

GAO

Report to the Chairman, Permanent
Subcommittee on Investigations,
Committee on Governmental Affairs,
U.S. Senate

July 1999

MEDICARE CONTRACTORS

Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

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July 14, 1999

The Honorable Susan M. Collins
Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate

Dear Madam Chairman:

At your request, this report examines the Health Care Financing Administration's (HCFA) oversight of its claims administration contractors. Specifically, the report discusses whether (1) there are weaknesses in HCFA's contractor oversight activities that may make Medicare more vulnerable to fraud, waste, and abuse and (2) any changes in HCFA's contracting authority may improve its ability to manage its contractors.

We will send copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of HCFA. We will also make copies available to interested parties on request.

If you or your staff have any questions about this report, please call William J. Scanlon at (202) 512-7114. Other GAO contacts and staff acknowledgments are in appendix II.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'Richard L. Hembra'. The signature is fluid and cursive.

Richard L. Hembra
Assistant Comptroller General

Executive Summary

Purpose

Investigations by the Health Care Financing Administration (HCFA), the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), and the Department of Justice have highlighted Medicare's vulnerability to erroneous and fraudulent billing practices by providers, such as hospitals and physicians. The first lines of defense against such abusive practices are the intermediaries and carriers with whom HCFA contracts to administer Medicare fee-for-service claims. Intermediaries primarily review and pay claims from hospitals and other institutional providers covered under Medicare part A, while carriers review and pay part B claims, which are submitted by physicians and other outpatient providers. These contractors processed claims worth an average of more than \$700 million each business day in fiscal year 1998.

How well these contractors safeguard the Medicare program from payment errors and fraud and how well HCFA monitors their work are important concerns because Medicare payment errors represent billions of dollars lost to the program each year. The OIG estimated that in fiscal year 1998, contractors improperly paid over \$12 billion for fee-for-service claims, the overwhelming majority of which were detected through medical record review, which determines whether medical services are covered by Medicare and are reasonable, necessary, and appropriate. The contractors, who are responsible for ensuring that providers do not defraud or abuse Medicare, have themselves been accused of defrauding the program; Justice and the OIG are now investigating several Medicare contractors regarding allegations of fraud.

Concerned about how HCFA is overseeing the Medicare contractors, the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, asked GAO to determine whether there are weaknesses in HCFA's contractor oversight activities that may make Medicare more vulnerable to fraud, waste, or abuse. During GAO's review, HCFA indicated that new contracting authority could mitigate many of the weaknesses GAO was identifying. Accordingly, this report also addresses whether any changes in HCFA's contracting authority may improve its ability to manage its contractors.

The Chairman also asked GAO's Office of Special Investigations to prepare a separate investigative report on contractors that had either been convicted of fraud or had settled civil fraud cases involving their participation in the Medicare program. GAO is issuing a companion report, Medicare: Improprieties by Contractors Compromised Medicare Program Integrity ([GAO/OSI-99-7](#), July 14, 1999), which describes deceptive activities

by six contractors and the impact of these activities on the Medicare program.

Results in Brief

Despite its efforts, HCFA's oversight of Medicare claims administration contractors has significant weaknesses that leave the agency without assurance that contractors are paying providers appropriately. Since 1993, six contractors have settled civil and criminal charges following allegations that they did not check claims to ensure proper payment or allowed Medicare to pay claims that should have been paid by other insurers. Even though inadequate management controls and falsified data are a common theme in these cases, GAO found that HCFA still does not regularly check contractors' internal management controls, management and financial data, and key program safeguards to prevent payment errors. Furthermore, HCFA's headquarters office generally has not set oversight priorities, leaving such decisions almost entirely to regional office reviewers. This has led to uneven contractor evaluations by regional reviewers, making it more difficult for HCFA to determine which contractors are performing effectively. HCFA's organizational structure contributes to the problem by dividing responsibilities for contractor oversight between the regions and headquarters without assigning overall accountability to one office. HCFA has begun to take steps to improve its oversight, but it is too soon to tell whether it will succeed in addressing fundamental problems.

HCFA officials believe that increased competition among contractors could enhance contractor performance but that statute and current regulations limit its authority to contract. The statutory limitations were enacted for easier initial implementation of Medicare, but the program now has over 30 years of operational experience. Consequently, HCFA is seeking new or explicit authority from the Congress that would allow it to (1) choose its intermediaries, rather than having providers nominate them, and contract with non-health insurance companies; (2) contract separately for specific functions—such as responding to beneficiary inquiries; and (3) use payment methods that would allow contractors to earn profits on their Medicare business, rather than reimbursing contractors only for their costs up to a preset target. While these changes might broaden the pool of contractors HCFA could choose from and would increase its flexibility in contracting for specific functions, past experience with other efforts to change the program has shown that HCFA will need several years to carefully plan, properly implement, and conduct a postimplementation review of any new contracting initiatives.

Background

When Medicare was enacted in 1965, the Congress decided to administer the program through contracts with organizations that already served as payers of health care services. The Congress also decided to pay on the basis of contractors' allowable costs, so that these contractors would neither be penalized for administering Medicare nor unduly profit by doing so. Because such exceptions are specifically written into the Social Security Act, Medicare contracting has unique features that differ from other federal contracting. Medicare contractors are responsible for all aspects of claims administration, including safeguarding the program by conducting particular activities designed to identify potential fraud and abuse and to prevent or recover erroneous payments.

HCFA is responsible for ensuring that contractors do their jobs accurately and efficiently, which includes overseeing contractor performance. Both HCFA headquarters and its 10 regional offices have roles in contractor oversight, although regional office staff generally provide direct oversight. Since 1995, to conduct routine oversight, HCFA has relied on its Contractor Performance Evaluation program, which allows regional staff to review any aspect of contractually required duties, classified in five general areas—claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities. When HCFA reviewers identify problems, contractors may be required to take specific corrective actions under a performance improvement plan. In addition to its routine oversight, HCFA sometimes conducts special "integrity reviews" when it learns of possible integrity or fraud problems at contractors.

Principal Findings

Weaknesses in Contractor Oversight Leave the Medicare Program Vulnerable

Medicare contractors are HCFA's front line of defense against provider fraud, abuse, and erroneous Medicare payments; however, several of them have committed fraud against the government. Such misconduct has led to the loss of Medicare program dollars when contractors fail to check provider claims properly to prevent payment errors. Since 1990, nearly one in four claims administration contractors has been alleged—generally by whistle-blowers within the company—to have integrity problems; GAO identified at least 7 of HCFA's 58 current contractors as being actively investigated by the HHS OIG or Justice. Since 1993, HCFA has received criminal and civil settlement decrees totaling over \$235 million from six contractors after investigations of allegations that the contractor

employees deleted claims from the processing system, manufactured documentation to allow processing of claims that otherwise would have been rejected because the services were not medically necessary, and deactivated automatic checks that would have halted the processing of questionable claims.

Despite recent efforts to improve, HCFA's oversight process has weaknesses that impede effective review of contractor performance. These include (1) limited checking of internal management controls and performance data; (2) few performance standards combined with limited priority-setting, which allows essential program safeguards to go unchecked; and (3) inconsistent treatment of contractors resulting from variations in the intensity of regional monitoring.

When contractors are accused of fraudulent practices, on investigation, HCFA often finds a lack of management controls and evidence of falsified data. However, in its ongoing oversight, HCFA generally does little checking of contractors' internal management controls and performance data. Instead, HCFA relies on the contractors themselves to certify that their controls over the accuracy and security of their payment and data systems are sound. Despite the OIG's finding in its recent audits of HCFA's financial statements that contractor financial management controls were a material weakness, GAO found that HCFA rarely validated the contractors' certifications. Furthermore, HCFA reviewed contractor performance by asking contractors to generate workload and other performance data—typically without validating the data's accuracy. HCFA staff indicated that validating contractor data is resource intensive, which may help explain why it often is not done.

Since 1995, when HCFA moved to the Contractor Performance Evaluation program, its 10 regional offices that directly oversee contractors were given wide discretion in how they conduct oversight—choosing what and how to review, and how to monitor contractors' corrective actions. The program also set few standards against which to judge performance—lacking particularly those with which to judge the contractors' effectiveness in reducing inappropriate payments and fraud. As a result, key activities directed toward safeguarding program dollars received limited scrutiny at some contractors. For example, GAO found that regional reviewers were not routinely checking how effective contractors were at identifying primary insurers other than Medicare.

HCFA has also not taken the actions needed to ensure that all regional offices provide consistent and adequate oversight. For example, while some regions imposed performance improvement plans on contractors when problems were identified, other regions rarely, if ever, required them. HCFA has not formally evaluated its regional offices' performance in the area of contractor oversight, nor has it regularly shared one region's best practices with the others.

HCFA has acknowledged that its oversight of contractors needs to be strengthened and has recently initiated some actions to improve it. HCFA set oversight priorities when the regions performed fiscal year 1998 contractor evaluations, and this year it restructured headquarters offices that are responsible for oversight activities. GAO believes that it is too early to tell whether these actions will address many of the fundamental problems HCFA faces in ensuring quality performance from its contractors.

New Contracting Authority Would Take Time and Experience to Properly Implement

HCFA's current legislative authority, its interpretation of that authority, and its regulations constrain its ability to allocate workload among contractors and attract new companies to administer claims. The Medicare statute's provider nomination provision allows the professional associations of hospitals and certain other institutional providers to choose claims processing intermediaries on behalf of their members, and the statute requires HCFA to choose health insurance companies as carriers. Further, because it has not yet changed certain regulations, HCFA has generally not been able to separate specific functions, such as conducting hearings or mailings, that it believes can be done more efficiently by other kinds of companies. In addition, HCFA generally contracts only on a cost basis because its authority to contract using other payment methods is restricted. Moreover, HCFA's leverage to manage its current contractors has weakened as the pool of companies willing and eligible to administer claims has shrunk.

HCFA has proposed several legislative changes to increase its contracting flexibility, such as giving HCFA new authority to contract with non-health insurers and clarifying its authority to choose its contractors. In addition, HCFA is seeking specific authority to contract with companies for individual program functions and a new authority to pay contractors on a basis that allows profit.

In 1996, the Congress gave HCFA authority to separately contract for program safeguard activities—activities to ensure that only appropriate

claims are paid and that providers participating in Medicare comply with program rules. HCFA has recently announced its selection of companies to conduct specialized safeguard activities for this new Medicare Integrity Program (MIP). HCFA's experience with these new MIP contracts may offer information that could help in implementing any other functional contracts and will be a first test of the wisdom of contracting for specific functions.

HCFA's previous tests of two methods that could allow companies to earn a profit raise concerns because these experiments had serious problems. This suggests that HCFA should proceed cautiously if it significantly changes its current, cost-based contractor payment method. HCFA experimented with fixed-price contracts, in which contractors that cut their costs could keep any savings, and contracts in which specified levels of performance led to incentive payments. As GAO reported in 1986, in two past fixed-price contracts, cost-cutting led to over \$130 million in benefit payment errors. More recently, some contractors who had received incentive payments were investigated for falsifying the performance data that gained them the incentive payments.

As HCFA gathers experience with its program safeguards contracts, it may be better able to utilize other new authorities. Clearly, these new authorities would require a long-term effort and, in any event, would not lessen the need for routine and adequate monitoring of contractors.

Matters for Congressional Consideration

The Congress may wish to consider amending the Social Security Act to allow the Secretary of Health and Human Services to (1) freely choose the companies with which HCFA may contract as Medicare intermediaries and (2) contract with non-health insurers for claims administration. The Congress may also wish to consider giving HCFA explicit authority to award functional contracts for selected claims administration activities to any appropriate kind of company and to offer other-than-cost contracts, both at the discretion of the Secretary of Health and Human Services. If legislation is enacted, to ensure that the new authorities improve the efficiency and effectiveness of Medicare program operations, GAO believes HCFA should be required to report to the Congress with an independent evaluation of its use of these authorities and their impact on the Medicare program.

Recommendations

In this report, GAO makes a number of specific recommendations to the HCFA Administrator to correct identified weaknesses and improve the agency's oversight of its claims administration contractors. Implementing these recommendations should help ensure that

- contractor internal controls are working,
- contractor performance is evaluated against a comprehensive set of clearly defined and measurable performance standards,
- HCFA's oversight of contractor performance is more consistent,
- best practices are shared among regions, and
- HCFA has a strategic plan for implementing requested legislative modifications sought in contracting proposals.

Agency Comments

In written comments on a draft of this report, HCFA agreed with each of the recommendations and described how it plans to implement them. Overall, GAO believes that HCFA has outlined a series of activities that—if properly designed and implemented—should help improve its management and oversight of Medicare's claims administration contractors.

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Abbreviations

| | |
|------|---|
| CMG | Contractor Management Group |
| CPE | Contractor Performance Evaluation |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |
| MIP | Medicare Integrity Program |
| MSP | Medicare Secondary Payer |
| OIG | Office of Inspector General |
| PIP | Performance Improvement Plan |
| RFP | request for proposal |

Introduction

With the help of claims administration contractors, the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers the Medicare program. Medicare is the nation's largest health insurer, covering nearly 40 million beneficiaries at a net cost of about \$193 billion in fiscal year 1998. Contractors processed about 900 million Medicare fee-for-service claims in fiscal year 1998—about 3.5 million claims and \$700 million in payments each working day. For processing these claims and for performing other Medicare-related activities, HCFA paid its contractors \$1.6 billion in fiscal year 1998.

The Medicare program, implemented in 1966, provides coverage under the traditional pay-per-visit or service arrangement. Part A—hospital insurance—covers inpatient hospital, some home health, skilled nursing, and hospice services. Part B—supplementary insurance—covers services provided by physicians, outpatient laboratories, and an array of other providers and supplies. Beneficiaries now have the option to enroll in managed care, but about 85 percent have chosen Medicare's traditional fee-for-service program.

Contracting Arrangements for Managing Medicare

The size and complexity of the fee-for-service Medicare program make its management a formidable task. The original Medicare legislation and the accompanying committee reports reflected the congressional decision that the government contract with organizations already serving as payers and managers of health care services to administer Medicare payment functions. HCFA has followed this direction and today uses 58 contractors to handle day-to-day program administration and to pay claims.

The claims administration contractors, themselves health insurers, are called intermediaries or carriers, depending on the types of claims they process. Intermediaries, which were chosen from among those nominated by provider associations, process part A and part B claims for institutions, such as hospitals and home health agencies. Carriers, which were chosen directly by the Secretary of Health and Human Services, process part B claims submitted by others, such as physicians and suppliers of durable medical equipment.¹

¹Most intermediaries are local Blue Cross Blue Shield companies that subcontract with the national Blue Cross Blue Shield Association. Most carriers are also Blue Cross Blue Shield plans but have direct contracts with HCFA. A local Blue Cross Blue Shield plan may have both an intermediary subcontract and a carrier contract. In this report, the term "contractor" is applied to both prime contractors and subcontractors and to both intermediaries and carriers.

Medicare contracting for intermediaries and carriers differs from contracting for most other federal programs. Generally, in accordance with the Federal Property and Administrative Services Act of 1949 and the implementing regulations known as the Federal Acquisition Regulations,² which govern standard federal contracts, federal agencies can contract with any entity for any purpose, so long as that entity is not debarred from government contracting and the contract is not for what is an essentially governmental function. Federal agencies can contract using any payment method except cost-plus-percentage-of-cost and are generally required to contract competitively, unless there are specific exceptions in their authorizing legislation, such as there are for Medicare claims administration contracting. Medicare contracts must comply with the Federal Acquisition Regulations except when the Social Security Act, which authorizes Medicare, provides otherwise. For example, the act 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 are not permitted to earn a profit on their Medicare claims administration activities, except in certain limited situations.³ Also, carriers may be chosen only from among health-insuring organizations.

The services performed by intermediaries and carriers have been bundled together in part by the law and more completely by HCFA-promulgated regulations in a way that makes it difficult to contract for individual functions. However, in 1996, the Congress enacted legislation that authorized separate contracts for payment safeguard activities (medical and utilization review, Medicare Secondary Payer (MSP) activities, cost report audits, and the preparation of fraud and abuse cases). The program created by this legislation, called the Medicare Integrity Program (MIP), has no limitation on the type of companies that can be awarded contracts for these activities or on the basis on which they must be paid. HCFA has identified 12 organizations that it plans to contract with to operate the MIP and refers to them as program safeguard contractors.

