United States General Accounting Office

GAO

Report to Ranking Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate

May 2001

MEDICARE

Opportunities and Challenges in Contracting for Program Safeguards

GAO-01-616

Contents

Table

Abbreviations

HCFA	Health Care Financing Administration
HHS OIG	Department of Health and Human Services Office of Inspector General
HIPAA	Health Insurance Portability and Accountability Act of 1966
PSC	program safeguard contractor

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

May 18, 2001

The Honorable Tom Harkin
Ranking Member
Subcommittee on Labor, Health and
Human Services, Education and
Related Agencies
Committee on Appropriations
United States Senate

Dear Senator Harkin:

In fiscal year 1999, the Medicare program, which ranks second only to Social Security in federal expenditures, paid over $200 billion to provide medical care to about 39 million elderly and disabled beneficiaries. Because of its size and complexity, we designated Medicare in 1990 as being at high risk for fraud, waste, abuse, and mismanagement and that designation continues today. The Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in part to provide better stewardship of the program.[1] This act gave the Health Care Financing Administration (HCFA)—the agency that administers Medicare—the authority to contract with specialized entities to combat fraud, waste, and abuse. Previously, such safeguard activities were exclusively performed by the insurance companies—known as claims administration contractors—that HCFA contracts with to process and pay Medicare claims.

In May 1999, HCFA selected 12 of these specialized entities to act as program safeguard contractors (PSCs). A little over a year later, you asked us to review HCFA's implementation of its new contracting authority. Specifically, you requested that we (1) describe HCFA's progress in implementing its PSC contracting authority and (2) assess whether HCFA could improve its management of the PSCs to ensure their most effective use.

To learn how HCFA is implementing its PSC contracting authority, we interviewed officials from two HCFA divisions—Program Integrity; and Acquisitions and Grants. We discussed their plans for managing the PSCs, evaluating their performance, and compensating them through different

[1]P.L. 104-191.

arrangements. We also interviewed representatives from six PSCs and four claims administration contractors. We reviewed relevant documents, including the general contract requirements—which apply to all the PSCs—and the individual task order contracts, which define the specific activities individual PSCs are to perform.

To identify ways that HCFA could improve its management of the PSCs, we interviewed HCFA officials and reviewed HCFA planning documents. We also interviewed 12 contract management specialists at federal and state agencies, as well as at private organizations. These specialists included experts in performance measurement and performance-based contracting, and a former director of the Office of Federal Procurement Policy. We conducted our work from June 2000 through April 2001 in accordance with generally accepted government auditing standards.

Results in Brief

HCFA is experimenting with different options for integrating the PSCs into Medicare's program safeguard activities. From September 1999 through April 2001, HCFA issued 15 task orders that include different ways of utilizing PSC services. Some task orders involve discrete activities that focus on specific areas vulnerable to fraud and abuse, such as community mental health center services; others require PSCs to replace some or all of the program safeguard activities traditionally performed by claims administration contractors. Still others may have a national impact on fraud and abuse prevention and detection, such as the development of a plan that all contractors could use for reviewing the appropriateness of physical, speech, and occupational therapy services. HCFA also plans to explore different methods of paying the PSCs to better control costs and encourage more effective performance. Finally, because the PSCs have begun to play a larger role in HCFA's program integrity efforts, the agency recently revised its approach to monitoring and evaluating the PSCs' performance.

HCFA lacks a long-term strategy for determining how best to use the PSCs. Instead, its approach has been to issue task orders ad hoc. This has afforded HCFA certain flexibilities, such as targeting its task orders on known problem areas. While this experimental approach may be prudent in the short term, it does not represent a process for systematically testing different options for using PSC services in the long term. Moreover, HCFA has not set clearly defined criteria for determining how the PSCs should be integrated into Medicare's existing program integrity efforts. In addition, HCFA has not established clear, measurable performance criteria

to assess the PSCs' performance on individual task orders. Although HCFA identified dimensions for evaluating PSC performance on most task orders, these dimensions are very broad and not well defined. One dimension, for example, deals with cooperation and coordination between the PSCs and stakeholders. However, HCFA has not developed criteria to rate how well the PSCs are performing in these dimensions.

We are making two recommendations to the Acting Deputy Administrator of HCFA to help improve the management of the PSCs. HCFA agreed that our recommendations are critical to ensuring the effectiveness of the PSCs and indicated that it is already beginning to implement them. However, HFCA expressed concern that we did not sufficiently recognize its efforts in managing the PSCs.

Background

Traditionally, HCFA's claims administration contractors performed most of Medicare's program safeguard functions. These five functions are intended to ensure that Medicare pays only appropriate claims for covered services performed by legitimate providers to eligible beneficiaries. They include:

- medical reviews of claims to identify claims for noncovered, medically unnecessary, or unreasonable services, conducted both before the claims are paid (prepayment review) and after payments are made (postpayment review);
- reviews to identify other primary sources of payment, such as private health insurers, that are responsible for paying claims mistakenly billed to Medicare;
- audits of cost reports submitted by institutional providers to determine if their costs are allowable and reasonable;
- identification and investigation of possible fraud cases that are referred to the Department of Health and Human Services Office of Inspector General (HHS OIG) for investigation and possible prosecution by the Department of Justice; and
- provider education and training related to Medicare coverage policies and appropriate billing practices.

