare statute permits entities with experience processing these types of claims, which have generally been health insurance companies, to perform this role for Medicare. In addition, Medicare gave hospitals a role in selecting their claims processor. Under section 1816(a) of the Social Security Act (SSA), if provider associations nominate fiscal intermediaries to process part A claims for them, the Secretary is authorized to contract with those entities without competition.[5] Soon after Medicare was established, the American Hospital Association nominated the BlueCross BlueShield Association to process hospital claims.[6] In regard to physician and other part B claims, Section 1842(b)(1) of the SSA provides that the Secretary may enter into contracts with carriers to process part B claims without following the usual requirements related to requests for proposals or "any other provision of law requiring competitive bidding."[7]

The Secretary was authorized to contract with entities that were existing payers of health care services. Thus, the Secretary began and has continued to contract with such entities—almost exclusively health insurers—including the BlueCross

[4] 48 C.F.R., Chapter 1.
[5] 42 U.S.C. 1395h(a).
[6] The Association subcontracts with 26 member plans to process part A claims in different states or regions of the country.
[7] 42 U.S.C. 1395u(b)(1).

BlueShield Association on behalf of its member companies. The statutory language authorizing the Secretary to contract for Medicare claims administration described a set of activities or functions to be performed. Claims administration contractors have generally been expected to perform all of these functions, except where the Congress has given explicit authority to the Secretary to contract separately for a claims administration function, as it did in 1996.[8]

Furthermore, the Social Security Act generally calls for the use of cost-based reimbursement contracts, under which contractors are reimbursed for necessary and proper costs of carrying out Medicare activities. However, these contracts do not expressly provide for profit.[9] Therefore, CMS has long paid claims administration contractors only for their incurred costs and generally has not offered them the type of fee incentives used in other federal procurement contexts.

Unlike standard federal contracting rules, sections 1816 and 1842 explicitly limit CMS' flexibility and options regarding termination of claims administration contracts. Although federal agencies can generally terminate a contract at any time, CMS cannot terminate contracts with Medicare claims administration contractors at the federal government's convenience.[10] On the other hand, claims administration contractors may terminate their contracts without penalty by providing the Secretary with 180 days notice.[11]

PROPOSED LEGISLATION WOULD GIVE
CMS NEEDED CONTRACTING FLEXIBILITY

The Secretary's legislative proposal would give CMS flexibility to better manage its contractors and their performance. It would grant CMS express authority to contract with any qualified entity for parts A and B claims administration. This would include qualified entities that were not health insurers. Further, the intermediary nomination process under section 1816(a) would be eliminated and the proposal would provide explicit authority for CMS to enter into contracts for the performance of specific functions.

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[8] For example, the Health Insurance Portability and Accountability Act of 1996 gave the Secretary explicit authority to contract separately for program safeguard activities, such as medical review of claims to ensure that the services were medically necessary.

[9] CMS has some limited authority to build financial incentives into intermediary and carrier contracts. This authority was first granted under section 2326(a) of the Deficit Reduction Act of 1984 and made permanent by section 159 of the Social Security Act Amendments of 1994.

[10] CMS contracts with poorly performing claims administration contractors may be terminated only after providing the contractor with 90 days notice and an administrative hearing if the contractor requests one. In contrast, under the FAR, contracts may be terminated when a contractor fails to remedy a performance problem within 10 days (unless extended by the agency) after receiving an agency notice specifying the problem.

[11] This is an option not normally available to federal contractors. Under the FAR, federal contractors are liable for breach of contract if they fail to perform or fail to make progess meeting time frames specified in the contract.

Under the proposal, CMS would also be able to use incentive-based payment methods available to other agencies to compensate contractors. The Secretary could use cost reimbursement contracts that could include the payment of fees in addition to cost or any other arrangements permitted under standard federal contracting rules. The proposed legislation would also eliminate a contractor's ability to terminate a contract unilaterally.[12] All of these provisions are consistent with standard federal contracting requirements.