HCFA believes, however, that specific requirements limit its choice of claims administration contractors. For its intermediaries, HCFA chooses

²C.F.R. title 48.

³HCFA has some limited authority to build financial incentives into intermediary and carrier contracts, as long as the intermediary or carrier agrees to enter into the arrangement; performs all of the services listed in sections 1816 or 1842 of the Social Security Act—the sections authorizing contracts with intermediaries and carriers, respectively; and is a health insuring organization. This authority can be found in the Deficit Reduction Act of 1984, section 2326(a), as amended by the Omnibus Budget Reconciliation Acts of 1986, section 9321(b), and 1989, section 6215; and the Social Security Amendments of 1994, section 159.

from among entities that are first selected by associations representing providers, a process called “provider nomination” as set forth in the Social Security Act. While the Congress intended, and the practice has been, for the government to contract with intermediaries and carriers for the administration of the Medicare program, the Congress did not mandate that such contractors be used. Sections 1816 and 1842 of the Social Security Act “authorize” the Secretary to enter into contracts with intermediaries and carriers, respectively, but section 1874 grants the Secretary the authority to “perform any . . . functions under this title directly, or by contract . . . as the Secretary may deem necessary.”

The Social Security Act also does not require that claims administration contractors be selected competitively. Provider nomination basically limits competition for intermediary contracts to those chosen by health care provider associations in 1966 and since. HCFA has not usually awarded either intermediary or carrier contracts on the basis of competition. An effect of the absence of competitive procurement is that HCFA has relatively little experience with writing statements of work and estimating the cost of certain tasks. Statements of work and cost estimates are required when contracts are written under the Federal Acquisition Regulations.

Contractors’ Role in Program Management

Medicare contractors are responsible for claims processing and administration, including (1) receiving claims; (2) judging their appropriateness; (3) paying appropriate ones promptly; (4) identifying potentially fraudulent claims or providers, and withholding payment if necessary; and (5) recovering overpayments or inappropriate payments. They are expected to manage Medicare’s funds in a fiscally responsible manner and to address effectively provider and beneficiary inquiries and problems. Each contractor must also develop a set of criteria to determine which claims it will pay. HCFA contractors use laws, regulations, the Medicare policy manuals, and periodic agency directives to guide their actions.

With its broad range of services and billions of dollars in payments to about 1 million providers, Medicare is inherently vulnerable to fraudulent and abusive billing and to payment errors. HCFA relies on contractors to safeguard the program by identifying inappropriate claims and payments. The contractors do this by focusing on four primary areas that constitute HCFA’s payment safeguard activities: (1) medical review, (2) MSP review, (3) audit and reimbursement activities, and (4) fraud unit investigations.

- Contractors conduct medical reviews of claims, including automated and manual prepayment and postpayment reviews, to identify inappropriate claims. Claims may be inappropriate because they are incorrectly prepared, are for services that are medically unnecessary or not covered, or represent fraudulent or abusive billing practices.
- Contractors' MSP activities identify other primary sources of payment, such as employer-sponsored insurance or third-party liability settlements for claims submitted to Medicare. Contractors are required to collect from primary insurers if claims have been paid with Medicare funds that should have been paid by these sources.
- Contractor audit and reimbursement activities include the review of overpayment collections and the audit of cost reports from institutions, such as hospitals, nursing homes, and home health agencies. The cost reports these providers submit are used in determining the amount of their Medicare reimbursement.
- Contractor fraud units develop potential cases of fraud or abuse identified by beneficiaries, other contractor safeguard units, or other sources; when appropriate, a case is referred to HHS' Office of Inspector General (OIG) for investigation and possible referral to the Department of Justice, which determines whether the case will be prosecuted.

HCFA requires its contractors to submit complete and accurate information on their performance. In addition, the Federal Managers' Financial Integrity Act of 1982 and the Chief Financial Officers Act of 1990 required each executive branch agency to establish and maintain a system of accounting and internal controls related to all assets for which it is responsible. In complying with this requirement, HCFA requires Medicare contractors, which control many of the funds for which HCFA is ultimately responsible, to submit annual certifications regarding their internal accounting and administrative controls. These certifications must reasonably ensure that the contractors are complying with applicable law and that their operations are safeguarded against waste, loss, or misappropriation.

In its audits of HCFA's financial statements for fiscal years 1997 and 1998, the HHS OIG estimated that contractors improperly paid more than \$20 billion and \$12 billion, respectively. Ninety percent of the improper payments for 1998 were detected through the medical review of records, which determines whether medical services are covered by Medicare and are reasonable, necessary, and appropriate. In addition, for each of those years, the OIG noted material internal control weaknesses for HCFA and its contractors.

HCFA's Role in Program Management

The Social Security Act requires that the Secretary of Health and Human Services develop standards, criteria, and procedures to evaluate intermediaries and carriers and determine whether contracts should be executed, renewed, or terminated. A few standards, such as how quickly certain claims are paid, are included in the law, and a few have resulted from lawsuit decisions.

As the Medicare program steward, HCFA is responsible for ensuring that contractors do their jobs accurately and efficiently. This responsibility is carried out through staff in headquarters and regional offices. At headquarters, the Medicare Carrier and Intermediary Management group, under the newly established position of Deputy Director for Medicare Contractor Management in HCFA's Center for Beneficiary Services, has overall responsibility for contractor operations. Although a number of other HCFA headquarters offices perform activities associated with contractors, this group serves as the focal point for contractor operations, issuing guidance and direction for contractor oversight. HCFA's 10 regional offices conduct most of the oversight and evaluation of contractors, although regional office staffs report to their respective regional administrators. They are not organized under the direction of the new Deputy Director for Medicare Contractor Management.

Although regions are generally responsible for overseeing contract operations in a specific geographic area, a regional office may oversee a contract outside that area. For example, the Atlanta regional office oversees 16 carrier and intermediary contracts for Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, South Carolina, and Tennessee. Although Louisiana and Missouri are outside Atlanta's geographic boundaries, the Atlanta region oversees the intermediary operations for those states. Conversely, the Dallas region oversees a contract held by a South Carolina company to administer durable medical equipment claims, even though that company is located within the boundaries of the Atlanta region.

While the Atlanta region oversees 16 contracts, these contracts are held by a smaller number of companies, because some companies hold multiple contracts. The South Carolina company mentioned, for example, holds intermediary and carrier contracts for several types of claims. In total, 44 companies hold the 58 intermediary and carrier contracts.

Since fiscal year 1995, the primary tool regions have used to conduct contractor oversight is the Contractor Performance Evaluation (CPE)

program. This restructured evaluation program, which places emphasis on continuous improvement, gives HCFA the flexibility to review a contractor's performance in any and all aspects of its contractually required duties. This approach was designed to give HCFA regional office reviewers flexibility in determining the types and levels of review for each contractor.

CPES are conducted in five general areas:

- claims processing,
- customer service,
- payment safeguards,
- fiscal responsibility, and
- administrative activities.

HCFA reviewers are expected to incorporate a review of internal controls into their assessments of particular contractor functions. HCFA's Regional Office Manual for Medicare provides guidance for performing such reviews and requires reviewers to perform a walk-through of internal control procedures to understand any obvious breakdown in controls or noncompliance with procedures.

After completing a review in a particular area, the reviewer is to report to the contractor on the results of the review. This report should spell out which areas, if any, need corrective action as a result of an identified deficiency. If corrective action is needed, the contractor must submit a Performance Improvement Plan specifying how the contractor will correct the deficiency. At the end of each fiscal year, the responsible HCFA region is to prepare a Report of Contractor Performance, which should summarize HCFA's overall evaluation of the contractor's performance based on the CPES that were conducted during the year and any other monitoring activity.

Recently, HCFA began to conduct what it calls "contractor integrity reviews" when it receives information of possible contractor wrongdoing. Headquarters and regional office staff usually conduct these ad hoc reviews with little advance notice to the contractor. An entrance conference is normally held, but few specifics about the allegations are provided to the contractor. In contrast to CPES, where very little is done through interviews, integrity reviews are conducted first through interviews in which pointed questions such as "Have you ever altered or been asked to alter documents?" are asked and then through the review of

contractor records, where available. Various actions could be taken as a result of an integrity review, including requiring a Performance Improvement Plan; not renewing or terminating the contract; referring the case to the HHS OIG; or, if circumstances dictate, simply closing the review with no action.

Scope and Methodology

To determine whether weaknesses exist in HCFA's contractor oversight activities that may make Medicare more vulnerable to fraud, waste, and abuse, we reviewed and analyzed documents related to HCFA's oversight of its claims administration contractors, including related GAO and HHS OIG reports, and other documentation concerning lawsuits and integrity reviews of HCFA contractors. We also reviewed and analyzed 225 of the CPES that HCFA regional reviewers had prepared concerning contractor operations for seven contracts for fiscal years 1995 through 1998. We discussed the oversight issue with responsible HCFA staff at headquarters and in HCFA's Atlanta, Dallas, and San Francisco regions. Within each of these regions, we discussed HCFA oversight activities with officials at selected claims administration contractors representing intermediaries and carriers and local Blue Cross Blue Shield plans and commercial plans. We also discussed oversight activities with representatives of the Blue Cross Blue Shield Association, which represents local plans, and the Medicare Administration Committee, which represents other Medicare contractors.

In addition, to determine whether any changes in HCFA's contracting authority may improve HCFA's ability to manage its contractors, we reviewed and analyzed Medicare's legislative history; legal authorities; the contracting bill proposed by the administration; relevant GAO reports; the Federal Acquisition Regulations, which implement federal contracting law; and HCFA regulations governing Medicare contractors.

We obtained written comments on a draft of this report from HCFA. HCFA's comments, other than its technical comments, are in appendix I. We also obtained oral comments from the Blue Cross Blue Shield Association and the Medicare Administration Committee. We have incorporated their comments where appropriate. We did our work between June 1998 and June 1999 in accordance with generally accepted government auditing standards.

To respond to a companion request that the Chairman made to GAO's Office of Special Investigations, that office prepared a separate report,

Medicare: Improperities by Contractors Compromised Medicare Program Integrity ([GAO/OSI-99-7](#), July 14, 1999), that discusses deceptive contractor activities in recently completed cases. This report describes how those activities were carried out without HCFA detection and assesses the impact of the activities on the Medicare program.

Weak Oversight of Contractors Leaves Medicare Vulnerable

HCFA's oversight of its claims administration contractors has not been sufficient to ensure that contractors are adequately protecting program dollars. One sign of HCFA's lax oversight is that six contractors since 1993 have settled civil and criminal charges after they were accused of improper activities, such as failing to check claims to ensure proper payment. These and other contractor integrity investigations have found common problems at some contractors—including falsified data and inadequate managerial controls. Despite these incidents, HCFA continues to let contractors self-certify their management controls, rarely checking to ensure that controls are working as required and rarely validating contractors' self-reported data. HCFA's oversight process lacks focus and accountability, setting few clear performance standards for contractors to meet and using limited priority-setting for regional reviewers. As a result, essential payment safeguard activities have gone unexamined for years at certain contractors. In addition, regional reviewers are inconsistent in requiring corrective actions when contractor problems are identified. HCFA's organizational structure for contractor oversight does not ensure regional offices' accountability for the oversight they perform. HCFA has acknowledged flaws in its oversight process and has begun to take steps to improve by moving toward a more structured evaluation process and reorganizing its contractor activities at headquarters. It is too soon to tell, however, whether these actions will resolve fundamental problems.

Contractor Integrity Problems Highlight Oversight Weaknesses

Since 1990, nearly one in four claims administration contractors have been alleged, most often by inside whistle-blowers, to have integrity problems—that is, that some of their activities were improper and potentially fraudulent. We identified at least 17 contractors that had either qui tam cases⁴ filed against them or had integrity reviews of their operations conducted by HCFA. Of the 58 contractors processing Medicare claims today, we identified at least seven that the Department of Justice or the HHS OIG is actively investigating. Since 1993, HCFA has entered into settlement agreements totaling more than \$235 million⁵ as a result of civil and criminal cases against six contractors⁶—with allegations that company employees

⁴Qui tam suits are filed under the False Claims Act, 31 U.S.C. sections 3729-3733. The act's qui tam provisions permit filers to share in financial recoveries resulting from their case.

⁵In addition to the \$235 million recovered from these companies as civil settlements and criminal fines and penalties in civil and criminal fraud cases, at least three of these companies have also entered into settlements in civil liability cases brought by HCFA for recovery of about an additional \$30 million owed to Medicare under the MSP program.

⁶For more detail on these cases, see [GAO/OSI-99-7](#), July 14, 1999.

- deleted backlogged claims from the processing system, thereby allowing the contractor to avoid paying interest on older claims;
- manufactured documentation to allow the processing of claims that otherwise would have been rejected because the services were not medically necessary;
- switched off the toll-free beneficiary inquiry lines when staff were unable to answer the calls within the prescribed amount of time; or
- disabled computer functions that would have otherwise halted the processing of questionable claims for further review.

Contractors misrepresented their performance to HCFA either to appear to meet standards they did not actually meet or to garner financial gain for the company. In a few cases, meeting performance standards was linked directly to financial incentives built into contracts, such as those in the 1991 through 1994 Health Care Service Corporation carrier contracts. In another case, a contractor's employee admitted that when the company used Medicare resources to conduct its private business, it no longer had enough Medicare resources to hire adequate staff to perform Medicare work. Falsifying workload data allowed the company to appear to continue meeting contractual obligations and avoid nonrenewal of its contract. Table 2.1 illustrates the nature of alleged contractor wrongdoing in three cases.

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Table 2.1: Allegations of Wrongdoing in Three Contractor Integrity Cases

| Contractor | Allegation |
|--|--|
| Blue Cross and Blue Shield of Florida | <p>In a 1991 case filed under the False Claims Act and settled in 1993, the contractor paid the Medicare program \$10 million to settle allegations that it had</p> <ul style="list-style-type: none"> —deleted durable medical equipment claims, —added false certifications of medical necessity to durable medical equipment claims to facilitate their processing, and —overridden computerized claims edits to speed claims processing without determining whether payment of the claims was proper. |
| Blue Cross and Blue Shield of Michigan | <p>In 1995, the contractor agreed to pay the Medicare program \$27.6 million in settlement of a <i>qui tam</i> suit filed by an employee who had alleged that the contractor had</p> <ul style="list-style-type: none"> —reported that provider cost report audits had been completed when, in fact, important steps had not been completed; —tampered with cost report audits chosen by HCFA for review; —provided false information to HCFA to avoid review of chosen audits in cases in which an audit had too many mistakes; and —falsified overpayment records to make it appear that overpayments had been collected within 30 days, avoiding payment of interest due the government. |
| Health Care Service Corporation (Blue Cross and Blue Shield of Illinois) | <p>In 1998, the contractor settled a False Claims Act case against it for \$140 million and pled guilty to eight felony counts, paying an additional \$4 million in criminal fines, because the contractor was alleged to have</p> <ul style="list-style-type: none"> —allowed Medicare payment of claims that should have been paid by private health insurance; —destroyed Medicare claims that should have been submitted to another contractor; —periodically disconnected the required toll-free telephone lines used for beneficiary inquiries; —paid claims under \$50 even if the services were not covered or not medically necessary; and —deleted, instead of suspending for review, claims with incorrect Health Insurance Claim numbers. |

HCFA is rarely the first to spot fraudulent practices through its routine oversight of Medicare contractors. Since 1990, HCFA's routine oversight reviews were the basis for referral to the HHS OIG for only 3 of the 17 contractors we identified as having had integrity problems cited. In another case not included in those three, HCFA received an anonymous complaint alleging that a contractor had falsified documents to pass its annual review. Although HCFA investigated the complaint, it found nothing wrong because the contractor forged a document indicating that the problem was due to a computer error. Two years later, a whistle-blower

filed a qui tam suit that eventually led to a guilty plea to criminal charges as well as multimillion-dollar criminal fines and civil penalties.

