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MEDICARE

Existing Contract Authority Can Provide for Effective Program Administration

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Comptroller General
of the United States

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To the President of the Senate and the
Speaker of the House of Representatives

In accordance with the requirements of section 2326(e)(1) of the Deficit Reduction Act of 1984 (Public Law 98-369), we evaluated the Health Care Financing Administration's management of Medicare claims processing under noncompetitive cost reimbursement contracts and under eight competitively bid fixed-price contracts. The report recommends changes to improve the administration of the Medicare program.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health and Human Services; congressional committees and subcommittees; and other interested parties.

Charles A. Bowsher
Comptroller General
of the United States

Executive Summary

Health insurance companies process Medicare claims under contract with the government. These contractors are responsible for serving about 31 million elderly and disabled beneficiaries and insuring that the over $60 billion in annual payments from the Medicare Trust Funds represent only expenditures for medically appropriate, covered services. Most of these contractors are paid for their services on a cost reimbursement basis. In fiscal year 1985, the government paid contractors about $933 million to process about 330 million Medicare claims.

Under the Deficit Reduction Act of 1984, GAO was required to determine whether (1) the advantages of fixed-price competition justify the broader use of this method of contracting in the Medicare program and (2) the Department of Health and Human Services' (HHS') current authority is sufficient to achieve increased administrative efficiency without a change in contracting methods. (See p. 16.)

Background

When Medicare began in 1966, the Congress determined that the use of cost reimbursement contracts in the program was appropriate, and competition for these contracts generally was not required. HHS was later given legislative authority to experiment with fixed-price or incentive arrangements with contractors as a way of potentially reducing costs and improving program administration. Since 1977, HHS has initiated eight competitive fixed-price contracts on an experimental basis.

After reviewing the first three experiments, GAO reported in 1981 that a major change to competitive contracting in the Medicare program was not advisable. The reports cited many opportunities for HHS to improve its administration of Medicare using its existing authority. (See p. 15.)

The Deficit Reduction Act gave HHS additional authority to use competition on a limited basis to remove poor performing contractors from the program.

Results in Brief

GAO believes that a major change in the method of contracting used in the Medicare program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program. HHS' current authority, if properly used, allows for effective program management and provides sufficient opportunities to achieve greater administrative efficiencies.

GAO believes, however, that HHS has not fully used its authority to remove poor performing contractors from the Medicare program. In addition, HHS' recent efforts to cut administrative costs are inconsistent with congressional intent that cost-cutting measures not adversely affect program payments and the quality of services to beneficiaries and providers.

Principal Findings

Competitive Contracting

While competition generally offers the potential for reducing administrative costs, GAO estimates that only three of the seven competitive fixed-price experiments in the Medicare program have actually resulted in savings. In addition, high payment error rates in two of these experiments resulted in over $130 million in benefit payments errors (both overpayments and underpayments). Thus, much of the estimated $48 to $50 million in administrative savings may have been offset by lost program dollars.

Moreover, HHS has been successful at controlling Medicare administrative costs using cost contracts—the cost per claim processed has been steadily declining, and contractor administrative costs currently represent only about 1.3 percent of program costs. This compares favorably with the administrative costs incurred by large private insurers, which is about 7 percent of premium revenues.

More importantly, regular competition would probably increase contractor turnover. This could increase the problems that have been associated with changing contractors, such as disrupted services, slower benefit payments, and higher payment error rates. In addition, the two experiments in Illinois have shown that the penalty provisions of fixed-price contracts do not assure prompt correction of deficient contractor performance, nor do they adequately compensate the government, bene ficiaries, or health care providers for unsatisfactory performance. (See p. 22.)

Additionally, competitive fixed-price contracting requires more HHS resources to manage than cost reimbursement contracts. HHS' staffing levels have been declining, and GAO questions whether HHS, without additional staff, could effectively manage a larger number of competitive contracts. (See p. 24.)

GAO believes, however, that the authority to use competitive fixed-price contracting on a limited basis would be desirable. The threat of losing their contracts through competition has stimulated some cost contractors to improve performance and reduce administrative costs. Thus, the limited competitive authority would give HHS leverage in negotiating with cost contractors and would provide an additional option for removing poor performers from the Medicare program. (See p. 30.)

Current Authority Sufficient but Not Used as Intended

Between 1980 and 1984 HHS consolidated contract territories, thereby reducing the number of contractors, and made other administrative improvements. Further, the Deficit Reduction Act increased HHS' authority to deal with inefficient contractors and the conferees stated that any cost-cutting measures should not adversely affect program payments or beneficiary services. HHS' recent efforts to further cut administrative costs are inconsistent with this. (See p. 47.)

Because of budgetary shortfalls, HHS abandoned the traditional budget negotiation process in fiscal years 1985 and 1986 and reduced the funds given to each contractor to carry out its claims processing functions. These cuts were without adequate consideration for individual contractor circumstances, and even the most cost-efficient contractors were required to reduce their costs. (See p. 47.)

These cuts left inadequate funds to implement additional legislative and HHS requirements or to process a workload that could exceed projections by as much as 66 million claims. Because of the limited budgets, contractors may have reduced their efforts to safeguard the program against inaccurate and unnecessary payments. In addition, the quality of services provided to beneficiaries and providers has deteriorated. (See p. 54.)

Matter for Congressional Consideration

The Deficit Reduction Act authority, allowing HHS to use a limited number of fixed-price competitions annually to remove poor performing contractors, expires at the end of fiscal year 1986. The Congress should consider extending this authority or making it permanent, thereby providing HHS an additional option for dealing with poor performing contractors.

Recommendations

GAO recommends that HHS use a Medicare contractor budget development process that places more emphasis on individual contractor circumstances to determine more realistically the funds needed to support program safeguards and an adequate level of beneficiary and provider service activities. HHS should also use existing legislative authorities to remove consistently poor performing contractors from the Medicare program.

Agency Comments

HHS maintains that fixed-price contracting is superior to the current method of contracting and that legislative authority to use fixed-price contracting is necessary for effective administration of the Medicare program. However, HHS provided no additional information in support of this position beyond that already considered by GAO.

HHS disagreed with GAO's recommendation concerning the contractor budget process because it believes that contractor circumstances were adequately considered in developing budgets. GAO identified a number of contractor-specific factors that HHS did not consider in setting contractor budgets. Moreover, the conferees for the Deficit Reduction Act emphasized the need to consider individual contractor circumstances in developing their budgets. Also, because of the experience of the Medicare contractor community, contractor input to the budget development process would help assure that the administrative budget is adequate for carrying out Medicare activities.

HHS generally agreed with the GAO recommendation to remove poor performing contractors from the Medicare program.

Contents

Abbreviations

BC	Blue Cross
BS	Blue Shield
CPEP	Contractor Performance Evaluation Program
DEFRA	Deficit Reduction Act of 1984
EDSF	Electronic Data Systems Federal Corporation
EOMB	Explanation of Medicare Benefits
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HCSC	Health Care Service Corporation
HHS	Department of Health and Human Services
OMB	Office of Management and Budget

Introduction

The Deficit Reduction Act of 1984 (DEFRA) (Public Law 98-369, July 18, 1984) directed us to review the contracting process for administrative services related to paying claims under the Medicare program. Under section 2326, we were required to determine

- if the advantages of competitive fixed-price procurement[1] justify the broader use of this method of contracting in the Medicare program, and
- whether the Department of Health and Human Services' (HHS') current authority is sufficient to achieve increased administrative efficiency without the need for a change in contracting methods.

The Medicare Program

Medicare is a federal program that pays much of the health care costs for eligible persons—almost all persons 65 and older and some disabled persons. Medicare was established by title XVIII of the Social Security Act and became effective on July 1, 1966. The program provides two basic forms of protection:

- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities, and care provided in patients' homes and by hospices.
- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums and federal contributions, covers physician services and many other health services, such as laboratory and physical therapy services.

In fiscal year 1984, benefit payments amounted to $41 billion for about 30 million part A beneficiaries and $19 billion for about 29 million part B beneficiaries. Most of the part B payments—about $14 billion—were for physician services.

Medicare Program Administration

Within HHS, the Health Care Financing Administration (HCFA) is responsible for the overall administration of Medicare, including establishing the regulations and policies under which the program operates. One of HCFA's primary responsibilities is contracting with and monitoring the

[1]We are using the term "competitive fixed-price" procurement or contracting to refer to competitively negotiated contracts in the Medicare program. Technically, the term encompasses both formal advertised contracts and negotiated competitive contracts. The negotiated competitive contract process does not have the rigid set of formalized procedural steps inherent in formal advertising, and factors other than the lowest price are used in making the contract award. To minimize the technical language, in this report competitive fixed-price procurement or contracting refers to competitive negotiation, not to formal advertisement.

performance of the insurance companies that process and pay claims under Medicare law.

Section 1816 of the Social Security Act authorizes HHS to contract with insurance companies[2] —called intermediaries—for the administration of part A, and section 1842 authorizes HHS to contract with insurance companies—called carriers—for the administration of part B. Both sections call for the use of cost reimbursement contracts under which contractors are reimbursed for necessary and proper costs of carrying out Medicare activities, but are not permitted to make a profit. Also, under procedures established in both sections, competition generally has not been required when contracting with intermediaries and carriers.

The original Medicare legislation and the accompanying committee reports reflected the congressional decision that program administration be carried out by contracting with private organizations that already served as third-party payers of health care services and performed in their private business many of the functions that they would perform for Medicare. Because these organizations had to adjust their systems to accommodate Medicare's complex payment methodologies and strict government reporting requirements for a new program, the Congress selected cost reimbursement contracts.

Intermediaries are responsible for processing and paying all part A claims, communicating with providers about the program and changes to it, and providing other related administrative services. Providers[3] generally have the option of selecting the intermediary that will process their claims, although home health agencies not associated with a hospital are assigned to specific intermediaries. Currently, Medicare has intermediary contracts with six commercial insurance companies, two Blue Cross plans, and the Blue Cross and Blue Shield Association, which in turn subcontracts with 46 local Blue Cross plans. The vast majority of providers deal with the local Blue Cross plans as their intermediaries. Intermediaries also process and pay claims for part B services—such as outpatient hospital services—furnished by providers.

Carriers are responsible for the same administrative functions as intermediaries, but process and pay part B claims from physicians and

[2]An intermediary does not have to be an insurance company, but all current intermediaries are.

[3]Under Medicare, providers are defined as hospitals, skilled nursing facilities, home health agencies, hospices, and comprehensive outpatient rehabilitation agencies.

suppliers.[4] Carriers handle all claims in the geographic area—normally a state—that is covered by their contracts. Currently, Medicare has carrier contracts with 10 commercial insurance companies and 29 Blue Shield plans.

In fiscal year 1984, intermediaries paid about 44 million claims, including about 12 million for inpatient hospital services, 25 million for outpatient hospital services, and 5 million for home health services. Intermediaries were paid $304 million for their efforts. Carriers paid about 184 million claims and were reimbursed $521 million for their services.

In fiscal year 1984, intermediary and carrier costs of $825 million represented about 1.3 percent of total Medicare costs. Other Medicare administrative costs, including HCFA's expenses, represented an additional 1.2 percent of total Medicare costs.

Changes in Medicare's Administrative Authorities

After the initial implementation of Medicare, the Congress became concerned about the program's administrative efficiency and the performance of its contractors. The staff of the Senate Committee on Finance criticized the inefficient and costly performance of Medicare contractors in a 1970 report.[5] The report cited the tremendous variations in performance and cost per claim processed among the carriers and intermediaries, indicating that the variations were so great that contractor terminations were justifiable. The staff believed that the continual renewal of contracts for poorly performing contractors was against congressional intent and that HHS had no active policy of complete and in-depth analysis followed by terminations of poor performers in favor of better ones.

Although the report did not mention contracting alternatives for part A services, it did suggest that part B carriers might be compensated on other than a cost basis (such as incentive payments that would be tied to performance and cost per claim processed). The staff report led to the enactment of section 222 of the Social Security Amendments of 1972 (Public Law 92-603, Oct. 30, 1972), which gave HHS the authority to

[4]Medicare's definition of physician includes other types of practitioners, such as podiatrists and chiropractors, and its definition of suppliers covers such things as clinical laboratories and durable medical equipment furnishers.

[5]Medicare and Medicaid—Problems, Issues, and Alternatives, report of the Senate Committee on Finance staff, Feb. 9, 1970.

experiment with incentive reimbursement arrangements and fixed-price contracts to determine whether such arrangements would induce the most effective, efficient, and economical performance.

Alternatives for part B contracting were further discussed in the June 21, 1974, report of the Advisory Committee on Medicare Administration, Contracting, and Subcontracting (the Perkins Committee). The Perkins Committee consisted of three members from outside the government who were appointed by the Secretary of HHS. The Committee was to consider the most important issues in Medicare contract administration and recommend improvements. Like the Senate Finance Committee staff report, the Perkins Committee noted the enormous variation in administrative costs among carriers. Although given numerous possible explanations for the differences in unit costs, the Committee concluded that most of the variation was attributable to the (1) differences in efficiency among carriers and (2) accounting practices (particularly in accounting for the proportion of a carrier's costs allocated to its Medicare business). The Committee concluded that, even if the reason for the cost variation could not be determined, it was unacceptable.

The Perkins Committee recommendations involved devising methods to provide incentives to carriers that would substitute for direct competition. Methods recommended included providing financial rewards, improved performance measurement, and a workable system for eliminating poor performers. The report cited several advantages to multiple carrier participation in Medicare and the overall good job that carriers had done in implementing the program. It also stated that the advantages of private participation in Medicare administration disappear if each carrier is not given adequate incentive to do the most effective job possible.

Two factors in the system at that time were believed to work against an effective system. First, carriers were assigned territories on an exclusive basis, with no direct competition within assigned areas. Second, they were reimbursed on the basis of reported costs; consequently, they had no financial incentive to minimize costs. The Perkins Committee was apparently reluctant to recommend wholesale competition because of the potential adverse effects of frequent carrier changes on services to the beneficiaries. However, the Committee did state that, for carriers that show significant deficiencies in cost or performance, the short-term problems of changeover should be outweighed by the long-range benefits of not allowing territorial monopoly. The Committee suggested the use of competitive fixed-rate procurement where a contract had been

terminated. It also suggested negotiating fixed-rate contracts with other carriers.

In 1976, as authorized by section 222 of Public Law 92-603, HCFA sought proposals from carriers to undertake fixed-rate contracts on a voluntary basis. While the contractors showed little interest in voluntarily changing from their cost contracts, Medicare did negotiate one fixed-rate contract—with Blue Shield of Maryland—and approved another carrier's data processing subcontract under which the subcontractor guaranteed that total carrier costs would not exceed a fixed amount per claim. In a 1979 report on Medicare contracting, we did not consider either of these agreements to be incentive contracts and concluded that incentive contracting remained an untried alternative that should be tested.[6]

Beginning in 1977 with HCFA's first experimental fixed-price competitive contract for a carrier for Maine—awarded to Massachusetts Blue Shield—Medicare has awarded eight such contracts under the authority of section 222.[7] These contracts are listed in table 1.1, and competitive contracting is discussed in detail in chapter 2.

[6]See More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing, HRD-79-76, June 29, 1979, pp. 97-112.

[7]Besides the competitive fixed-price contracts, HCFA has undertaken a noncompetitive fixed-price contract under part A for the state of New York. The experiment was initiated by the Blue Cross and Blue Shield Association and the seven Blue Cross plans that acted as intermediaries in New York. Under the negotiated fixed-price contract, the seven contractors were consolidated. One of the seven was selected as the intermediary, and the other six obtained subcontracts. The initial experiment covered the period May 1, 1981, to Apr. 30, 1984, and was later extended to Sept. 30, 1987.

Table 1.1: Medicare's Competitively Awarded Contracts

State(s)	Operational period From	To	Number of offerors
Maine I (part B)	12/1/77	9/30/81[a]	5
Illinois I (part B)	4/1/79	4/1/84[b]	5
Western New York (part B)	6/1/79	9/30/82	6
Missouri (part A)	7/1/81	9/30/86[c]	2
Maine II (part B)	10/1/81	9/30/85[a]	2[d]
Colorado (parts A & B)	8/2/83	9/30/86	1
Illinois II (part B)	4/2/84	3/31/87	3
Tri-state— Maine, Vermont and New Hampshire (part B)	10/1/85	9/30/88	3

[a]Includes a 12-month extension.

[b]Includes a 6-month extension.

[c]Includes a 12-month and a 15-month extension.

[d]Originally three, but one withdrew.

Section 2326 of DEFRA authorized HHS to award two part A and two part B competitive fixed-price contracts during each of fiscal years 1985 and 1986. HCFA has not awarded any contracts under this authority. Section 2326 also provided that HHS could limit payments under cost contracts to "the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier [or intermediary] in carrying out the terms of its contract." HCFA is using this authority in approving carrier and intermediary budgets under cost contracts (see ch. 4).

Previous GAO Reports on Medicare Contracting

In our June 29, 1979, report (required by section 12 of Public Law 95-142), we cited many opportunities for HHS to improve its administration of Medicare contracting and recommended a number of actions to the Congress and HHS. In that report, we concluded that

- a careful and objective evaluation of the competitive fixed-price experiments was needed before making a major change to this method of contracting in the Medicare program;
- further experiments were needed to evaluate the feasibility of (1) merging parts A and B under a single contractor and (2) using incentive contracts in the Medicare program; and
- immediate action (including the implementation of performance standards) was needed to eliminate the less efficient performers from the

program, thereby reducing the unacceptably high number of contractors.

An important finding of our study was that consolidation of contractor areas should reduce administrative costs, because contractors, when assuming additional workloads, incur only incremental costs for the new workload. That is, the contractor's fixed costs remain the same and only its variable costs increase.[8] We concluded that HCFA had adequate legislative authority to undertake consolidations to achieve administrative cost savings in this manner. HCFA has undertaken a number of consolidations since our report (see p. 33).

In a follow-up report issued on December 1, 1981,[9] we reviewed experimental competitive contracts in Illinois, Maine, and New York. We concluded that to use competitive fixed-price contracting in the Medicare program, except in experiments, the Congress would have to enact authorizing legislation. We stated that such a legislative change was still premature because

- a thorough evaluation of the experiments had not yet been completed,
- the results of the part B experiments revealed several weaknesses in HCFA's contracting procedures,
- more improvements could be made under existing contracting authority to achieve some of the advantages sought by competitive fixed-price contracting, and
- long-term expectations of cost savings from competitive fixed-price contracting should be viewed with caution because recompeting the contracts might not produce savings.

