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United States General Accounting Office
Washington, DC 20548

August 17, 2001

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

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

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

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

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

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

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

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

BACKGROUND

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

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

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

CLAIMS ADMINISTRATION CONTRACTING DEVIATES FROM STANDARD FEDERAL CONTRACTING IN SEVERAL WAYS

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

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

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

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

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

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

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

PROPOSED LEGISLATION WOULD GIVE CMS NEEDED CONTRACTING FLEXIBILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AGENCY COMMENTS AND OUR EVALUATION

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

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

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

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

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

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

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

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

Enclosure

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 16 2001

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

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

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

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

Issue - Competitive Contracting

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

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

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

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

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

Issue – Contractor Liability For Third Party Claims

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

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

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

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

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

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

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

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

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

Example of Current Indemnification Provision

Source: Standard Medicare Carrier Contract
Article XIV – Indemnification

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

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

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

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