Because it is often difficult to detect wrongdoing when collusion is involved, fraudulent actions may go unnoticed for years. One integrity case involved contractors' actions over a 13-year period, while another involved improper activity for more than 10 years. More than a dozen of these integrity cases were developed from qui tam suits filed by company insiders; leads reported to the HHS OIG; or senior company managers themselves, who called HCFA directly when problems were brought to their attention.⁷

However, information from whistle-blowers and HCFA officials familiar with integrity investigations suggests that the way that HCFA conducted on-site verification of contractor's work allowed problems to remain undetected. HCFA reviewers notified contractors in advance concerning the dates of their on-site reviews and specific or probable records to examine, which allowed contractors to manipulate what HCFA reviewed. For example, Blue Cross and Blue Shield of Illinois allegedly used this prior notification to alter sample claim files scheduled for review. Similarly, Blue Shield of California allegedly deleted references to motor vehicle accidents in some claim files, because the medical claims paid might have been the responsibility of a liability insurer rather than Medicare. Moreover, when HCFA had contractors pull the records to be reviewed, it relied on copies of documents provided by the contractor, rather than originals, which made alteration harder to detect. Also, in some cases, HCFA representatives developed close relationships with contractor staff, which impeded HCFA's ability to objectively review contractor performance, according to investigators, contractor staff, and HCFA officials.

HCFA's Oversight of Contractor Activities Is Uneven and Inconsistent

HCFA's oversight process does not ensure that the contractors are efficiently and effectively paying fee-for-service claims and protecting the integrity of the program. First, while HCFA requires contractors to certify annually that they have sound internal management controls over all of their Medicare operations, we found that HCFA neither regularly validates the effectiveness of the processes behind these self-certifications nor routinely tests contractors' reported data to ensure that they are accurate. Second, HCFA has set few standards to measure contractor

⁷HCFA is not always aware of qui tam suits, which are generally filed under seal until judicial decisions have been published.

performance—particularly in the area of safeguarding the program—and has generally given regional offices wide discretion in overseeing contractors without setting clear priorities and direction. This has predictably led to uneven results: certain essential payment safeguards at some contractors go unexamined for years, and corrective actions at some contractors are monitored more intensely than at others. HCFA has started to move toward a more structured evaluation process but has not yet addressed all of its oversight weaknesses.

**HCFA Does Not Regularly
Check Contractors’
Self-Certifications of
Internal Controls, Nor
Does It Validate Their
Performance Data**

A fundamental activity in overseeing contractor performance is obtaining reasonable assurance that the contractors’ reporting data are accurate. As a first step in providing such assurance, HCFA requires contractors to certify that they have developed effective internal management controls over all aspects of their operations. However, we found that HCFA rarely looks behind the contractors’ self-certifications to ensure their validity, nor does it independently validate contractors’ performance data, instead relying heavily on financial and workload data reported by the contractors themselves. HCFA therefore lacks assurance that contractors’ reports of financial and performance data—such as the amount of accounts receivable or claims processing timeliness, volume, and accuracy—are reliable.

Medicare contractors are required to certify annually that they have established a system of internal management controls that help ensure that they meet program objectives, comply with laws and regulations, and are able to provide HCFA with reliable financial and management information concerning their operations. This is an important requirement because internal controls, effectively designed and operated, provide the best assurance that Medicare’s objectives will be achieved.

In April 1998, as part of its fiscal year 1997 audit of HCFA’s financial statements, the HHS OIG reported that regional offices were not evaluating the accuracy and reliability of the documentation supporting contractor internal controls.⁸ In response, HCFA sent guidance to its regional reviewers reminding them to validate contractors’ self-certifications during their 1998 evaluation review cycle. Nevertheless, our analysis of fiscal year 1998 reviews performed at seven contractors found no case in which reviewers documented that they had assessed and validated contractors’ self-certified controls. We did find two cases that mentioned such reviews,

⁸HHS OIG, Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997, A-17-97-00097 (Washington, D.C.: HHS, Apr. 1, 1998).

but the reviewers merely checked whether the contractors had provided the required self-certifications—not whether the internal controls were actually in place or effective.

The superficiality of these reviews is difficult to understand in light of the large number of contractors that have been found to have, or that are currently being investigated for, integrity problems. When HCFA performs an integrity review that confirms problems at a contractor, the report often concludes that there is a serious lack of internal controls and recommends that any corrective action plan include establishing such controls in vulnerable areas. With only minimal regular review of the contractors' self-certifications of their management controls, HCFA has little information to assess the integrity of contractors' operations or the reliability of their management and financial performance. Where internal controls are weak or untested and the risk of error is high, the need to validate self-reported data becomes increasingly important.

HCFA largely relies on contractor-submitted financial and workload data when evaluating and monitoring performance and does little independent validation of these data. In our analysis of 170 reviews completed for fiscal years 1995 through 1997 covering seven contractors, only two reviews documented reviewers' efforts to validate contractor workload data. In one review, HCFA staff tested the accuracy of contractor workload data related to the time the contractor took to perform desk reviews and audits. In the other, HCFA reviewers tested the accuracy of the filing date for claims subjected to medical review to determine whether the contractor reported correct claims processing times. For 1998, staff in one of the three regions we visited validated workload data in five of its reviews—checking, for example, the accuracy of workload data on medical reviews and telephone inquiries that the contractors had reported to HCFA. Staffs in the other two regions did not validate any workload data in fiscal year 1998.

Validating workload data has not been a consistent management priority. A HCFA headquarters official told us that although headquarters staff used to validate this type of data—sometimes with the assistance of regional office staff and in addition to any other regional reviews—it has not done so on a routine basis since 1994, when the headquarters group performing validation was dissolved. Regional officials told us that they believe the staff resources and travel funds available to perform detailed testing and validation are not adequate to ensure the accuracy of contractor-reported data. During our work at the regional offices, we found that the frequency

of on-site reviews varied greatly, and it was not unusual for staff to spend as little as a few days once a year at a contractor's site. For 1998, however, HCFA directed the regions to validate claims during their examination of contractor medical review activities, and each of the three regions we reviewed did so for at least one contractor. Also, according to HCFA's Comprehensive Plan for Program Integrity issued early in calendar year 1999, HCFA has contracted for the verification and validation of medical review claims on a sample basis at selected contractors. On the basis of the results of this effort, the verification and validation contractor will make recommendations to HCFA for any necessary corrective action.

In addition to workload data being vulnerable to error or misrepresentation, critical financial information also gets limited review and validation—either by the contractors or by HCFA staff. The HHS OIG report on HCFA's financial statements for fiscal year 1997 found that HCFA relies on its Monthly Contractor Financial Report to ensure that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. When OIG auditors reviewed these reports, their supporting documentation, and the processes used to produce them at 11 contractors, they found that the contractors' accounting ledgers were not maintained properly to support these reports, and some contractors did not subject the reports to independent verification. According to the auditors, although they had noted similar weaknesses in prior OIG reports issued to HCFA, the agency had not ensured that contractors had corrected these problems.

In response to the OIG's 1997 audit, HCFA headquarters officials advised regional reviewers in fiscal year 1998 to check key financial data for the largest intermediaries and for any carrier contracts held by the same contractors. As a result, the two regions in our study to which this advice applied reviewed financial data for three of their large contractors, checking items such as accounts payable and accounts receivable. Although the OIG's 1998 report noted some improvement in this area, it was not sufficient to remove the qualification on the OIG's opinion of HCFA's financial statements.

**Lack of Performance
Standards and Wide
Discretion Given to
Reviewers Leads to
Inconsistent Oversight**

HCFA's efforts to evaluate contractor performance in the last decade have suffered from extremes—a previous evaluation approach was inflexible and not focused on outcomes, while the current approach, in our opinion, is too discretionary and still fails to focus on outcomes. Under its current approach, HCFA has set few measurable performance standards for

contractors, has given regional oversight staff wide discretion over what aspects of contractor performance to review, and does not check on the quality of regional oversight. Not surprisingly, important program safeguards have received little scrutiny at some contractors, and regions have been inconsistent in their responses to contractor performance problems. HCFA has begun to give more oversight direction, but its actions to date have been limited.

HCFA's Evaluation Process Emphasizes Flexibility

Under the evaluation process used from fiscal years 1980 to 1995, HCFA examined a predetermined subset of contractors' activities each year and assigned each contractor a numerical score. Although performance standards were explicit under this approach, we reported that the standards focused more on process than outcome. Therefore, the evaluation process did not sufficiently emphasize efforts to ensure that program benefits were paid appropriately, particularly by measuring the effectiveness of program safeguards.⁹ Furthermore, HCFA believed that this approach encouraged contractors to manage their activities in a way that would maximize their score, thus dissuading HCFA reviewers from targeting other potentially troublesome areas.

HCFA developed a new evaluation approach for fiscal year 1995, known as the CPE process, designed to allow individual reviewers "greater flexibility in determining the appropriate types and levels of review for each contractor."¹⁰ Under this approach, HCFA's reviewers may examine any aspect of contractor operations and, with a few exceptions, have no common standards against which to assess the 58 contractors. Until fiscal year 1998, HCFA did not issue guidance for reviewers to evaluate even a minimum set of essential operations. But because of the OIG's and our concern about HCFA's oversight of Medicare contractors, HCFA issued guidance for its regions to review certain areas for fiscal year 1998. The guidance was issued late, however—not until the eighth month of the fiscal year.

HCFA's contractor performance evaluations do not follow a set report format, although regional staffs were reminded by memo in 1998 that evaluations should contain certain key items. Such a flexible evaluation

⁹Medicare: HCFA's Contracting Authority for Processing Medicare Claims (GAO/HEHS-94-171, Aug. 2, 1994) and Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

¹⁰HHS, HCFA, Regional Office Manual, Section 1100, "Contractor Performance Evaluation" (Baltimore, Md.: HCFA, May 1995).

process has produced a varying assortment of reports that make analytic interpretations difficult and cross-contractor comparisons impossible.

**HCFA Has Few Measurable
Performance Standards**

Except for standards mandated by legislation, regulation, or judicial decision, HCFA's current CPE process eliminated the previous evaluation system's process standards for contractors without requiring sufficient outcome standards (see table 2.2 for the mandated standards). As a result, the current process contains few measurable standards to ensure that contractors adequately perform important program safeguards, such as medical review of claims. The lack of sufficient standards is worrisome because, in the case of medical review, HCFA has made more effective medical review part of its plan to strengthen program integrity. In our opinion, the lack of clear performance standards decreases the likelihood that HCFA will get maximum performance from contractors.

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Table 2.2: Performance Standards Mandated by Law, Regulation, or Judicial Decision, by Evaluation Area

| Evaluation area | Applies to | Performance standard |
|------------------------|--|--|
| Claims processing | Electronic part A and part B claims properly prepared and submitted | 95 percent paid within 14-30 days of receipt |
| | Paper part A and part B claims properly prepared and submitted | 95 percent paid within 27-30 days of receipt |
| | Part A Administrative Law Judge reversal rate of claim decisions | 5 percent or less |
| | Part A reconsideration of claim decisions | 75 percent processed within 60 days, 90 percent within 90 days |
| | Part B reviews of claim decisions | 95 percent completed within 45 days |
| | Part B hearings of claim decisions | 90 percent completed within 120 days |
| Customer service | Part B notice to beneficiaries explaining the basis for coverage and reimbursement decisions | 98 percent properly generated |
| | Part B telephone inquiries from beneficiaries | Calls answered within 120 seconds; callers are not to get busy signal more than 20 percent of time |
| Payment safeguards | Part A skilled nursing facility demand bills ^a | All processed accurately |
| | Part A Tax Equity and Fiscal Responsibility Act of 1982 target rate adjustments, exceptions, and exemptions ^b | Completed within 75 days or returned as incomplete within 60 days |

^aSkilled nursing facilities are required to determine whether a beneficiary's care will be covered by Medicare. If a skilled nursing facility determines that a beneficiary's care will not be covered, it must still submit a demand bill to the contractor for review of the coverage determination, if the beneficiary demands it.

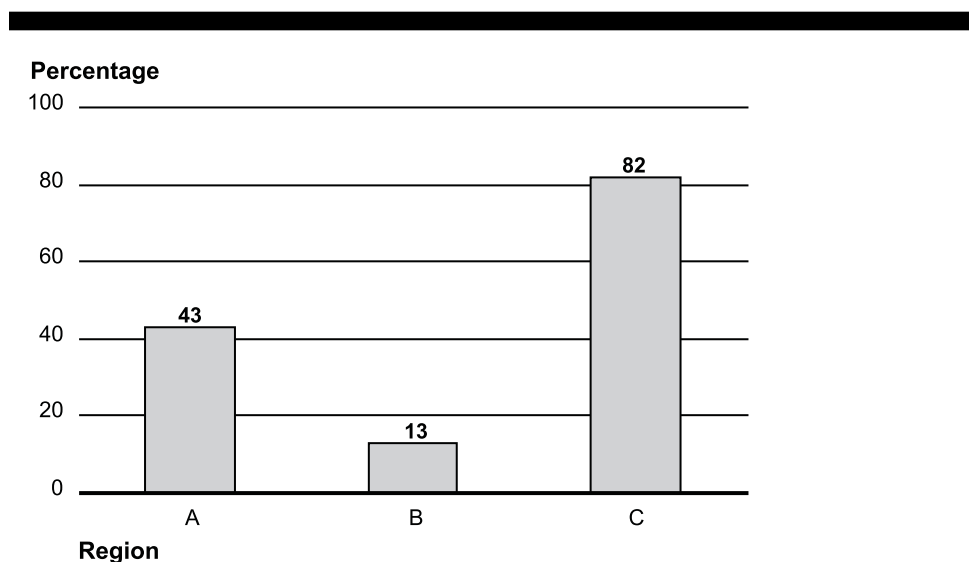
^bFor hospitals not paid on a prospective basis, the 1982 act provided for a ceiling on the allowable rate of increase in hospital inpatient operating costs. Adjustments, exceptions, and exemptions, if properly documented, can be made under the act's provisions at the request of the hospital.

Even for the mandated standards listed in table 2.2, HCFA does not require that regional reviewers check them routinely. According to a HCFA manual, reviewers are not required to evaluate whether contractors meet the mandated standards unless the reviewers choose to evaluate that specific

area of contractor performance.¹¹ If regional reviewers choose to look at a contractor's claims processing activity, for example, they are required to check whether contractors met the mandated claims processing timeliness standards.

Our analysis of CPE reports for three regional offices found that these regions often did not meet the requirement to review claims processing standards when reviewing claims processing activities. For fiscal years 1995 through 1998, we found that, for seven contractors, claims processing was reviewed at least once a year at one contractor and less frequently at the others. When HCFA reviewers did assess claims processing activities, they checked about half of the applicable mandated standards. In addition, the three regions varied considerably in the percentage of applicable mandated standards their staff checked, as shown in figure 2.1.

Figure 2.1: Three Regions' Rates of Compliance With Requirement to Check Whether Contractor Met Mandated Claims Processing Standards, FY 1995-98



HCFA Does Not Examine Essential Contractor Payment Safeguards

The combination of wide discretion, few common measures, and limited headquarters guidance leads to uneven review of contractor performance in critical areas, including the effectiveness of payment safeguards. The following illustrates this effect for two types of program safeguards—MSP and contractor fraud unit activities.

¹¹HHS, HCFA, Regional Office Manual, Section 1100, p. 1-21.1.

Medicare Secondary Payer—MSP activities seek to (1) identify insurers that should pay claims mistakenly billed to Medicare and (2) recoup any payments Medicare made for claims not first identified as the responsibility of other insurers. (Table 2.3 shows some of these key activities.)