Objectives, Scope, and Methodology

As specified in DEFRA, our objectives were to study

- HCFA's ability to manage "competitive bidding" for agreements and contracts under sections 1816 and 1842 of the Social Security Act, and the relative costs and efficiency of such competitive agreements and contracts as compared to current "cost reimbursement" for such agreements and contracts;

[8]Fixed costs, such as rent on a building, do not vary with relatively small changes in workload. Variable costs, such as postage and data processing costs, change as the workload changes.

[9]Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare, GAO/HRD-82-17, Dec. 1, 1981.

- the need (if any) for eliminating the provider nomination procedure under section 1816(a);
- the disparities (if any) in costs and quality of claims processing among the various entities performing claims processing pursuant to sections 1816 and 1842;
- whether HHS' standards for evaluating costs and performance of intermediaries and carriers are adequate and properly applied; and
- whether HHS' statutory authority is sufficient to deal with inefficient intermediaries and carriers either through the contract negotiation and budget review process or through the process for termination or non-renewal of contracts.

In a May 10, 1985, joint letter to the Comptroller General, the Chairmen of the House Committee on Ways and Means and the Senate Committee on Finance discussed the requirements of Public Law 98-369. The letter cited a number of specific issues and concerns that we should address in evaluating the fixed-price experiments and HCFA's management of cost reimbursement contracts. Because this letter expanded the scope of our study, the Chairmen stated that the reporting date called for in the law, July 1985, could be delayed.

We performed work at HCFA's central office in Baltimore and at 5 of the 10 HCFA regional offices—Boston, Philadelphia, Chicago, Kansas City, and Denver. We also met with officials of the Blue Cross and Blue Shield Association in Chicago and obtained copies of the results of a questionnaire it sent to member plans concerning fixed-price contracting and HCFA's budgetary process used in fiscal years 1985 and 1986. In addition, we met with officials of the contractor representative groups (the Carrier Representative Group and the Fiscal Intermediary Group) and visited 14 Blue Cross or Blue Shield plans and five commercial insurance companies that serve as Medicare contractors. We also contacted three other contractors by phone. The carriers and intermediaries visited, along with the type of contract they have, are shown in table 1.2.

Table 1.2: Contractors Visited

Name of contractor	Function		Type of contract	
	Intermediary	Carrier	Cost	Fixed-price
Commercial insurance companies:				
Aetna	X	X	X	
Connecticut General		X	X	
Prudential	X	X	X	
Equitable Life		X	X	
Mutual of Omaha	X	X	X	
Blue Cross (BC)/Blue Shield (BS) plans:				
BC of Connecticut	X		X	
Associated Hospital Service (Maine)	X		X	
BS of Massachusetts		X	X	X
BC/BS of New Hampshire/ Vermont	X	X	X	
BC/BS of Rhode Island	X	X	X	
BC/BS of Colorado	X	X		X
BC/BS of Utah	X	X	X	
BC/BS of Wyoming	X		X	
BC Hospital Service (St. Louis)	X			X
BC/BS of Kansas City		X	X	
BS of Pennsylvania		X	X	
BC/BS of Maryland	X	X	X	
Health Care Service Corporation (Illinois)	X	X	X	X
BS of Western New York[a]		X	X	X

[a]BS of Western New York's fixed-price contract expired in 1982, and the contractor has had a cost contract since then.

To address the issues concerning competitive fixed-price contracting, we reviewed various HCFA and contractor documents and reports pertaining to the contract award process, the transition from the outgoing to the incoming contractor, and ongoing cost and performance. These documents included requests for proposals, contracts, annual contractor evaluation reports, cost reports, and contract change orders. We also reviewed the formal evaluation reports on five of the fixed-price experiments prepared by Abt Associates under contract with HCFA. We met with the project director for these evaluations to discuss the methodology and results of the Abt studies and to obtain his views on our methodology for projecting cost savings from the experiments.

We interviewed five contractors who attended a preproposal conference (but chose not to submit an offer) and six unsuccessful offerors in other competitions to obtain their views on competition and the contracting process. To estimate the savings realized from the seven experiments completed or operational as of September 1985, we compared the actual costs and workloads of the fixed-price contracts with projections for the outgoing contractor derived through regression analysis.

To evaluate HCFA's management of cost contractors, we studied the process for developing and negotiating contractor budgets, reviewing contractor performance, and dealing with poor performing contractors. As part of this effort we reviewed administrative budget guidelines, proposed and approved budgets, expenditure reports, correspondence files, performance standards, results of HCFA's contractor evaluations, and various processing time and workload reports.

Our work was performed from October 1984 through October 1985 in accordance with generally accepted government auditing standards.

Change to Competitive Fixed-Price Contracting in Medicare Is Not Justified

We have historically supported the use of competitive procurement by the government because it helps assure a fair and reasonable price and quality of services. In our 1981 report on Medicare's experimental contracts, however, we questioned whether the change to competitive fixed-price procurement was necessary in the Medicare program. Based on HCFA's experience to date, we continue to question whether Medicare should make general use of competitive fixed-price contracting for several reasons. First, the frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance. Poor performance can result in lost program dollars through erroneous benefit payments and can also adversely affect services to beneficiaries and providers. Second, administering competitive fixed-price contracts generally has consumed more of HCFA's management resources than cost reimbursement contracts, and sufficient resources may not be available for multiple competitions.

In addition, although competitive fixed-price contracting is one mechanism for controlling administrative costs, there may be little need for such a mechanism in Medicare because:

- Medicare's administrative costs are already quite low, representing only about 2.5 percent of total program costs in fiscal year 1984 (about 1.3 percent for contractor costs). In 1983, large private health insurers incurred about 7 percent of premium revenues for administrative costs.
- DEFRA gave HCFA additional authority to control payments to cost contractors by permitting it to disallow costs that exceed a standard for efficiency.
- The experiments have not convincingly demonstrated that competitive fixed-price contracts will generate savings. Only three of the seven fixed-price experiments have resulted in administrative cost savings. Overall, we estimate that through fiscal year 1984, the competitive fixed-price contracts have reduced administrative costs by a total of $48 to $50 million. However, high payment error rates in two of these experiments resulted in about $130 million in payment errors (overpayments and underpayments).

Finally, we continue to believe that HCFA can achieve many of the potential advantages of competitive fixed-price contracting under the existing authorities for cost contracting. However, we believe that continued authority for the use of competitive fixed-price contracting on a limited basis is desirable. The ability to use competitive fixed-price contracting, as part of a coordinated management strategy, would give HCFA added

flexibility and leverage in dealing with the contractor community and in removing poor performers from the Medicare program.

Competitive Contracting Could Increase Medicare Problems

Whenever Medicare changes contractors, performance problems may arise, particularly during the early period after the new contract becomes effective. We believe, however, that the routine use of competitive fixed-price contracting could increase the risks to the Medicare program. First, the regular use of competitive fixed-price contracts would probably increase the number and frequency of contractor changes, thus increasing the potential for disruption of service, slower benefit payments, and higher payment error rates. Second, open competition can result in the selection of inexperienced contractors who may encounter difficulties while learning the many complex and unique requirements of Medicare claims processing, as was the case in the two Illinois experiments.

Finally, we believe that Medicare has less flexibility under fixed-price contracts to correct problems that may arise during the performance of the contracts. Under a fixed-price contract the contractor agrees to provide the required services at the stated price. If performance is unacceptable, Medicare can penalize the contractor, but this does not help to process correctly the daily stream of claims. In fact, if a fixed-price contractor is experiencing cost problems, assessing monetary penalties could exacerbate performance problems. Also, approving contract modifications to overcome performance problems is a more involved process under fixed-price contracts. On the other hand, we believe Medicare has more freedom of action in dealing with cost contractors to overcome performance problems. For example, HCFA can increase a contractor's budget to enable it to improve its computer system or to hire more staff to overcome backlog problems.

Overall, the transitional and ongoing performance of competitive fixed-price contractors has generally been similar to that of cost contractors. Contractor performance has ranged from satisfactory for both Maine part B experiments to unsatisfactory in both Illinois part B and the Colorado part B experiments. Performance has been satisfactory in Missouri and the Colorado part A experiments, and after 6 months of operation, contractor performance in New York improved to the satisfactory level.

However, the experience under the two competitive fixed-price contracts in Illinois has shown the problems that can arise and the adverse

consequences of these problems to Medicare, its beneficiaries, and the providers of health services.

Performance Problems Have Occurred With New Contracts

Any change of contractors in the Medicare program can involve problems because of the inexperience of the new contractor's staff, unfamiliarity with the new claims workload, and the possible need to make complex system changes. Problems have occurred to varying extents under both cost and competitive fixed-price contracts. For example, in one of the first competitive fixed-price experiments in New York, there were initial increases in claims backlogs and payment error rates. However, after 6 months, the contractor was able to correct these problems and performed satisfactorily through the remainder of the contract period. Similarly, minor problems occurred when Medicare removed Medical Services of D.C. and Delaware Blue Shield from the program and Pennsylvania Blue Shield took over these two areas on a cost contract basis.

On the other hand, the problems that arose under both fixed-price competitions in Illinois were more serious. Under the first contract, average processing times increased dramatically, as did pending claims backlogs. Both experiments had extremely high payment error rates. It took over 2 years to get performance under the first Illinois fixed-price contract to acceptable levels. After a year and a half, the payment error rate was still unacceptable under the second Illinois contract.

Each of the Illinois experiments involved similar problems. The first contract was awarded to Electronic Data Systems Federal Corporation (EDSF) and initially covered the period July 1, 1978, to September 30, 1983. The contract was later extended through April 1, 1984. Although EDSF had been extensively involved in subcontracting for data processing operations with Medicare carriers, it had never been a Medicare contractor. Illinois II was awarded to Health Care Service Corporation (HCSC), a Blue Shield plan that was a losing offeror in the first experiment. HCSC was considered new to Medicare because it had not been a part B contractor since 1978 and was not completely up to date on the program changes since that time.

Our 1981 report on competitive contracting covered EDSF's experience through June 1981. The report cited the many problems encountered during the transition from the outgoing to the incoming contractor, as well as performance deficiencies during the operational period. Two

major problems cited concerning the transition were (1) EDSF's inexperience as a carrier coupled with the scope of work involved in the transfer of two carrier workloads to one and (2) HCFA's insufficient monitoring of EDSF's transitional tasks. In 1981, HCFA and EDSF were working on problems that should have been corrected 2 years earlier during the contract's transition phase.

As stated, EDSF and HCSC experienced performance problems during their initial operational periods. As of June 1981 EDSF had failed 55 of 84 standards and was subject to damage assessments of $2.9 million. Because of EDSF's appeals, the amount of damages was reduced to $2.3 million. The damage assessments may not fully compensate for actual losses to Medicare because EDSF made estimated payment errors of $67.6 million[1] during the first 2 years of the contract and beneficiaries and providers had to devote considerable time and effort to obtain satisfactory settlement of their claims. EDSF's performance improved significantly after fiscal year 1981.

HCFA officials stated that the Illinois II transition was very labor intensive, requiring substantial HCFA time and resources. HCFA wanted to insure that this transition was not a repeat of the EDSF experience. While all the key tasks were not performed as scheduled, the transition was considered by HCFA to be a success, and HCSC managed to begin its operational period on schedule.

During HCSC's first 6 months of operation, it met or exceeded all standards used to measure the timeliness of claims processing. This seems noteworthy considering its new staff and the 23-percent increase in workload over the comparable period with the previous contractor.

However, HCSC failed the standard on quality of claims processing, which could cause millions to be paid in error. During the first year of operations, it experienced high payment error rates. Based on projections from HCFA's part B quality assurance program, HCSC made payment errors of $65 million during this period. HCFA's evaluation of performance for April-June 1984 shows that HCSC had a 10.8-percent payment error rate compared to the contract standard of 1.6 percent and a national average payment error rate of 1.8 percent for fiscal year 1984. HCFA assessed damages of $404,000 for fiscal year 1984. Both HCSC and HCFA took a number of actions, including restructured training, to correct poor performance in the quality of claims processing.

[1]Payment errors were about equally divided between underpayments and overpayments.

HCFA data for the year ended June 1985 (the most recent available) shows that HCSC's payment error rate decreased to 4.5 percent. However, this error rate—after more than a year of operation—was the highest of any Medicare carrier and almost three times the national average of 1.8. We estimate that the Illinois II experiment saved Medicare more than $5 million in administrative costs for the first 6-month period of operation, with a potential for much greater savings over the life of the contract (see p. 29). On the other hand, these savings could be offset by additional costs resulting from payment errors.

Although the problems that have arisen under competitive fixed-price contracting are not necessarily inherent to such contracts, we believe that they illustrate the risks to Medicare and its beneficiaries involved in this method of contracting. Because of the nature of these contracts, it is basically the contractor's responsibility to overcome any problems that arise and suffer a loss if necessary to do so.

When poor performance occurs in a fixed-price contract, the government generally has two remedies. The first is to assess penalties—which does not assure that problems are corrected and may not fully indemnify Medicare for payment errors made. The second is to terminate the contract—which, considering the long lead times necessary to obtain a new contractor, is really not a very viable alternative. Under cost contracts, however, the government has more options—assuming funds are available—to help a contractor overcome problems and keep the program operating until a replacement is feasible.

Competitive Contracts Have Required More HCFA Resources

HCFA has learned from the competitive fixed-price experiments and has attempted to apply these "lessons learned" in its more recent competitions. While some of these lessons relate to technical details of the competitive process and to better contract clauses and requirements, a key lesson was that HCFA has to devote more resources to awarding the contracts and monitoring the transition phases. For example, after the problems with the first Illinois experiment, HCFA concluded that in subsequent competitions it needed to devote more staff to insuring that new contractors completed all transition tasks successfully. Another lesson was that any problems that arise during the initial operation phase can have a compounding effect (for example, as backlogs grow, so do inquiries from providers and beneficiaries, which in turn increase workload and can result in further backlogs). HCFA recognizes that it must devote sufficient staff to monitoring the initial operation phase to quickly identify budding problems.

HCFA's lessons learned illustrate that during the transition and early operational phases of the contract cycle, the administration of competitively awarded fixed-price contracts has generally required more HCFA resources than the traditional cost-type contracts. They also pointed out that the competitive contracting process requires resources for activities not normally needed in cost contracting—preparing requests for proposals, holding preproposal conferences, evaluating proposals, and awarding contracts. They added that there is very little difference in HCFA staff resource requirements for cost contracts and fixed-price contracts after the contracts are fully operational. HCFA officials told us they do not record staffing by type of contract; therefore, we could not quantify the staffing differences by contract type.

Abt Associates addressed this issue in its 1983 report to HCFA on the evaluation of part B competitive fixed-price experiments. Abt's analysis shows that on average, HCFA required an additional 2.5 staff years per contract year for the four experiments evaluated. Abt pointed out that the typical experience of these contracts was that they required more regional effort than did the traditional cost-type contracts.

In the competitive fixed-price experiments to date, HCFA has been able to borrow staff from other functions in its efforts to manage these contracts. But HCFA's staffing has been declining over the past few years, and HCFA officials told us that they do not have sufficient staff to manage Medicare contracting under a total competitive environment.

HCFA Has Controlled Administrative Costs Without Fixed-Price Contracting

Although competitive fixed-price contracting provides a mechanism for reducing administrative costs, the need for such a mechanism in the Medicare program is diminishing. In our June 29, 1979, report on Medicare contracting, we pointed out that, since the inception of Medicare, benefit payments had increased dramatically year after year while increases in intermediary and carrier costs had been more moderate and on a cost per claim basis had actually decreased substantially. That same general trend has continued.

Between 1980 and 1984, benefit payments nearly doubled from $33 billion to $59.9 billion, but total contractor administrative costs increased by only 34 percent from $614 million to $822 million. The total volume of claims processed increased steadily during this period.

The individual cost per claim processed for part A and part B have changed differently—part A has increased slightly over the 5-year

period, while part B has steadily decreased. Data for fiscal years 1980 and 1984 are summarized in table 2.1.

Table 2.1: Medicare Claims Volume and Processing Costs

(Volumes in millions)

	Part A		Part B	
Fiscal year	Volume	Unit cost	Volume	Unit cost
1980	39.8	$5.43	152.3	$2.61
1984	50.2	5.89	224.7	2.30

When the effects of inflation are removed, the unit costs for both part A and part B have actually decreased since 1980. Table 2.2 shows the change in the adjusted unit costs between 1980 and 1984 in constant 1970 dollars.

Table 2.2: Change in Unit Processing Costs From 1970 to 1984 in 1970 Dollars

	Cost per claim	
	Part A	Part B
1970	$6.34	$3.16
1980	2.54	1.26
1984	2.33	.85

These figures show that HCFA has been successful in constraining Medicare's administrative costs and has done so primarily through controls over the cost contracts. Considering that Medicare administrative costs represent only 2.5 percent of program costs and that large private insurers generally incurred about 7 percent in administrative costs in 1983, overall, Medicare's contract costs do not appear to be unreasonably high.

DEFRA Gave HCFA Additional Authority to Reduce Administrative Costs

DEFRA gave HCFA expanded authority to control payments to cost contractors. The law gave HCFA the authority to limit payments to the costs that must be incurred by an "efficiently and economically operated" contractor. In effect, HCFA can now disallow contractor costs that exceed a standard for efficiency, thereby preventing cost contractors from receiving unreasonable payments. This authority, combined with HCFA's other authorities for cost contracts (see ch. 6), gives HCFA adequate tools to control the costs of cost contractors and to remove poor performing contractors from the program.

When HCFA uses the increased DEFRA authority to limit payments to contractors, it should be to reduce payments to inefficient contractors.

However, HCFA has used this new authority to reduce all contractors' budgets—requiring even the most cost efficient to cut costs further. Use of the DEFRA authority in this manner may have adversely affected benefit payments (see ch. 4).

Savings From Competition Less Than Projected

Overall, the competitive fixed-price experiments have saved the government millions of dollars in administrative costs. However, fixed-price contracts do not always generate savings. Our analysis showed that the actual cost of the fixed-price contracts was more than the projected cost of cost reimbursement contracts in four of the seven experiments completed or operational as of September 1985 and that HCFA has realized less savings than it originally projected from the seven experiments. Moreover, the two contracts expected to yield the greatest savings—Illinois I and II—had the biggest problems in terms of payment errors, and any administrative savings may have been more than offset by a loss of program dollars.

HCFA's original estimates of the cost per claim of the winning contractors generally were lower then the national average cost and the outgoing contractor's cost experience, as shown in table 2.3. The estimates are based on HCFA's projections of the claims volume for the initial period of each contract.