PROPOSED LEGISLATION WOULD ALLOW, BUT NOT REQUIRE, FULL AND OPEN COMPETITION

While the provisions discussed above are important, we are concerned that the proposal might not result in CMS fully benefiting from an improved contractor selection process. The proposal would not require that CMS initiate or complete a move to exclusive use of full and open competition to select claims administration contractors. As a result, CMS could continue to select claims administration contractors noncompetitively, without being required to use a selection process that is consistent with standard federal contracting requirements.

The FAR provides agencies with detailed rules governing the procedures to be used in the competitive procurement process. Among other things, the FAR provides that federal agencies generally must compete contracts at least every 5 years and may unilaterally terminate them at any time. Officials at CMS are experienced with these FAR requirements because the agency generally uses full and open competition to select contractors that provide it with goods and services other than the administration of Medicare claims.

Although the proposal states that competitive contracting procedures should be used when hiring claims administration contractors, it does not require such procedures to be put in place within a given time frame. In addition, under this legislative proposal, the Secretary would retain authority to deviate from the FAR's competition requirements when initiating and renewing its claims administration contracts. Specifically, subsection (2)(i) would permit the Secretary to enter into initial claims administration contracts without full and open competition. In addition, subsection (2)(h) would permit the Secretary to renew claims administration contracts without requiring competition when the contractor has met or exceeded contract performance requirements.

Provisions that allow CMS to deviate from FAR in its initial selection of contractors and reallocation of work could permit postponing the introduction of competition indefinitely. We recognize that transition from the current arrangement to competitive selection is apt to be difficult and potentially disruptive to providers and beneficiaries. For these reasons, as we noted in our testimony, sufficient time should

[12] The proposal would also repeal the provision requiring the government to offer the contractor a hearing before a contract could be terminated.

be allotted for the transition to fully competitive contracts for all of Medicare's claims administration workload. Medicare's claims administration contractors currently pay about 900 million claims each year to nearly 1 million hospitals, physicians, and other health care providers billing the program. Given this massive workload, moving to competitively-selected contractors will need to be done in stages so that in the future CMS will be able to stagger its contract competitions and not have to compete all of its workload in the same year. Nevertheless, we believe that there needs to be a definite beginning and ending date for this transition.

INDEMNIFICATION PROVISIONS COULD CREATE OPEN-ENDED LIABILITIY FOR THE FEDERAL GOVERNMENT

Our review of the proposed legislation has also raised concerns regarding its indemnification provisions. Generally under an indemnification agreement, one party promises, in effect, to reimburse another party's losses or expenses. Absent express statutory authority, an agency generally may not enter into an agreement to indemnify where the amount of the government's liability is indefinite, indeterminate, or potentially unlimited. An agreement to do that would violate both the Antideficiency Act, 32 U.S.C. §1341, and the Adequacy of Appropriations Act, 41 U.S.C. §11 because it can never be said that sufficient funds have been appropriated to cover an unlimited liability.

However, subsection (2)(f) of the proposed legislation would require, among other things, that the Secretary pay all reasonable expenses incurred by a claims administration contractor in connection with the defense of any civil suit, action, or proceeding so long as the contractor exercised due care. While it appears that the proposed language attempts to limit liability, for example, by the use of such modifiers as "reasonable amount of expenses incurred, as determined by the Secretary," it would create an open-ended, potentially unlimited liability. The Congress has rarely authorized this type of open-ended liability and the Secretary has not explained the need for claims administration contractors to receive such an unusual benefit.

If legislation were to be enacted to require indemnification in this context, a more prudent approach would be to clearly limit CMS' liability. Because federal agencies are seldom authorized to indemnify their contractors, another alternative is to cover the cost to contractors for private insurance against potential liability. This approach would need to be studied to see if it would be a cost-effective alternative for Medicare claims administration contracting.

In conclusion, due to statutory language and current practice, Medicare claims administration does not follow standard federal contracting requirements. The Secretary's legislative proposal has provisions that we believe would be beneficial to the Medicare program, such as giving the Secretary express authority to contract with any qualified entity for claims administration and to use payment methods and termination procedures currently routine at other federal agencies. However,

because the provisions that would permit CMS to continue contracting without competition and require CMS to provide open-ended indemnification do not follow standard federal contracting requirements, we believe that those provisions should be modified.