Table 2.3: Key MSP Activities Conducted by Contractors

| | |
|---|--|
| First claim development | Research the first claim of a beneficiary to identify the possibility that future claims may not be the primary responsibility of Medicare. One way that contractors determine whether they should pay such claims is to contact beneficiaries when their first claims are received. After first claim development, contractors should be able to catch MSP claims and forward them to the proper payer. |
| Data match | Match data contained in several federal information systems—including files from the Internal Revenue Service and the Social Security Administration—to identify beneficiaries that have the potential for being covered by employee health insurance. |
| Claims processing through the common working file | Before paying a claim, check information in HCFA's regional databases, known as the common working file, to determine beneficiary eligibility and reasons for not paying, such as when the beneficiary has other insurance. |
| Retroactive recovery or waiver of recovery | Recovering erroneous Medicare claim payments after mistakes have been discovered, such as cases in which coverage, especially by automobile liability and no-fault plans, is not immediately discernible. The recovery can be waived in certain situations, such as when the beneficiary is without fault or recovery would be more expensive than the amount in question. |

Saving about \$3 billion annually from 1994 through 1998, MSP review is a substantial Medicare payment safeguard. Despite the opportunity for large dollar savings, however, our review of three regions' CPE reports—documenting which of the multiple MSP activities were examined—shows that, over 4 years, reviewers did not check many of the key activities most germane to spotting claims covered by MSP provisions. The check marks in figure 2.2 show that key MSP activities were reviewed rarely, particularly by Region B.

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Figure 2.2: Key MSP Activities Reviewed for Seven Contractors, FY 1995-98

| | | Region A | | Region B | | | Region C | |
|--|------|----------|---|----------|---|---|----------|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| First Claim Development | FY95 | ✓ | ✓ | | | | ✓ | ✓ |
| | FY96 | | | | | | | |
| | FY97 | | | | | | | |
| | FY98 | | | | | | ✓ | |
| Data Match | FY95 | ✓ | ✓ | | | | ✓ | ✓ |
| | FY96 | | | | | | | |
| | FY97 | | ✓ | | | | | ✓ |
| | FY98 | | | | ✓ | | ✓ | |
| Claims Processing Through the Common Working File | FY95 | | | | | | ✓ | ✓ |
| | FY96 | | | | | | | |
| | FY97 | | | | | | | |
| | FY98 | | | | | | ✓ | |
| Recovering or Waiving Recovery of Medicare Payments | FY95 | ✓ | ✓ | ✓ | | | | |
| | FY96 | | | ✓ | ✓ | | ✓ | ✓ |
| | FY97 | | ✓ | | | | ✓ | ✓ |
| | FY98 | ✓ | ✓ | ✓ | ✓ | | ✓ | |

The potential for contractor fraud regarding MSP activities is significant because of an inherent conflict of interest: the private insurance business of the contractor can be the primary payer for some claims subject to the MSP provisions. HCFA has had to pursue certain insurance companies—some with related corporations that are Medicare contractors—in federal civil court for refusing to pay before Medicare when the government contends that Medicare should have been the secondary insurance payer. Since 1995, settlements in cases in which a related company was a Medicare carrier or intermediary have totaled almost \$66 million.¹² HCFA currently has an additional \$98 million in claims

¹²These contractors include the national Blue Cross Blue Shield Association, Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Transamerica, and Travelers.

filed against current and former contractors. In our opinion, the considerable size of annual MSP savings, coupled with HCFA's past experience with contractor performance and the extra effort involved in identifying beneficiaries' primary insurers, underscore the need for regular scrutiny of these activities.

Fraud Units—HCFA requires all intermediaries and carriers to operate special units for detecting and deterring fraud. The units are expected to, among other activities, determine the factual basis of fraud complaints made by beneficiaries and others, explore leads, and develop and refer cases to the HHS OIG. The OIG's 1998 report on intermediaries' fraud units found significant disparities in the fraud units' performances: one unit handled over 600 fraud cases, and others handled none; one referred over 100 cases to the HHS OIG, and others referred none.¹³

The HHS OIG also found weaknesses in HCFA's evaluations that allowed contractor performance to go unchecked. For example, HCFA's reviewers did not routinely check and report on whether contractors were identifying program vulnerabilities, such as loose program guidelines that invited inappropriate billings. Although identification of program vulnerabilities heads the list of fraud unit responsibilities, only 10 percent of HCFA's CPE reports on fraud units stated whether the unit had carried out this responsibility. In its 1998 report, the OIG recommended that HCFA establish standards for contractor performance; measure performance against those standards; and require that CPE reports list HCFA's performance standards and state contractors' compliance with the standards explicitly.

HCFA substantively concurred with all of the OIG's recommendations and noted certain initial steps it had already taken in fiscal year 1998 and its intent to address the recommendations more comprehensively in later years.

Reviewers Inconsistent in Prescribing Corrective Actions

Without a set of clearly defined and measurable performance standards or measures, contractors lack clear expectations. This has resulted in inconsistencies in HCFA reviewers' handling of contractor performance problems. Besides the inequity for contractors, such uneven review leaves HCFA without the ability to discriminate between contractors' performance when assigning new work.

¹³HHS OIG, Fiscal Intermediary Fraud Units, OEI-03-97-00350 (Washington, D.C.: HHS OIG, Nov. 1998).

HCFA officials told us that some regions are known to be “easier” on contractors than others. We found instances in which regions handled similar types of contractor activities differently. For example, one company held two contracts for two states—each overseen by a different region. As part of its program safeguard activities, the company analyzed paid claims at one central location to identify possible fraudulent or abusive provider billing trends. While the company conducted identical types of analyses for both contracts, one region found that the contractor’s data analysis activities did not fulfill HCFA’s expectations, while the other region found the contractor in compliance with HCFA’s analytic expectations. Although these regions had signed a memorandum of understanding to seek consistency in how they directed the contractor, and to coordinate oversight to avoid duplication of effort, they did not work together to resolve their differences and guide the contractor with one voice.

HCFA reviewers may not only disagree about whether a problem exists but also take dissimilar actions once a performance problem is identified. HCFA’s normal procedure after identifying a program deficiency is to require the contractor to develop a Performance Improvement Plan (PIP) to correct the problem, and then to monitor the plan. PIPs can be stringent corrective actions for contractors. Contractors operating under a PIP can be required to make complex changes in operations and to submit performance data and reports about their activities until HCFA decides that their performance has improved.

HCFA reviewers differ in whether they require PIPs, even in cases that seem quite similar. For example, in one region, a contractor with a high error rate in one component of its medical review process passed its periodic evaluation without any requirements to improve. In another region, a contractor with a similarly high error rate was required to develop and follow a PIP.

Similarly, one region required a contractor to develop and follow PIPs for deficiencies in its performance in fraud and abuse prevention and detection. This contractor did not maintain and use a fraud investigation database. All cases were not entered into the database, and there were quality problems with some of the cases that were entered. In contrast, another region, reviewing a different contractor, found many more serious weaknesses with that contractor’s fraud and abuse prevention and detection activities. The reviewer concluded that the contractor did not meet HCFA’s performance expectations, yet did not require a PIP. Included

in the weaknesses the reviewer identified were (1) spending little or no time actively detecting fraud and abuse; (2) not using data to detect egregious cases; (3) focusing on small, rather than large and more complex, dollar cases; (4) referring only one case to the HHS OIG during the year; (5) inadequately recovering overpayments; (6) failing to suspend payments to questionable providers; (7) failing to prioritize cases; and (8) preparing no fraud alerts.

Regions varied widely in their use of PIPs in 1996 and 1997. As table 2.4 shows, some regions required few or no PIPs of the contractors they oversee, while others used this mechanism extensively. We could not determine whether this variance was due to better contractor performance in some regions, or regional practices regarding the use of PIPs. However, HCFA was concerned enough about the variation that in 1998 it provided additional guidance to regions clarifying the difference between a program deficiency, which requires a PIP, and a program vulnerability, which does not.

Table 2.4: Number of Contracts Overseen and PIPs Required for Contractors, by Region, FY 1996 and 1997

| Region | FY 1996—number of | | FY 1997—number of | |
|---------------|-------------------|-----------|-------------------|------------|
| | Contracts | PIPs | Contracts | PIPs |
| Boston | 10 | 7 | 11 | 3 |
| New York | 7 | 3 | 7 | 7 |
| Philadelphia | 10 | 8 | 9 | 16 |
| Atlanta | 18 | 30 | 16 | 40 |
| Chicago | 14 | 16 | 13 | 100 |
| Dallas | 9 | 1 | 6 | 6 |
| Kansas City | 8 | 15 | 8 | 11 |
| Denver | 8 | 4 | 8 | 0 |
| San Francisco | 8 | 9 | 5 | 21 |
| Seattle | 6 | 0 | 4 | 10 |
| Total | 98 | 93 | 87 | 214 |

Source: HCFA data.

HCFA Has Begun to Move to a More Structured Evaluation Process

HCFA has recognized that its oversight of contractors has been less than adequate and issued guidance in fiscal year 1998 to have regional reviewers follow a somewhat more structured evaluation process. However, these actions are only a first step in addressing problems with contractor oversight.

In May 1998, citing concerns raised by the HHS OIG and us regarding HCFA's level of contractor oversight, HCFA announced the "need to reengineer our current contractor monitoring and evaluation approach and develop a strategy demonstrating stronger commitment to this effort." Specifically, HCFA issued a contractor performance evaluation plan specifying three evaluation priorities for fiscal year 1998: (1) year 2000 compliance activities, (2) activities focusing on a subset of financial management operations—accounts receivable and payable, and (3) activities focusing on a subset of medical review activities. Because of the regions' workload concerns, HCFA later scaled down its requirements in the financial management area.

Also in 1998, HCFA emphasized the need for regions to follow its structured CPE report format, including clearly stating whether the contractor complied with HCFA's performance requirements. Nonetheless, we found that some of the 1998 reviews continued to lack a structured format, making it difficult to compare contractor performance. For example, HCFA's contractor evaluation plan for fiscal year 1998, issued 5 months before the close of the fiscal year, called for examining contractors' activities with regard to reviewing claims for medical necessity before they are paid (called prepayment medical review). Our review of the three regions' fiscal year 1998 CPE reports shows that (1) two regions did not review contractors' determinations of medical necessity at all contractors included in our study before payment and (2) two regions did not consistently follow the structured report format, making it difficult for HCFA headquarters to evaluate or compare the results.

Despite HCFA's intent to provide more direction to the regions on contractor oversight activities, it continues to issue review guidance late in the year. Agency officials recently told us that its plan for CPE reviews for fiscal year 1999 will include more headquarters involvement in the assessment process, review teams from headquarters and the regions, and multiregional reviews. As of May 1999—7 months into the fiscal year—HCFA had not yet issued its fiscal year 1999 guidance.

HCFA Lacks a Structure That Ensures Accountability

Two aspects of HCFA's current organizational structure create problems for overseeing contractors. First, HCFA reorganized its headquarters operations in 1997, dispersing responsibility for contractor activities from one headquarters component to seven. Second, although HCFA's 10 regional offices are the front line for overseeing contractors, they do not report directly to headquarters units responsible for contractor performance.

Instead, they report to the HCFA Administrator, through their respective regional administrators and consortia directors. We found that the structural relationship and the dispersal of responsibility for contractor activities to multiple headquarters components contribute to communications problems with contractors, exacerbate the weaknesses of HCFA's oversight process, and blur accountability for (1) having regions adopt best practices; (2) routinely evaluating the regional offices' oversight; and (3) enforcing minimum standards for conducting oversight activities, including taking action when a particular region is not performing well in overseeing contractors. To establish more consistency and improve the quality of contractor management and oversight, HCFA recently modified its organizational structure again, but these changes may not be sufficient.

HCFA's Structure Contributes to Problems in Communications and Oversight

HCFA's 1997 agencywide reorganization dispersed contractor responsibilities to seven headquarters offices. To ensure that contractors received clear program direction under the new structure, HCFA formalized its process for issuing contractor guidance and making system changes. However, contractors report continued problems in receiving all required information. In addition, HCFA does not share among regions best practices or lessons learned from integrity reviews, nor does it evaluate the quality of regional oversight. Furthermore, since regional contractor oversight staffs do not report to headquarters staff responsible for contractor activities, HCFA's structure does not foster consistent accountability and oversight.

Before HCFA's 1997 reorganization, responsibility for managing Medicare contractors fell to the Bureau of Program Operations in headquarters and the 10 regional offices. The Bureau provided guidance to regional offices and was responsible for almost every aspect of contractor management at headquarters, including selection, budgeting, and ensuring proper monitoring of contractor performance. The regional offices carried out the day-to-day oversight at specific contractors.

Under the 1997 reorganization, regions retained their role as the primary contract monitors, but responsibility at headquarters for contractor functions was dispersed among seven headquarters components. This functional dispersion, in part, was in response to concern that one office, such as the Bureau, should not oversee all contractor activities, and instead offices with responsibility for contractor functions should have

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more functional independence. Table 2.5 shows the headquarters units involved in contractor management.

Table 2.5: HCFA Headquarters Units With Responsibilities for Medicare Contractor Issues

| HCFA organizational component | Subcomponents | Component responsibilities |
|---------------------------------------|---|--|
| Center for Beneficiary Services | <p>Medicare Carrier and Intermediary Management Group: Division of Contractor Operations, Division of Contractor Planning, Division of Contractor Integrity and Performance Evaluation</p> <p>Customer and Teleservice Operations Group: Division of Contractor Customer Service Operations and Division of Call Center Operations</p> <p>Beneficiary Membership Administration Group: Division of Membership Operation and Division of Member Rights and Protections</p> | Contractor management focal point. Contractor performance evaluations, transitions, customer service, beneficiary enrollment, coordination of benefits, and appeals. |
| Center for Health Plans and Providers | <p>Provider Purchasing and Administration Group: Division of Institutional Claims Processing, Division of Practitioner Claims Processing, Division of Supplier Claims Processing, and Division of Provider/Supplier Enrollment</p> | Claims processing and payment issues, provider/supplier enrollment. |
| Office of Financial Management | <p>Financial Services Group: Division of Accounting and Division of Financial Integrity—MSP Operations Branch, Debt Collection Branch, and Provider Audit Operations Branch</p> <p>Program Integrity Group: Division of Program Integrity Operations</p> | Accounting operations, budget, cost reporting, cash management/letter of credit, MIP, other payment safeguards, and internal controls. |

(continued)

**Chapter 2
Weak Oversight of Contractors Leaves
Medicare Vulnerable**

| HCFA organizational component | Subcomponents | Component responsibilities |
|---|--|---|
| Office of Information Services | Business Systems Operations Group: Division of Change Management and Division of Standard Systems and Common Working File Security and Standards Group: Division of Health Care Information Systems Standards: Division of HCFA Enterprise Standards | Change management, standard systems, common working file, paper and electronic data interchange, administrative transactions, and systems security. |
| Office of Internal Customer Support | Acquisition and Grants Group: Division of Medicare Contractors | Contracting issues. |
| Office of Clinical Standards and Quality | | Coverage issues. |
| Office of Communications and Operations Support | Operations Support Group: Division of Regulations and Issuances | Manual and program guidance. |

Source: HCFA.

Because the 1997 reorganization spread contractor-related responsibilities among multiple headquarters units, the Medicare Contractor Management Group (CMG), in the Center for Beneficiary Services, was established as a focal point for providing guidance to the contractors and the regional offices. The CMG worked with other headquarters components and the regional offices to coordinate the issuance of guidance and activities related to contractor selection, budgets, transitions, processing systems, and performance evaluations.

Recognizing that the dispersal of responsibilities could confuse contractors, HCFA also established the Medicare Change Management Process in October 1997 to ensure that the newly reorganized agency provided clear program direction directly to its contractors. This process required that the CMG, after coordinating the development of guidance or system programming instructions for the contractors, formally certify the instructions before they were implemented. It also effectively removed the regional offices as conduits for information from headquarters to the contractors.

Despite these efforts, there have been problems. Primary among them are the uncertainties that contractors are, in fact, receiving and implementing

all instructions and that regions are not always aware of the instructions being conveyed. According to agency officials, HCFA is developing a checking process to remedy these problems.

To test the adequacy of HCFA's communications with its contractors, the Blue Cross Blue Shield Association analyzed recent documents that three contractors reporting to three different regions received from headquarters or their respective regional offices. According to the Association's analysis, each of the three contractors did not receive about half of what they classified as key directives. In addition, at the time, certain HCFA directives were still being funneled through regions to contractors. Regions also varied in how well they transmitted information to their contractors, with one region being noticeably slower at transmitting directives than the other two.