Table 2.3: Winning Prices From Experimental Contracts

Territory	Total price	Estimated price per claim	National average cost per claim	Outgoing contractor's cost per claim
Maine I	**$ 5,285,000**	$ 2.88	$ 2.98	$3.01
Illinois I	**41,800,000**	2.03	2.86	3.26
New York	**20,296,150**	1.53	2.79	3.06
Missouri	**13,791,100**	3.92	5.40	4.54
Maine II	**9,065,813**	2.89	2.68	2.54
Colorado:				
Part A	**31,899,886[a]**	4.51	5.26	5.33
Part B	•	2.58	2.51	2.78
Illinois II	**29,200,850**	1.20	2.37	2.35

[a]This figure represents the total price for parts A and B.

We do not believe, however, that HCFA's estimating procedures accurately predicted administrative savings under the contracts. This resulted because HCFA compared the outgoing contractor's costs to the estimated cost per claim over the life of the competitive contract. Such a

procedure does not take into account the experience under the cost contract, which was generally a downward trend in average cost per claim. Also, HCFA's estimating procedure is sensitive to errors in predicted workload levels because all of the contracts were awarded on a total cost, not a cost per claim, basis. Thus, any difference between projected and actual claims volume directly affects the cost per claim.

HCFA revised its method for projecting savings for the fixed-price experiments, and the current method compares the actual fixed-price contract costs, including contract modifications, to the average national cost per claim for each year of the contract. Actual claims volumes are used where available.

We estimated differences in cost between the cost and fixed-price contracts using a regression model and data from 1970 to 1984. For each fixed-price contract service area, we computed that area's trend under the cost contract, adjusted for inflation, and compared the resulting estimate to actual payments under the applicable fixed-price contract. These estimates, which were made at the 95-percent confidence level, predict what the cost would have been if the outgoing contractor had continued a cost reimbursement contract. We believe this methodology produces a better cost projection because it better reflects the downward trend in unit costs and actual workloads and includes more relevant factors, including inflation. The actual costs under the experiments are based on the contract prices and the cost of contract changes through fiscal year 1984. Table 2.4 shows HCFA's and our estimates of administrative cost savings and losses from the competitive experiments through fiscal year 1984.

Table 2.4: Administrative Savings (Losses) From Competitive Contracts Through Fiscal Year 1984

(Amounts in millions)

	Savings (losses)				
Territory	HCFA original estimate	HCFA current estimate	GAO estimate		
Maine I (part B)	$ 0.8	$ 0.6	$(0.07)	to	$(0.5)
Illinois I (part B)	39.1	14.3[a]	37.7	to	40.1
New York (part B)	15.5	10.2	12.7	to	17.3
Missouri (part A)	2.4	7.1	(1.3)	to	(5.7)
Maine II (part B)	1.1	(2.5)	(4.8)	to	(6.2)
Colorado (parts A & B)	(1.9)	(3.1)	(1.6)	to	(2.2)
Illinois II (part B)	7.1	3.5[b]	5.5	to	7.6
Total	**$64.1**	**$30.1**	**$48.1**	**to**	**$50.4**

[a]Does not include 6-month extension.

[b]Savings estimated to be $27 million over entire period of contract.

Overall, we estimate that through fiscal year 1984, the competitive fixed-price experiments have reduced administrative costs by a total of $48.1 to $50.4 million. This is from $13.7 to $16 million less than HCFA originally projected. In four of the seven experiments, we estimate that the costs of the fixed-price contractors were higher than they would have been had the territories remained under cost contracts.

According to our estimates, the Illinois I and the New York experiments resulted in the greatest administrative savings. Both of these experiments involved the consolidation of multiple contractors' territories; thus, we believe some of the savings can be attributed to economies of scale. Also, the New York contractor reduced costs by moving its operation to a more central location, primarily because of the lower wage rates there. The same strategy of moving to a lower wage rate location was adopted by the successful offerors for both Illinois contracts.

Cost contractors have also been looking for cost-saving alternatives. In HCFA's Denver region, for example, three part A contractors and two part B contractors consolidated their computer systems. Also, one of the carriers for California relocated to a lower labor cost area to reduce its costs. We believe that more of these types of actions can be accomplished under the cost contracts to achieve savings.

The first Illinois experiment resulted in the greatest administrative cost savings to the government, and Illinois II has the potential to save even

more over the life of the contract. However, these two experiments have also resulted in about $73 million in overpayments; thus, administrative savings may be offset by excessive benefit overpayments (see p. 23.)

In addition to any administrative cost savings resulting directly from the competitive experiments, the authority to use fixed-price contracting has indirectly helped HCFA reduce the cost of all contractors. HCFA officials stated that this authority has provided them with additional leverage in negotiating with the cost contractors. Some contractors agreed, pointing out that the threat of losing their territories through competition has stimulated them to improve their performance and their administrative costs.

Most Recent Experiment May Be Less Attractive Than HCFA Believes

The most recent competitive fixed-price procurement involved a tri-state area—Maine, Vermont, and New Hampshire. Massachusetts Blue Shield won the competitive fixed-price contract for an estimated cost per claim of $1.35. Massachusetts Blue Shield was the fixed-price contractor for Maine I and Maine II while serving as the cost contractor for Massachusetts. Although the $1.35 per claim price is attractive, it may not be a realistic estimate of costs under the contract.

Massachusetts Blue Shield anticipated a tri-state procurement and was willing to absorb short-term, one-time losses to remain a part of what it believes is HCFA's intent to consolidate carrier areas. Also, officials of the carrier stated that the fixed-price workload would be processed through the same computer system used for its cost reimbursement workload. Thus, the experiment, in effect, is a four-state operation.

As we discussed extensively in our 1979 report on Medicare contracting, there is a large potential to achieve administrative cost savings by consolidating contractor areas. This savings results because, depending on the extent of workload added to a contractor, its fixed costs remain constant and only its variable costs increase. This concept is known as incremental costs. Massachusetts Blue Shield officials said that they had basically made their offer for the tri-state contract based on the incremental costs of adding the workload to their existing workload.

We computed a "national incremental cost" for part B claims for fiscal year 1984 by comparing the increase in part B contract costs from fiscal years 1983 to 1984 and dividing the difference in costs by the increase in claims. This resulted in a cost per additional claim processed of $1.40

in fiscal year 1984 over fiscal year 1983. Thus, the price offered by Massachusetts Blue Shield ($1.35 per claim) is quite close to the "national incremental cost." We would tend to attribute a substantial portion of any savings that result from the tri-state contract to the ability of the carrier to offer the incremental cost of the new workload rather than to competition.

Moreover, if the tri-state contract is viewed as a four-state operation (including Massachusetts) as we believe is reasonable under the circumstances, the cost per claim for the four states would be $1.99. This figure seems more realistic and compares favorably with the national average estimated cost per claim of $2.30 for fiscal year 1984.

Finally, the estimated unit cost for the tri-state contract of $1.35 is based on HCFA's workload projection. However, contractor officials stated that HCFA's projection was too high and, based on their workload projection, the estimated unit cost would be $1.59. Contractor officials also stated to HCFA that its low bid was a one-time offer and pointed out that HCFA should not expect such a relatively low bid for the tri-state area in the future.

Savings May Diminish With Recompetition

In our 1981 report, we expressed concern that in cases where true administrative cost savings are realizable, they are generally realizable only from the initial contract change. Although these savings should continue, recompeted contracts or subsequent contract changes may not produce additional savings beyond those already realized.

We believe that this concern is still valid in light of recompetitions to date and prognosis for future recompetitions. The administrative cost savings from competitive contracting stem from several factors, chiefly

- replacing high-cost incumbent contractors with more efficient contractors,
- consolidating contractor territories or taking other opportunities to create internal economies of scale previously unavailable to the incumbent contractors,
- eliminating or modifying certain contractor functions, and

- contractors lowering their offers to levels below costs[2] in order to become or stay a Medicare contractor or for other longer term objectives.

Whatever the reasons, greater savings might not occur in subsequent contract awards. Once an efficient level is obtained, a new award at the expiration of the contract period might not produce additional savings.[3] However, many of the problems with contractor turnover could occur again should a new contractor be selected. Also, to the extent that the initial award went to a contractor whose price was unreasonably low, there is a "false savings" because subsequent awards are likely to produce a higher price.

As shown in table 1.1, there has been a general decrease in the number of offerors for competitive fixed-price contracts. The number for the two recompetitions to date has been reduced from five in the initial experiment to three and two. In response to the general decline in competition, several Medicare contractors had the following comments:

- Contractors believe that HCFA's intent is to consolidate territories to the point where there will be only several large regional contractors in the country.
- Contractors are concerned that the larger contractors will win competitive fixed-price procurements by offering prices below actual costs, hoping that they will later be able to obtain additional funds through contract amendments.

HHS commented that another reason for the decline in competition is the advantage of incumbent contractors because of lower transition costs. HCFA is attempting to deal with this in several ways, most prominently by eliminating requirements for data entry and claims processing within the competed territory.

[2]Often referred to as "buying-in." This concept assumes the contractor knows what a reasonable offer is, but chooses to bid under that and either take a loss or less profit in order to acquire the contract. This underbid may be to compensate for known deficiencies elsewhere in the award process or to gain the perceived long-term advantages of having the contract.

[3]The savings from eliminating an initial high-cost incumbent contractor would generally always be there, if such a comparison is made. Subsequent recompetitions may not produce further savings.

Program Improvements Under Existing Authority

In previous reports to the Congress on Medicare contracting, we made several recommendations concerning improvements that could be made under existing legislative authority. Among them were the consolidation of contractor areas and the replacement of high-cost contractors, both of which should result in cost savings and higher quality services for beneficiaries and providers. We further stated in our previous reports that:

"A system of strict contract monitoring and budgetary control, followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress."

We believe this position is just as valid today.

Since our earlier reports, HCFA has taken a number of actions in line with our recommendations and has achieved program improvements under the cost-type contracts. For example, since 1980, HCFA has consolidated the areas of several Medicare contractors, primarily to achieve program efficiencies and administrative cost savings. Consolidations can also be used to eliminate poor performers but generally have not been used for this purpose (see ch. 6). Recent contractor consolidations are shown in table 2.5.

Table 2.5: Consolidations of Contractor Areas Since 1980

Outgoing contractor	Date	Incoming contractor
Part A		
Memphis Blue Cross	4/30/81	Chattanooga Blue Cross
Parkersburg Blue Cross	9/30/82	Charleston Blue Cross
Wheeling Blue Cross	9/30/82	Charleston Blue Cross
Allentown Blue Cross	9/30/84	Pittsburgh Blue Cross
Harrisburg Blue Cross	9/30/84	Pittsburgh Blue Cross
Wilkes-Barre Blue Cross	9/30/84	Pittsburgh Blue Cross
Cleveland Blue Cross	9/30/84	Cincinnati Blue Cross
Columbus Blue Cross	9/30/84	Cincinnati Blue Cross
Toledo Blue Cross	9/30/84	Cincinnati Blue Cross
Roanoke Blue Cross	9/30/84	Richmond Blue Cross
Part B		
Delaware Blue Shield	7/30/81	Pennsylvania Blue Shield
Medical Services of D.C.	10/1/81	Pennsylvania Blue Shield
GHI-Florida	10/1/82	Florida Blue Shield

Generally, although we did not evaluate the results, these consolidations were expected to achieve savings for the program because when a contractor assumes the workload of another, it results in fewer computer systems and a net reduction in personnel and other overhead items. Pennsylvania Blue Shield's assumption of the workload of Medical Services of D.C., for example, resulted in about $3 million in savings. In fiscal year 1981, Medical Services of D.C. operated at $4.11 per claim; in fiscal year 1982, Pennsylvania Blue Shield processed the workload for $2.49. By the end of fiscal year 1984, Pennsylvania Blue Shield's unit cost was $2.27 for processing the same workload.

In addition to the above consolidations, other contractors have voluntarily withdrawn from the program because of the increasing complexity and technical requirements, as well as heightened demands for efficient performance. Certain contractors have also carried out partial mergers along functional lines such as the bill processing consortia in the Denver Region, where three intermediaries and two carriers jointly use one bill processing system and one claims processing system.

HCFA has taken other actions intended to improve the program, including:

- Monitoring key operational indicators to identify poor performers with consultation and technical assistance provided to deficient contractors. Where the contractor is unable to improve, it becomes a candidate for DEFRA section 2326 replacement or administrative removal from the program.
- Consolidating certain functions for greater control and productivity. For example, two regional carriers have been assigned responsibilities for processing all claims related to the parenteral and enteral (nutritional) programs, and by law, home health agency claims will be processed by 10 regional intermediaries. HCFA told us that it is reviewing its operations for further specialization actions.

HCFA stated that "this multiplicity of approaches permits the evolutionary development of the program in continuing partnership with the contracting community, while avoiding major disruptions."

HCFA's consolidation efforts have reduced the number of contractors in Medicare from 104 in fiscal year 1983 to 91 in fiscal year 1985. For the same period HCFA stated that it achieved cost per claim reductions of 27 percent in part A and 15 percent in part B.

Medicare Contractors Generally Oppose Competitive Fixed-Price Contracting

Since the late 1970's, HHS has expressed its desire for broader authority to award Medicare contracts on a competitive fixed-price basis. In November 1985, HCFA officials stated that they continued to believe that broader authority for competitive fixed-price contracting in the Medicare program is appropriate. They said that such contracting provided them with a vehicle to motivate contractors to meet performance and price requirements.

We also obtained the views of many Medicare contractors concerning competitive fixed-price contracting. The Blue Cross and Blue Shield Association continues to oppose such contracting in Medicare. In responding to an Association survey, the individual Blue Cross and Blue Shield plans generally stated that:

- Competitive fixed-price contracts offer no advantage to the plans or the government over negotiated contracts.
- The government could save administrative costs through competitive fixed-price contracting initially, but the periodic disruption of services to beneficiaries and providers would outweigh the savings.
- In a totally competitive environment, the government would eventually end up with only a few, very large contractors whose presence would dominate the market and nullify the advantages of competition.

In reference to advantages and disadvantages of competitive fixed-price contracting in Medicare, the Blue Cross and Blue Shield Association stated that its

"... policy position on the mode of Medicare contracting is that it opposes periodic fixed price competitive bidding to select Medicare contractors on the basis that competitive bidding does not serve the purpose of the Medicare program - high quality service to beneficiaries - nor does it promote the most effective management of total Medicare expenditures. Periodic fixed price bidding ensures that a contractor's foremost priority will be its own financial gain or loss rather than flexible responses to meet changing program needs and effective program administration. Also periodic fixed price competitive bidding entails periodic and unavoidable disruptions of beneficiary services, as well as provider relationships, and raises significant potential for major operational failures. We are in favor of strengthening opportunities to gain the advantages of competition within a generally stable contractor community, operating under contractual and financing arrangements which encourage and facilitate appropriate balance between efficiency and effectiveness of administration."

Conclusions

The experiments undertaken by HCFA have not demonstrated that competitive fixed-price contracting provides Medicare any clear advantage over the cost reimbursement contracts presently used to administer the

program. While competitive fixed-price contracting offers the potential for reducing administrative costs, we estimate that only three of the seven experiments have actually resulted in savings. Because of high payment error rates in two of these experiments, the administrative savings may have been offset by lost program dollars. Also, HCFA has been relatively successful at controlling Medicare administrative costs with the cost contracts—cost per claims processed have been steadily declining, and contractor administrative costs currently represent only about 1.3 percent of program costs. DEFRA provided additional authority to require greater efficiency from contractors and should, therefore, enhance HCFA's ability to control administrative costs.

Moreover, the regular use of fixed-price competition would probably increase the number and frequency of contractor changes, which in turn could increase the problems associated with contractor turnover, such as the disruption of services, slower benefit payments, and higher payment error rates. When problems do arise—as in the two Illinois experiments—Medicare has less flexibility to correct them under fixed-price contracts. We also believe that HCFA would need additional staff to effectively administer competitive contracts on a broader basis. Accordingly, we do not believe a major change in the contracting method used in the Medicare program is justified.

We believe that limited authority to competitively award fixed-price contracts, similar to the authority provided in DEFRA, could be a useful tool for HCFA to use when removing poor performing contractors from the Medicare program.

Agency Comments and Our Evaluation

HHS believes we misinterpreted the provisions of section 2326 of DEFRA. As HHS interprets the section, it authorizes the use of competition for cost reimbursement contracts, not competition for fixed-price contracts. Therefore, HHS concluded, our review of "HCFA's fixed-price contracting experiences does not appear to be responsive to the study requirements" to review HCFA's ability to manage competitive bidding under sections 1816 and 1842 of the Social Security Act. (See pp. 85 and 86.)

We believe that HHS has authority under section 2326(a) of DEFRA to enter into fixed-price contracts on a limited basis and that our review of competitive fixed-price contracts was in keeping with the DEFRA study requirements. The principal reasons for these conclusions are:

- HHS already had authority under sections 1816 and 1842 of the Social Security Act before the enactment of section 2326(a) of DEFRA[4] to use competition for cost reimbursement contracts. Thus, it is not appropriate to interpret section 2326(a) only as providing authority to use cost reimbursement contracts.
- Section 2326(e) requires our study to compare the relative costs and efficiency of competitive bidding with current cost reimbursement contracts. The only competitively bid contracts available for comparison were the fixed-price experimental contracts.
- The DEFRA conferees instructed us to report with our study any recommendations on the appropriateness of moving from cost reimbursement to some other basis of payment for claims processing.

Is Fixed-Price Contracting Advantageous?

HHS disagreed with our conclusion that HCFA's experiments have not demonstrated that competitive fixed-price contracting gives Medicare any clear advantage over cost reimbursement contracts. HHS said that while all fixed-price contracts have not been perfectly executed, this related more to HCFA's management of the contracting process, which has improved and is expected to continue improving. HHS concludes that fixed-price contracting is superior. HHS based its conclusions on (1) its estimate that costs per claim processed will be 19.9 percent (40 cents per claim) lower under part A fixed-price experiments and 13.6 percent (24 cents per claim) lower under part B fixed-price experiments during fiscal year 1986 and (2) its observation that the average performance measures, including payment safeguards and beneficiary service, appear equal for cost and fixed-price contracts. (See p. 86.)

In this report and in our previous ones, we have consistently stated that fixed-price contracting holds the promise to contain Medicare's claims processing costs. Our concern has been the potential problems that can arise and, in fact, have arisen relating to the accuracy of payments and the quality of services to beneficiaries and providers. As stated in this chapter, it is the risk of performance problems combined with HCFA's demonstrated ability to control administrative costs under the cost contracts that leads us to conclude that broad authority for HHS to award fixed-price contracts is not necessary.

[4]Section 1816 allows HHS to exercise discretion in determining whether to contract with a nominee, and HHS is not prohibited from using competition in selecting a contractor. Section 1842 permits, but does not require, HHS to contract without regard to certain requirements for competition.