In May 1999, HCFA selected 12 entities to act as PSCs, using a competitive bidding process.[2] These entities represent a mix of health insurance

[2]HCFA initially selected 13 PSCs, but one dropped out.

companies, information technology businesses, and several other types of firms. To be selected as a PSC, potential contractors had to indicate that they were capable of performing four of HCFA's five program safeguard activities—either directly or through subcontracts with other organizations.[3] Almost all of the PSCs have had experience as HCFA contractors: Six are currently Medicare claims administration contractors[4] and an additional five have other types of contracts with HCFA.

HCFA awarded each of the PSCs an indefinite delivery/indefinite quantity contract. This type of contract allows HCFA to select a contractor and outline in broad terms the activities to be performed. When HCFA identifies a specific function to be performed, it issues a task order proposal for that work, and the PSCs compete to receive the task order contract. HCFA can issue numerous task orders covering one, several, or the entire range of program safeguard activities, and it can award multiple task orders to an individual PSC.

HCFA Is Experimenting With Different PSC Approaches

HCFA is exploring different ways to use and pay the PSCs to combat fraud, waste, and abuse in the Medicare program. Because the PSCs represent a new means of promoting program integrity, HCFA took an incremental approach to implementing its specialized contracting authority and awarding the task orders. This incremental approach gave HCFA the opportunity to test multiple options for how the PSCs will function. These options include, for example, a PSC performing all safeguard functions in a particular region of the country and PSCs conducting work targeted at specific types of providers or benefits considered particularly vulnerable to fraud and abuse. In addition, HCFA plans to experiment with different methods of paying PSCs to enhance their performance. Finally, HCFA recently revised its approach to monitoring and evaluating the PSCs' performance because of their growing role in program integrity.

[3]One of HCFA's program safeguard activities is to identify other insurers responsible for paying claims mistakenly billed to Medicare. Because HCFA has a separate contractor to perform this activity, however, the PSCs are not required to do so.

[4]Two of the six PSCs with claims administration contracts have established new entities to perform PSC work.

HCFA Is Taking an Incremental Approach to Implementing the PSCs

In September 1999, about 3 years after HIPAA was enacted, HCFA awarded its first PSC task order. Officials emphasized that they needed time to consider how best to implement HCFA's contracting authority. This included the time necessary to develop the indefinite delivery/indefinite quantity contract and the proposed regulations governing their new program integrity efforts. By April 2001, HCFA had awarded 15 task orders focusing on different aspects of program integrity, such as fraud detection and medical review of claims.

HCFA first awarded task orders for projects that would not disrupt the processing of Medicare claims; for example, several projects involved reviewing claims after they have been processed. In developing the initial task orders in 1999, HCFA was concerned about the potential effects of the year 2000 conversion on its claims processing systems and the possibility that one or more of the claims administration contractors would leave the program. HCFA decided that its initial task orders would either be focused on tasks that were independent of claims processing or that supplemented, but did not replace, the claims administration contractors' program safeguard activities. Subsequent task orders have, in many cases, given the PSCs greater safeguard responsibility for performing work, including replacing the functions traditionally performed by the claims administration contractors.

Based on our assessment, the 15 task orders can be divided into four categories representing different ways of structuring the PSCs' responsibilities. As shown in table 1, these categories cover a wide range of options, from discrete, narrowly focused task orders related to a particular service or provider type to task orders with a broad focus that can have a national impact on Medicare's program safeguard activities. HCFA is testing these options to identify how the PSCs can make the most significant contributions to program integrity.

Table 1: General Categories of HCFA's PSC Task Orders

Name	Purpose	Start of Contract
Category 1: Task orders that are discrete and narrowly focused.		
Community Mental Health Center Reviews	Conduct unannounced site visits to selected community mental health centers to determine whether they are complying with Medicare requirements.	11/22/99
Home Office Cost Report Audits	Conduct field audits at the home offices of large provider chains, such as skilled nursing facilities.	11/24/99
Compliance with Corporate Integrity Agreements	Perform on-site reviews of providers subject to corporate integrity agreements to determine whether they are complying with the terms of their agreements.	11/24/99
Nebulizer Project	Conduct medical reviews and participate in field investigations on the use of nebulizer drugs[a] in three states.	6/14/00
Category 2: Task orders that support or replace some safeguard activities at one or more claims administration contractors.		
Benefit Integrity Support Center	Perform postpayment data analysis and support fraud unit activities at New England claims administration contractors.	11/24/99
Statistical Analysis Center	Conduct statistical analyses and trending activities on Medicare claims data in three midwestern states.	3/14/00
Western Integrity Center	Perform postpayment medical review, fraud detection, and data analysis for 12 western states.	7/14/00
Category 3: Task order that replaces all safeguard activities at a claims administration contractor.		
Durable Medical Equipment	Perform all program integrity functions, including prepayment and postpayment review, for the northeast region's claims processing contractor for durable medical equipment.	11/7/00
Category 4: Task orders that have a broad focus and a potential national impact on improving the efficiency and effectiveness of Medicare's safeguard activities.		
Year 2000 Analysis	Conduct national analyses to minimize the risk of increased fraud and abuse as technological changes were made for the year 2000.	9/30/99
Provider Education Plan	Conduct a national education needs assessment and develop a comprehensive educational plan for Medicare providers.	11/15/99
Systems Requirements	Assess Medicare claims processing systems and recommend modifications required to fully integrate the PSCs into the claims payment process.	3/8/00
Comprehensive Error Rate Testing Program	Develop national paid claim error rates by contractor, benefit category, and provider type through independent review of a random sample of claims.	5/17/00
Therapy Services	Perform data collection and statistical analyses related to therapy services and create a plan for reviewing therapy services and developing educational materials.	8/14/00
Correct Coding Initiative	Maintain automated system edits used by all claims administration contractors to identify certain types of inappropriate claims.	9/29/00
Managed Care Payment Validation	Analyze Medicare+Choice payment data to validate accuracy of payments and to identify program integrity vulnerabilities and solutions.	11/22/00