In addition to having communications problems with contractors, HCFA also has not communicated to regional reviewers lessons learned from best oversight practices or from integrity investigations. HCFA acknowledges that some regions do a better job than others and would like to capitalize on the successful approaches particular regions employ. In fact, in a memorandum to the regions dated August 4, 1998, from HCFA's Division of Contractor Integrity and Performance Evaluation, the division director indicated that a sample of regional CPE reports would be reviewed and periodic summaries developed to share best practices with other regions. However, HCFA has not yet prepared any best practices summaries, in part because the CPE reports were submitted late, according to the director. The director also was concerned that the untimely submission of CPE reports to headquarters may indicate that the regions are not providing their contractors with timely information on review results. But because this Division's relationship with the regions is advisory, the director could not require regions to be more timely.

Regions could also benefit from information obtained from contractor integrity investigations, but HCFA has not incorporated such lessons into its routine oversight practices. These integrity investigations follow allegations of wrongdoing and entail interviewing company employees and combing through company records. In some cases, the employee interviews have given HCFA leads that may not have been evident through HCFA's current CPE process, such as instructions to alter Medicare performance data or to destroy company records. According to staff experienced in conducting integrity reviews, HCFA's on-site presence also typically leads to the discovery of performance problems not previously

identified at the contractor under review. We found that integrity reviews are typically done in reaction to allegations of wrongdoing and usually are conducted or directed by headquarters personnel. Because these reviews are seen largely as one-time, unusual events rather than as a pattern of practices at more than one contractor, HCFA has not developed a formal mechanism to communicate information learned about root causes and prevention of these problems. Nor has it incorporated such knowledge into HCFA's routine oversight.

Finally, with few formal requirements for regions to report to headquarters, HCFA does not collect, analyze, or evaluate information on the quality of regional oversight across the country. It does not have information on the relative strengths and weaknesses in regional performance or on whether all contractors are being treated equitably; therefore, it cannot provide formal feedback to regions to improve their performance.

Even if it had good information on regional performance, the structural relationship between headquarters units and the regions would not lend itself to HCFA's scrutiny of its regions. Regional offices report directly to the HCFA Administrator through their respective regional administrators and consortia directors. Regional staffs responsible for contractor oversight do not report to the headquarters unit most involved with contractor oversight. As a result, this headquarters unit is not clearly directing contractor oversight. To illustrate, a HCFA memo to the regions concerning the validation of contractor self-certifications as part of the 1998 review cycle stated that reviewers should perform this activity "if it would be convenient." A HCFA headquarters staff member told us that the memo was intended to strongly encourage reviewers to do this activity but did not directly order reviewers to do it because the headquarters unit lacked the authority to do so.

HCFA Is Again Reorganizing Headquarters Functions to Address Management Weaknesses

HCFA officials have come to recognize that the agency does not have an adequate contractor strategy. During the latter part of our review, HCFA officials told us that they were reorganizing the agency's contractor management activities. This may be a good start, but it is too soon to tell how well this will address the fundamental problems HCFA has had ensuring adequate and consistent contractor oversight.

In late 1998, HCFA established the Medicare Contractor Oversight Board, a subgroup of the Executive Council,¹⁴ to provide high-level oversight of contractor activity and to better represent contractor issues at HCFA. In addition, the HCFA Administrator has created a new deputy position for contractor operations in HCFA's Center for Beneficiary Services. According to HCFA officials, as a senior HCFA official responsible for contractor operations, this deputy will bring contractor issues to the Executive Council more effectively and will serve as the Executive Director of the Oversight Board, which reports to the HCFA Administrator. HCFA has also established a group of headquarters and regional officials to work with an outside expert to develop a strategic plan for managing Medicare contractors. The plan is expected to be complete in the summer of 1999. Finally, HCFA is adding 21 new contractor management staff at headquarters—11 of which will be involved in coordinating activities with other organizational components.

These changes have the potential to elevate contractor issues to more senior decisionmakers and improve communications among the units that share responsibility for contractor management and oversight. However, it is too soon to tell whether this new organization will lead to improved contractor oversight.

¹⁴The Executive Council is a group of senior HCFA executives chaired by the Administrator. Responsible for the operation of HCFA programs, the council establishes performance standards for all HCFA programs and monitors the agency's operations to ensure that the standards are being met.

HCFA Would Need Time and Careful Implementation to Benefit From New Contracting Authority

HCFA's current legislative authority, its interpretation of that authority, and its regulations constrain its ability to choose contractors and attract new companies as contractors. To remedy this, HCFA has proposed legislation that addresses perceived barriers to effective contracting for Medicare claims administration services. The proposed changes include obtaining (1) authority to contract with other than health insuring organizations, coupled with repeal of the provider nomination provision for selecting intermediaries, (2) authority to contract for specific activities other than payment safeguards, and (3) unrestricted authority to award other than cost-based contracts. In 1996, HCFA was given new authority to contract separately just for payment safeguard activities, such as medical review of claims, to ensure the services were medically necessary. HCFA's experience in implementing its new payment safeguard contract authority attests to the need for significant time to explore and resolve several feasibility issues. In addition, HCFA's previous experience with the use of fixed price and cost-plus-incentive payments suggests that any change from cost-based contracting will need to be carefully designed and thoughtfully monitored to prevent loss to the Medicare program. Testing different methods of contracting could help HCFA ensure that implementation would improve, rather than weaken, program administration.

Constraints on Contracting Authority Limit HCFA's Ability to Attract New Companies

When Medicare was implemented in 1966, the government used existing health insurers, as the Congress intended, to process and pay claims, and their expertise helped launch the new program. Subsequent regulations and decades of the agency's own practices have further limited how HCFA contracts for claims administration services. In this regard, HCFA has

- not contracted with companies other than health insurers to handle any aspects of administering Medicare claims, and only health insurers have met the statutory definition of carriers;
- not awarded separate contracts for discrete claims administration functions because its law and regulations impede it from doing so, except for payment safeguard contracts, which have recently been awarded under its 1996 authority to contract separately for these activities only; and
- infrequently used financial inducements, such as incentive payments, that would allow a company to earn a profit for superior performance, and its authority to do so has specific limits.

The Congress intended the government to contract with intermediaries and carriers for the administration of the Medicare program, but it did not mandate that such contractors be used. Sections 1816 and 1842 of the

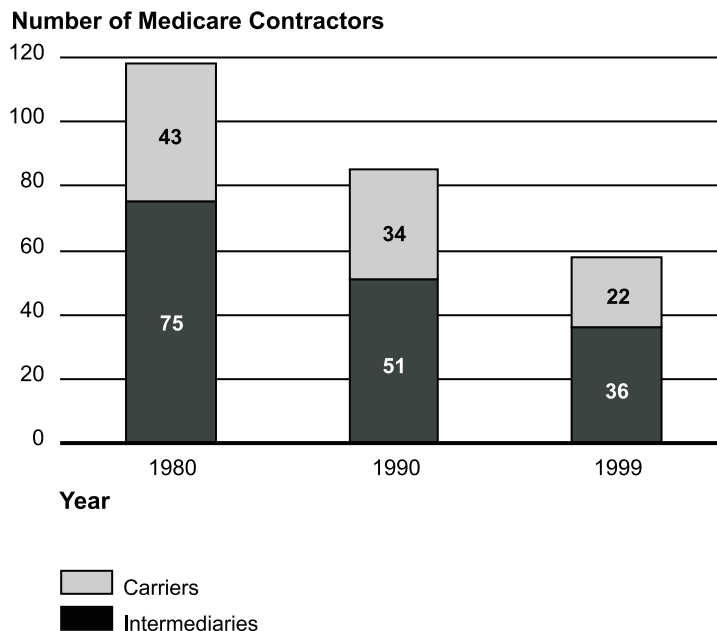
Social Security Act “authorize” the Secretary of Health and Human Services to enter into such contracts. Section 1874 grants the Secretary authority to “perform any of [the] functions under [Medicare] directly, or by contract. . . .” Based largely on what it understands to have been congressional intent, HCFA believes that it is required to contract with intermediaries and carriers for all claims administration. HCFA is pursuing legislation that will provide explicit authority for it to do otherwise.

The initial rationale for some of HCFA’s practices under current authority and regulations has faded against the backdrop of today’s health care business environment. In the three decades since Medicare’s creation, the explosion in information management technology, coupled with the diversification of the health insurance industry into activities such as provision of health services, has generated the potential and need for Medicare to use new types of business entities to administer its claims processing and related functions. However, the combination of the health insurer-only limitation, constraints on disaggregating administrative functions, and limits on contractor financial incentives severely hamper efforts to modernize Medicare’s contracting processes and encourage new companies to become contractors.

The need to broaden the pool of eligible Medicare contractors has become acute in light of contractor attrition. Since 1980, the number of contractors has dropped by about half. In some cases in the 1980s, contractors were consolidated to achieve administrative efficiencies. However, continued erosion in the number of contractors has left HCFA with fewer choices when one contractor withdraws from the program and another must be chosen to process the claims.¹⁵ In the last 10 years, the number of Medicare contractors dropped about a third—from 85 to 58. (See fig. 3.1.)

¹⁵The desired attrition that began in the 1980s occurred after our 1979 report calling for consolidating carrier and intermediary workloads to achieve greater efficiency. See *More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing* (GAO/HRD-79-76, June 29, 1979).

Figure 3.1: Number of Medicare Claims Administration Contractors, 1980-99



The pool of contractors eligible and able to assume reassigned work is, in effect, smaller than the 58 intermediaries and carriers currently serving Medicare. First, some existing contractors are too small to easily absorb a substantially increased workload. When a Blue Shield carrier announced that it was leaving the program in 1996, for example, another one wanted to assume the workload, which would have increased the second contractor’s workload about tenfold. According to HCFA officials, however, the agency avoids adding so much work to smaller contractors to mitigate the risk of a breakdown in service—most notably, timely and accurate payments to providers. Second, some contractors may not be interested in expanding their workload. Third, it is not desirable for HCFA to choose a contractor that it knows is being investigated or prosecuted. HCFA has allowed at least one contractor that had been the subject of an investigation to expand its workload.¹⁶

¹⁶Several reasons accounted for HCFA’s unusual decision in this case, including (1) the contractor’s self-disclosure of the problem; (2) its willingness to cooperate with HCFA when the agency stepped in to investigate; and (3) the steps the contractor took to ensure that the problem did not recur, including firing employees involved in wrongdoing.

The threat of financial penalties can influence a company's decision to drop out of the program. About a third of the nonrenewing contractors since 1990 had allegations of wrongdoing made against them. Of the 58 contractors remaining today,¹⁷ at least 7 are subject to ongoing investigations. These seven contractors administered over 30 percent of Medicare's fee-for-service claims in fiscal year 1998.

HCFA Proposals Seek to Remove Constraints on Contract Authority

In recent years, HCFA has sought legislation that would loosen its constraints and allow it to contract in new ways. HCFA has once again made legislative proposals that would make explicit its authority to award contracts

- to any type of competent business or public entity to perform functions now done by the intermediaries and carriers;
- for just one or a subset of the functions now performed by the Medicare fee-for-service contractors; and
- using any method of payment appropriate for the contract, without the current restrictions.

Authority to Contract With Other Than Health Insurers Would Expand HCFA's Options

Historical circumstances explain why Medicare law differentiates between intermediaries and carriers and why, from the outset, the government has contracted with only health insurers to process program claims. Before Medicare's enactment in 1965, providers feared that the program would give the government too much control over health care. To achieve Medicare's acceptance, the program was designed to (1) only include hospital insurance (Medicare part A) for senior citizens and (2) be administered using insurance plans, like Blue Cross, that were already processing private claims submitted by hospitals. For example, the national Blue Cross Association,¹⁸ to which many of these plans belonged, was chosen to act as an "intermediary" between the government payer and many hospitals.

The decision to cover physician services (Medicare part B) was a late development, thus leading to a claims administration arrangement separate from the intermediary version. The commercial insurance

¹⁷These 58 contractors are actually part of only 44 different companies. In addition, two companies with five contracts are planning a merger, and another with three contracts has agreed to buy a smaller company with only a single contract. Also, four intermediaries have announced their intention to withdraw from Medicare service before the end of fiscal year 1999.

¹⁸At that time, the Blue Cross Blue Shield Association was two separate entities: the Blue Cross Association and the Blue Shield Association.

industry and certain Blue Shield plans were chosen by geographic locale to process physician claims as “carriers.” Unlike intermediaries, all carriers contract directly with HCFA.

The Congress did not mandate that either intermediaries or carriers be used for the administration of the Medicare program. It did, however, authorize the Secretary of Health and Human Services to contract with such entities and clearly expected that this would happen. Nonetheless, HCFA believes that it needs a legislative change in order to contract with other than health insuring organizations for functions currently performed by carriers and intermediaries and to choose intermediaries without using the current provider nomination process. Because of this belief—bolstered by the clear intent of the Congress, HCFA practice, and HCFA’s interpretation of the Social Security Act—intermediaries and carriers have been limited almost entirely to established health insurance companies.

To encourage hospitals to participate in the new Medicare program by giving them some choice in their claims processor and to protect current relationships between hospitals and health insurers, the Medicare statute contained a provision called “provider nomination.” This provision authorized, but did not mandate, a system that allowed the professional associations of hospitals and certain other institutional providers to choose claims processing contractors on behalf of their members. When the program began, the American Hospital Association nominated the national Blue Cross Association to serve as its intermediary.¹⁹ In 1966, the Association entered into a prime contract and subcontracted with 74 local member Blue plans. Currently, the Association is one of Medicare’s five intermediaries and serves as prime contractor for 32 local member plan subcontractors that together process over 85 percent of all benefits paid by intermediaries. All intermediaries are also health insurance companies.

Under the prime contract, when one of the local Blue plans declines to renew its Medicare contract, the Association—rather than HCFA—chooses the replacement contractor. For example, the local Blue plan for Minnesota recently announced that it would soon be giving up its Medicare part A business. Because the hospitals serviced by the Minnesota plan had nominated the Association to serve as their intermediary, the

¹⁹The nominated intermediaries initially chosen were the Blue Cross Association, nine commercial insurance companies, two independent plans, and one state agency. The Association paid claims at that time for most of the nonprofit community hospitals and 87 percent of all hospitals. The Association was also selected by more than half of the extended care facilities in the country. As a result, the Association was responsible for many more providers than the other 12 intermediaries first chosen. No new intermediaries have been named since December 1969, when one of the initial intermediaries was replaced.

Association conducted a competition among any interested member plans and named Noridian Government Services, formerly known as Blue Cross and Blue Shield of North Dakota, as Minnesota's successor. This process effectively limited HCFA's flexibility to choose a commercial plan or even a different local Blue plan to replace a local Blue plan that was withdrawing from the program.

Similarly, the government was authorized, but not mandated, to contract directly with individual carriers that were existing payers of health care services for the processing of physician claims.²⁰ The pool of eligible contracting companies has been limited almost entirely to established commercial health insurers and Blue Shield plans. Currently, HCFA contracts with about 22 carriers, of which about two-thirds are local Blue Shield plans that process about 60 percent of all part B claims.

Using health insurers entailed certain conflicts of interest. As Medicare contractors, these companies had control over sensitive health status information and payment decisions that could be used to improperly benefit their private lines of business. These inherent conflicts were acknowledged in the companies' Medicare contracts, which included provisions prohibiting the improper use of privileged information. In addition, the companies responsible for paying Medicare claims were the same companies responsible for later checking that these payments had been made appropriately. More recently, additional conflicts were introduced when insurance companies serving as Medicare contractors began establishing health maintenance organizations and provider networks. The fundamental conflict under such circumstances occurs when a company responsible for reviewing the appropriateness of Medicare claims is also a corporate partner with hospitals, physician networks, and other providers billing the program.