AGENCY COMMENTS AND OUR EVALUATION

We provided CMS with a draft of this correspondence for comment. In its written comments (see enclosure I), CMS agreed that the Secretary's proposal would increase its contracting flexibility and emphasized the agency's intention to move to full and open competition in contracting for Medicare claims administration services. CMS stated that the proposal would initially permit it to enter into new noncompetitive contracts and it must use full and open competitive procedures thereafter. However, agency officials expressed concern that requiring competition on a regular schedule—such as every 5 years—would be difficult and potentially disruptive.

It is not clear to us, however, that a contractor successfully performing its duties would ever have to compete in a full and open competition under the Secretary's proposal. This is because subsection (2)(i) would permit the Secretary to enter into initial claims administration contracts without full and open competition as well as renew claims administration contracts without requiring competition when the contractor has met or exceeded contract performance requirements. While we agree that CMS needs time to make the transition to full and open competition, without a requirement to move to competitive procurements within a specified time frame, the agency could avoid such competition indefinitely. In addition, without a requirement to compete these contracts periodically, Medicare would not realize the full benefits of competition.

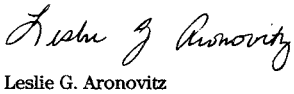
CMS also took issue with our characterization of the provision indemnifying contractors' against legal costs of civil suits as open-ended and inappropriate for the Medicare program. CMS pointed out that within the Medicare program, there is statutory precedent for indemnifying contractors, because the proposed language regarding contractors' indemnification was modeled on similar provisions applicable to peer review organizations. CMS officials stated that the indemnification provision is essential to ensuring competition in their future contracting efforts. They also asserted that it was likely to be far less expensive to indemnify the contractors than to cover the costs of insuring them against the full risks associated with the legal costs of third party claims. While we recognize that there may be a precedent within the Medicare program,[13] we remain concerned that the wording of the provision to indemnify contractors for the "reasonable" costs of defending against third party suits is too broad and exposes the government to potentially unlimited liability. The agency would need to explore whether paying for private insurance to cover the legal expenses of suits would be cost-effective.

[13] 42 U.S.C. 1320c-6 (d).

CMS also stressed the importance of providing a federal limitation on contractors' liability with respect to third party claims. Under this provision for limitation on civil liability in the Secretary's proposal, as long as contractors exercise due care in performing Medicare duties, a third party lawsuit cannot proceed against them. This provision is also part of the statutory framework for peer review organizations, and has been referenced in statutory provisions pertaining to the Medicare Integrity Program.[14] We do not take issue with the limitation on civil liability, which would provide contractors with strong protection against suits by third parties, at no cost to the government, so long as they exercised due care in the performance of their responsibilities.

CMS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of it until 30 days from the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. The letter will also be available on GAO's home page at http://www.gao.gov. Please contact me at (312) 220-7600 or Sheila K. Avruch at (202) 512-7277 if you or your staff have any questions. Stefanie Weldon and Craig Winslow made key contributions to this correspondence.



Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Enclosure

[14] 42 U.S.C. 1395ddd(e).

Enclosure I: Comments from the Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 16 2001

TO: Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

FROM: Ruben J. King-Shaw, Jr. Jay White for Ruben King-Shaw
Chief Operating Officer and Deputy Administrator
Centers for Medicare & Medicaid Services

Subject: General Accounting Office (GAO) Draft Correspondence, *MEDICARE: Comments on HHS's Claims Administration Contracting Reform Proposal* (GAO-01-1046R)

Thank you for providing the Centers for Medicare & Medicaid Services (CMS) with the opportunity to review and comment on your draft letter analyzing the Secretary's proposal to modify Medicare's contracting authority. We appreciate your broad support of many aspects of our proposal, and in particular appreciate your finding that the proposal would increase our contracting flexibility and enable us to better manage the contractors and their performance. We also welcome this opportunity to address certain points where GAO may not have understood our instructions.