[a]These drugs are intended to provide relief to individuals suffering from respiratory problems and may be used with a nebulizer, a medical device to aid inhalation.

Source: GAO analysis of task orders awarded to HCFA's program safeguard contractors as of April 2001.

The task orders in the first category represent special projects that focus attention on particular areas that are considered vulnerable to fraud and abuse. For example, in recent years, community mental health center services have been the target of investigations by law enforcement agencies, including the HHS OIG and the Federal Bureau of Investigation. These investigations were due, in part, to concerns about steep increases in the cost per patient treated and increases in the number of these providers in certain regions of the country. Further, the nebulizer task order was awarded because nebulizer drugs have historically been a source of fraud and abuse—including kickbacks from suppliers to beneficiaries and physicians.

The second category represents task orders in which the PSC supplements or replaces some of the routine program integrity activities of one or more claims administration contractors. For example, the Benefit Integrity Support Center task order calls for the PSC to work with all the claims administration contractors that have jurisdiction over the New England states to identify potential cases of fraud and abuse. In addition, the PSC staff are also supplementing the work conducted by fraud control units at four of these contractors—partly because these units have few staff. The PSC that was awarded the Western Integrity Center task order is replacing some of the safeguard activities—including postpayment reviews and fraud case development—of two claims administration contractors that serve 12 western states.

The third category, in which a PSC performs all program safeguard functions, consists solely of the Durable Medical Equipment task order. This task order is important in that it represents a test for determining whether a PSC can effectively replace the safeguard activities performed by the claims administration contractors. These activities include the performance of prepayment medical reviews by the PSCs. These reviews must be completed before the claims can be processed and paid by the responsible claims administration contractor. This process poses a challenge because the PSC must complete an assessment of whether claims should be paid without delaying the processing and payment of appropriate claims to legitimate providers by the claims administration contractors.[5] Although this is the only task order being used to test this

[5]Several years ago HCFA conducted a pilot project testing this separation of duties between different contractors. HCFA found that separating prepayment review and claims processing posed logistical challenges that could make it difficult to complete prepayment reviews without creating a backlog of unprocessed claims.

option, the results may provide HCFA with important insights regarding how to identify improper claims prior to payment without creating undue processing delays.

The task orders in the fourth category are national in scope and aim to build HCFA's knowledge base and systems to enhance the prevention and detection of fraud, waste, and abuse. For example, the PSCs that were awarded the Systems Requirement task order are identifying potential changes to existing claims processing systems to enable PSCs' automated systems to be fully integrated with those of the claims processors. The Therapy Services task order requires the development of a plan that all contractors could use for reviewing the appropriateness of physical, speech, and occupational services—services that the HHS OIG has identified as prone to improper Medicare payments. HCFA expects the PSC's efforts on this task order will reduce payment error rates for therapy services without disrupting the delivery of these services to Medicare beneficiaries.

HCFA Plans to Experiment With Different Types of Contract Payments

HCFA plans to explore a variety of methods for paying PSCs to determine which are most appropriate for the specific functions required in the task orders. These methods fall under the general categories of cost-reimbursement, fixed-price, and cost-plus-incentive contracts. Most of the task orders are currently paid on some variation of a cost-reimbursement basis. Under a cost-reimbursement contract, HCFA reimburses the PSCs for their allowable costs—including such items as salaries, travel, and subcontractors needed to perform the activities specified in the task order. This type of contract provides the least incentive for a PSC to manage its costs because HCFA assumes most of the risk for inefficient performance. Thirteen of the 15 task orders are paid on this basis.[6]

A fixed-price contract requires a PSC to assume most of the risk for managing its costs and provides it with the greatest incentive for efficient performance. Despite these potential benefits for HCFA, a fixed-price contract has been used for only one task order.[7] Establishing fixed-price contracts is difficult because HCFA has no prior experience with using

[6]This includes four time and materials contracts, in which direct and indirect labor are paid at specified rates, while materials are paid at cost.