Under HCFA's proposal to repeal the provider nomination authority and the requirement that all carriers be health insurers, HCFA would be free to select its own contractors. The repeal of the nomination authority would allow HCFA to eliminate the prime contract arrangement with the Blue Cross Blue Shield Association. Under the proposed change, whenever a Medicare subcontract is not renewed for a local Blue plan serving as an

²⁰Under section 1842(f) of the Social Security Act, a "carrier" is (1) "a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization" or (2) a Medicare intermediary.

intermediary, HCFA would be able to award that contractor's workload to any company or combination of companies—including those outside the existing contractor pool—and would no longer be limited to using a plan selected by the Association. In fact, the merit of this nomination authority has been questioned for nearly three decades. In 1970, a Senate Finance Committee report concluded that the original purpose of the provision for provider nomination of the intermediary has largely been served and that with the maturation of Medicare, the Congress should consider modifying the provision.²¹ Similarly, the proposal to expand carrier eligibility criteria beyond the health-insurer-only restriction could also be used to increase the pool of eligible contractors.

Clarified Authority to
Award Functional
Contracts Could
Restructure Claims
Administration

Health insurers are not the only companies with experience and skills in some of the activities now performed by carriers and intermediaries, but until recently, HCFA has not tried to separately contract for specific claims administration functions. HCFA interprets its Medicare regulations, as well as the Social Security Act, as constraining it from awarding separate contracts for individual claims administration activities. HCFA believes it must obtain clarifying authority from the Congress to do otherwise, as it did recently for payment safeguards, or must publish a superseding regulation.²² Though HCFA is interested in trying to contract by function, Medicare intermediaries and carriers have expressed concern that contracting by function would be disruptive to their operations and the program. While HCFA could revise its regulations and remove some of the constraints on functional contracting, it has chosen for several years to approach the Congress for clarifying legislation so that all of the constraints can be addressed at once. In 1996, HCFA received new authority to contract separately for program safeguard functions. Implementing these functional contracts will give HCFA useful experience in the advantages and possible pitfalls to such contracts.

Regulations Limit HCFA's
Ability to Contract by Function

HCFA's regulations stipulate that, to qualify as a carrier or intermediary, the contracting organization must perform all of the Medicare claims

²¹Medicare and Medicaid: Problems, Issues, and Alternatives, Report of the Staff to the Committee on Finance, U.S. Senate, Feb. 9, 1970, p. 114.

²²HCFA has published proposed regulations that included language that would change these constraining provisions, but the provisions have never been included in a final regulation. Such language has been included most recently as part of the MIP proposed rule (63 Fed. Reg. 13,590, Mar. 20, 1998), which has not yet been finalized.

administration functions.²³ These functions include, among others, claims processing, adjudicating appeals of payment decisions, collecting debt and recovering overpayments, and responding to customer inquiries.

Under this all-or-nothing interpretation, HCFA requires each Medicare claims processing contractor to perform functions that could otherwise be consolidated into a single contract or a few regional contracts to achieve economies of scale. For example, in the fee-for-service Medicare program, each contractor conducts hearings on provider and beneficiary appeals of its own claims decisions. Despite the possible conflict of interest in reviewing its own corporate decisions and the possible inefficiency of operating an individual appeals function at each contractor, HCFA contends that Medicare regulations do not permit awarding a separate consolidated contract for a function such as appeals. In contrast, under different contracting authority used for the Medicare managed care program, which is composed of more than 300 health plans, HCFA consolidated the appeals function into one contract. Similarly, there are companies that could perform some of the functions currently performed by Medicare contractors. With the prospect of separate contractors for medical review activities included as part of the new program safeguard contracts, the argument that contractors for intermediary and carrier functions must be medically oriented is less persuasive. Functions such as printing and mailing or answering beneficiary inquiries might be more economically and efficiently handled under one or a few contracts.

The proposal to permit functional contracting could significantly restructure Medicare's contracting process. Coupled with the proposals that would broaden the choice of contracting entities, functional contracting could enable HCFA to make better business decisions in selecting and retaining contractors. HCFA could select companies on the basis of their particular areas of expertise, consolidate operations to achieve economies of scale, and, in some cases, mitigate the conflicts of interest that currently exist for most Medicare contractors.

On the other hand, functional contracting could introduce new problems into the Medicare program. After 30 years of integration, contractors' functions are not necessarily easy to separate. Contractor representatives told us that their claims processing systems are structured for end-to-end

²³Since 1965, the Medicare statute has required that intermediaries perform payment and payment determination functions as well as some or all of a number of listed functions. Carriers are required to perform some or all of a number of listed functions, which include payment and payment determination functions. Since 1980, regulations governing the functions of intermediaries and carriers have elaborated on their specific responsibilities and what they must do to meet them. 42 C.F.R. part 421.

claims administration activities. Having multiple companies doing different tasks in claims administration with the current claims systems could create coordination difficulties for the contractors, providers, and HCFA staff. As the functions best suited for separate functional contracts have not yet been determined, feasibility tests might be necessary for the success of such an initiative.

MIP Will Test Functional Constraints

HCFA's new efforts to contract for program safeguards will test the efficacy of functional contracting. The program safeguard authority is significant in that it is explicit and, potentially, enables HCFA to mitigate the conflict inherent when an entity processing Medicare claims is the same entity reviewing the claims for error. In addition, the new contracting authority provided under this program affords HCFA greater flexibility in selecting from among competing eligible entities, creating other-than-cost-based contracts, and awarding contracts to conduct specific sets of program safeguard functions rather than the full set of carrier and intermediary activities. This will also provide HCFA with experience in managing a competitive procurement.

HCFA's goal for program integrity is to make correct and prompt payments to legitimate providers for appropriate services rendered to eligible beneficiaries. Accordingly, payment safeguard functions to be performed under the MIP contract include reviewing providers' claims (medical, utilization, and fraud reviews); auditing providers' and managed care plans' cost reports; performing MSP reviews and recovering erroneous program payments; educating providers and beneficiaries about program integrity issues; and maintaining lists of durable medical equipment items requiring prior approval.

However, HCFA's efforts to implement new contracting authority under MIP have moved more slowly than anticipated, suggesting that contracting changes—and any resulting benefits from them—will take time to be fully realized. Over 2 years elapsed before HCFA had a contract and was ready to seek contract bids; the request for proposals was not released until September 1998. In its proposed rule, which includes provisions on the MIP payment safeguard contract, HCFA outlined its strategy to “implement the MIP incrementally in a manner that will provide a way to test alternatives and to transition integrity activities to MIP contractors.” HCFA announced its award of 12 contracts in May 1999. Time will be needed to award task orders, transition workload, and allow contractors to perform the task order functions before an assessment of the program can be made. Also, HCFA does not plan to transfer any workload from the existing contractors

until it is determined that they have successfully implemented year 2000 computer changes.

In preparing to issue a request for proposals (RFP) for the payment safeguard contracts, HCFA had to grapple with several problems similar to those it would face if given the opportunity to implement similar, but more broadly based, contracting changes. For example, HCFA had to define the payment safeguard functions in enough detail in the statement of work so that bidders could understand the functions well enough to allow them to prepare competitive bids. Implementation decisions on task orders in addition to those already released must still be made. The RFP called for the award of one or more contracts with

- uncertain delivery dates;
- no delineation of which functions within the program integrity statement of work are to be performed;
- the possibility of cost-based reimbursement, firm fixed-price, or time and materials pricing arrangements;²⁴ and
- no identification of which geographic areas will be served.

The 12 companies that HCFA competitively awarded MIP contracts will be eligible to bid on MIP task orders for specific work to be performed within specified time periods under a stated reimbursement method in a specified area. Contractors may refuse any particular task order. HCFA has no obligation to issue any particular task order and will merely be bound by its commitment to offer each contractor a task order worth at least \$50,000 during the contract term. While a bidder had to bid for the whole range of possible MIP work and could not bid just for a portion of it in which it might have special expertise, HCFA reserves the right to award any or all of the possible MIP work for a geographic or substantive area to one contractor.

Even after full implementation of the MIP contracts, including the transfer of program safeguard activities to the new MIP contractors, HCFA must continue to manage its intermediaries and carriers. To control attrition among them, we believe HCFA must determine what incentives can be offered to those whose program integrity functions are transferred to MIP contractors. Achieving a successful balance between the effective implementation of the new MIP authority and preservation of the current

²⁴Firm fixed-price contracts require a contractor to perform all specified tasks and activities for an agreed-upon price, no matter what the actual cost is to the contractor. (48 C.F.R. 16.202-1.) Time and materials pricing contracts provide for acquiring goods or services on the basis of labor hours at a fixed hourly rate and materials at cost. (48 C.F.R. 16.601.)

system of intermediaries and carriers, which will continue to process fee-for-service Medicare claims, answer inquiries, and conduct hearings, will be a formidable challenge. The MIP implementation will also give HCFA needed experience that could be used to help implement the additional contractor management changes it is seeking.

**Past Experience Suggests
Caution When Adding
Financial Inducements for
Medicare's Claims
Processing Contractors**

Medicare law generally requires intermediary and carrier contracts to be based on costs. Contractors are paid for the necessary and proper costs of carrying out Medicare activities but are not permitted to make a profit. HCFA pays contractors on a unit-cost basis²⁵ up to a targeted amount. If a contractor's costs exceed the target during the contract year, the contractor can request supplemental funding. While not able to earn profits, contractors can benefit when Medicare pays a share of corporate overhead. In addition, Medicare has paid for innovations in the program, particularly in electronic claims technology, knowledge, and experience, which some Medicare contractors have been able to transfer to their private businesses. Nevertheless, the adequacy of current contractor funding to fully cover costs is in dispute and may be contributing to contractors withdrawing from the program. HCFA has offered other-than-cost-based contracts in the past, using first its demonstration authority and later its limited authority to use such contracts, as an inducement to contractors, but some of these experiments have had problems.

HCFA's contracts differ from standard government contracts in ways that affect contractor reimbursement for specific work done. Unlike other federal contracts, HCFA's claims administration contracts do not contain conventional statements of work detailing the tasks and activities to be performed and relating those particular tasks to the price or budget to perform them, but rather incorporate by reference all regulations and general instructions issued by the Secretary of Health and Human Services.²⁶ Such an arrangement gives HCFA flexibility to ask contractors to add specific tasks without going through a formal contract amendment coupled with either additional payment or abatement of other contractually required activities. However, such an arrangement makes less clear the specific tasks and activities that HCFA expects contractors to

²⁵These unit costs are based on updated historical cost data, adjusted for the contractors' mix of claims.

²⁶Intermediary and carrier contracts list types of functions to be performed, but these short lists of a page or two do not compare with the complete descriptions, as found, for example, in the MIP solicitation, which exceeds 100 pages.

accomplish. It has also left HCFA with a lack of experience in pricing those claims administration tasks and activities that may make moving beyond cost-based reimbursement difficult.

Contractor budgets for claims administration have been falling relative to the volume of claims they process. Before fiscal year 1996, contractor budgets were based on an amount per claim—up to a target—for all claims administration activities, including program safeguard activities. After fiscal year 1996, program safeguards were funded separately, but other claims administration activities are still budgeted on a per-claim basis, up to the preset target. In the past two decades, the cost per claim has dropped significantly. Between 1975 and 1997, the amount per claim was reduced by two-thirds without consideration of inflation over the period. Reducing this amount reflected HCFA's strategy to achieve program savings from increased use of electronic claims processing. However, our past studies showed that program safeguards funding did not keep up with claims volume, which left Medicare vulnerable to unnecessary program outlays and erroneous payments. Although separate funding for program safeguards is now guaranteed through the MIP, contractors continue to express concern that the payments they receive do not fully cover their claims administration costs.

One contractor representative summed up the dilemma of contractor reimbursement by stating that:

“Some contractors have found that Medicare reimbursement of their operating costs is so inadequate that . . . they are subsidizing Medicare operations. Once a thorough analysis of corporate finances reveals this imbalance, a corporation must decide whether it can balance the books by achieving economies of scale or whether there is some benefit to being a Medicare contractor that makes it worth paying the government for the privilege.”

The constraints on earning a profit make participation in the Medicare program less attractive to some current contractors. Initially, the prestige of serving as a Medicare contractor and the advantages of having the government pay a share of overhead costs and being introduced to new automation technology were sufficient to encourage companies to participate in Medicare. Today, however, some of these companies are refocusing their business interests on more lucrative enterprises, such as managed care plans and physician networks, according to the Blue Cross Blue Shield Association and commercial insurer representatives. When these companies consider whether to renew their Medicare contracts,

HCFA is not in a position to offer financial incentives for their continued participation.

Under the proposal to repeal the cost-based contract restrictions, HCFA would be free to award contracts that would permit contractors to earn profits. HCFA's past experiments with financial incentives, however, generally have not been successful and raise concerns about the success of any immediate implementation of such authority without further testing.

HCFA's experiments with both competitive fixed-price-plus-incentive-fee contracting and adding financial incentives to cost-based contracts have had significant problems. Between 1977 and 1986, eight competitive fixed-price contracts, designed to consolidate the workload of two or more small contractors, were established on an experimental basis. Under these fixed-price-plus-incentive-fee contracts, contractors knew the gain or loss to them from specific ranges of performance of certain activities and concentrated on maximizing reimbursement, to the detriment of other activities.

Our 1986 report noted that three of the contracts generated administrative savings.²⁷ Two of the contracts resulted in over \$130 million in benefit payment errors (both overpayments and underpayments), so that much of the estimated \$48 million to \$50 million in administrative savings attributed to the more successful experiments may have been offset by payment error losses. One of the contractors that appeared successful in 1986, having the potential to achieve some administrative savings—the Health Care Service Corporation (Blue Cross Blue Shield of Illinois)—has since agreed to pay a \$4 million criminal fine and a \$140 million civil settlement for fraudulent and improper activities conducted between 1984 and 1997. This contractor pleaded guilty to eight felony counts in response to allegations that it had failed to safeguard program dollars by paying claims with Medicare funds that should have been paid by other insurers, paying claims for durable medical equipment without checking for medical necessity, and paying claims under \$50 without properly screening them.

Beginning in 1989, HCFA provided financial incentives in several cost-based contracts when it was given some limited authority to award other-than-cost contracts. Incentives were offered to a few contractors to lower claims unit costs and to improve performance in some safeguard

²⁷Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 22, 1986).

activities. HCFA found that some of the self-reported data contractors used to claim incentive payments were inaccurate. In one case, the financial incentives would not have been paid had a contractor with integrity problems not cheated by “correcting” errors in about a quarter of the 60 claims that were going to be reviewed by HCFA.

HCFA’s contracting proposals, besides giving HCFA new authorities, would require a move to competitive contracting in some situations and will thus likely require more initial managerial time and effort than maintaining the current contracting arrangements. In our 1986 report, we questioned HCFA’s ability to manage a large number of competitive contracts. Such contracts require more resources in the beginning of the contracting process for activities not needed for traditional cost-based contracts, such as preparing requests for proposals, evaluating proposals, and awarding contracts. In addition, competitive contracting would increase the need to transition-in new contractors, and HCFA has found that such transitions require additional staff time and travel funds to accomplish successfully. However, HCFA believes that competitive contracting will reduce costs and increase efficiency in the long run.

Feasibility Testing Needed to Facilitate Transition to New Contracting Environment

The combination of contracting proposals sought by HCFA might enable it to broaden its pool of eligible bidders, improve the administration of Medicare claims, and increase options for attracting and retaining contractors. However, HCFA’s experience in designing the payment safeguard specialty contract suggests that sufficient time should be allowed to test the feasibility of certain concepts before implementing them. Furthermore, HCFA’s past experience with other-than-cost contracting suggests that its new approaches must be carefully thought through so that the incentives that are built into the contracting arrangements improve, rather than weaken, program administration.

HCFA would need to test the practicality of separating functions that single contractors have performed for over 30 years. Insurance industry representatives commenting on this issue contended that HCFA would need to ensure coordination among the multiple companies performing different Medicare functions, each using different automated systems to administer a set of claims. They noted that some functions, like hearings and appeals, might be more conducive to performance in isolation. Likewise, building on past experience, HCFA would need to test ways to offer financial incentives that would not foster incentives to submit false data or neglect critical functions.