Regarding HHS' fiscal year 1986 estimated claims processing savings through fixed-price contracts, similar estimates have been optimistic in the past. Based on actual data through September 1985, we estimate that only three of the seven experiments had actually reduced Medicare claims processing costs. Regarding HHS' statement that fixed-price and cost contractors, on the average, showed similar performance in the payment safeguard and beneficiary service areas, it is difficult to compare the two groups based on published HCFA data. Fixed-price contractors' performance is measured against the Contractor Performance Evaluation Program (CPEP) criteria in effect in the year the contract is awarded. These criteria remain unchanged during the entire contract period. Cost contractors are also measured against CPEP criteria, but these criteria change from year to year. Thus the performance criteria for cost contractors and fixed-price contractors may differ, and HCFA has not ranked the performance of cost and fixed-price contractors together in most areas. In one area where both types of contractors are ranked together, part B payment error rates, for the July 1984-June 1985 period (the latest available), one fixed-price contractor (Maine II) ranked 16th out of 46, another (Illinois II) ranked last, and the third (Colorado) was not ranked because it submitted invalid data.

HHS also said that having the authority to make changes in contractors through competitive fixed-price contracting does not mean that the authority would be used too frequently or in an indiscriminate manner resulting in high contractor turnover. We did not conclude that HHS would overuse a grant of authority for fixed-price contracting. We concluded that changing contractors can lead to performance problems, at least during the initial operational period and that HHS does not need general authority for competitive fixed-price contracting to manage the contracting program. We did conclude that limited authority for fixed-price contracting could be beneficial (see p. 36 and ch. 6).

Provider Nomination Is Not Currently a Problem

Provider nomination is the process by which hospitals and skilled nursing facilities, with HCFA's approval, may select the intermediary who will process their claims for payment. HCFA has requested that the providers' right to nominate their intermediary be repealed. DEFRA required us to address the need (if any) for eliminating the provider nomination procedure. We believe that there are no strong arguments for changing this process.

HCFA Has Authority to Control the Provider Nomination Process

At the beginning of the Medicare program, part A providers were given the opportunity to nominate the intermediary that would pay their claims. Using this methodology, the original fiscal intermediaries were chosen. Hospitals and skilled nursing facilities[1] may still select the intermediary of their choice, subject to HCFA approval. If HCFA does not concur, the provider may continue to nominate contractors until one acceptable to HCFA is chosen.

HCFA does not maintain data on its actions related to original nominations by providers. However, it maintains data on providers who want to change intermediaries. During the period April 1, 1982, to March 31, 1984, HCFA received 327 requests from providers for a change of intermediary. HCFA approved 156 of these requests and denied 171. The most frequently cited reason for the denials (77, or 45 percent) was that HCFA believed the change would not be in the government's best interest.

HCFA would like to eliminate the provider nomination process and assign providers to intermediaries without regard to their preferences. According to HCFA, there is an inherent conflict of interest in allowing a provider to nominate the organization that is responsible for the provider's payment, audit, and cost settlement. HCFA's position is that the provider nomination process encourages providers to "shop around" for the intermediary that gives them the "best deal"— presumably, intermediaries who pay the most, pay the fastest, and ask the fewest questions are in great demand among providers.

We asked HCFA officials for any analysis to support their criticism of the provider nomination process and were told that no such data or study exists. We believe, however, that even if providers are nominating intermediaries for inappropriate reasons, HCFA has the authority to deny the request if the change is not in the government's best interest. Indeed,

[1]HCFA has the authority to assign intermediaries for home health agencies that are not part of a hospital. The nomination procedure has never been available to part B providers.

HCFA denied more requests than it approved in the 2-year period cited above.

Provider nomination has created administrative problems when HCFA has attempted to award competitive fixed-price contracts under part A. In the Colorado and Missouri experiments, providers challenged HCFA's legal authority to assign an intermediary without considering the providers' right of nomination. HCFA ultimately won the litigation, but the contracts were delayed and extra effort was expended in the courts. Thus, similar challenges to the legality of HCFA's assigning providers to intermediaries could arise if HCFA (1) were to use its experimental authority in other jurisdictions, or (2) were given the authority to use competition on a broad scale.

Currently, the temporary authority for using competition under section 2326 of DEFRA allows HCFA to enter into contracts "without regard to the nominating process."

Contractor and HCFA regional office officials cited a number of reasons for retaining the nomination process. For example:

- Some providers may want to change intermediaries because they believe their intermediary is not providing adequate service. HCFA data show variations in performance among intermediaries indicating that, in some cases, providers may have good cause for dissatisfaction with some intermediaries.
- Chain organizations with centralized administrative functions may find dealing with one intermediary more efficient than dealing with separate intermediaries in each state or contract area where the chain's facilities are located. Of the 156 intermediary changes approved in the 2-year period discussed earlier, 112 (about 72 percent) were approved for this reason.
- Computerized billing is easier if providers can select intermediaries with the most compatible computer systems.

Conclusions

There appears to be little justification for changing the provider nomination process at this time. HCFA has not demonstrated that providers are misusing the process, and the agency has the authority to deny providers' nominations if they are not in the best interests of the government. Further, provider nomination should not be a problem in competitive contracting under DEFRA. However, if the Congress gave

HCFA general authority for competitive contracting, retaining provider nomination could create problems.

Agency Comments and Our Evaluation

HHS disagreed with our conclusion that there is little justification for changing the provider nomination process at this time. HHS said that the process is an unnecessary encumbrance on HCFA's management and that there is little justification for retaining it now that all contractors are required to meet the same performance standards (see p. 87).

HHS provided no further evidence to indicate that the process is an unreasonable administrative burden, nor did it attempt to refute the reasons cited by contractor and HCFA regional office officials in support of retaining the process.

While eliminating the provider nomination process might in some instances ease HCFA management responsibilities, this by itself does not demonstrate that the process must be abolished. Absent data showing that the process has adverse effects on Medicare, we are not recommending its elimination.

HCFA's Management of Cost Contractors—Recent Budgetary Actions Adversely Affecting Program Payments and Services

As stated in chapter 2, the unit cost of processing Medicare claims has been steadily declining, and the total administrative cost of Medicare contractors represented only about 1.3 percent of benefits paid in fiscal year 1984. In an effort to further reduce program administrative costs, the Office of Management and Budget (OMB), HHS, and HCFA allowed little growth in the fiscal year 1985 Medicare contractor budget and virtually no growth in the amount requested for 1986. These budgets, however, were inadequate considering the contractors' costs to implement additional administrative and legislative requirements and to process a workload that will be significantly greater than projected for the 2 fiscal years.

Although DEFRA gave HCFA additional authority to deal with inefficient contractors, HCFA used this authority to reduce every contractor's budget—even those of the most cost efficient contractors—in an attempt to offset the 1985 and 1986 budgetary shortfalls. Because of the limited budgets, some contractors have reduced their efforts to safeguard against inappropriate payments, and Medicare could lose millions in erroneous payments. In addition, the quality of services provided to beneficiaries and providers has deteriorated—contractors are taking longer to pay claims, claims backlogs are growing, and efforts to improve communications with beneficiaries and providers have been impeded.

The Fiscal Year 1985 Contractor Budget Was Inadequate

The administration's contractor budget request submitted to the Congress for fiscal year 1985 was $917.6 million, an increase of 6 percent over the fiscal year 1984 budget of $862 million. Considering inflation and the projected workload growth, the budget was conservative but probably sufficient. However, the budget was severely strained by increased costs from changes that occurred after the budget was submitted to the Congress, including

- additional requirements placed on contractors by DEFRA,
- additional requirements placed on contractors by HCFA, and
- a workload that exceeded projections by 17 million claims, or 6 percent.

We estimate that the potential budgetary shortfall in fiscal year 1985 could have been as high as $48 million.

DEFRA, approved on July 18, 1984, had a major impact on the fiscal year 1985 contractor budget, placing several additional requirements on the contractors' 1985 operations after the budget had been submitted to the

Congress. For example, DEFRA established a 15-month freeze on payment rates to physicians beginning July 1, 1984. DEFRA required that carriers monitor physician charges, maintain toll-free telephone lines for participating physicians, publish a directory of participating physicians, and perform a number of other related activities. In total, HCFA estimates DEFRA added about $31.8 million to the costs of contractors' fiscal year 1985 operations. Because of the additional requirements for the physician freeze, the Congress did appropriate an additional $15 million above HCFA's budget request, resulting in a total 1985 contractor appropriation of $932.6 million.

The budget was further affected by additional HCFA requirements placed on the contractors. OMB, HHS, and HCFA believed that increasing contractor payment safeguard activities could help reduce Medicare outlays. Accordingly, HCFA required contractors to expand their efforts to identify Medicare beneficiaries covered by other insurance (Medicare's secondary payer program), to identify inappropriate service (utilization review), and to audit provider cost reports. Like the DEFRA changes, these changes were also made after the fiscal year 1985 budget request was submitted to the Congress.

HCFA budget officials estimate that the additional HCFA-initiated and DEFRA-required efforts placed $80.2 million in costs on the contractors above the budget request amount. However, HCFA funded only $31 million of this amount—$15 million from the extra appropriation by the Congress and $16 million from the contingency fund, which totaled $20 million in HCFA's original budget request. To account for the remaining $49.2 million in excess costs above appropriated funds, HCFA reallocated money among the contractor budget categories,[1] with the biggest change being a $35.7 million decrease in the funds allocated to claims processing. HHS did not seek a supplemental appropriation for contractor funding in fiscal year 1985.

[1]Contractor administrative budgets are generally divided into three categories:

- Claims Processing—bill payment activities, case reconsiderations, and hearings and appeals for part A; and claims payment, reviews and hearings, and beneficiary inquiries for part B.
- Program Safeguards—medical review/utilization review and Medicare secondary payer activities for both part A and part B; and provider audit for part A.
- Productivity Investments/Administrative Enhancements— initiatives designed to make Medicare contractor operations more efficient.

HCFA Unilaterally Cut Contractors' Budgets

In the fiscal year 1985 contractor appropriation request submitted to the Congress, HCFA included about $537 million for claims processing. To help fund the additional DEFRA and HCFA requirements, HCFA reduced the claims processing budget to $501 million and shifted the funds to the other contractor budget categories. Because of the significantly reduced amount available for claims processing, HCFA abandoned the traditional budget negotiation process and unilaterally determined the amount each contractor would receive to process Medicare claims.

In the past, contractors developed budget proposals that reflected their total administrative costs for processing Medicare claims and related activities for the upcoming fiscal year. To assist contractors in this process, HCFA regional offices provided each contractor with estimated workloads and benefit payments for the ensuing year and then reviewed the proposed budgets. According to HCFA regional office and contractor officials, differences were negotiated with contractors on a one-to-one basis, and the final budget generally reflected each contractor's unique operating conditions.

The fiscal year 1985 budget process proceeded normally until July 1984, with contractors submitting their budget proposals. However, to stay within the reduced claims processing budget request, HCFA determined the maximum amount each contractor would receive for this function by establishing a "cost cap." These cost-per-claim caps were established using a formula, rather than by evaluating each contractor's needs and circumstances. In general, the beginning point for these caps was the lower of a contractor's fiscal year 1983 reported cost per claims[2] or its estimated fiscal year 1984 cost per claim as of the end of the second quarter. For this determination, however, the fiscal year 1983 cost per claim of the highest 80 percent of contractors was first reduced 5 percent, or half of the difference between each contractor's cost per claim and the national average cost per claim, which ever was the greater reduction. The derived cost per claim was further reduced to reflect HCFA-projected savings from increased use of electronic media ("paperless") claims and other initiatives designed to improve contractor efficiency.

HCFA headquarters officials compared the cost per claim derived through this process for each contractor to the one it submitted in its fiscal year 1985 budget proposal and selected the lower of the two. This cost per

[2]Final contractor cost reports for fiscal year 1983 were the most recent ones available at the time the fiscal year 1985 cost caps were set.

claim was considered the maximum amount acceptable, but HCFA regional offices were encouraged to negotiate lower costs with contractors if possible.

Through this process, HCFA reduced the amounts contractors requested in their submitted fiscal year 1985 budget proposals by about $40.8 million. The individual cost caps became standards against which contractor performance was measured, and HCFA told contractors that failure to meet these standards could lead to termination of their contracts.

HCFA Inappropriately Used DEFRA Authority

HCFA justified the cost-per-claim caps to contractors by citing the provision of DEFRA which states that HHS should limit payments to contractors to "the amount that is reasonable and adequate to meet the cost which must be incurred by an efficiently and economically operated" carrier or intermediary. While this provision does give HCFA more authority to achieve greater administrative efficiency, we believe that the way HCFA used this authority was inappropriate.

HCFA's methodology for establishing the claims processing caps required even the most cost-efficient contractors to reduce their costs. For example, Rhode Island Blue Shield's fiscal year 1985 cost cap required a reduction of about $160,000 in claims processing costs (about 6 percent), even though this contractor had the lowest claims processing unit cost among all carriers in fiscal year 1983 and the second lowest in fiscal year 1984.

Section 2326(d) provides that in determining the necessary and proper costs of each contract, the Secretary must take into account the amount that is reasonable and adequate to meet the costs incurred by an efficiently and economically operated enterprise carrying-out these programs. Section 2326(d) is aimed at reducing the costs of inefficient contractors which exceed a standard of efficiency. It does not provide authority to reduce payment to all contractors whether efficient or inefficient.

Further, the following statement of the DEFRA conferees when considering section 2326(d) illustrates that individual contractor circumstances should be considered when HCFA determines the amount paid each contractor.

"It is the Committee's intent that the rates paid to contractors take account of their individual circumstances. Thus such factors as the relative complexity of the claims to be reviewed, the prevailing wages in the area, the relative need for beneficiary services, and other circumstances that may legitimately vary from contractor to contractor should be taken into account in determining each contractor's reasonable operating costs."

We do not believe that the formula HCFA used to reduce claims processing costs adequately considers individual contractor circumstances. For example, in establishing the cost-per-claim caps for contractors, HCFA assumed that each contractor could and would process the workload increase between 1984 and 1985 at 75 percent of that contractor's base unit cost for 1984. This assumption requires the same level of productivity among all contractors. A July 1985 HCFA task force report shows that this is not the case. Based on a study of productivity at selected contractors, the task force concluded that there are significant differences in productivity caused by differences in bill mix, levels of paperless claims received, and percentage of claims submitted by physicians. Further, a standard assumption about volume economies does not take into account the difference in each contractor's fixed price per claim for such factors as data processing subcontracts and personnel costs, which cannot be easily changed in the short term.

Similarly, in establishing the 1985 unit cost caps, HCFA projected the same growth rate in the workload for all intermediaries and the same rate for all carriers. The internal HCFA task force report points out, however, that the actual workload growth rate for individual contractors can vary significantly from the national figure. The task force recommended that budget officials take steps to provide more accurate forecasting of individual contractor workloads.

HCFA also used the same savings estimates for all contractors (based on expected improvements during fiscal year 1985) in arriving at the cost-per-claim caps. In developing the caps, HCFA uniformly reduced all intermediaries' costs by $.10 per claim and all carriers by $.03 per claim for savings from implementing certain prescribed efficiency initiatives. However, not all contractors could expect this level of savings. For example, correspondence from one intermediary showed that these cost saving initiatives had been implemented in prior fiscal years, and the residual savings would be only about $.01 per claim. (Correspondence from another intermediary showed that the same situation occurred when HCFA established the fiscal year 1986 cost caps.)

The following written statement by an official of Massachusetts Blue Shield summarizes the views of many Medicare contractors on HCFA's cost-per-claim caps:

"Cost contracting which includes targeted costs or costs with a cap could work. However, it will not work by putting all contractors (high cost and low cost) in the same category and mandating cuts on a national basis without comprehending the impact it will have on the individual contractor or [Medicare] in general. The need to address high cost contractors or poor performers must be handled on an individual basis and cannot be mandated 'across the board' if it is to be equitable."

HCFA Underprojected the Fiscal Year 1985 Workload

The fiscal year 1985 contractor budget for claims processing, already strained because of questionable cuts, was further affected by a greater than projected growth in the claims workload. HCFA originally projected[3] that the part A bill workload would grow by 7.7 percent, from 52.6 million bills in 1984 to 59.1 million in 1985 and the part B claims workload would grow by 11 percent from 227.6 million to 253.8 million claims. Based on contractor experience through September 1985, the actual part A and part B workloads were 59.5 million bills and 270.8 million claims, respectively. This represents a 17.4 million (6-percent) net increase in claims over the level used to establish the cost-per-claim caps. HCFA estimated the cost of processing these additional claims at $14 million. To help offset these additional costs, HCFA used the $4 million remaining in the contingency fund, increasing the funds available for claims processing from $501.6 million to $505.6 million. A HCFA budget official told us that the agency attempted to defray about $6 million of the remaining $10 million by allowing contractors to backlog claims (see p. 59).

Exact Shortfall for Fiscal Year 1985 Difficult to Determine

As discussed, a conservative contractor budget request for fiscal year 1985 was affected by several factors after the budget was submitted, and HCFA did not seek additional appropriations to offset these affects. Table 4.1 shows the financial effect of these factors.

[3]These projected growth rates did not factor in the claims workload previously processed directly by HCFA, but being transferred to contractors in fiscal year 1985. Also, the fiscal year 1984 workloads used in these projections were estimates, not the actual workloads.

Table 4.1: Financial Effect of Additional Requirements on the Fiscal Year 1985 Medicare Contractor Budget

(Amounts in millions)		
HHS/HCFA contractor budget request		$ 917.6
Plus:		
Additional HCFA and DEFRA requirements	$ 80.2	
Unprojected workload	10.0	90.2
HCFA estimate of total requirements		1,007.8
Less:		
HCFA cost reductions/reclassification	26.5	
Amount appropriated	932.6	−959.1
Potential shortfall		**$ 48.7**

HCFA budget officials stated that most of the potential shortfall was offset by the "savings" from capping claims processing budgets. Based on their analysis of contractor interim expenditure reports through the end of fiscal year 1985, these officials estimated in October 1985 that the actual shortfall should be about $10 million.

On the surface, this shortfall (about 1 percent of the total budget of $932 million) does not appear significant considering the additional requirements placed on the Medicare contractors. However, we do not believe the $10 million figure accurately represents the financial condition of the Medicare administrative budget because contractors may not be reporting their actual costs.

HCFA has encouraged contractors to report only those costs that are consistent with the capped budgets. For example, a record of a telephone conversation between a HCFA Region VIII budget official and a contractor shows that the contractor was informed that it would receive additional funding for the unprojected fiscal year 1985 workload based on a rate equal to 75 percent of its unit cost cap. The contractor officials were instructed not to exceed this approved amount on their interim expenditure report, but were told that they could report the actual costs for the incremental workload on the final administrative cost report—as long as the actual costs reported "do not exceed their unit cap."