[7]One other task order was initially awarded as fixed-price contract, but was changed to a cost reimbursement contract before any substantial work had been conducted.

task orders for program safeguards. HCFA officials told us that this type of contract currently may not be feasible for most task orders because the agency generally lacks the data necessary to reasonably estimate costs. As a result, neither HCFA nor the PSCs can have a complete understanding of the costs associated with meeting the contract requirements. Without reliable cost data, HCFA officials fear that PSCs could submit high bids that include excessive profits or low bids that lead to disagreements over the scope of work and subsequent requests for additional funds.

To address these concerns, HCFA officials stated that they are developing a new reporting system to obtain cost data associated with different program safeguard activities. They believe this system, which may be implemented by the end of 2001, will establish an independent data source to assess the reasonableness of the PSCs' estimated costs and will ultimately provide a stronger basis for competing future task order contracts on a fixed-price basis. For example, in regard to a task order for prepayment medical review, HCFA could use this data system to estimate the cost for a registered nurse to review 1,000 claims. Certain types of program safeguard work, however—such as the development of fraud cases—might not be amenable to a fixed-price contract due to the uncertainties inherent in detecting, investigating, and developing such cases.

The third type of contractor payment incorporates the use of financial incentives, such as performance awards or fees, that a contractor can earn for meeting certain performance goals. For example, HCFA has begun to experiment with financial incentives on the Comprehensive Error Rate Testing program task order. This task order requires the PSC to evaluate the accuracy of a random sample of claims processed by the claims administration contractors. The PSC has the opportunity to earn two separate award fees: One is based on the PSC's success in obtaining medical records from providers after the claims have been submitted, and the second is based on having few successful appeals of its medical review decisions. HCFA chose the first measure because obtaining relevant medical records is critical to the PSC's ability to accurately determine if a claim was paid correctly, while the second measure is an indicator of the quality of the PSC's medical review decisions.

HCFA Has Revised Its Approach to PSC Monitoring and Evaluation

HCFA's initial efforts to manage the task orders generally have focused on the PSCs' start-up activities. HCFA has worked closely with the PSCs to ensure that they acquire and develop the resources and systems needed to ultimately fulfill contract requirements. This focus on the PSCs' early

efforts has resulted in HCFA's central office assuming a major role in overseeing the PSCs and managing the individual task orders. HCFA recognized that as the PSCs play a larger role in its program integrity efforts, it would be appropriate to reconsider its approach to PSC monitoring and evaluation.

Consistent standards for monitoring and evaluating PSC performance are important for developing a common understanding of how to use PSCs most effectively. We have previously reported that HCFA's regional office staff charged with monitoring the work performed by the claims administration contractors were given wide discretion in how they conducted their oversight, resulting in inconsistent evaluations.[8] We subsequently reported that HCFA was taking a number of steps to strengthen its oversight of the claims administration contractors, such as providing detailed direction to the regions to improve the quality and consistency of contractor reviews.[9]

HCFA has revised its approach to PSC monitoring and evaluation to more effectively assess the PSCs' progress in accomplishing the task orders' specific objectives. Until recently, the same staff who generally monitored the PSCs' day-to-day progress were also responsible for periodically evaluating these contractors' performance in completing certain tasks. HCFA has since assigned primary responsibility for day-to-day monitoring of the PSCs to the regional offices. To ensure independence, the central office will be responsible for separately evaluating the PSCs. This approach should help HCFA maintain an appropriate level of objectivity and independence in these assessments.

Improvements in PSC Strategy and Evaluation Process Are Needed

HCFA has not followed a systematic, strategic approach for testing and evaluating how best to use the PSCs to promote program integrity. Also, HCFA has not yet developed clear, measurable criteria to evaluate PSCs' performance on the individual task orders. By addressing both of these issues, HCFA would be in a better position to ensure that the PSCs are used most effectively.

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

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

HCFA's Implementation of the PSC Task Orders Lacks a Strategic Direction

HCFA lacks a strategy for determining how best to use the PSCs in the long term. During our review, HCFA officials could not provide us with specific goals and objectives for using the PSCs to combat fraud, waste, and abuse or their evaluation criteria for assessing which PSC options work best under different circumstances. While an incremental, experimental approach for implementing its new contracting authority may be prudent in the short term, a long term strategy would help HCFA to better target its PSC resources and provide a basis for deciding where and how to use the PSCs to promote program integrity.

Without a clearly defined strategic direction, HCFA has issued the task orders ad hoc. This ad hoc approach has provided HCFA significant flexibility in targeting its task orders on known problem areas and in using the PSCs in different ways. However, it does not represent a strategy for systematically testing different PSC options and for building upon the results of one task order to issue future task orders—a strategy we believe would provide HCFA with a sound basis for deciding how best to use its PSC resources. Currently, HCFA relies on its staff to identify and develop proposals for work that the PSCs should perform. Task orders are also developed as opportunities arise—such as when a claims administration contractor leaves the program, creating the opportunity to shift some or all of the contractor's program safeguard activities to a PSC.