Chapter 3
HCFA Would Need Time and Careful
Implementation to Benefit From New
Contracting Authority

Unlike the other proposals, the repeal of provider nomination raises few initial implementation concerns. Allowing HCFA to award intermediary contracts as it determines necessary for the administration of the Medicare program might contribute to the efficiency and effectiveness of the program. With this change in authority, if HCFA is faced with additional Blue contractors unwilling to continue service to the program or unfit because of performance or integrity problems, it could assign intermediary workloads in whatever way makes the most sense.

HCFA does not yet have a strategy for use of the proposed authorities, but it has become increasingly concerned that the diminishing pool of current contractors will not have the capacity to meet the future needs of the Medicare program. The experience gained under the MIP program in functional contracting will be valuable in devising a strategy. If the contracts are awarded to entities outside the current contracting pool, and a payment method other than cost reimbursement is used, additional lessons can be learned. However, the delay in implementing MIP, as well as the time necessary to conduct meaningful evaluations of this contracting approach, means that few immediate benefits can be expected from the strategic use of any new authority granted to HCFA.

Conclusions, Recommendations, and Agency Comments

Conclusions

Medicare's fee-for-service program pays out the lion's share of program dollars expended by HCFA. With billions of dollars at risk, it is a business that must be carefully monitored. During the last 9 years, HCFA, the HHS OIG, and the Department of Justice have found instances of contractors "cooking the books" to appear to meet HCFA's requirements. Yet HCFA conducts limited review of contractor activities to ensure that contractors are accurately processing claims and safeguarding Medicare dollars. In its monitoring and oversight of contractors, HCFA has generally accepted financial and workload information as presented, without verifying contractors' self-certifications that internal controls are working effectively and without systematically validating that financial and workload information is accurately reported. Until HCFA starts regularly assessing that contractor internal controls are working effectively and that contractor performance and financial information is accurate, it cannot be assured of contractors' integrity, that their payments to providers are accurate, and that they are fiscally responsible in their handling of Medicare funds.

HCFA's current contractor evaluation process has the virtue of allowing regions to focus on contractor weaknesses they may have identified. However, in our opinion, HCFA has not regularly guided its regions in using their limited oversight resources most effectively. Contractor oversight could be strengthened if HCFA balanced an appropriate level of regional discretion with sufficient effort to (1) establish measurable contractor performance standards—particularly in the program safeguard area, (2) set programwide priorities for the assessment of all contractors on core performance standards, and (3) develop a standardized report format that will facilitate comparisons of contractor performance and the use of trend data that will allow for longitudinal assessments of individual contractor performance. Setting clear standards and priorities and measuring contractors on how well they meet the priorities would give HCFA a clearer picture of how well contractors are performing. This also would help HCFA determine which contractors should be given increased work. In addition, giving contractors clear and consistent direction would help meet HCFA's priorities.

Relatedly, HCFA has not established a mechanism for reviewing regions' oversight for consistency and uniformity and for sharing effective regional oversight strategies. To do so, HCFA needs an organizational structure for contractor oversight that will ensure that regions are evaluated on, and held accountable for, the quality of the oversight they provide to contractors. HCFA headquarters offices must also be accountable to regions

for providing adequate policy guidance and direction so that regional oversight can be effective. HCFA has begun to address its headquarters structure as far as communications is concerned, but it still needs to address the issue of regional accountability. Headquarters should be able to enforce minimum standards for contractor oversight and provide formal feedback to the regions to improve their performance. HCFA also needs a mechanism to regularly share best practices and to ensure that regional oversight staff adopt best practices as they review contractors. Finally, despite its numerous integrity reviews, HCFA has not incorporated the information gained through them to improve routine contractor oversight.

Doing more consistent and thorough oversight may require HCFA to allocate more of its resources to these activities. But given the HHS OIG's estimate of over \$12 billion in improperly paid fee-for-service claims and current concerns about fraud, such an investment seems prudent.

Because of statutory requirements and established practices, HCFA contracts out claims administration to a shrinking pool of companies whose private interests are increasingly competing with their Medicare responsibilities. HCFA is seeking legislative remedies—including explicit authority to contract in different ways. But even if the Congress grants these authorities, HCFA would need time, additional information, and experience to properly implement them. Eliminating provider nomination, removing the requirement to contract only with health insurers, as well as allowing HCFA to more freely use other-than-cost contracts would give HCFA more control over which companies to use as contractors. In addition, doing so might broaden the pool of prospective contractors. Allowing HCFA to conduct more functional contracting might make Medicare more efficient. Yet HCFA's experience with the MIP and with previous other-than-cost contracts suggests that many carefully considered intermediate steps need to be taken before HCFA can realize the benefits of such legislative changes. HCFA would need to proceed cautiously, evaluating its implementation of such changes, to be sure that the changes would ultimately benefit the Medicare program. For that reason, over the long term, HCFA could benefit from a strategic plan for routinely conducting competitive procurements and managing claims administration contractors. This plan could be used as a guide on the path from HCFA's current contracting mode to a new one. HCFA could design this plan to help it determine (1) which contractor activities are most conducive to functional contracting, (2) which activities could be performed by other than health payers, (3) better cost information to facilitate the move to competitive contracting, (4) the functional contracts

that might be conducive to other-than-cost payments, and (5) the feasibility of building financial incentives into the contracts.

Legislative change will not solve HCFA's oversight problems. Even if the Congress grants HCFA the contracting changes it is seeking, the agency will still have to make sure that it addresses the weaknesses associated with its management and oversight of the contractors. Also, if it is authorized to contract in new ways, it will have to customize its oversight to each new type of contract it awards.

Matters for Consideration by the Congress

The Congress may want to consider giving HCFA explicit authority to award functional contracts for selected claims administration activities to any appropriate type of company and to offer other-than-cost contracts, both at the discretion of the Secretary of Health and Human Services. Also, in view of the possible advantages for managing the Medicare program, the Congress may wish to consider amending the Social Security Act to repeal provider nomination and to allow the Secretary to choose the companies with which HCFA will contract.

If the Congress decides to grant HCFA any of the additional contracting authorities it is seeking, the Congress should consider requiring HCFA to report on its implementation of this new authority with an independent evaluation to ensure that these administrative changes improve the efficiency and effectiveness of Medicare program operations.

Recommendations to the Administrator, Health Care Financing Administration

To improve oversight of Medicare's claims administration contractors, we recommend that the HCFA Administrator take the following actions:

1. Establish a contractor management policy that requires
 - verification that each contractor has the internal controls necessary to ensure the adequacy of its operations, starting with the controls most critical for ensuring the financial integrity of the Medicare program; and where controls are weak or lacking, require contractors to strengthen or establish them; and
 - systematic validation of statistically significant samples of essential contractor-reported data.
2. Improve annual assessments of contractors by

- developing a comprehensive set of clearly defined and measurable performance standards, including measures to test how effectively contractors are safeguarding program dollars; these standards should include collecting comparable baseline data on each contractor's claims administration and related activities;
- assessing all contractors regularly on core performance standards and reviewing any other activities identified through the risk assessment at individual contractors; and
- developing a performance report annually for each contractor that includes contractor performance on the core standards and other HCFA-assessed standards, using a uniform format that permits comparisons across contractors as well as longitudinal assessments of individual contractors.

3. Designate a HCFA unit to be responsible for

- evaluating the effectiveness of contractor oversight policy and procedural direction provided by headquarters staff to regional offices' staff,
- evaluating regional office performance in conducting contractor oversight activities based on those policies and procedures, and
- enforcing minimum standards for the conduct of oversight activities.

4. Ensure that all HCFA staff responsible for contractor oversight learn about contractor problems and best practices and that contractor review staff adopt best oversight practices.

5. Develop a strategic plan for managing Medicare's claims administration contractors that would include how HCFA intends to use the new authorities it is seeking, the information it will gain by evaluating its current efforts to contract for program safeguard activities, and the results of previous fixed-price and incentive contracting experiments. To do this, HCFA should

- assess the feasibility of contracting for specific functions—that is, contracting separately for activities such as hearings and appeals, inquiries and complaints, and printing and mailing;
- determine which functional contracts could be performed by entities other than health care payers;
- determine the cost of each of the various contractor functions now performed by intermediaries and carriers;
- determine which functional contracts would be conducive to the use of other-than-cost contracts; and

-
- assess the feasibility of building in financial incentives for exceeding performance standards or for developing innovative practices that improve claims administration and can be replicated by other contractors.

Agency Comments and Our Evaluation

In written comments on a draft of this report, HCFA agreed with each of our recommendations. Appendix I contains HCFA's general as well as specific comments on each recommendation and its plan for implementing each one. HCFA also provided technical comments, which we incorporated in the report as appropriate. In addition, HCFA listed several other activities that it believes will help to improve and strengthen its contractor management and oversight. Overall, we believe that HCFA has outlined a series of activities to respond to our recommendations that—if properly designed and carried out—should go a long way toward improving its management and oversight of the contractors that engage in claims administration activities for the Medicare program.

With regard to verification of internal controls and contractor-reported data, HCFA said that it is hiring an independent public accounting firm to develop standard review procedures and methodologies for the evaluation of documentation supporting the annual certification of internal controls. This firm will prepare individual contractor review reports and recommend improvements in the internal control certification and evaluation processes. On the basis of the result of the firm's internal control reviews, HCFA said it will also consider using accounting firms to conduct even more in-depth internal control audits. HCFA said it will develop a protocol for validating contractor-reported performance data in fiscal year 2000, which will serve as the basis for data validation reviews beginning in fiscal year 2001.

For our recommendation to improve annual contractor assessments, HCFA lists a number of steps it will take during its fiscal year 1999 assessment cycle. These include establishing core evaluation areas, promoting greater consistency through the use of standardized protocols and national review teams for on-site reviews, and using accounting firms to evaluate the quality of the contractors' provider audits. Concerning performance standards, HCFA said that it will emphasize the development of outcome measures, including development of a contractor-specific claims error rate, assessing the effectiveness of contractor education and outreach activities to reduce provider billing errors, and developing a contractor-specific "fraud rate." To assist in these measurement efforts, HCFA is developing a new management reporting system that will use data

derived directly from contractor claims processing systems rather than relying on contractor-reported data.

HCFA said that it will assign responsibility for evaluating the effectiveness of regional office oversight to its newly reorganized contractor management group in headquarters, will take steps to share best practices, and will develop a business strategy for contractor management that will include plans for implementation of any new contracting authority.

Comments From the Health Care Financing Administration

Note: HCFA's technical comments are omitted.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

Ms. Leslie G. Aronovitz
Associate Director
Health Financing and Public Health Issues
General Accounting Office
441 G. Street, N.W.
Washington, D.C. 20548

Dear Ms. Aronovitz:

As requested, the Health Care Financing Administration (HCFA) has reviewed the General Accounting Office draft report entitled, "Medicare: Despite Its Efforts, HCFA Cannot Ensure Integrity of Claims Contractors" (GAO/HEHS-99-115). I would like to thank you for the opportunity to review the draft report. I would also like to express my thanks to you and your staff for your work on this report.

We have taken a number of steps to strengthen oversight of the contractors who pay and process Medicare claims for the health care of nearly 40 million beneficiaries, and your recommendations provide invaluable support for the work we have been doing. Among the most important steps we have taken to date is to restructure the contractor management function within HCFA. In November 1998, I consolidated responsibility for contractor management within the Agency, establishing the position of Deputy Director for Medicare Contractor Management within the Center for Beneficiary Services. I believe this change will substantially strengthen our contractor oversight in the future.

The law that created Medicare in 1965, required the program to use contracts with the private insurance companies that already served as payers of health care services. These contractors, which in 1966 numbered more than 130, are responsible for all aspects of claims administration. Now, only 58 Part A and Part B contractors handle nearly 1 billion claims from more than 1 million providers annually.

The Social Security Act required HCFA to pay contractors based on their allowable costs, so there would be no penalty nor profit incurred by the insurance companies. Today, this provision limits HCFA's ability to use marketplace competition to get better value for the taxpayer. For example, back in 1965, all Medicare claims were submitted on paper.

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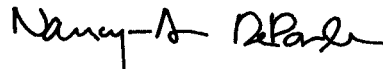
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Today, the majority of claims are processed electronically. With the technological and performance imperatives rapidly changing, we need additional flexibility in contracting to manage this important work.

HCFA has proposed contracting reform legislation numerous times since 1993. If enacted, this legislation would provide the Secretary with more contracting flexibility, bring Medicare contracting more in line with the standard contracting procedures used throughout the Federal government, and create an open marketplace so we do not have to rely on a steadily shrinking pool of contractors. We are pleased that the GAO shares our view regarding the need to update our contracting authorities.

Attached are our comments on the specific recommendations in the report, followed by a few general comments and some technical comments.

Sincerely,



Nancy-Ann Min DeParle
Administrator

RECOMMENDATIONS

To improve oversight of Medicare claims administration contractors, we recommend that the HCFA Administrator take the following actions:

GAO Recommendation #1

Establish a contractor management policy that requires: verification that each contractor has the internal controls necessary to assure the adequacy of its financial and performance operations, starting with the controls most critical for ensuring the financial integrity of the Medicare program; and where controls are weak or lacking, require contractors to strengthen or establish them; systematic validation of statistically significant samples of essential contractor reported data.

HCFA Comment:

HCFA agrees. We recognize the importance of validating our contractors' internal controls and validating reported data, and we have specific activities underway to achieve these goals.

We are hiring an Independent Public Accounting (IPA) firm to develop standard review procedures and methodologies to evaluate contractor documentation in support of annual self-certification of internal controls. In addition to preparing individual contractor review reports, the IPA firm will recommend best practices, improvements in the management control certification process and improvements in management control evaluation activities. At the same time, we are evaluating the resources required to do a sample of internal control reviews each year.

Based on the results of the internal controls reviews, we will also consider contracting with accounting firms to conduct even more in-depth SAS-70 internal control audits which examine in detail the adequacy of the contractors' internal controls policies, procedures and documentation..

We also plan to issue a contract in FY 2000 to develop a protocol for validating performance data reported to HCFA by the contractors. This protocol will serve as the basis for data validation reviews that will begin in FY 2001.

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GAO Recommendation #2

Improve annual assessments of contractors by: developing a comprehensive set of performance standards, including measures to test how effectively contractors are safeguarding program dollars. This should include collecting comparable baseline data on each contractor's claim administration and related activities. Assessing all contractors regularly on core performance standards and reviewing any other activities identified through the risk assessment at individual contractors. Developing a performance report annually for each contractor that includes contractor performance on the core performance standards and other HCFA assessed standards, using a uniform format that will permit comparisons across contractors as well longitudinal assessments of individual contractors.

HCFA Comment:

We agree, and again are taking steps to achieve these objectives. The FY 1999 Contractor Performance Evaluation (CPE) review program contains a set of ten core evaluation areas. For each area, there are nationally standardized review reporting requirements. In addition, we have developed nationally standardized protocols in key evaluation areas and are working on additional standardized protocols to further the consistency of our reviews nationwide. In addition to the nationally standardized review reporting requirements, we have standardized national management information reporting requirements, including tracking reports and data reports, and we will be training the regional offices on the proper use of these standardized forms.

To promote greater consistency, HCFA is using national review teams for onsite reviews. These teams are being assembled for many contractor reviews, and our goal is to increase the number of these types of reviews. Some review activity, such as provider audit quality will be evaluated through contracts with accounting firms, using a standard review protocol.

We agree that program integrity performance standards are essential. Contractor medical review and benefit integrity units are core evaluation areas for the contractors identified through risk analysis for more intensive reviews in FY 1999. Improving contractor functions essential to program integrity, such as medical review, benefit integrity, and provider enrollment, was a central focus of HCFA's Comprehensive Plan for Program Integrity issued in February.

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We have already made significant progress in enhancing contractor oversight in these areas. In the past year, we have tightened evaluation standards for contractor medical review and benefit integrity units and have developed core standards for the medical review and benefit integrity units. To evaluate these activities, we collect quantitative information to identify strengths, weaknesses and improvements over previous periods. This information is assessed, validated and tracked to its original source.