Issue - Competitive Contracting

Our clear intention, as expressed in the Secretary's proposal, is to move to a contracting environment which is based on the principle of full and open competition. However, as your draft letter recognizes, the transition from the current arrangement to competitive selection will be difficult and potentially disruptive to providers and beneficiaries. Accordingly, section 2(i) of our legislative proposal would provide us with the discretion to initially enter into new Medicare claims administration contracts on a non-competitive basis. After the transition period elapses, our proposal would require us to enter into all new Medicare claims administration contracts through use of full and open competitive procedures in keeping with the Federal Acquisition Regulation (section 2(h) of the proposal).

We agree with the goal of subjecting all Medicare claims administration contracts to full and open competition on a periodic basis. Our proposal to permit (but not require) CMS to renew Medicare contracts without competition, so long as the contract performance requirements are met, merely reflects our desire to retain contractors that are performing well and avoid disrupting beneficiaries and providers simply due to contract term limits

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

imposed in the general Federal procurement cycle. A mandatory 5-year procurement cycle such as the one referenced in your letter might provide some benefits. However, such a procurement cycle would require CMS to compete, on average, claims processing workloads involving nearly $40 billion in annual Medicare provider and beneficiary payments every year. Even as we want to adopt Federal acquisition norms in most respects, this unique Medicare program environment has led us to seek flexibility with respect to mandatory contract term limits. There is some precedent within the Medicare program context for our proposed renewal authority. It is modeled on the contracting flexibility provided to CMS by Congress with respect to the Medicare Integrity Program (MIP) contracts.[1]

In short, we agree with your perspective that Medicare contracts should be awarded on the basis of full and open competition, and we share your concern that the transition from the present contracting arrangement to the new environment be handled appropriately. We believe our proposal is consistent with the objective of establishing a competitive contracting environment, while we recognize the Medicare program need for flexibility during the transition period and with respect to the procurement cycle. However, we would certainly consider alternative proposals that provide for somewhat less Agency flexibility as long as these proposals recognize the program concerns discussed above.

Issue – Contractor Liability For Third Party Claims

Similarly, CMS understands your argument that the government does not readily provide open-ended indemnification to contractors with respect to claims raised by third parties, although we believe there are precedents in a number of Federal programs. However, we disagree with the draft report's analysis that our proposal would provide such open-ended protection to Medicare contractors, and do not agree with any suggestion that our proposal is unprecedented or inappropriate in the context of Medicare program administration. In fact, we believe our proposal reflects a measured and even-handed approach to the difficult issue of contractor liability with respect to third party claims.

Our Agency position has been that it would not serve the interests of the Medicare program to have Medicare claims contractors and their personnel modify their contractual efforts in reaction to the threat of third party suits. Based on this position, since the early years of the Medicare program, agency regulations[2] and the Medicare contracts have offered apparent broad indemnification "to the extent permitted by law"[3] to the contractors of the very type discouraged by your letter. However, subsequent case law[4] seems to indicate that such contractual protections carry little force absent express statutory authority, thereby putting the current Medicare regulations and contractual

[1] Section 1893(d)(3) of the Social Security Act.
[2] See 42 CFR 421.5(b)
[3] See, for example, Article XIV of the standard Medicare Carrier contract (1987). Enclosed).
[4] See, for instance, Hercules Inc. v. U.S., 116 S.Ct. 981, 987 (1996).

provisions into question. Needless to say, this is an issue of substantial concern to current and potential Medicare contractors.

To address this issue, we did not propose that Congress provide the Medicare contractors with the open-ended indemnification to which they have become accustomed. For the general reasons mentioned in your draft, we do not believe such a proposal would be feasible. However, within the Medicare program context, there is ample statutory precedent for providing a Federal limitation on contractor liability to external claims and for assuming limited responsibility for contractor legal costs. Such limitation is subject to an agency finding that such costs are reasonable and allowable and that the contractor's activities were performed with due care. In fact, our proposal on this issue was modeled on the existing Peer Review Organization statute, which more recently was identified by Congress as an appropriate framework for MIP contractors.[5] We do not agree that our proposed approach is equivalent to an open-ended indemnification agreement.