HCFA officials said that they believe that it is important to gain some experience with their PSC contracting authority before establishing HCFA's strategic direction for these contractors. They also told us that they have a vision for consolidating program safeguard activities among the PSCs and fewer claims administration contractors and are currently drafting a plan to this effect. Until May 2001, however, they could not tell us when this plan would be issued or whether it would contain goals and objectives for its PSCs or criteria for evaluating the success or failure of these contractors. In commenting on a draft of this report, HCFA officials identified four general questions they are using to evaluate the PSC options. They also told us that they plan to complete their evaluation of the PSC options by October 2001 in order to have a more clearly defined long-term strategy in place for fiscal year 2002.

HCFA Lacks Clearly Defined Criteria for Evaluating PSC Performance

HCFA has not clearly defined the specific outcomes it would like to achieve under each task order. Instead, we found that many of the specific outcomes outlined in the PSC task orders describe work processes—critical steps to be performed that serve as a substitute for outcomes. For example, under the Benefit Integrity Support Center task order, two of

HCFA's desired outcomes are that the PSC will (1) use a variety of methods to detect potential fraud cases, and, (2) establish good working relations with its law enforcement partners. Both of these are processes that HCFA believes will contribute to accomplishing its desired outcome, developing "quality" fraud cases.

Contract specialists told us that it is not always possible to develop specific outcomes during the initial stages of a project and that using processes as proxies for outcomes is therefore acceptable. However, they also said that outcomes could begin to be developed once work has proceeded for a period. As of April 2001, work on 8 of the 15 task orders had been ongoing for at least a year, thereby providing HCFA with information from which to review and better define its expected outcomes on each.

HCFA has begun to evaluate the PSCs' performance. However, HCFA has not developed clear, quantifiable performance measures and standards for most of these task orders. HCFA officials told us that several task order evaluations are under way but none have been completed. They said that the ongoing evaluations generally consist of reviewing the PSCs' self-assessments, progress reports, and general performance. For most of its task orders, HCFA established seven broad dimensions for assessing PSC performance: (1) cooperation and coordination, (2) innovation, (3) integrity, (4) quality, (5) timeliness, (6) value added, and (7) satisfaction.[10] However, it has not developed measures to determine how well the PSCs performed in these dimensions nor established standards against which to judge whether the PSCs' performance was satisfactory.

To illustrate, as part of the Provider Education task order, HCFA plans to assess the PSC's cooperation and coordination with stakeholders based, in part, on stakeholder feedback and the number of outstanding issues that reflect a lack of communication. However, HCFA has no written guidance explaining how it will obtain and measure stakeholder feedback. This task order does not explain how HCFA will define an outstanding issue or judge what constitutes a lack of communication between the PSC and a stakeholder. It also does not define the standards against which HCFA will differentiate between PSC performance that is excellent, good, acceptable,

[10]Some task orders include performance requirements that are specific to the work performed for that task order. For example, HCFA plans to assess the effectiveness of the audit determinations made by the PSC conducting the Home Office Cost Report Audits task order.

poor, or unacceptable. Therefore, HCFA will not have a strong basis for assessing the PSC in this dimension.

One of HCFA's attempts to develop performance measures and standards that are clear and quantifiable has been for the Statistical Analysis Center task order. This task order requires the PSC to develop a wide variety of data analyses for claims data in three states. These measures and standards were drafted by the PSC at HCFA's request and were recently incorporated into the task order requirements. The PSC's performance measures for the quality dimension, for example, require that the findings resulting from these data analyses be accurate and able to withstand external validation. The PSC's standards are that HCFA will rate the quality of the PSC's data analyses as excellent if 95 percent or more of the PSC's analyses meet these criteria, while HCFA will rate them unacceptable if the performance measures are met fewer than 86 percent of the time.

Contract specialists told us that, ideally, measures and standards should be incorporated into the task orders before work begins, so that all parties agree on how performance will be evaluated. They also emphasized that developing clear, quantifiable performance measures and standards is an evolving process. While HCFA has not yet developed such measures and standards for nearly all of its task orders, we believe that it is best for the agency to now start with fairly simple measures and refine them over time as it gains experience with each task order. It is also important to collect data on various aspects of PSC performance and test different measures to identify the right combination for motivating the PSCs to perform well.

Developing the right mix of measures that will not distort contractor behavior but will lead to the desired outcomes is a challenging task facing HCFA. For example, HCFA officials consider more traditional performance measures for program safeguards—such as the number of fraud referrals to the HHS OIG—to be inappropriate because they might motivate a PSC to be overzealous in its pursuit of marginal cases. While it is important to consider how performance measures can potentially distort contractor behavior, such concerns should not prevent HCFA from developing appropriate measures. For example, testing different combinations can help HCFA identify the right mix of performance measures to minimize such distortions.

HCFA officials told us they are trying to develop appropriate performance measures and acknowledge that they need better information to evaluate the PSCs. For example, HCFA plans to contract with a consulting firm to

collect data on the performance measures and standards used by private insurers to assess their program safeguard functions. In addition, HCFA is developing error rate data by contractor, benefit category, and provider type as part of the Comprehensive Error Rate Testing program task order. HCFA officials told us that they would eventually like to use these data as the basis for performance measures for future task orders—perhaps judging a PSC by how much it reduces the paid claims error rate for hospitals or for durable medical equipment.

