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## Testimony

Before the Subcommittee on Health and the  
Subcommittee on Oversight and Investigations,  
Committee on Energy and Commerce, House of  
Representatives

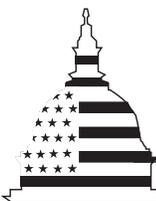
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# MEDICARE CONTRACTING REFORM

## Opportunities and Challenges in Contracting for Claims Administration Services

Statement of Leslie G. Aronovitz  
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Administration and Integrity Issues



GAO

Accountability \* Integrity \* Reliability

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Messrs. Chairmen and Members of the Subcommittees:

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

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

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

In summary, Medicare could benefit from full and open competition and its relative flexibility to promote better performance and accountability. If legislation removes the current limits on Medicare contracting authority, CMS could (1) select contractors on a competitive basis from a broader array of entities capable of performing needed program activities; (2) issue contracts for discrete program functions to improve contractor

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<sup>1</sup>Our statement will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

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performance through specialization; (3) pay contractors based on how well they perform rather than simply reimbursing them for their costs; and (4) terminate poor performers more efficiently.

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

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## Background

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

Medicare contracting for intermediaries and carriers differs from that of most federal programs. Most federal agencies, under the Competition in Contracting Act and its implementing regulations known as the Federal Acquisition Regulation (FAR),<sup>2</sup> generally may contract with any qualified

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<sup>2</sup>48 CFR, Chapter 1.

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entity for any authorized purpose so long as that entity is not debarred from government contracting and the contract is not for what is essentially a government function. Agencies are to use contractors that have a track record of successful past performance or that demonstrate a current superior ability to perform. The FAR generally requires agencies to conduct full and open competition for contracts and allows contractors to earn profits.

Medicare, however, is authorized to deviate from the FAR under provisions of the Social Security Act enacted in 1965.<sup>3</sup> For example, there is no full and open competition for intermediary or carrier contracts. Rather, intermediaries are selected in a process called nomination by provider associations, such as the American Hospital Association. This provision was intended at the time of Medicare's creation to encourage hospitals to participate by giving them some choice in their claims processor. Currently, there are three intermediary contracts, including the national Blue Cross Blue Shield Association, which serves as the prime contractor for 26 local member plan subcontractors. When one of the local Blue plans declines to renew its subcontract, the Association nominates the replacement contractor. Carriers are chosen by the Secretary of Health and Human Services from a small pool of health insurers, and the number of such companies seeking Medicare claims-processing work has been dwindling in recent years.

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

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<sup>3</sup>Section 1816 addresses fiscal intermediaries and section 1842 addresses carriers.

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

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## Medicare Could Benefit from Open Competition and Increased Flexibility

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

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

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

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

Since 1993, the agency has repeatedly submitted legislative proposals to repeal the provider nomination authority and make explicit its authority to

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

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### Contracting for Specific Functions Could Strengthen Service to Beneficiaries and Providers

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

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

CMS has had some experience with functional contracting under authority granted in 1996 to hire entities other than health insurers to focus on

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program safeguards.<sup>5</sup> CMS has contracted with 12 program safeguard contractors (PSC) who compete among themselves to perform task-specific contracts called task orders.<sup>6</sup> These entities represent a mix of health insurers, including many with prior experience as Medicare contractors, along with consulting organizations, and other types of firms. The experience with PSCs, however, makes clear that functional contracting has challenges of its own, which are discussed later in this testimony.

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### Offering Contractors Payment Incentives Could Result in Greater Efficiencies

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

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

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

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## CMS Needs to be Able to Terminate Poor Performers More Efficiently

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

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

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## Contracting Reform Poses Many Implementation Issues

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

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## Contracting With New Entities Will Take Time and Require Careful Planning

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

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

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## Coordination Is Critical for Functional Contractors

Developing a strategy for how to incorporate functional contractors into the program and coordinate their activities is key. While there may be benefits from specialization, having multiple companies performing different claims administration tasks could easily create coordination difficulties for the contractors, providers, and CMS staff. For example, between 1997 and 2000, HCFA contracted with a claims administration contractor that subcontracted with another company for the review of the

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medical necessity of claims before they were paid.<sup>7</sup> The agency found that having two different contractors perform these functions posed logistical challenges that could make it difficult to complete prepayment reviews without creating a backlog of unprocessed claims.

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

Coordination is also necessary to ensure that new efficiencies in one program area do not adversely affect another area. For example, better review of the medical necessity of claims before they are paid could lead to more accurate payment. This would clearly be beneficial, but could also lead to an increase in the number of appeals for claims denials. Careful planning would be required to ensure adequate resources were in place to adjudicate those appeals and prevent a backlog.

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

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## Experience Is Needed to Develop Effective Evaluation Criteria

Taking advantage of benefits from competition and performance-based contracting hinges on being able to identify goals and objectives and to measure progress in achieving them. Specific and appropriate evaluation criteria would be needed to effectively manage any new arrangements under contracting reform. Effective evaluations are dependent, in part, upon clear statements of expected outcomes tied to quantifiable measures and standards. Because it has not developed such criteria for most of its

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<sup>7</sup>A claims administration contractor has the flexibility to subcontract under section 1842 of the Social Security Act.

<sup>8</sup>*Medicare: Opportunities and Challenges in Contracting for Program Safeguards* (GAO-01-616, May 18, 2001).

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PSC task orders, we reported<sup>9</sup> that CMS is not in a position to effectively evaluate its PSCs' performance even though 8 of the 15 task orders had been ongoing for at least a year as of April 2001. If CMS begins using full and open competition to hire new entities for other specific functions, it should attempt to move quickly to develop effective outcomes, measures, and standards for evaluating such entities.

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

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## Concluding Observations

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

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

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<sup>9</sup>GAO-01-616, May 18, 2001.

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

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**GAO Contact and Staff  
Acknowledgments**

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

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# Related GAO Products

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

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

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

*High Risk: An Update* ([GAO-01-263](#), Jan. 2001).

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

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

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

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

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

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

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