In response to a Blue Cross and Blue Shield Association questionnaire, this same contractor stated that cost caps "have not improved contractor efficiency one iota. They have only served to cause more contractors to further subsidize . . . the Medicare program."

We found other examples of contractors being asked to "absorb" costs. For example:

- A HCFA Region V contractor requested $188,600 to process the unprojected workload. In discussing this request, a regional memo to HCFA's central office points out that the requested amount is based on the contractor's capped unit cost; based on the actual unit cost, the contractor would require $388,600. The memo states that the "contractor is expected to absorb the $200,000" difference.
- A HCFA Region VII contractor, in a July 30, 1985, letter, officially requested an additional $527,000 to process the unprojected workload. The letter states, however, that the requested amount is based on the unit cost cap and that "based on full-absorption accounting, ignoring the cost cap, we project that our total costs . . . will be $615,000."
- A HCFA Region VIII contractor showed us two sets of cost reports—one prepared for HCFA based on the unit cost cap, and one for the contractor's records based on actual costs. A comparison of the contractor's actual cost report covering the period ending June 1985 and the interim expenditure report submitted to HCFA for the same period indicated that the contractor absorbed $99,396 in claims processing costs.

Some contractors told us that they are absorbing costs because they do not want to fail their performance evaluations and risk having their contracts terminated.

HCFA had not received or analyzed all the final administrative cost proposals for fiscal year 1985 at the time we completed our work.

Fiscal Year 1986 Budgetary Shortfall Could Be Much Greater Than That in 1985

The consensus among Medicare contractors is that, while the fiscal year 1985 budget was inadequate, the HHS fiscal year 1986 budget request submitted to the Congress was seriously inadequate. The $935 million budget—only $2.4 million greater than the 1985 appropriation—appears to be insufficient in light of significantly increased workloads now being projected and even greater demands being placed on the contractors for fiscal year 1986.

The HCFA/HHS budget proposal submitted to OMB requested $957.1 million, and this budget request was prepared before the claims volume surge that occurred during fiscal year 1985. The HCFA budget included a request of $568.5 million[4] to process 315 million claims. Based on the increased 1985 workload and HCFA's projected growth rates for 1986, we

[4]This amount includes $39.9 million for fixed-price contracts that were expected to be awarded under the DEFRA authority. The budget submitted to the Congress made no provision for such contracts.

now estimate that the fiscal year 1986 workload could be about 363 million claims.

OMB cut the HHS/HCFA budget proposal by $22.1 million to $935 million. At the same time, OMB increased program safeguard, productivity investment, and other requirements. The net effect of the cuts and shifts in funds was to reduce the amount HCFA requested for claims processing—an amount that in our opinion was already insufficient—by about $89 million from $568.5 to $479.4 million.

To put this request for claims processing funds in perspective, table 4.2 shows the total workloads and claims processing budgets for fiscal years 1984-86. As can be seen from the table, under the fiscal year 1986 budget request, contractors would be expected to process about 89 million more claims than they did in fiscal year 1984, but would be given $5 million less to do it.

Table 4.2: Claims Processing Workload and Funding

(Workload and funding levels in millions)

Fiscal year	Total workload	Claims processing funding levels	Cost per claim
1984	274	$484	$1.77
1985	330	506	1.53
1986	363	479	1.32

A HCFA budget official told us that after the fiscal year 1986 budget submission, HCFA reallocated $19.5 million from other budget categories for claims processing, increasing the budgeted amount for this function to $498.9 million. In addition, he said that other program and economic changes added an estimated $67.4 million to HCFA's original budget estimate. These changes included increased postage rates, increased audit requirements, and increased initiatives to reduce Medicare overpayments. HCFA offset some of these increases by eliminating certain productivity investments and other planned initiatives, but the budgetary shortfall is still significant.

Table 4.3 shows the effect of all the changes discussed above on the original HCFA budget estimate, and our estimate of the potential budgetary shortfall based on HCFA budgetary information for fiscal year 1986 as of October 1, 1985.

Table 4.3: Original HCFA Budget Request and Subsequent Changes, Fiscal Year 1986

(Amounts in millions)		
HHS/HCFA proposed budget submitted to OMB		$ 957.1
Plus:		
Additional OMB requirements	$67.0	
Increased workload	10.4	
Other increases	67.4	144.8
Estimated requirements (gross)		1,101.9
Less:		
Reduced requirements/other savings		−39.6
Estimated requirements (net)		1,062.3
Less: OMB budget request		−935.0
Potential shortfall		**$ 127.3**

HCFA officials acknowledged to us that the $935 million was inadequate, noting that to stay within the budgeted amount would require even deeper cuts in contractor operations through the use of statistically determined cost caps. Most of the cuts were projected for claims processing ($50 million), but because of the size of the potential shortfall, cost caps were developed for other budget line items as well.

HCFA developed the fiscal year 1986 cost-per-claim caps with virtually no input from contractors and with little consideration for their individual circumstances.[5] In his May 8, 1985, testimony on the fiscal year 1986 budget, the representative for nine commercial insurance Medicare contractors told a subcommittee of the Senate Committee on Appropriations that HCFA acted unilaterally in establishing the budget, using:

"... an arbitrary and inequitable formula to distribute inadequate funds, despite provisions to the contrary in the Medicare contracts. Our contract provides that the contractor 'shall submit to the Health Care Financing Administration ... a budget of its estimated administrative expenses for a period corresponding to the Federal fiscal year.' Further, it provides that '[t]he Secretary and the Carrier shall negotiate the amount of the annual budget ... based on the amount submitted by the Carrier in an amount calculated to pay the costs of administering the Carrier's contract.' Aside from its existence as a binding contractual requirement, this approach makes sense because the contractor's on-the-job experience is considered in the budget process."

HCFA budget officials told us that the formula used to establish the cost caps was a method for spreading the estimated budget shortfall among all the contractors.

[5]In September 1985, HCFA did adjust the claims processing caps to more closely reflect each contractor's actual workload growth rate.

Because of the radical cuts that would have been required, the contractor community was vocal about the inadequacy of the fiscal year 1986 budget. After receiving HCFA's proposed unit cap for claims processing, 72 of the 104 contractors indicated they would not be able to operate within HCFA's capped amounts. About 70 percent of the 72 contractors submitted two budgets for claims processing costs—one consistent with HCFA's cap, and one showing their estimate of actual costs.

Actions in the Congress also recognize that the fiscal year 1986 budget request of $935 million was inadequate. The House Committee on Appropriations-approved bill provided $972 million. The Committee's September 26, 1985, report states, "While the Committee fully supports efforts to manage the contractor program in the most efficient manner, it does not believe that the FY 1986 budget estimate is realistic."

The Senate Committee on Appropriations-approved bill provided $985 million for the Medicare contractors. The committee's October 4, 1985, report states:

"The Committee believes that an adequate funding level for Medicare administrative functions is essential to maintaining the integrity of the Medicare Program and to assure the timely and accurate processing of claims. Further, the Committee believes . . . that first priority should be given to the claims payment functions to reduce claims backlogs and to prevent any further deterioration in the quality and timeliness of claims processing functions."

Budget Cuts Affecting Program Payments and Beneficiary Services

HCFA's recent cutbacks in the Medicare contractor budget are limiting the contractors' ability to safeguard Medicare against inappropriate payments and are causing a deterioration in services to beneficiaries and providers.

In recent appropriations hearings, contractor representatives testified:

"This cost-cutting, which has been mandated by HCFA, is passing the breaking point. Cuts of this magnitude are causing substantial damage to the Medicare program in terms of quality of service, and ironically these cuts can actually cause cost increases."

They also said that:

"The funding . . . proposed in the Administration's FY 1986 budget will demand cost reductions which far outstrip the ability of the contractor community to meet

through increased operating efficiency. As a result, there is a high risk of a deterioration in service to beneficiaries and providers and a diminishment in the capacity of the administrative structure to control benefit payouts."

HCFA's budgetary actions and their impact on the Medicare program are contrary to the concerns of the DEFRA conferees, as reflected in the conference report on DEFRA:

"The conferees want to urge that any cost cutting measures be implemented in a careful manner with the understanding that the processing of medicare claims is an important function and that savings measures not undermine beneficiary services, professional relations, productivity investment or program safeguards."

HCFA's stated objective of protecting Medicare dollars by increasing contractor payment safeguard activities—such as utilization review, audit, and Medicare secondary payer—is good. However, funding payment safeguard activities through severe cuts in the claims processing budget is a counterproductive way of trying to meet this objective. In addition, some contractors have cut back their payment safeguard efforts because of the overall limit on administrative funds available for this purpose.

Cuts in Claim Processing Funds Increase Risk of Erroneous Payments

HCFA and contractors point out that the claims processing function involves more than receiving, processing, and paying claims. A very important part of this function is ensuring the accuracy of the payments made. This involves a myriad of edits—both automated and manual—to ensure that services are covered, that charges are reasonable, that the claim is not a duplicate, and that numerous other payment criteria have been met.

Based on the results of a recent study, HCFA estimates that about 30 percent of contractor claims processing costs are used to deny claims using the above-mentioned screens. The study, done by five part B contractors (representing about 25 percent of the part B claims processed), also showed that the $28.6 million in fiscal year 1984 claims processing costs spent on these screens resulted in about 32.5 million denied claims, potentially saving Medicare over $922 million—a savings ratio of over 32 to 1.

While the contractors who performed the study cited qualifiers that probably limit the precision of the dollar savings projections, we believe that the claims processing edits are a necessary and cost-effective way to reduce erroneous Medicare payments.

We also believe that the actual and proposed cut of about $90 million in claims processing funds over fiscal years 1985 and 1986 may limit contractors' ability to prevent these erroneous payments. For example, one of the five contractors who participated in the HCFA study stated in response to the Blue Cross and Blue Shield Association questionnaire that the cost-per-claim cap received from HCFA for fiscal year 1986 requires them to eliminate any cost containment prepayment screens that are not mandated by HCFA. While the contractor said that its non-mandated screens saved Medicare an estimated $65 million in benefit payments in fiscal year 1984, the contractor felt it can no longer afford to do more than what is required. Thus, cuts in the claims processing budget could actually be costing Medicare much more in erroneous payments than is being "saved" in administrative costs.

In addition, although HCFA intended to increase the program safeguard activities by transferring claims processing funds, the budget cuts may have had the opposite effect. For example, HCFA Region VII officials informed the central office in an August 1985 memo that they were projecting a budget shortfall for fiscal year 1985 of $2.9 million, including underfunding of about $1.3 million for claims processing. The memo stated that regional officials would shift about $470,000 in audit funds, part of which became available when they "halted all audit subcontracts that have not been started."

The cuts in contractor claims processing budgets have had another potentially adverse affect on both program payments and administrative costs. An internal HCFA task force report states that because of the budget restrictions, contractors have reduced the level of educational programs and materials previously made available to providers. This may result in billing and processing problems, such as incorrectly prepared claims forms, and increased payment adjustments resulting from them. One contractor made this point in its response to the Blue Cross and Blue Shield Association questionnaire:

"The cap does not allow for any provider servicing costs, particularly seminars for physician office staff, provider manuals or bulletin notices. With the multitude of significant changes during the past 3 years, and the traditional high turnover of office staff within physician offices, it is becoming very evident that many of the claims processing difficulties contractors are experiencing are a direct result of providers' inappropriate billing techniques. Further, this weakness in professional relations undermines support for the [physician] participation program."

And another contractor stated:

". . . maintaining good provider relations may not be possible with limited funds. This could then impact the quality of claim submission, reduce our high percentage of assigned claims and make providers less responsive to automation, all of which impact the cost of processing a claim."

Thus, the reduction in provider relations and educational activities could result in more error-prone claims, which are more costly to process, and could increase the risk of incorrect payments.

Overall Budget Cuts Limit Funds for Program Safeguards

Even though HCFA has emphasized the importance of program safeguard activities, the overall budget cuts during the past 2 fiscal years have prevented contractors from achieving the savings that could have been realized from these activities.

Table 4.4 shows the various funding levels proposed for program safeguard activities for fiscal years 1985 and 1986—the amount in the budget request for fiscal year 1985, the operating budget for that year reflecting funding shifts resulting from DEFRA and HCFA requirements, the HHS/HCFA budget request for fiscal year 1986, and the OMB-approved request.

Table 4.4: Program Safeguard Funding Levels

Function	Fiscal year 1985 budget request	Fiscal year 1985 actual budget request	Fiscal year 1986 request (HHS/HFCA)	Fiscal year 1986 request (OMB)
Medical/utilization review	$ 58.9	$ 76.4	$ 85.4	$ 90.9
Audit	89.1	99.0	90.9	90.9
Medicare secondary payor	3.0	26.3	3.0	28.0
Total	**$151.0**	**$201.7**	**$179.3**	**$209.8**

While the funds available for program safeguards have increased, there is still a difference between these amounts and the amounts contractors estimated they need to adequately protect Medicare from inappropriate payments. For example, HCFA reduced all contractor budgets for medical review and utilization review activities in fiscal year 1985 by 2.9 percent below the amount requested and all intermediary audit budgets by 7.74 percent. The amount HCFA budgeted for program safeguard activities for fiscal year 1986 was also less than contractor estimates.

HCFA's cuts have caused some contractors to reduce their safeguard efforts and presumably also reduce the Medicare dollars saved. For example:

1. A part B carrier, recognized by HCFA as having "an exemplary and productive" utilization review program, requested $1,965,400 for utilization review activities in fiscal year 1985. In an attempt to meet HCFA's spending goals, the contractor lowered its request to $1,804,200. HCFA cut the revised amount by 2.9 percent to $1,752,000. The carrier reduced or eliminated many activities previously used to identify abusive physician billings or practice patterns. For example, the number of postpayment reviews was reduced from 50 in 1984 to 30 in 1985. The contractor estimates that this specific cutback cost the Medicare program about $373,000 in lost savings. Because of further cutbacks in the 1986 utilization review budget, the contractor estimates as much as $37.6 million in potential savings will be lost.

2. Another part B carrier requested $99,600 in fiscal year 1985 to establish a unit to identify and develop claims with other insurance coverage, thus reducing Medicare payments (Medicare secondary payer program). HCFA, however, gave the contractor only $12,200, which the contractor used in the first 3 months of the fiscal year to achieve its savings goal of $114,880. The contractor requested additional funds at that time, pointing out that additional savings of $285,120 could be achieved. Because the request was denied, the contractor stopped all Medicare secondary payer activities from January 1985 to June 1985, when additional funds were provided.

3. HCFA reduced another contractor's fiscal year 1986 budget for medical review and utilization review from $1,613,000 to $1,180,761. Because of the reduction, the contractor notified HCFA that it would eliminate its postpayment review staff (13 positions) and reduce its prepayment review staff by 4 positions.

4. Contractor officials at one location we visited told us that because of inadequate funds available for claims processing in fiscal year 1985, the contractor reduced the number of audits and medical reviews. These officials also said that to help stay within their 1986 cost cap, they had to lay off personnel.

Services to Beneficiaries and Providers Deteriorating

In addition to being responsible to the government for controlling program expenditures, Medicare contractors have an equally important responsibility for providing quality service to beneficiaries and providers. This responsibility includes paying claims timely and providing channels of communications to help resolve beneficiary and provider

problems and to help them better understand changes in the Medicare program.

HCFA's emphasis on reducing administrative costs has caused a deterioration in the quality of these services. Because of the budgetary cutbacks, contractors are

- taking longer to pay claims and allowing backlogs to grow,
- not providing the level of phone service required by HCFA and the federal courts, and
- unable to improve the quality of their written communications as required by the courts.

Because of budgetary shortfalls, HCFA began to encourage contractors to process claims slower and allow the unprocessed claims backlogs to grow in fiscal year 1985. Table 4.5 shows the overall change that has taken place in processing time and backlogs between 1980 and 1985.

Table 4.5: Part B Contractors' Processing Times and Claims Backlogs

	1980	1985
Average processing time— beneficiary claims	14.3 days	16.6 days
Average processing time— provider claims	11.8 days	14.1 days
Days work on hand[a] (end of year)	6.9	9.4
Claims pending (end of year)	4.4 million	11 million

[a]Days work on hand is equivalent to the backlog divided by the number of claims a contractor processes daily.

This situation is expected to get worse. In a September 27, 1985, memo to the HCFA regional administrators, the Director of HCFA's Bureau of Program Operations stated, "Due to the constraints imposed by the $920 million budget, we anticipate that the contractors work in-process will increase to an average of 15-18 days." Some HCFA officials said that backlogs could be even higher in 1987.

To accomplish the work slowdown and backlog buildup, HCFA has relaxed a number of the fiscal year 1986 CPEP processing time standards. For example, in fiscal year 1985 contractors were required to process 93 percent of the claims they received from beneficiaries in 30 days in order to obtain a maximum CPEP score. Based on the fiscal year 1986 standard, a contractor can now get a maximum score by processing 79 percent of the claims in 30 days.

HCFA acknowledged that the slowdown in claims payment is due in part to "the intense administrative cost containment pressure" put on contractors. However, this action was justified as a means of removing the incentive for "overly prompt" payments and potentially saving Medicare dollars through interest earned on invested Medicare Trust Fund money.

Some contractors disagree with this position. One pointed out that the elderly beneficiaries cannot afford to wait longer for reimbursement of funds they have already spent for health care. Others believe that a slowdown in claims payment will cause an increase in beneficiary and provider inquiries, adding costs and additional strain on their claims processing operations.

Intentionally letting backlogs grow is risky because it allows no margin for unexpected problems. We have seen numerous instances in our past Medicare work and in this study where large backlogs were caused by problems in implementing new data processing systems or new HCFA initiatives (such as the HCFA Common Procedure Coding System and Uniform Part A Billing System). Program and system changes are common, and problems can be expected. However, additional backlogs caused by these problems could be particularly damaging to beneficiaries and providers when backlogs are already high.

In a June 1985 report,[6] we pointed out that the federal courts had ruled that part B beneficiaries were not being given an adequate explanation about why their claims were denied or reduced, nor were they given an adequate opportunity for a hearing. HHS was directed to improve the readability of the written notice—Explanation of Medicare Benefits (EOMB)—sent to beneficiaries. In addition, to provide a better opportunity for communications, HHS proposed that carriers add toll-free telephone systems which would allow beneficiaries to discuss their claims with a professional employee of the carrier.

HCFA's cuts in contractor budgets have impeded some carriers' ability to implement these improvements. For example, two carriers in HCFA's Region II requested additional funds in their fiscal year 1985 budget to improve the readability of their correspondence to beneficiaries. This

[6]Medicare Part B Beneficiary Appeals Process, GAO/HRD-85-79, June 28, 1985.

was done to comply with a ruling of the U.S. District Court, Eastern District of New York.[7] HCFA central office denied both funding requests, and a HCFA regional office memo stated that, "Since HCFA has not funded these activities we appear to be in contempt of court."