Conclusions

HCFA was prudent in using an incremental approach to test the integration of PSCs into Medicare's program safeguard activities in the short term. However, HCFA now has well over a year's experience with the PSC task orders and should develop a long-term strategy to ensure that the PSCs are used most effectively. We believe it is important for HCFA to now define its goals for the PSCs and determine how it will evaluate different options for PSC integration into Medicare's program safeguard efforts. Creating a long-term strategy would enable HCFA to test different options more systematically and to use the results of this testing in the development of future task orders.

Although HCFA has already started to evaluate PSC performance on several task orders, it cannot do so effectively because it lacks clear, quantifiable performance measures and standards that are linked to defined outcomes. We recognize that it will take some time for the agency to develop appropriate performance criteria, but we believe it is important to start experimenting with different performance measures, standards, and outcomes to lay the groundwork for effective task order performance evaluations in the future. This need for better performance measures, standards, and outcomes will become especially critical if HCFA adopts more fixed-price contracts containing financial incentives and penalties that are based on PSC performance.

Recommendations for Executive Action

To assist HCFA in determining if the PSCs are an effective approach to safeguarding Medicare payments, we recommend that the Acting Deputy Administrator of HCFA define the strategic direction for future use of the PSCs. This should include setting goals and objectives for the PSC program and devising evaluation criteria for assessing the overall effectiveness of the PSCs in promoting program integrity.

In addition, as HCFA gains experience with PSC performance, the Acting Deputy Administrator should begin to develop clear, quantifiable performance measures and standards tied to well defined outcomes for each of the task orders.

Agency Comments

In written comments on a draft of this report, HCFA agreed that our recommendations are critical to ensuring the effectiveness of the PSCs. However, HCFA also expressed concern that we did not sufficiently recognize its efforts in managing the PSCs. In addition, HCFA supplied new information to update us on its management of the PSCs and indicated that it is already taking steps to implement our recommendations. We have included HCFA's letter as appendix I. HCFA also provided us with technical comments, which we incorporated as appropriate.

Regarding our first recommendation, HCFA agreed that it needs to establish a strategic direction for future use of the PSCs, but stated we should give greater recognition to its ongoing planning efforts. HCFA also provided new information regarding its PSC strategy. For example, HCFA noted that it has finalized its PSC Management and Performance Evaluation Strategy and stated that it intends to evaluate five different models as part of its effort to develop a long-term strategy. HCFA also noted that its plan identifies the following critical questions to be used in its evaluation of the PSC models.

- Did the model achieve the desired outcomes?
- What was the level of internal and external customer satisfaction?
- What are the costs and benefits of the model?
- How well does the model meet HCFA's implementation criteria?

HCFA stated that its goal is to complete the assessment of the PSC models by October 2001 and to develop a more clearly defined long-term strategy for fiscal year 2002.

HCFA's written comments describing its plan contain new information that is substantively different from the draft version it provided us during the course of our review. Although the new information lacks sufficient detail for us to fully assess its plan, we agree that it is an important step. However, it is difficult for us to assess the evaluation questions without more precise definitions of the terms used, such as the "desired outcomes" for each of the models and the "implementation criteria." In our view,

these questions are too vague to provide a meaningful basis for determining which PSC models are most effective. Moreover, we question whether HCFA will be able to complete its analysis of the models by October 2001 because it will not have had the opportunity to fully test all the PSC models. For example, although the task order that requires the PSC to perform all prepayment and postpayment reviews was awarded last year, the test of its ability to effectively perform prepayment reviews is not scheduled to begin until October 2001—the same month HCFA stated that its analysis would be complete.

In responding to our second recommendation, HCFA said it agreed that it should develop improved performance evaluation criteria for individual task orders. However, HCFA pointed out that it has already identified some performance measures in several task orders, such as the Statistical Analysis Center and the Comprehensive Error Rate task orders. We described the performance measures used on these two task orders in our draft report and believe that they represent positive steps. However, as we noted, the majority of the task orders still lack clearly defined performance evaluation criteria.

HCFA also said that we should recognize that there are two different methods for evaluating contractor performance—a basic approach that assesses general performance in areas such as quality or timeliness and performance-based contracting which focuses more on outcome than on process. HCFA said we should discuss the two methods it is using for the PSC task orders. We do not believe that such a discussion is necessary. Regardless of which method is used, an effective evaluation of contractor performance depends on the development of well-defined performance measures and standards. Our report recognizes both the difficulty of developing these criteria and HCFA's initial efforts to do so. As we noted in our report, most of the performance dimensions HCFA has developed thus far are not well defined and lack measurable standards. We believe that HCFA will not be able to effectively evaluate the PSCs until it develops clearly defined performance criteria.