With respect to future performance standards, we have made a conscious choice to emphasize the development of outcome measures. For many years, contractor performance in program integrity was based on quantitative output measures including return on investment, cases referred to the OIG, recoupments, etc. These are items that need to be tracked, and are indicators of performance, but they do not provide critical information on whether contractor activities are resulting in desired outcomes. For example, a review based on the number of case referrals to the OIG does not provide information on the quality of the referrals. Below are some examples of our activities to develop and/or test outcome-related measures:

- we are modifying the methodology used to calculate the national Medicare fee-for-service error rate (which has dropped 45% in two years) to apply it at the contractor level and develop contractor-specific error rates;
- we are pilot testing a method--called the Provider Compliance Rate (PCR) methodology--to assess the effectiveness of contractor education and outreach activities on reducing provider billing errors; and
- we have developed a methodology to provide a contractor specific "fraud rate"

To assist us in these measurement efforts we are also developing a new management reporting system--Program Integrity Management Reporting (PIMR)--that will use data derived directly from contractor claims processing systems, as opposed to our current management system, which uses self-reported contractor data. The PIMR system will use information directly from contractors' standard claims processing system to provide data about contractor activities and outputs. In addition to providing HCFA with valuable, quantitative information regarding the contractors' program integrity efforts, this automated reporting mechanism will significantly increase the reliability and usefulness of contractor activity data.

The Budget and Performance Requirements (BPR) for Fiscal Year 2000 also highlight our commitment to improving the effectiveness of medical review and benefit integrity activities. Both the medical review and benefit integrity requirements call for the implementation of quality improvement programs.

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With respect to using risk assessment to target review resources, we are further developing a structured risk assessment protocol to be used at both the national and regional level for the FY 2000 evaluation cycle to set priorities and commit resources. In FY 1999, we have selected contractors for more intensive review based on a national risk assessment which considers such factors as claims volume, administrative costs, benefit payments, integrity issues and past performance.

One important risk assessment tool is coming out of HCFA's Y2K compliance effort. The Pulse System is being designed as an initial post Y2K monitoring and early warning system, but it will have long term utility as a contractor workload and risk management tool. Specifically, the system will identify variances and monitor system performance as close to real-time as possible. Workload statistics from each Medicare contractor will be collected and sent to HCFA on a daily basis. The system will then tabulate the data, compare it against calculated norms, and group it in such a way as to help HCFA identify potential problems as well as whether a potential problem is isolated or is common to all contractors.

Finally, we agree with the recommendation for uniform formats for annual performance reports. The Report of Contractor Performance (RCP) is HCFA's annual formal notification to contractors with respect to their overall performance for the fiscal year. For FY 1999, HCFA is standardizing the report format. In addition, we are requiring use of standard definitions of adverse CPE findings (e.g., "program deficiency" and "program vulnerability") and issuing clear instructions on when to require a Performance Improvement Plan. The regional offices are being trained in the use of the new reports and report definitions. Further, central office staff is reviewing a sample of CPE Reports for consistency with report preparation guidelines. These reports summarize the results of individual reviews and serve as the principal input into the RCP. Feedback is being provided to each regional office; lessons learned will be shared with all regions. This process will be incorporated in our yearly performance evaluation practices.

GAO Recommendation #3

Designate a HCFA unit to be responsible for: evaluating the effectiveness of contractor oversight policy and procedural direction provided by the central office staff to the regional office staff, evaluating regional office performance in conducting contractor oversight activities based on those policies and procedures, and enforcing minimum standards for the conduct of oversight activities.

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HCFA Comment:

HCFA agrees and responsibility for evaluating the effectiveness of Regional Office oversight of contractors will be housed within HCFA's Medicare Contractor Management Group, headed by Dr. Marjorie Kanoph. HCFA is also exploring the use of an independent evaluation of our oversight policy and procedures. HCFA began the groundwork for the evaluation of regional office performance by strengthening contractor evaluation in FY 1999, with national review teams, standardized reporting requirements, and national evaluation protocols. Several improvements to the contractor evaluation process will assist in the monitoring of regional office activities:

- ◆ To avoid having only those with day-to-day oversight also having responsibility for performance evaluations, onsite contractor reviews will be conducted mostly by teams composed of multi-regional or regional-central office staff.
- ◆ Major national team review efforts and reviews of contractors with field operations in more than one region's territory will have Project Leaders. The Project Leaders will be Associate Regional Administrators or Division Directors from central office.
- ◆ Reviewers will be required to adhere to timeliness requirements for completing performance evaluation reports; Associate Regional Administrators will issue the reports to contractors.
- ◆ As mentioned above, uniform requirements for CPE reports as well as for contractor evaluation management reports were established. Reports will be submitted to the Central Office that will include monthly reporting on the status of those performance evaluations and bimonthly reporting on the status of the performance improvement plans requested in the prior year's evaluations.

GAO Recommendation #4

Ensure that all HCFA staff responsible for contractor oversight learn about contractor problems and best practices and that contractor review staff adopt the best oversight practices.

HCFA Comment:

We agree and have begun developing a process for sharing this information. We will hold a conference at the end of the FY 1999 review cycle to build improvements into our FY 2000 review and to provide a face-to-face opportunity for national and regional consortia review team members to share experiences, including best practice information.

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This will be incorporated into normal procedures.

GAO Recommendation #5

Develop a strategic plan for managing Medicare's claims administration contractors that would include how HCFA intends to use the new authorities it is seeking, the information it will gain by evaluating its current efforts to contract for program safeguard activities, and the results of previous fixed-price and incentive contracting experiments. To do this, HCFA should assess the feasibility of functional contracting for specific functions, determine which functional contracts could be performed by entities other than health care payers, determine the cost of each of the various contractor functions currently performed by intermediaries and carriers, determine which functional contracts would be conducive to the use of other than cost contracts, and assess the feasibility of building in financial incentives for exceeding performance or for developing innovative practices that improve claims administration and can be replicated by other contractors.

HCFA Comment:

We agree and are currently developing a business strategy for Medicare fee for service contractor operations. Our strategy takes into account both past experience and current environmental factors, including the changing business environment for Medicare contractors. One of the primary goals of the business strategy is a more consistent approach to contractor performance management. A key question is the feasibility of functional contracting and different procurement approaches that would promote greater innovation in claims administration. We believe that the validation of different strategic approaches through limited pilots will be critical. Our strategy will include plans for implementation of our vital contracting reform legislation.

In this regard, we also agree with the GAO that our work with the new MIP Program Safeguard Contractors will be instructive. Through the Medicare Contractor Oversight Board, we will provide regular reports and data about the implementation of these contracts, as a way to use that experience in future contracting efforts for other functional areas. We will issue an annual report on MIP and our contracting efforts.

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We agree with GAO that the agency will need several years to reap the full benefits of the contracting reform legislation that we are currently seeking, and will incorporate implementation of this legislation into overall business strategy implementation.

With respect to determining the cost of each of the contractor functions, HCFA has taken initial steps to determine the feasibility of an "Activity-Based Costing" approach to identify the percentage of costs associated with particular functions within the claims processing and provider education activities.

GENERAL COMMENTS

Impact of Effective Oversight

HCFA agrees that there is a pressing need to improve contractor oversight and management, but cautions that these improvements alone will not be sufficient to impact some of the vulnerabilities mentioned in the report. There are several references to the Department of Health and Human Service's Office of Inspector General (OIG) estimate that Medicare contractors paid significant dollars for claims that did not comply with Medicare laws and regulations. The kind of errors identified by the OIG were associated with claims that, based on information submitted, were correctly processed by Medicare contractors. However, by looking beyond the actual claim to the medical documentation related to the service, the OIG determined that Medicare contractors had made improper payments. To address this vulnerability requires many activities--including more extensive and costly review of medical documentation associated with claims on a prepayment basis, more provider education, and improved contractor oversight and management.

Further, the Chief Financial Officer (CFO) error rate is not a proxy for specific contractor performance since it is based on a sample of selected intermediaries, carriers, regional home health intermediaries and durable medical equipment contractors. The CFO error rate is a better barometer of Medicare program expenditures as a whole.

The error rate is used as a measure of the collaborative efforts of HCFA, its contractors, law enforcement and providers, and we have seen great improvement. Medicare's fee for service payment error rate for FY 98 was 7.1 percent, or \$12.6 billion. This error rate is \$10.6 billion less than for FY 1996. The OIG attributed the error rate reduction to HCFA's efforts under the Medicare Integrity Program, fraud and abuse initiatives, improved provider compliance with Medicare reimbursement rules, HCFA/OIG efforts to emphasize provider compliance with Medicare documentation requirements to support services billed, and implementation of HCFA's corrective action plan.

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There are also references to contractors who have been found guilty of defrauding the Medicare program. While improved contractor oversight and management is an important tactic to safeguard against such behavior, intent to commit fraud is often hidden and difficult to uncover; therefore, whistle blowers and complaints will continue to be important avenues of uncovering such misconduct. In short, HCFA cannot rely on improved contractor management and oversight alone to solve problems such as the error rate identified by the HHS-OIG or contractor integrity problems. There will be a continued need to develop combined strategies based on the nature of the problem.

Authorized vs. Mandated Contracting

The report states that HCFA has a greater authority under Section 1874 of the Social Security Act to administer the Medicare program than the authorities provided under Sections 1816 and 1842. It is GAO's view that Section 1816 "authorized" contracts with nominated intermediaries and that Section 1842 "authorizes" the Secretary to contract with carriers, but that neither authority mandates contracts with those entities. Hence, GAO believes the broader contracting authority accorded the Secretary under Section 1874 would allow contracts with other than organizations that meet the qualifications under Sections 1816 and 1842. However, in over thirty years of Medicare contract administration, HCF has not viewed the Medicare authorities as giving the Secretary such broad contracting discretion. HCFA's view has been supported by its Office of General Counsel. Further, courts, such as the United States Court of Appeals for the Tenth Circuit in *Blue Cross Association, et al. v. Harris, et al.*, 664 F.2d 806 (10th Cir. 1981), have interpreted Sections 1816 and 1842 as mandating contracts with nominated intermediaries and carriers. Hence, while HCFA is currently seeking contracting flexibility, we do not concur with GAO's reading of our statutory authorities.

We do note that we have issued a draft regulation associated with implementation of contracting authorities under the Medicare Integrity Program, which alters the list of required functions carriers and intermediaries must perform.

Implementation of the Medicare Integrity Program

The report notes that HCFA's Program Safeguard Contractor (PSC) Request for Proposal (RFP) contained several open-ended requirements. This is because HCFA decided to establish an indefinite delivery indefinite quantity (IDIQ) type of contract with the PSC contractors. An IDIQ contract is appropriate when the exact times and/or exact quantities of future deliveries are not known at the time of contract award. The contract provides flexibility as changing needs arise and limits the government's obligation to the minimum amount specified in the contract (the minimum in the MIP PSC contract is \$50,000 over the life of the contract, not \$50,000 per year as indicated in the report).

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In this case, the IDIQ contract also facilitates HCFA's transition strategy after the year 2000. We are proceeding incrementally to ensure contractors can perform the work successfully before deciding whether to and how to transition program safeguard contractor work to MIP PSCs from carriers and intermediaries.

Contract specifics will be spelled out in specific task orders. The first six task orders were issued for comment at the same time as the IDIQ contracts were awarded.

Pre FY 1995 Performance Evaluation

The draft report notes HCFA's decision to redesign its contractor performance evaluation process for reviews effective FY 1995. The reason for this change was that many contractors were focusing too many resources on the functional areas that were reviewed, to the detriment of other functions. Under the pre-FY 1995 Contractor Performance Evaluation Program (CPEP) strategy, HCFA annually published, in the Federal Register, specified performance criteria and standards against which fiscal intermediaries and carrier would be evaluated, and those same criteria and standards were included in contractor manuals, along with the methods of evaluation. One of the unintended consequences of this approach was a number of integrity problems specifically relating to maximizing CPEP scores that were recently identified and successfully prosecuted. Another consequence was that contractors neglected important operational functions, while HCFA was unable to detect the deficiencies.

As a result of this experience, HCFA changed its policy so that, beginning in FY 1995, HCFA reviewers could evaluate any aspect of operations for which there was a contractual responsibility.

Medicare Secondary Payer Activities

With respect to MSP activities, the allocation of duties among contractors will be changing soon. On 2/1/99, HCFA issued an RFP to solicit proposals for a Coordination of Benefit Contractor as part of the Medicare Integrity Program. This contractor will consolidate all activities supporting the collection, management and reporting of all insurance coverage of Medicare beneficiaries who have other-than-Medicare coverage. Some front-end MSP data collection efforts that currently reside in carrier and intermediary operations will become the responsibility of this contractor. We are currently evaluating the proposals received. This contract is targeted for award in September 1999.

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Title of Report

We would suggest that you revisit the title of this report. The focus of the report is HCFA's management and oversight of the contractors' performance yet the phrase in the title "...Integrity of Claims Contractors" suggests that the focus is on fraudulent activities of the contractors that usually require the involvement of law enforcement.

ADDITIONAL HCFA ACTIONS

In addition to the actions noted above that we taking in conjunction with the GAO's recommendations, there are several other activities that we have undertaken that we would like to bring to your attention. We believe that these activities also will help to improve and strengthen our contractor management and oversight programs. Specifically:

Environmental Scanning

HCFA's Office of Strategic Planning recently completed an analysis of how other government agencies and private sector companies manage the contractors from whom they purchase goods and services. It was the goal of this project to: identify strategies that might assist HCFA in its oversight of the Medicare contractors; get a sense of how HCFA's contractor oversight efforts compare to those of other organizations in terms of strength, depth, and innovation; and, spark creative thinking about future contractor oversight activities.

The findings of this report and the best practices that it identified will serve as a useful reference tool as we formulate our future CPE plans.

Corporate Compliance Plans

HCFA is in the early stages of developing a standard corporate compliance plan for Medicare contractors. We hope to foster a culture at each contractor that promotes prevention, detection and resolution of conduct that does not conform to law, regulations and program requirements.

Stakeholder Feedback

Feedback from providers and beneficiaries is an important component of evaluating how well the contractor is fulfilling its program administration responsibilities. We are exploring ways to collect this feedback and use it both as a component of the contractor evaluation and as a source for systemic process improvements.

Internal and External Oversight Boards

As noted in the GAO report, HCFA has established a Medicare Contractor Oversight Board comprised of the Agency's senior managers with responsibility for the Medicare Contractors. In addition, HCFA is in the very early stages of establishing an External Advisory Council on the Management of HCFA. This entity would be an advisory body

that would be comprised of members from academia, private consulting, public and private sector health purchasing entities and private companies and tasked with providing HCFA with guidance on such issues as contractor oversight, training, customer service and cultural change.

Council for Excellence in Government

HCFA will be participating in the Council for Excellence in Government Fellows Program. Under this program, a number of managers will have the opportunity to participate in a year long developmental opportunity designed to challenge them into focusing on strategies and actions that lead to measurable results. One specific project that participants will be presented with is managing our work through third parties, e.g., Medicare contractors. The fellows also will participate in a number of site visits in both the public and private sectors.

Central Office - Regional Office Relationships

As part of a management initiative that HCFA is currently developing, a small team of senior managers has been established to examine reengineering the relationship between HCFA's Central and Regional Offices. Although there are many positives in our existing relationship, concerns have been raised by a number of entities, including the GAO, about a variety of critical aspects of this relationship. While this effort is only in its very early stages, a number of areas have already been identified as needing clearer delineation of roles and responsibilities. The lines of authority and accountability for contractor management and oversight is a priority issue for review.

GAO Contacts and Staff Acknowledgments

GAO Contacts

Leslie G. Aronovitz, (312) 220-7600
Sheila K. Avruch, (202) 512-7277

Staff Acknowledgments

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Related GAO Products

Medicare: Improprieties by Contractors Compromised Medicare Program Integrity ([GAO/OSI-99-7](#), 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 Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy ([GAO/AIMD-98-284](#), Sept. 28, 1998).

Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities ([GAO/HEHS-98-160](#), June 1, 1998).

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High-Risk Series: Medicare ([GAO/HR-97-10](#), Feb. 1997).

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

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More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing ([GAO/HRD-79-76](#), June 29, 1979).

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