Some contractors are also having difficulty meeting HCFA's requirement that the toll-free telephone systems be at a level of service where beneficiaries receive a busy signal only 20 percent of the time—called the P-20 level of service. For example:

- A HCFA Region VI memo noted that one of its part B carriers had a level of service of about P-95 and that it would take $2.2 million in fiscal year 1985 to bring the contractor to the P-20 level of service. The memo states that the contractor requested only $1 million because it did not want to exceed its unit cost cap—"It is more concerned with the consequences of exceeding the cost cap than it is with providing P-20 level of telephone service."[8]
- A HCFA Region I contractor memo to the regional office stated that in order to attain HCFA's 1986 unit cost cap, the contractor would have to reduce costs by $347,800. These cuts would mean a reduction in services—including not supporting the P-20 level of service.

In summary, many contractors have expressed the opinion that the traditional level of services to beneficiaries and providers can no longer be provided with the funding available.

Conclusions

We believe HCFA is justified in requiring efficiency from Medicare contractors. However, recent efforts to cut contractor administrative costs have been characterized by inadequate budget requests and unilateral cuts in individual contractor budgets.

Of the three budget categories, HCFA has made (or proposed) the deepest cuts in the funds available for claims processing, thus limiting the contractors' ability to prevent erroneous Medicare payments. These actions are short sighted—preventing incorrect payments through the claims processing function is more cost effective than trying to correct errors after they have occurred. Further, although it has increased funds for

[7]David v. Heckler (E.D.N.Y. 1984).

[8]The contractor received an additional $996,500 in January 1985 to implement the physician fee freeze provision of DEFRA. The contractor used some or all of these funds to upgrade the toll free phone system, and the contractor achieved a P-20 level in fiscal year 1985.

contractor program safeguard activities, HCFA has provided less funding than the contractors say is necessary. Because of the overall limit on funds available for program safeguards, contractors have reduced their efforts and may not be achieving the savings they believe are possible. HCFA's emphasis on administrative cost cutting has also resulted in contractors' reducing services to beneficiaries and providers.

We believe that HCFA's recent cost cutting measures, which do not adequately consider individual contractor circumstances, may be affecting program payments and services and were an inappropriate use of its authority.

Recommendation to Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to use a Medicare contractor budget development process that places more emphasis on the individual circumstances of contractors than the formula-based cost caps. The process should consider the input of the Medicare contractors in order to more realistically determine the funds needed to sufficiently support program safeguards and assure an adequate level of beneficiary and provider service activities.

Agency Comments and Our Evaluation

HHS disagreed with our recommendation. HHS said that individual circumstances should be a budgetary consideration and that it believes that appropriate consideration was given through adjustments to contractor cost caps for wage levels, bill mix, and part A reconsiderations. (See pp. 87 and 89.)

While HCFA did consider the three factors mentioned above in setting the individual contractor cost caps, many other important circumstances that legitimately vary among contractors were not considered. As discussed on page 48, the formula that HCFA used to establish the claims processing cost caps did not account for contractor differences in workload growth rates, levels of paperless claims processed, percentages of claims submitted by physicians, or costs of data processing subcontractors.

HHS also said that HCFA cannot return to the pre-DEFRA budget process, where contractors were allowed to set their own reimbursement without cost limitations. To our knowledge contractors were not allowed to set their own budgets and reimbursements before DEFRA. Funds for contractors were appropriated and HCFA, and the contractors had to live within the appropriation or justify to the Congress an increase in funding.

Moreover, HCFA did not merely accept contractor budget requests. It negotiated with the contractors the amount each would be provided and monitored contractors against the agreed upon amount. Also, contractor costs for each year were audited to help assure that only reasonable and allowable costs were claimed by and paid to contractors.

With respect to returning to the "pre-DEFRA budget process," HHS went on to say that the Congress directed it, through section 2326 of DEFRA, to pay only the amount reasonable and adequate to meet the costs of an efficiently and economically operating contractor. HHS said that HCFA used this authority to save over $45 million in contractor funding in fiscal year 1985 and that a return to the old budget process would be self-defeating and costly.

DEFRA did direct HHS to take into account the costs of an efficiently and economically operating contractor. However, in our opinion, this does not mean that the most cost-efficient contractors should have their budgets reduced as was the case in fiscal years 1985 and 1986. DEFRA directs HCFA to establish a standard of economy and efficiency for contractors to insure that administrative costs are reasonable. However, we do not believe that HCFA applied a true standard for this purpose. In fiscal years 1985 and 1986, HCFA chose a "standard"—the national average processing cost for 1985 and the lowest 25th percentile for 1986—based on funding availability after the budget requests for those years were determined. This was a means of spreading the estimated budget shortfalls among the contractors, rather than a true measure of economy and efficiency (see p. 53). Moreover, we did not recommend that HHS "return to the old budget process" but rather that more emphasis be placed on individual contractor circumstances in the budget development process than is the case with formula-based caps. Further, because of the experience of many of the Medicare contractors, we believe that the budget process should consider their input to help determine the level of funding necessary to adequately support program safeguards and beneficiary services.

In addition, HHS commented that any contractor that believes its funding level is too low has the right to leave the program, but only 1 of 91 has decided to do so. According to HHS, this illustrates that its budget process is working and is reducing costs per claim. There are many reasons why a contractor may want to stay in the Medicare program, and some contractors told us they are absorbing Medicare costs to do so. However,

as emphasized throughout this chapter, our concern is that the contractor funding levels be developed with the need for program safeguards and beneficiary and provider services in mind and be adequate to meet these needs. HHS' next comment addresses this issue.

HHS commented that this chapter is full of anecdotes that purport to indicate that payment safeguards and beneficiary services have suffered as a result of budget savings. HHS said it strongly disagreed with this because since fiscal year 1982, payment safeguard dollars have been increased about 20 percent a year, program savings have also increased substantially, and beneficiary service dollars have increased over 10 percent a year.

We have discussed and commended HHS' and HCFA's recent emphasis and increased funding for program safeguard activities several times (see pp. 45 and 57). However, program safeguard expenditures have not increased by 20 percent each year since 1982, and the actual increases that occurred were not entirely due to HHS and HCFA decision making. Also, data which became available after we sent our draft report to HHS for comment indicate that program safeguard activities have been adversely affected by the reductions in claims processing budgets.

In fiscal year 1982 HCFA spent $12 million less on contractor program safeguard activities than it did in fiscal year 1981. In June 1982, we testified that we believed contractor funding for audits and utilization review should be increased because these activities were cost effective and would help control growth in Medicare spending.[9] Section 118 of the Tax Equity and Fiscal Responsibility Act of 1982 authorized $45 million in additional funds in fiscal years 1983-85 to be used exclusively for provider cost report audits and reviews of medical necessity. The Congress appropriated these extra funds, which accounted for all of the increase in program safeguard expenditures in fiscal year 1983 ($43.7 million). Thus, it was the Congress' action that accounted for the increase in that year.

In fiscal year 1984, HCFA spent $22.6 million (16.8 percent) more on contractor program safeguard activities than was spent in fiscal year 1983. However, program safeguard expenditure per claim processed increased only 9 percent from $.56 per claim in fiscal year 1983 to $.61 in 1984.

[9]June 15, 1982, testimony before the Subcommittee on Health, House Committee on Ways and Means, on the 1983 budget proposals relating to Medicare.

We believe that expenditures per claim provide a better indication of the level of activity in program safeguards than does total expenditures.

In fiscal year 1985, contractor program safeguard expenditures increased $41.6 million (26.5 percent) to an expenditure per claim of $.65 (an increase of about 7 percent). However, much of the increase was due to the funding of a major new activity—the Medicare Secondary Payer program—on which $24.1 million was spent. While this new activity is an important one resulting from changes in Medicare law, to enable a more accurate comparison of levels of effort with previous years, we believe that it is necessary to remove the new program from the funding, leaving a comparison of like activities. After adjusting for this change, program safeguard expenditures increased from fiscal year 1984 to 1985 by $17 million (11 percent) and expenditures per claim decreased to $.58 (5 percent). We believe it is important to point out that the increased dollars for program safeguard activities in 1985 came primarily from decreases in funding for claims processing. As discussed on page 55, HCFA estimates that about 30 percent of claims processing expenditure are actually for program safeguard activities. Thus, we continue to believe that funding program safeguard activities through cuts in the claims processing budget is a counterproductive way of trying to protect the Medicare Trust Funds.

In summary, after adjusting for Medicare Secondary Payer program expenditures and for the funds added by the Tax Equity and Fiscal Responsibility Act of 1982, program safeguard activities increased about 43 percent from fiscal year 1982 to 1985, but expenditures per claim increased only 2.4 percent. This increase does not consider the effect of inflation. Based on this analysis, we do not believe that HHS' comment that program safeguard funding has increased 20 percent per year since 1982 tells the real story.

To determine whether the 1985 contractor funding cuts had an adverse effect on program safeguards, we attempted to compare the fiscal year 1985 CPEP evaluation results (available after our report was drafted) for program safeguard activities to the fiscal year 1984 CPEP results. This comparison would show whether more contractors had failed to meet program safeguard requirements. However, because of changes in both the criteria and the scoring method, such a comparison was impossible. But the 1985 CPEP results do show that many contractors did not meet a number of HCFA's program safeguard performance criteria. For example, 10 of the 61 intermediaries evaluated (16.4 percent) failed to achieve the Medicare Secondary Payer savings targets, and 17 of 48

intermediaries reviewed (35.4 percent) failed to conduct prepayment medical reviews of all home health agency claims when such reviews were required. Fourteen of 49 carriers (28.6 percent) had overpayment deductible error rates in excess of the CPEP standard, and 18 (36.7 percent) had underpayment deductible error rates that did not meet CPEP standards. These relatively high failure rates indicate that all is not well in the program safeguard area.

In addition, other information available since our report was drafted shows that the funds available for program safeguard activities in fiscal years 1986 and 1987 have been reduced, thus limiting contractors' ability to adequately protect Medicare dollars. For fiscal year 1986, HCFA has eliminated $10 million for cost report audits of end stage renal dialysis facilities, skilled nursing facilities, home health agencies, and nonprospective payment system hospitals. Historically, cost report auditing has been highly cost effective in reducing improper Medicare payments to providers. Further, according to a HCFA budget document, the OMB budget request for fiscal year 1987 is $38.7 million less than the HHS request, and the reduction "comes almost entirely from payment safeguard activities"

HHS also said that there was a 10-percent growth in funds in each year for beneficiary services during fiscal years 1983 to 1985, and cited this as an indication that services have not deteriorated. However, the cited growth rate is inaccurate. Fiscal year 1983 expenditures for beneficiary services were $68.6 million, down $1 million (1.4 percent) from the fiscal year 1982 expenditure level of $69.6 million. Beneficiary service expenditures increased to $74.2 million in 1984 (an 8.2-percent increase), and to $92.9 million in fiscal year 1984 (a 25-percent increase).

In absolute dollars, these increases represent an overall increase of about 33 percent from fiscal year 1982 to fiscal year 1985. However, on an expenditure per claim basis, there was a 3-percent decrease ($.32 per claim to $.31 per claim). Further, during that same period (fiscal years 1982-85), demand for services was increasing dramatically. For example, part B phone inquiries from beneficiaries increased from 7.8 million to 12.1 million (about 55 percent), written inquiries increased from about 2.9 million to about 3.8 million (about 31 percent), and requests for review of denied claims increased from about 2.4 million to about 3.9 million (about 63 percent).

Because of this situation, contractors are having difficulty providing the quality of service required by HCFA's CPEP standards. For example, preliminary CPEP results for fiscal year 1985 show that 9 of 48 carriers evaluated (18.8 percent) failed to achieve a P-20 level of phone service (see p. 61), 17 of 49 carriers (34.7 percent) failed to meet the standard for answering beneficiary inquiries within 30 days, 18 of 46 carriers (39.1 percent) failed to provide readable written responses to beneficiary inquiries, 15 of 48 carriers (31.2 percent) failed to complete reviews of denied claims within 45 days as required, and 21 of 45 carriers reviewed (46.7 percent) failed to provide written review determinations that were readable (see p. 60).

The quality of beneficiary services for fiscal year 1986 could be worse than in 1985 because HCFA's proposed budget for these services was reduced from $92.9 million to $80.3 million.

HCFA Has Improved Its Ability to Measure Contractor Performance

In 1979, we recommended that HCFA establish a performance measurement system that could be used as a basis for terminating poor performing contractors. Others made similar recommendations during the 1970s. Beginning in fiscal year 1980, HCFA implemented CPEP, which uses standards to measure performance. CPEP's development has been evolutionary, with refinements and improvements made each year. We believe that CPEP provides a good basis for identifying poor contractor performance.

We expect that HCFA will continue to improve CPEP and that one such improvement could be to use the CPEP standards to encourage contractors to increase efforts to save Medicare benefit payments.

Development and Evolution of CPEP

From the beginning of the Medicare program, there has been a recognized need for performance standards that could be used to evaluate the contractors who process Medicare claims. In a 1970 report, the staff of the Senate Committee on Finance indicated that performance variations were so great that terminations were easily justifiable but that there had been no active policy of complete and in-depth analysis followed by terminations of poor performers in favor of better ones.

The Advisory Committee on Medicare Administration, Contracting and Subcontracting (the Perkins Committee) recommended that HHS develop a viable means for measuring contractor performance and promptly announce a policy of nonrenewal of contracts for contractors consistently having the poorest performance over the 3-year period July 1973 through June 1976. The committee also indicated that for each succeeding year, there might be additional contractors terminated on the basis of their performance over the prior 3 years.

In our June 1979 report, we recommended that HCFA incorporate performance standards into all contracts and implement a firm policy of contract termination for poor or marginally performing contractors.

To meet the need for a systematic evaluation of contractor performance, HCFA developed CPEP, which measures contractor performance against a set of standards announced at the beginning of each fiscal year. CPEP went into effect in fiscal year 1980 for intermediaries and in fiscal year 1981 for carriers. The first standards emphasized the same general areas of concern as today's standards—timeliness, cost, and quality of performance.

The development of CPEP standards is a continuing effort involving HCFA central office and regional office staffs, as well as representatives of the contractors. While the major areas of concern have remained the same, the specific performance standards and program emphasis change from year to year.

Each year HCFA develops the CPEP standards that will be used to evaluate contractor performance during the next year. The process considers legislative changes, problem areas identified by HCFA and others, and refinements to previous standards in setting the emphasis for and specifics of the CPEP standards. Thus, the CPEP standards have evolved as experience with this evaluation program was gained and as the Medicare program changed. For example, changes in the hospital payment methodology from a retrospective to a prospective payment system have required changes in CPEP that emphasize proper and timely computation of the prospective rates. Other standards have also been changed in response to the transition from Professional Standards Review Organizations to Peer Review Organizations.

CPEP has also been changed to reflect the level of the program's administrative funding. For example, in fiscal year 1982 intermediaries were expected to process 84.5 percent of inpatient hospital bills in 30 days or less. In fiscal year 1983, as a cost-saving measure, HCFA relaxed the standard to 80 percent processed in 30 days or less. In fiscal year 1986, HCFA relaxed processing time standards for carriers because of tight administrative budgets (see p. 59).

Over time, the standards have also been improved to allow HCFA to better measure performance. For example, in fiscal year 1981 HCFA had several standards dealing with the process for collecting overpayments. However, these standards did not actually measure the intermediary's success in collecting overpayments. In 1981, intermediaries were to (1) send demand letters to providers, (2) process provider requests for extended overpayment repayment schedules, and (3) refer uncollectible overpayments to the HCFA regional office. Intermediaries were compared based on their compliance with HCFA's processes. In fiscal year 1986, intermediaries are scored based on the actual ratio of overpayments to benefit payments. Thus, the standard appears to be more effective because it gives contractors incentives to avoid making overpayments.

While all CPEP standards for contractor performance are considered important, each standard is weighted according to the relative importance HCFA believes is appropriate to the function being assessed: 1 is

least important, 3 is moderately important, and 5 is critical to the program. A contractor failing one standard with a weight of 5—a "critical element"— automatically fails CPEP, regardless of scores on other CPEP standards. For fiscal year 1986 there are 20 critical elements for part A, and 14 for part B.

HCFA regional offices are responsible for performing the CPEP reviews, which are conducted both at the contractors' sites and at the HCFA regional office, depending on the nature of the elements to be reviewed. CPEP standards are reviewed in portions as contractor performance is monitored throughout the year. Many reviews cannot be done until the end of the fiscal year because they rely on reports that are not available earlier. HCFA staff can review potential problem areas early in the fiscal year so that contractors can take corrective action for a later re-evaluation. Scores for re-reviews replace initial scores.

Beginning in fiscal year 1986, HCFA does not plan to review all contractors for every CPEP standard. HCFA regional offices are expected to review at least the following categories of standards:

- All "critical elements."
- All elements that can be reviewed in the regional office using HCFA or contractor-supplied data.
- All elements where the contractor scored less than 7 points (the minimum passing score) in the prior year's CPEP.
- Sixty percent of all other standards.

Annual review of every standard has been time consuming and administratively burdensome in view of the reduced resources available for both HCFA regional offices and contractors. For example, in fiscal year 1985, regional office staff were responsible for reviewing 98 standards for every intermediary and 78 standards for every carrier. HCFA officials believe that it was not necessary to continually review areas in which certain contractors have not historically had problems.

During our discussions with HCFA regional office staff and contractor representatives, we found a general acceptance that CPEP provides a reasonable method of comparing contractor performance. Moreover, they believe that improvements have been made in CPEP and that their concerns about the program are generally considered by HCFA central office staff when the standards are revised.

Additional CPEP Improvements Are Possible

Although CPEP is generally accepted as a useful tool in comparing contractor performance, many of the users we spoke with had suggestions for improvements. The primary improvement suggested was an increased emphasis on program benefit payments. There are also other areas in which users believed changes would be beneficial.

CPEP Does Not Sufficiently Emphasize Efforts to Save Program Benefit Payments

In some areas CPEP does not encourage contractors to do more than the minimum required to save Medicare dollars and in fact can penalize a contractor for expending more effort in such areas. For example, the utilization review standard requires that, for a satisfactory score, the contractor must spend at least 95 percent of the funds allocated to this function and achieve a ratio of at least $5 saved for every $1 spent. The performance levels for the standard for fiscal years 1985 and 1986 are shown in table 5.1.

Table 5.1: CPEP Scoring for Part B Utilization Review

CPEP score	Ratio of dollars saved to dollars spent		
10	$25.01 or more		to 1
9	$15.01 to 1	—	$25.00 to 1
8	$6.01 to 1	—	$15.00 to 1
7	$5.00 to 1	—	$6.00 to 1
6	$3.50 to 1	—	$4.99 to 1
4	$2.50 to 1	—	$3.49 to 1
2	$2.00 to 1	—	$2.49 to 1
0	$1.99 to 1	—	less

Note: Part A levels are slightly lower for scores 8 through 10. A ratio of 5 to 1 is still required to pass CPEP.