Finally, HCFA took issue with our statement that it lacks clear goals and objectives for the PSCs. HCFA stated that these goals and objectives are inherent in the Medicare Integrity Program legislation, which is part of HIPAA. We recognize the importance of these goals and objectives and believe that they provide a foundation on which HCFA can strengthen its program safeguard activities. However, as we noted in our report, we believe that sufficient time has elapsed since the Medicare Integrity Program legislation was enacted to enable HCFA to translate the

legislation's goals and objectives into a more specific and clearly defined role for the PSCs, especially in terms of PSC operations and their future contributions to program integrity.

As agreed with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Honorable Tommy Thompson, Secretary of Health and Human Services, Michael McMullan, Acting Deputy Administrator of HCFA, and other interested parties. We will make copies available to others upon request.

If you or your staff have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff who made major contributions to this report are listed in appendix II.

Sincerely yours,

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

Appendix I: Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: MAY -1 2001

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

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: *Medicare: Opportunities and Challenges in Contracting for Program Safeguards* (GAO-01-616)

We have reviewed the above-referenced GAO report and have significant comments regarding the report's recommendations and technical content. Our specific comments are identified below. However, we would first like to emphasize that, contrary to the information in the GAO report, the Health Care Financing Administration (HCFA) has clear goals and objectives for Program Safeguard Contractors (PSCs). These goals and objectives are inherent in the Medicare Integrity Program (MIP) legislation and in HCFA's desire for program integrity (PI) contracting reform. These goals and objectives are as follows:

- To create a new pool of contractors capable of performing PI activities.
- To build unique expertise and experience necessary to perform traditional PI activities in new and innovative ways.
- To experiment with separating claims processing functions from PI functions in order to promote appropriate quality (PI) efforts.
- To minimize HCFA's potential risk with regard to potential conflicts of interest that could arise as the traditional Medicare contractors expand their business interests.

Additionally, we recommend that GAO frame the PSCs in the overall context of HCFA's PI efforts. The GAO should recognize in its report that the PSCs are one of many tools the Agency uses to ensure that it pays claims appropriately. HCFA has a clear and consistent measurable goal of reducing the claims payment error rate, and the PSCs are one of the tools HCFA uses to meet that performance measure.

Finally, we would like GAO to mention in its report that HCFA is currently conducting a full and open competition to create a list of contractors that will be referred to as

Medicare Managed Care Program Integrity Contractors (PICs). These contractors will perform PI and other tasks related to HCFA's Medicare managed care program. This procurement and the PIC contracts will be run similarly to the PSC program. HCFA will consider the recommendations made in this GAO report as it proceeds with the managed care procurement.

Report Recommendations:

GAO recommends that HCFA:

(1) Define the strategic direction for future use of the PSCs; and,
(2) Begin to develop clear, quantifiable performance measures and standards tied to well-defined outcomes for each of the task orders.

HCFA views both of these recommendations as critical to the success of the PSCs. With regard to the first recommendation, we agree that HCFA needs to establish a strategic direction for future use of the PSCs. In fact, we have already started this process. In the short term, HCFA made a conscious decision to be flexible in its implementation strategy and experiment with various PSC models. This flexibility has given us the ability to target our resources, to address specific program vulnerabilities, and to test the implementation of various PSC models without the constraints of a preconceived plan for long-term implementation.

Now that we have been operating our PSC contracts for about a year and a half, we have started to formulate our long-term strategy. In February, HCFA finalized a PSC Management and Performance Evaluation Strategy that established a management plan, an evaluation plan, and a vision for future implementation of the PSCs. This document identifies how HCFA will evaluate five PSC models for future implementation. These models are as follows:

Model 1 - Data Analysis Model: This model tests the effectiveness of having an independent contractor perform proactive data analysis in order to discover PI leads. In March of 2000, HCFA awarded the Statistical Analysis Center (SAC) contract to DYNCorp in order to test this model. The SAC focuses on performing Part A and Part B data analysis on a beneficiary basis in three mid-western states: Minnesota, Wisconsin, and Michigan.

Model 2 - Benefit Model: Under this model, the PSC focuses on performing PI activities related to a specific benefit type (i.e., therapy services), in order to target vulnerabilities within that benefit area. In August 2000, a contract for the Therapy Review PSC was awarded to DYNCorp. Under this contract, DYNCorp is responsible

for conducting data analysis, developing medical review policies, performing medical review, and developing an error rate for therapy services.

Model 3 - Functional Model: Under this model, a PSC performs a specific PI function (i.e., benefit integrity), for all provider and service types within a specific geographic area. In November 1999, HCFA awarded the Benefit Integrity Support Center (BISC) contract to Electronic Data Systems (EDS). Under the BISC contract, EDS performs post-payment benefit integrity activities for all Part A providers and services in New England.

Model 4 - Post-Payment Model: Under this model, the PSC performs multiple PI activities for all providers and service types, but only on a post-payment basis within a specified geographical region. In July 2000, HCFA awarded the Western Integrity Center (WIC) contract to Computer Sciences Corporation (CSC). Under its WIC contract, CSC is responsible for Noridian's Part A and Part B post-payment medical review and benefit integrity activities in 12 states.