We believe our proposed limitation of liability framework for third party-initiated claims is an essential ingredient to our future contracting efforts. As our proposed liability arrangement is less favorable to contractors than past contractual arrangements have been, there may be some need for additional funding in order to compensate future contractors for assuming incremental business risk in this area. However, our proposal will likely be far less expensive to the government than GAO's suggested alternative of covering contractors' costs of insuring against the full risk associated with third party claims. This expense could not be supported except through a substantial increase to CMS's appropriation.

Finally, we believe that failure to adopt our proposal in this area could result in a decision by many entities to not pursue contracting opportunities with the Medicare program. This outcome would be directly opposed to the vigorous, competitive contracting environment our overall Medicare contracting reform proposal seeks to promote.

I would like to express once more our appreciation for your support for the general thrust of our proposal, and look forward to working with you to more fully addressing any concerns you may have.

[5] See §§ 1157(b) and (d) of the Social Security Act (PRO); also, § 1893(e) of the same Act (MIP).

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Example of Current Indemnification Provision

Source: Standard Medicare Carrier Contract
Article XIV – Indemnification

A. In the event the Carrier or any of its directors, officers, employees, or other persons who are engaged or retained by the Carrier to participate directly in the claims administration process, are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any functions for the Carrier under this contract in connection with any claims for benefits by any individual or his assignee or provider of service, then the Secretary shall, to the extent permitted by law, hold the Carrier harmless for all judgments, settlements (subject to paragraph B below), awards, and costs, in favor of such individual or his assignee or provider of services, incurred by the Carrier or any of its directors, officers, or employees, or other persons who are engaged or retained by the Carrier to participate directly in the claims administration process, in connection therewith. The Carrier shall reimburse the United States for the amount of any valid judgment or award paid by the United States in the discharge of the Secretary's obligations under this Article if the liability underlying the judgment or award was the direct consequence of conduct on the part of the Carrier and is determined by judicial proceedings or the agency making the award to be criminal in nature, fraudulent, or grossly negligent; provided, however, the Carrier shall not be required to reimburse the Secretary that portion of an award or judgment directly attributable to an allowable program benefit under Title XVIII of the Social Security Act.

B. In the event the Carrier is a party to any judicial or administrative proceeding described in paragraph A above, and proposes to negotiate a settlement of the proceeding prior to final judicial or administrative determination, the Carrier must first obtain the prior written approval of the Secretary.

C. If the Carrier is either list developer and/or list holder for the Secretary's Second Surgical Consultation Program, the same protection as described in paragraph A shall also apply to any judicial or administrative proceedings arising from those activities.

(290110)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

AUG 15 2001

The Honorable Michael Bilirakis
Chairman, Subcommittee on Health
House of Representatives
Washington, D.C. 20515

Dear Mr. Bilirakis:

This is in response to your July 23 letter requesting answers to two follow-up questions on Medicare contractor reform as discussed in the joint subcommittee hearing on June 28, 2001.

Specifically, you asked us to provide answers to the following questions:

> (1) If you were starting from scratch, how would you design the Medicare contracting system?
>
> (2) What are your thoughts and recommendations regarding the administration's draft bill, the "Medicare Contracting Reform Amendments of 2001?"

Enclosed are detailed responses to these questions. In general, we believe that the essential elements of an effective and cost-efficient Medicare contracting system include: flexible contracting; an emphasis on outreach and education; an adequate and stable infrastructure; a high level of coordination among and within contractors; and, appropriate incentives and oversight. Many provisions in the "Medicare Contracting Reform Amendments of 2001" are consistent with these general principles.

If you were starting from scratch, how would you design the Medicare contracting system?

As I said in my written statement, Medicare contractors are the heart of the Medicare program:

> When they function well, providers are paid promptly, beneficiaries receive the health care services they need, and the Trust Fund is protected against wasteful spending. When they don't function properly, the entire program is jeopardized — those who benefit from it, those who provide care, and those who pay for it all suffer the consequences.