This is a "critical element," so a score of 7 is necessary to pass CPEP. If the contractor spends at least 95 percent of its goal and has reached a 5-to-1 return ratio, it passes CPEP. If the contractor has achieved a 5-to-1 ratio and wants to spend an additional $100,000, for example, on utilization review, but believes it can only obtain a return of $400,000, that would drop the overall return ratio to less than 5 to 1. As a result, the additional effort would cause the contractor to fail CPEP even though the government would have gained, in this example, a net benefit of $300,000.

Another example is the Medicare secondary payor standard for fiscal years 1985 and 1986. Like the utilization review standard above, the contractor must, for a satisfactory score, spend at least 95 percent of its allocated budget on this element. If the contractor achieves the savings

target established for it by HCFA, it receives a score of 10, the maximum points available for that standard; there is no incentive for the contractor to do better than the HCFA-established target.

On the other hand, CPEP generally provides incentives for contractors to submit reports to HCFA before they are due. It would seem more appropriate for HCFA to establish additional incentives within CPEP for contractors to save program funds rather than provide incentives for contractors to submit reports earlier than required.

In a 1983 report,[1] we noted the differing prepayment edits used by carriers and recommended, among other things, that HCFA compare the prepayment utilization edits used by Medicare carriers, identify the more effective ones in terms of valid denials, and require their implementation (at least on a test basis) by all carriers, except where a carrier has a reasonable basis for believing that the implementation of a particular edit would not be cost beneficial. HCFA has since mandated that certain edits be used by all carriers. However, several of the contractors we visited during this review stated that the number and type of prepayment edits which the contractors use in their claims processing efforts still vary. Certain edits are mandated by HCFA but contractors have found additional edits helpful in controlling program payments.

We continue to believe that HCFA should focus attention on the effectiveness of prepayment edits in controlling program payments. In addition, we believe that contractors who are taking the lead in identifying and successfully using such edits should receive recognition, through bonus points or some other method in CPEP or elsewhere where relative contractor performance is considered. In summary, we believe Medicare could increase savings by using CPEP standards to place additional emphasis on payment safeguards.

Other Potential Problems With CPEP

During our visits with HCFA and contractor staff, we were told about several perceived problems with CPEP. Contractor and HCFA regional office staff were concerned about the subjectivity of many of the standards. They told us that scores for some standards can vary based on the reviewer's judgement and the standards are subject to interpretation. They expressed concern about ambiguous elements, subjective

[1] Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services, GAO/HRD-83-16, Feb. 8, 1983.

wording, and difficulties in interpretation. Examples of subjective terminology cited are "minor," "major," "effective," "equitable," "satisfactory," "accurately," and "timely," terms that are used throughout the standards. There are standards which require reviewers to evaluate the accuracy of the medical necessity decisions made by contractor medical staff and decide whether the contractors made a "good faith effort."

Finally, because many standards use data provided by the contractor, the accuracy of the CPEP evaluation depends upon the accuracy of the contractor-provided data. We recently looked into the accuracy of certain contractor-supplied data that is used in CPEP and reported that use of the data could involve risks.[2] It is possible for contractors to manipulate the data because of inadequate HCFA controls.

Conclusions

We believe that CPEP gives HCFA a good basis for assessing the performance of Medicare contractors and a means of identifying poor performing contractors. The application of CPEP has evolved since its inception in 1980, and we believe that this evolution has resulted in an ever-improving performance measurement mechanism. We expect that this evolutionary process will continue, and we believe that one way CPEP could be improved is to use it as a means of providing additional incentives to contractors to safeguard against inappropriate payments.

Recommendation to Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to increase contractor incentives for saving program benefit dollars above the minimum performance standards during future revisions of the CPEP.

Agency Comments and Our Evaluation

HHS agreed with our recommendation. HHS said that while CPEP can be used to place additional emphasis on program safeguards, there is no substitute for adequate funding and heightened management of the payment safeguard activity. HHS cited increases in funding for program safeguards and greater HCFA direction of contractor activities in this area. (See pp. 88 and 89.)

We agree with HHS that adequate funding of program safeguard activities is the key to having adequate payment protection and that CPEP is a

[2]Second-Year Implementation of the Financial Integrity Act in HHS, GAO/HRD-86-9, Nov. 8, 1985.

means of providing additional incentives for these activities. That is precisely why we discussed the need for adequate funding of program safeguards in chapter 4 and recommended that the contractor budget process be revised to assure adequate funding is provided. We also agree that increased HCFA management of the program safeguard area is appropriate and have made a number of recommendations to this effect over the years. For example, in 1983[3] we recommended that HCFA require all carriers to use certain cost-effective computerized prepayment utilization control edits and HCFA subsequently did so. HHS' comments about the funding levels for program safeguards are discussed in chapter 4. (See pp. 64-66.)

HHS also said that it intended to develop a program safeguard experiment to test the feasibility of funding a contractor to achieve a maximum of program savings. We would support a well-designed experiment in this area.

Finally, HHS commented that it believes that fixed-price contracts with incentive payments would provide the best vehicle for achieving better contractor payment safeguard performance. The incentive payment concept has not yet been tested by HHS for Medicare contractors. Such a test would need to be carefully designed to enable attribution of the results to the contract incentives and to balance the incentives to deny program payments with the necessity of contractors to pay legitimate claims.

[3]Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services, GAO/HRD-83-16, Feb. 8, 1983.

HCFA Needs to Use Its Authority to Remove Poor Performing Contractors

HCFA has various legislative authorities it can use to remove poor performing contractors; however, the agency has rarely used these authorities for this purpose. Rather, HCFA's actions have stemmed primarily from a desire to obtain the economies of scale available from consolidating contractor areas and to test the effectiveness of competitive contracts. Removing poor performers was at best a secondary objective of these actions.

We believe that HCFA has sufficient authorities to improve Medicare administration. However, HCFA needs to apply them to remove poor performing contractors.

Contractor Performance Varies

CPEP has been in operation for more than 5 years, and HCFA now uses the results of CPEP reviews, in conjunction with other performance indicators, to compare contractor performance annually. In analyzing various performance indicators that have been available since 1980, we found that substantial differences in contractor performance still exist. The change over time in performance differences is mixed—for certain indicators, the difference is increasing, while for others it is decreasing. For example:

1. Total contractor unit costs for part A ranged from $3.28 to $10.66 in fiscal year 1980 and from $3.94 to $10.19 in fiscal year 1984.

2. Total contractor unit costs for part B ranged from $1.91 to $3.36 in fiscal year 1980 and from $1.88 to $3.04 in fiscal year 1984. Thus, the range between highest and lowest—already relatively narrow in 1980 compared to part A intermediaries—decreased further.

3. Part B carrier payment error rates ranged from 0.7 percent to 4.4 percent in calendar year 1980 and from 0.4 percent to 3.2 percent in calendar year 1984.

4. The percent of inpatient hospital claims processed by intermediaries in 30 days or less ranged from 25.1 to 98.7 percent in fiscal year 1980. In fiscal year 1984, the range was 82.2 to 100 percent.

5. Average carrier processing time ranged from 4.3 to 31.7 days in June 1980. In June 1985, the range was from 6.5 to 42.4 days.

In addition, although the evaluation results vary considerably from one period to another, certain contractors can be identified as consistently poor performers. We observed that

- administrative cost rankings were reasonably consistent from year to year—the highest cost contractors in 1984 were also among the highest in prior years;
- some contractors with the worst CPEP rankings were also among the worst in terms of unit cost, payment error rates, and timeliness; and
- several contractors were consistently ranked among the worst performers according to their CPEP scores.

HCFA Has Done Little to Terminate Poor Performers

HCFA can identify contractors with consistently inefficient and error-prone operations, and the Social Security Act authorizes the agency to deal with inefficient intermediaries and carriers. However, HCFA has done little to remove poor performers from the Medicare program.

Sections 1816 and 1842 of the act allow HCFA to reassign providers among intermediaries and to terminate or refuse to renew the contracts of intermediaries and carriers. In addition, the CPEP guidelines expand the formal "contract actions" HCFA may take, including

- sending letters of concern or admonition,
- deleting the automatic renewal clause from the contract,
- deleting automatic renewal clauses and providing for termination after a 90-day notice, and
- reducing a contractor's territory.

Table 6.1 shows the number of contractors that received official adverse contract actions in fiscal years 1981 through 1985, based on 1980 through 1984 performance.

Table 6.1: Number of Adverse Contract Actions

	Part A fiscal year					Part B fiscal year				
Description of action	**85**	**84**	**83**	**82**	**81**	**85**	**84**	**83**	**82**	**81**
Number of contractors	54	63	64	68	76	38	40	40	40	42
Letters of concern/ admonition	9	7	•	•	6	7	4	•	•	8
Deletion of automatic renewal clause	4	4	•	4	1	2	2	1	•	1
Limited contract renewal	•	•	3	2	1	•	•	1	1	•
Reduction in territory	•	•	•	•	1	•	•	•	•	•
Nonrenewal	•	•	•	•	•	•	•	•	1	1

As shown in table 6.1, HCFA has refused to renew contracts for only two carriers since 1980. HCFA did not renew the contract with (1) Medical Services of D.C. (effective Oct. 1, 1981) because it was found to be manipulating the data used to compute its error rates and (2) the Oklahoma Department of Human Services (effective Apr. 1, 1983) because of continuing poor performance. During this period, other contractors voluntarily left the program, lost competitive bids, or were involved in consolidations.

Consolidations Have Eliminated Few Poor Performers

In our 1979 report on Medicare contracting, we concluded that there were too many carriers and intermediaries administering Medicare and that savings could be realized by consolidating carrier and intermediary workloads and distributing larger workloads to fewer contractors. Beyond savings achievable by economies of scale, a move to reduce the number of contractors would provide an opportunity to terminate the less efficient ones.

HCFA has eliminated 10 intermediaries and 3 carriers through consolidations since 1980. Most of these consolidations (10 of 13) were to achieve administrative efficiencies, rather than to eliminate poor performers. Using CPEP and other data, we analyzed four consolidations that took place in HCFA's Philadelphia region and found that good performers as well as poor ones were removed from the program. In one of the consolidations, three poor performers were consolidated into one contract.

HCFA's CPEP and unit cost rankings for all contractors consolidated since 1980 are shown in table 6.2. The rankings are for the year in which each consolidation took place.

Table 6.2: HCFA's Rankings of Consolidated Contractors

Area consolidated	Ranking of outgoing contractor(s)		Ranking of contractor assuming workload	
	CPEP	Cost per claim	CPEP	Cost per claim
Part A				
Tennessee	[a]	37 of 76	54 of 70	61 of 76
West Virginia	[a] [a]	59 of 67 21 of 67	51 of 70	15 of 67
Pennsylvania[b]	47 of 66 22 of 66 3 of 66	56 of 66 14 of 66 6 of 66	8 of 66	11 of 66
Ohio[b]	31 of 66 65 of 66 62 of 66	40 of 66 52 of 66 65 of 66	53 of 66	26 of 66
Virginia[b]	[a]	10 of 66	22 of 66	2 of 66
Part B				
Delaware	[c]	6 of 42	[c]	21 of 42
District of Columbia	[c]	42 of 42	[c]	21 of 42
Florida	[a]	[a]	22 of 47	8 of 40

[a]Contractor not ranked by HCFA.

[b]Performance rankings in 1984 considered CPEP and the Annual Contractor Evaluation Report.

[c]For fiscal year 1981, part B contractors were ranked as either passing or failing CPEP; Pennsylvania, Delaware, and the District of Columbia were among those failing one or more CPEP standards.

Note: In certain years, HCFA did not rank some contractors under both CPEP and unit cost.

Fixed-Price Experiments Rarely Removed Poor Performers

Like the consolidations, one of the primary purposes of most of the fixed-price experiments was also to achieve administrative savings. As discussed in chapter 2, HCFA has achieved savings—although less than originally projected—in three of the seven experiments. Competitive fixed-price contracting has indirectly helped HCFA reduce the cost of all contractors because the fear of losing their territories through competition has stimulated some contractors to reduce their administrative costs.

HCFA attempted to use its competitive authority to remove a poor performing contractor, but did not achieve this objective. One reason cited for initiating the Colorado experiment was the deteriorating performance of the incumbent contractor, Colorado Blue Shield. In fiscal years 1980-82, Colorado Blue Shield's error rates had been among the worst in the country.

The incumbent, however, was the only contractor to submit a proposal for the fixed-price experiment and thus was awarded the contract. The fixed-price contract in Colorado became operational in August 1983, but through 1984 the contractor's relative performance did not improve after changing to a fixed-price contract. Table 6.3 shows the contractor's relative performance before and after the change.

Table 6.3: Error Rates of Colorado Blue Shield

	Payment errors		Occurrence error[a]	
Fiscal year	Rate	Ranking	Rate	Ranking
80	2.7	31 of 47	14.2	43 of 47
81	3.1	43 of 48	20.6	48 of 48
82	3.5	49 of 50	14.4	50 of 50
83[b]	•	•	•	•
84	3.4	48 of 49	14.0	49 of 49

[a]All errors including those not affecting program payments.

[b]Data not available.

Statistics for fiscal year 1985 were not available at the time of our review.

A representative of Blue Cross and Blue Shield of Colorado told us that before 1983, the contractor needed a new computerized claims processing system to resolve the error rate problem, but HCFA had been unwilling to fund the system under the cost contract. The contractor obtained a new system under the fixed-price contract, but the system did not solve the problem.

During fiscal year 1984, the contractor focused attention on the relationship between changes to the Medicare program and the incentives and damages clause in its contract. Consequently, the problem with error rates did not receive attention during that year. During fiscal year 1985, however, the contractor said that it has been able to emphasize quality in part B claims processing and has now established an action plan to identify and correct causes of its high error rate.

Rather than removing a poor performer, HCFA's most recent competitive fixed-price experiment removed one of the best performers in the country. In May 1985, HCFA awarded a contract to Massachusetts Blue Shield for consolidated claims processing in the tri-state area of Maine, New Hampshire, and Vermont. The new contract became operational on

October 1, 1985. Before that time Maine was being served by Massachusetts Blue Shield under a fixed-price contract, and New Hampshire and Vermont were being served by New Hampshire/Vermont Blue Shield under a cost reimbursement contract. Table 6.4 shows the selected rankings of New Hampshire/Vermont Blue Shield in the 2 years before losing the tri-state contract.

Table 6.4: Selected Rankings of New Hampshire/Vermont Blue Shield

	Fiscal year	
Criteria	**1983**	**1984**
CPEP performance	4 of 47	2 of 47
Claim payment unit cost	14 of 48	10 of 48
Overpayment/deductible error rate	13 of 48	1 of 44

Changing to a competitive contract and consolidating the tri-state territory was obviously not intended to eliminate a poor performer, but to save administrative costs. HCFA knew when it issued the request for proposals that at least one of Medicare's better performers would be leaving the program— either Massachusetts Blue Shield or New Hampshire/Vermont Blue Shield.

Additional Authority Provided to Remove Poor Performers Not Yet Used

DEFRA gives HCFA additional authority to award competitive contracts for the primary purpose of removing poor performers from the program. The new authority allows HHS to enter into no more than two competitive fixed-price contracts under part A and two such contracts under part B in fiscal years 1985 and 1986. This authority can be used only to replace contractors who are poor performers—those who fall into the lowest 20th percentile of contractors, as measured by cost and performance criteria.

The DEFRA authority has not yet been used. HCFA is developing a methodology for identifying the lowest 20th percentile by weighting cost and performance factors over a 3-year period. HCFA plans to begin using this authority in fiscal year 1986.

Conclusions

HCFA has implemented a contractor evaluation program, CPEP, which uses standards to measure contractor performance. In addition, HCFA's legislative authority provides a number of options that can be used to improve program administration. To date, however, HCFA has seldom used its authority and capabilities as a means of removing poor performing contractors from the Medicare program.

HCFA should use its authority and options to deal with poor performers as a means of achieving future improvements in operational efficiency and quality of services. Toward this end, we believe that the use of competitive fixed-price contracting—on a limited basis as specified in DEFRA—gives HCFA added flexibility and leverage in dealing with the contractor community and removing poor performers from Medicare.

Matter for Congressional Consideration

We believe that legislation authorizing the general use of competitive fixed-price contracting in the Medicare program is not necessary, but that the continued use of fixed-price contracting on a limited basis may be desirable.

The DEFRA authority, allowing HHS to use a limited number of fixed-price competitions annually to remove poor performing contractors, expires at the end of fiscal year 1986. The Congress should consider extending this authority or making it permanent.

Recommendation to Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to use existing legislative authorities to remove consistently poor performing contractors from the Medicare program.

Agency Comments and Our Evaluation

HHS agreed with our recommendation. HHS added that, in view of the difficulties and resources required to replace contractors, it believed maximum effort should first be applied to correcting poor performers. HHS said that the federal government's interest is best served by helping poor performing contractors to improve performance and that this course of action is less expensive and less risky than replacement. HHS also stated that it intends to use the authority granted in section 2326 of DEFRA to conduct cost reimbursement contract competitions in Idaho and New Mexico during fiscal year 1986. (See p. 90.)

We agree that HHS should first try to get contractors to improve performance before replacing them. That is why we recommend removing consistently poor performers when presumably HCFA's efforts to get the contractor to improve have failed. As discussed in chapter 2, we also agree that there are difficulties associated with replacing contractors and that such actions consume significant HCFA resources.

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

JAN 30 1986

Mr. Richard L. Fogel
Director, Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicare Contracting: Existing Authority Can Provide for Effective Program Administration." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

for Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare Contracting: Existing Authority Can Provide for Effective Program Administration"

Overview

The Department recognizes the difficult task faced by GAO in reviewing the Health Care Financing Administration's (HCFA's) contracting process for administrative services. This task is mandated by Section 2326 of the Deficit Reduction Act of 1984 (DEFRA). We are concerned, however, that GAO has misinterpreted the provisions of DEFRA. Specifically, GAO indicates that Section 2326 requires that it determine if the advantages of fixed-price competition justify the broader use of this method of contracting in the Medicare program. GAO goes on to conclude that Section 2326 authorizes the use of competitive fixed-price contracting.

We believe that GAO's interpretation of Section 2326(a) of DEFRA touches upon a significant issue. In our opinion, all that Congress has so far seen fit to provide HCFA with, in Section 2326(a), is the authority to avoid the provider nomination process in a limited number of agreements and contracts under Sections 1816 and 1842 of the Social Security Act on the basis of competitive bidding. The text of Section 2326(a) restricts HCFA to conduct such competitions under the cost reimbursement limitations of Section 1816 and 1842 of the Social Security Act. Therefore, any contract awarded by HCFA under the authority of Section 2326 must be a cost reimbursement, and not a fixed-price, type of contract. We believe that the Comptroller General should review and affirm GAO's position in the final report.