Model 5 - Full PSC Model: Under this model, the PI workload of a current Medicare contractor is moved to a PSC. The PSC, serving as the replacement contractor, would perform the full scope of PI activities, pre- and post-payment, for all benefit types. In November 2000, HCFA awarded a PSC contract to TriCenturion for it to perform all medical review, policy development, benefit integrity, and data analysis activities for all durable medical equipment claims in the northeastern section of Region A.

Testing these various PSC models was part of an Agency Government Performance and Results Act performance goal for fiscal year (FY) 2001. HCFA successfully met the goal of implementing these models and, as defined in HCFA's PSC Management and Performance Evaluation Strategy, these models are being evaluated based on the answers to four critical questions.

(1) Did the model achieve the desired outcomes?
(2) What was our level of internal and external customer satisfaction?
(3) What are the costs and benefits of the model?
(4) How well does the model meet our implementation criteria?

It is HCFA's goal to complete the model evaluation by October in order to have a more clearly defined long-term strategy in place for FY 2002. We recommend that GAO modify its report to reflect HCFA's efforts to further develop its long-term strategy.

Additionally, it is important for GAO to note that HCFA can not further develop its long-term PSC strategy in a vacuum. HCFA's plan must consider the overall contracting strategy of the Agency from a traditional Medicare contractor perspective, as well as from the perspective of its stakeholders and customers. Furthermore, we recommend that

Page 4 – Leslie Aronovitz

GAO mention the efforts of the PSC Steering Committee as the governing body responsible for implementation and long-term planning.

With regards to GAO's second recommendation on developing performance measures and standards tied to outcomes for each of the task orders, it is important for GAO to distinguish in its report the differences in contractor performance evaluation methods. We believe that there are basically two different methods for evaluating a contractor's performance. They are as follows:

(1) Basic Contractor Evaluation - This method assesses the contractor's performance, in general, for achieving quality of products or service, timeliness of performance, cost controls, and contract administration.

(2) Contractor Evaluation Under Performance-Based Contracting - This method states the contract requirements in terms of what is to be the required output rather than how the work is to be accomplished. This method also employs a process for evaluating the contractor against measurable performance standards so that a desired performance quality level is achieved. It also promotes the use of objective positive and negative incentives tied to the performance standards.

We also believe that it is important for GAO to distinguish in its report the differences between contractor performance outcomes that would be used in contractor evaluations under performance-based contracting, and the outcomes identified for the MIP. Contractor performance outcomes are not necessarily tied to MIP program outcomes. For example, a contractor task order performance measure of maintaining a 95 percent reliability rate when performing medical review is not the same as the measurable outcome for reducing the error rate by 3 percent for all claims processed.

It should be noted in the report that HCFA has provided value to the PSC program efforts by instituting performance-based contracting initiatives. We agree that HCFA needs to better define the contractor performance measures and standards identified in the task orders. However, we recommend that GAO recognize in its report that we have already identified some performance measures in several task orders such as the Statistical Analysis Center and the Comprehensive Error Rate Testing task orders.

Further, GAO should recognize in its report that we are beginning to establish MIP or PSC program performance outcomes. One way we are achieving the development of these performance outcomes is to identify and benchmark our PI efforts against the performance measurement efforts of the private health insurance industry. We plan to award a contract this May for an independent entity to perform this work, and we will gladly share the information we gain with GAO.

Further, as HCFA defines these program performance outcomes, we recommend that GAO acknowledge the fine line that HCFA must walk in order to promote quality PI efforts while avoiding the motivation of inappropriate or overzealous PSC activities. An

example is the establishment of a performance measure objective that establishes numerical or percentage goals for identifying fraudulent or abusive providers.

We also recommend that GAO identify the inherent improvement in contracting that is gained by competing Federal Acquisition Regulation (FAR) contracts versus traditional Medicare carrier-and fiscal intermediary (FI)-directed contracts. Because the PSC contracts are FAR contracts, HCFA has more flexible tools to manage these contracts and the performance of PSC contractors.

We thank GAO for the opportunity to comment on this report.

Appendix II: GAO Contact and Acknowledgments

GAO Contact

Geraldine Redican-Bigott, (312) 220-7678

Staff Acknowledgments

Robert Dee, Laura Greene, Anna Kelley, Teruni Rosengren, and Michelle St. Pierre

201073

Ordering Information

The first copy of each GAO report is free. Additional copies of reports are $2 each. A check or money order should be made out to the Superintendent of Documents. VISA and MasterCard credit cards are also accepted.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:
U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

Orders by visiting:
Room 1100
700 4th St., NW (corner of 4th and G Sts. NW)
Washington, DC 20013

Orders by phone:
(202) 512-6000
fax: (202) 512-6061
TDD (202) 512-2537

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

Orders by Internet
For information on how to access GAO reports on the Internet, send an e-mail message with "info" in the body to:

Info@www.gao.gov

or visit GAO's World Wide Web home page at:

http://www.gao.gov

To Report Fraud, Waste, and Abuse in Federal Programs

Contact one:

- Web site: http://www.gao.gov/fraudnet/fraudnet.htm
- E-mail: fraudnet@gao.gov
- 1-800-424-5454 (automated answering system)