The Centers for Medicare and Medicaid (CMS) needs its contractors to process claims quickly and accurately, to conduct periodic reconciliations to ensure that providers receive all payments due and return overpayments, to educate beneficiaries and providers on coverage requirements and billing processes, to identify inappropriate and potentially fraudulent claims, and to take appropriate actions in response. Each of these functions requires different skills and resources,

but each also interacts with the others. CMS will need an unprecedented level of coordination and cooperation among its contractors.

CMS should have the flexibility to select, organize and pay its contractors in the most effective manner. That flexibility should include being able to contract with a wide variety of organizations (not limited to a set of insurance companies) that have the ability to perform specific program responsibilities.

To facilitate this, CMS needs the flexibility to craft different contract structures and incentives for different kinds of work. Therefore, CMS needs the ability to pay for their contractors on an other than cost reimbursement basis, such as a fixed price contract with possible incentives for outstanding performance. In addition, should a contractor not be performing effectively and in the best interest of the program, a system should be in place to allow for the efficient termination of that contractor by CMS. Reliable contractor performance measures should be well monitored and rigorously validated, as CMS will need to constantly reevaluate its strategic allocations of work and resources.

To enhance understanding of the Medicare program, CMS will need substantial provider education efforts, both to improve provider billing practices and to reduce anxiety about compliance. Training organizations are very different from the systems giants that might process Medicare claims, but both need to have the same understanding of coverage policies if they are truly to ease the provider's burden.

Whatever the configuration of contractors, CMS must have integrated, compatible, and modern information technology to support the program. Medicare must achieve an integrated, dual entry accounting system for its accounts receivable to accurately portray and control billions of dollars in transactions. Since payment policies will continue to evolve with the industry, CMS systems must be structured to allow frequent modification and timely access for management decision support.

Managing Medicare well will require investment. Extensive provider education efforts, integrated information systems, and development of an agile complex of specialized Medicare contractors will all involve up-front dedication of manpower and dollars. We believe, however, that the long-term savings associated with improved program management will be substantial.

What are your thoughts and recommendations regarding the administration's draft bill, "The Medicare Contracting Reform Amendments of 2001?"

As outlined in our testimony, we believe that the current law restricting the selection, payment, responsibilities, evaluation, and termination of Medicare contractors needs to be modified to reflect current program requirements. Over the years, we have consistently supported proposals for providing broader and more flexible contracting authority to HCFA (now CMS). The Medicare program could benefit from full and open competition in the selection of contractors,

and increased flexibility in its ability to oversee its contractors. As we noted:

> CMS needs to be given greater flexibility in the methods it uses to select, organize, and supervise the contractors who handle the day-to-day operations of the Medicare program. This includes authorities to use entities other than insurance companies, select them competitively, pay them on other than a cost basis, organize them according to functions or benefits area, and hold them accountable for performance.

Many of the ideas contained in the Administration's recently announced proposal for Medicare contracting reform are meritorious. The Office of Inspector General believes that the following proposed changes in current law are necessary:

- Allowing the selection of contractors on a competitive basis from a broad group of entities that may be capable of performing discrete program responsibilities;
- Allowing the awarding of contracts for discrete program functions;
- Allowing for payment on other than a cost reimbursement basis, such a fixed price contract with possible incentives for outstanding performance;
- Allowing for the efficient termination of poorly performing contractors;
- Allowing for the development and operation of performance goals and reliable measures for monitoring and evaluating the extent of contractor performance.

By changing current law to allow such flexibility in the administration of the Medicare program, we believe that Congress will be taking significant steps for improving the efficiency and responsiveness of the program to the needs of both providers and beneficiaries. This will result in promoting better performance and accountability.

We appreciate the opportunity to provide additional thoughts on this important issue. We look forward to continuing our work with you on improving efficiencies in the Medicare program. This same response has been provided to Congressman James C. Greenwood.

Should you have any questions, please call me or have your staff contact Helen M. Albert, Director of External Affairs, who may be reached at (202) 260-8610.

Sincerely,

Michael F. Managano
Principal Deputy Inspector General

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