In addition, and contrary to GAO's stated premise to review the relative advantages of fixed-price contracting for Medicare, Section 2326(e)(1) of DEFRA requires GAO to conduct a study on the ability of HCFA to manage competitive bidding for agreements and contracts under Sections 1816 and 1842 of the Social Security Act. In other words, Congress seems to have directed GAO to review HCFA's management of competitively awarded cost reimbursement contracts. Thus, GAO's indepth review of HCFA's fixed-price contracting experiences does not appear to be responsive to the study requirements prescribed by Section 2326(e)(1).

At the same time, we do not disagree that GAO's review of HCFA's competitive fixed-price contracting efforts would, at some future point in time, be appropriate to any consideration of Medicare contracting authority. However, because of the way in which Section 2326(a) has been written, Congress has limited the competitive procurements to one form of contracting, i.e. cost reimbursement. GAO has reached the general conclusion, based upon its review of HCFA's past fixed-price contracting experiences under our experimental contracting authority, that the use of competitive fixed-price contracting is not necessary, but that continued use of competition on a limited basis may be desirable. It therefore suggests that Congress consider either extending Section 2326 authority or making it permanent. We believe that before reaching the conclusion that HCFA's existing contracting authority is sufficient, HCFA should be provided the opportunity to conduct additional demonstrations using alternative forms of contracting. Thus, if the authority under Section 2326(a) is extended, it should be revised to provide independent authority to award fixed-price contracts on the basis of competition.

Apart from GAO's interpretation of DEFRA, we believe the Medicare contractors have, for the most part, done an outstanding job of providing service to beneficiaries, responding to change, safeguarding trust fund dollars and improving efficiency. The issues which confront the future administration of the contractor operations are the extent to which additional improvement is possible and the best methods to obtain it. The basic conclusion of GAO's report is that no additional legislative authority beyond that granted in DEFRA is needed by HCFA to motivate improvement. Negotiation with "cost" contractors and use of the limited "competitive" authority granted by DEFRA is viewed as sufficient.

HCFA maintains that further progress to improve service and reduce cost cannot be achieved without the use of judiciously managed, competitively let fixed-price contracts with incentive payments for superior performance. Without the necessary legislative authority to remove poor performers and achieve economies of scale while vigilantly protecting services to our beneficiaries, the great strides recently achieved by the Medicare contractors may be compromised. Greater flexibility to manage the contractors is necessary to tailor each contract to the specific needs of the individual intermediary or carrier as well as the Medicare program.

Following is a summary of our comments on the draft report's conclusions and recommendations. Additionally, Attachment A is a synopsis of HCFA's current contractor management strategy. Finally, Attachment B describes a number of technical concerns with the report.

GAO Conclusion

Competitive fixed-price contracting is not demonstratively better than cost contracting.

Department Comment

We disagree. We acknowledge that all fixed-price contracts have not been perfectly executed. However, this speaks more to HCFA continuing to improve its management of contractor's rather than to fault fixed-price contracting. HCFA management processes have and will continue to improve. The following chart illustrates the price differential between our current cost and fixed-price contractors.

	Average Cost Per Claim (FY 1986)	
	Fixed-Price Contractors	Cost Contractors
Intermediaries	$1.61	$2.01
Carriers	$1.53	$1.77

It is clearly evident that fixed price contracting results in substantial savings. The cost per claim is 19.9 percent less for Part A fixed price contractors and 13.6 percent less for Part B fixed price contractors. Our contractors will process over 300 million claims in FY 86. Other performance measures including payment safeguards and beneficiary service appear equal for cost and fixed-price contractors on average. We would conclude fixed-price contracting is superior.

With respect to frequency of contractor changes, having the authority to make changes does not mean it would be used too frequently or in an indiscriminate manner. We fully recognize the problems of transition to a new contractor. When a decision is made to change contractors, adequate resources will be available to ensure a successful replacement. We have learned a number of lessons about fixed-price contracting which have been and will be applied to all future procurements.

GAO Conclusion

There is little justification for changing the provider nomination process.

Department Comment

We disagree. The nomination process is an unnecessary encumbrance on HCFA's management process as indicated in the nomination section of the draft report concerning problems encountered with it under experimental fixed-price contracts. There is little justification for its retention now that all contractors are required to meet the same performance standards. As indicated in the draft report, the nomination process has only been available to Part A providers, not under Part B.

GAO Conclusion

Place more emphasis on individual contractor circumstances in budget development.

Department Comment

We agree that individual circumstances should be a budget consideration and assert that they are appropriately considered through adjustments for wage levels, bill mix, and Part A reconsiderations. However, HCFA cannot return to the pre-DEFRA budget process where contractors were allowed to set their own reimbursement without cost limitations. The Congress, in enacting section 2326, directed HCFA when determining the proper cost of administration to pay only the amount reasonable and adequate to meet the costs incurred by an efficiently and economically operating contractor. We have used the DEFRA authority to save over $45 million in contractor funding in FY 85. A return to the old budget process would be self-defeating and costly. Again, our fixed price contracts have aided us in establishing a market price for efficient and economical administration.

This budget section of the report is full of anecdotes that purport to indicate payment safeguards and beneficiary services have suffered as a result of budget savings. We strongly disagree. Objective evidence indicates the opposite. Payment safeguard dollars have been increased approximately 20 percent in each and every budget since fiscal year 1982. Program savings have also increased substantially over this period of time. In addition, beneficiary services dollars have increased over 10 percent in each year during the same period.

GAO Conclusion

Increase contractor incentives to improve payment safeguard performance.

Department Comment

We agree that the Contractor Performance Evaluation Program (CPEP) can be augmented to place additional emphasis on program safeguards. We have already made a number of changes in CPEP to emphasize program safeguards. However, the recommended CPEP changes cannot take the place of adequate funding and heightened management of the payment safeguard area. We have made great strides with regard to payment safeguards. The Medicare audit effort has almost doubled in dollars expended since FY 1982. HCFA has become increasingly prescriptive in targeting providers for audit. This includes establishment of an audit priority matrix for contractors to use in developing their workloads as well as specific audit protocols to follow. A better than 5:1 benefit to cost ratio has been consistently maintained by HCFA's audit program. Savings in FY 1985 will be approximately $1.0 billion.

Medical review has also been doubled within the last few years. HCFA, again, is becoming more prescriptive in targeting providers and certain types of claims for review. Medical review savings have been better than 5:1 during this period of increased emphasis. Savings in FY 1985 will be approximately $625 million, an increase of $148 million over FY 1984.

In FY 1985, we launched a major program to implement the Medicare Secondary Payer (MSP) provisions. The emphasis of the MSP activities was to identify potential recovery situations. A cost benefit ratio of 28:1 was achieved for all FY 1985 with savings of over $750 million, representing a new category of money recovered for the benefit of the Medicare trust funds.

Although CPEP changes offer some incentive for better contractor payment safeguard performance, we feel fixed-price contracts with incentive payment will provide the best vehicle for achieving this objective. Instead of intangible bonus CPEP points, actual monetary awards for increased savings and/or transferable ideas would be possible.

GAO Conclusion

Use legislative authority to remove poor performers.

Department Comment

We agree and plan to do so in FY 1986 where appropriate. However, we should point out that the goal of performance management is to maintain and improve performance, not to remove contractors. The combination of HCFA's management action and the pressure of our ability to remove poor performers has resulted in significant performance improvements at a number of sites. Improving the performance of incumbents is less expensive and less risky than their removal and replacement. Fixed-price contracts with incentive payments and penalties for good and poor performance, respectively, to correct performance problems, would be a most useful tool in moving in this direction.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to use a Medicare contractor budget development process that places more emphasis on the individual circumstances of contractors than the formula-based cost caps. The process should consider the input of the Medicare contractors in order to more realistically determine the funds needed to sufficiently support program safeguards and assure an adequate level of beneficiary and provider service activities.

Department Comment

We disagree. We already recognize individual differences in contractor budget requirements by including in the budget negotiation process adjustments for area wages, bill mix, and levels of Part A reconsiderations. HCFA's regional offices have the authority to make changes in contractor claims processing budgets to further account for individual contractor circumstances. If a contractor has a reasonable rationale for its inability to meet the budget target, the target can be negotiated.

Of course, any contractor has the right to leave the program if it believes the funding level is too low. However, only one contractor out of 91 has made a decision to leave the program. This would seem to illustrate that our budget negotiation process is working as well as the fact that costs per claim have been substantially reduced.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to increase contractor incentives for saving program benefit dollars above the minimum performance standards during future revisions of the CPEP.

Department Comment

We agree that additional incentives should be given to contractors to increase program safeguard savings. In addition to the achievements concerning payment safeguards listed earlier in the comments on the draft report's conclusions, we intend to develop a program safeguard experiment to test the feasibility of funding a contractor to achieve a maximum amount of trust fund savings. We will continue to budget additional dollars for payment safeguard activities as long as we believe additional savings are achievable. Funding is only constrained by the need to justify the expenditure increase. We will continue to strengthen the potential for recovering misspent dollars in future revisions of CPEP.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to use existing legislative authorities to remove consistently poor performing contractors from the Medicare program.

Department Comment

We agree. However, in view of the difficulties and resources required to replace contractors, we believe maximum effort needs to be applied to correcting poor performers.

The history of Medicare contract management actions is replete with examples of contractors improving their performance trends following aggressive monitoring by HCFA regional office and central office staff. It is in the Federal Government's best interests to strive to assist a poorly performing contractor to better meet its obligations to the beneficiaries and the provider community for prompt and accurate service. In egregious situations we have nonrenewed poor performers with the intent of providing improved service. Our initial contract action must remain as aggressive management techniques, applied in a fair and equitable manner, to promote improved performance.

Nonetheless, we intend in FY 1986 to use the Section 2326 authority granted in DEFRA to conduct cost competitions in Idaho and New Mexico.

GAO Note

Table I.1 contains a word-for-word copy of HHS' "Technical Comments," which were included as an appendix to the agency's comments. The page numbers have been changed to correspond to the pages in the report. Our evaluation follows each comment.

Table I.1: HHS' Comments and Our Evaluation

Page	HHS comments	GAO Evaluation
Executive Summary: Results in Brief; Change in Method of Contracting is Not Justified		
2	Section 2326 does not appear to require that GAO study the advantages of fixed- price contracting. (See the "Overview" section of our comments.)	See pages 36 and 37 for discussion of this comment.
2	HCFA has not proposed a major change in contracting; merely a removal of restrictions on use of one option— fixed-price competition.	HHS' comment relates to our conclusion that a major change in the method of contracting for intermediaries and carriers is not justified because the competitive fixed- price experiments have not demonstrated any clear advantages over the cost contracts currently used. The removal of restrictions on the use of fixed-price competition in administering the Medicare program would be a major change requiring a change in legislation.
Principal Findings; Competitive Contracting		
3	Our calculations indicate that six of the eight experimental contracts saved administrative costs. However, the point is irrelevant because the contracts were undertaken in an experimental mode from which we were able to influence the overall efficiency of the contractor community.	Table 2.4 on page 29 shows that HCFA estimated that six of the experimental contracts saved administrative costs. As explained on page 28, we attribute the difference between HCFA's estimates and our estimates to the methodology used. We believe our methodology produces better estimates because it better reflects the downward trend in unit costs of the cost contractors and includes more relevant factors, including inflation. Because administrative cost savings has been a major argument for using fixed-price competition in Medicare, we do not consider our analysis irrelevant. In its comments in chapter 2, HHS sites the estimated administrative savings during fiscal year 1986 for the fixed-price contracts as a major reason for concluding that "fixed- price contracting is superior" to cost contracting (see p. 86).
3	Contractor turnover is not necessarily a result of a competition. Incumbents often win, with the government obtaining better terms. We do not agree that more resources are required to manage fixed price contracts on a day to day basis; clearly all contracts require management. All transition and poor performer situations require a great deal of resources—reimbursement mechanism is not a distinguishing feature.	We did not conclude that all competitively awarded contracts would result in contractor turnover. Rather, we said that regular competition would increase contractor turnover. Experience from the eight fixed- price competitions in the Medicare program shows that six of the eight resulted in contractor turnover. Of the other two, one involved a single bidder (the incumbent), and the other was a recompetition. Regarding the level of HCFA resources needed to manage contracts, on page 25 we stated that there is very little difference in resource requirements between cost contracts and fixed-price contracts after the contracts are fully operational (i.e., "on a day to day basis"). We also point out that competitively awarded fixed-price contracts have generally required more HCFA resources than the traditional cost-type contracts during the transition and early operational phases of the contract cycle. Further, the competitive contracting process requires resources for activities not needed in cost contracting—preparing requests for proposals, holding pre-proposal conferences, evaluating proposals, and awarding contracts. This is the basis for the statement in the executive summary.

Page	HHS comments	GAO Evaluation
		We agree that all transitions require a great deal of resources, but we believe the number of transitions would increase if competitive fixed-price contracting were more frequently used. With HCFA's resources declining, there may not be adequate resources to manage more transitions.
Executive Summary: Principal Findings; Current Authority Sufficient But Not Used as Intended		
4	It is in the best interest of the Federal Government that every effort be made to improve current contractors' performance. It should be kept in mind that Congress felt that the DEFRA authority would act as an incentive to improve contractor performance and reemphasize the need for nonrenewal of long term poor performers which are deficient in terms of efficiency, quality, and timeliness, not timeliness alone.	We agree that it is in the government's best interest to improve current contractors' performance.
4	While HCFA has reduced unit costs, we have allocated additional resources to undertake considerable payment safeguard activities in the areas of: medical review, audit and Medicare Secondary Payer (MSP).	See pages 64-66 for a discussion of this comment.
Matter for Congressional Consideration		
4	Section 2326 does not appear to allow HHS to use a limited number of fixed- price competitions. (See the "Overview" section of our comments.)	See pages 36 and 37 for a discussion of this comment.
Introduction		
10	Section 2326 provides that GAO is to study HCFA's ability to manage competitive bidding for agreements and contracts under Sections 1816 and 1842; therefore, it does not appear to require GAO to study the advantages of fixed-price competition. (See the "Overview" section of our comments.)	See pages 36 and 37 for a discussion of this comment.
Medicare Program Administration		
11	GAO states that Sections 1816 and 1842 exempt the Medicare program from the normal Federal procurement rules. However, in two separate opinions, GAO has previously held that the Medicare contracts are subject to the standard Federal procurement regulations. See, Letter to the Chairman, Subcommittee on Intergovernmental Relations, House Committee on Government Operations, January 8, 1974, B-164031(4) and Letter to the Secretary of Health, Education and Welfare, April 20, 1977, B-164031(3).125. Thus, GAO is incorrect that the Medicare agreements and contracts are not subject to the normal Federal procurement rules. GAO inaccurately describes the requirements of Sections 1816 and 1842 of the Social Security Act. First, GAO indicates that the Secretary is authorized to enter into contracts with "insurance companies" under Section 1816. However, Section 1816 authorizes the Secretary to enter into agreements with national, State, or other public or private agencies or organizations. Thus, the Secretary is not absolutely limited to contracting with insurance companies.	Our statement that the Medicare law exempts the program from normal federal procurement rules when contracting with intermediaries and carriers was meant to apply to the rules relating to competitively awarding contracts. We have modified the applicable sentence to make this meaning clear. HHS' comment about its authority to contract with other than insurance companies to be intermediaries is technically correct. However, because only insurance companies can be carriers and only insurance companies are currently functioning as intermediaries, we used the term insurance companies to simplify the explanation of these provisions of the law. We have added a footnote that points out that intermediaries do not have to be insurance companies. Our characterization of cost contracts as involving no profit or loss for the contractor is based on the original congressional intent and was used to simplify the explanation of the law. It was meant to convey the fact that cost contractors are not supposed to make a profit from their Medicare work. Also, before DEFRA, contractors were not supposed to suffer a loss on their Medicare activities. We have modified the sentence in question.

Page	HHS comments	GAO Evaluation
	GAO further indicates that Sections 1816 and 1842 "call for the use of cost reimbursement contracts under which the contractors neither profit nor lose from carrying out Medicare activities." However, nowhere do these sections use the terms "profit or loss." They instead provide that the Secretary shall pay as much of a Medicare contractor's cost of administration as is determined to be necessary and proper. Moreover, Section 2326(d) of DEFRA provides HCFA with authority to reimburse inefficient contractors for less than their actual costs.	
Changes in Medicare's Administrative Authorities		
15	Although HCFA has not awarded any contracts under the 2326 authority to date, HCFA has devised a methodology to identify the potential sites for competition and used this information as leverage in the budget negotiations. We plan to conduct cost competitions in Idaho and New Mexico in FY 1986.	HCFA's plans and methodology for using this DEFRA authority are discussed in chapter 6 (see p. 81).
Change to Competitive Fixed-Price Contracting in the Medicare Program Is Not Justified		
20	HCFA believes that experimental fixed-price contracting has contributed significantly to increasing the efficiency of contractors in the Medicare program. HCFA has learned a great deal from these experiments in terms of administrative cost avoidance resulting in significant savings enabling HCFA to process unprecedented workload volumes.	We agree that the authority to use competition has indirectly contributed to the reduction of costs for all contractors and discussed this on pages 30, and 79. Also, we agree that HHS has learned from the competitive experiments and that the knowledge gained can be applied under cost contracts to achieve the potential advantages of competition. This is the basis for our conclusion that the authority to use competitive fixed-price contracting, on a limited basis, would give HCFA added flexibility in administering the Medicare program (see pp. 36 and 82).
21	Fixed-price contractors are just as easy to manage as cost contractors. HCFA has considerable flexibility in dealing with fixed-price contractors. This has been demonstrated not only in terms of the numerous program changes that are required by law but also in performance matters. Change orders not only provide the needed flexibility when new program requirements are introduced but also aid in overcoming problems of performance beyond the contractor's control.	For the reasons stated on page 21, we believe that because of the differences between fixed-price and cost contracts, Medicare has less flexibility under fixed- price contracts to correct performance problems. For program changes that result from changes in law or regulation, the contract change order process should be adequate because fixed-price contracts have provisions for dealing with such changes. However, when a fixed-price contractor encounters performance problems, it may not have a basis under the contract to request a change order. Our concern relates to performance problem situations.
Performance Problems Have Occurred With New Contracts		
23	The cited Illinois II error rate is for 1 quarter only. Such a rate for a brand new contractor in its first operational period is regrettable, but understandable because of transition issues.	The error rate for Illinois II represents the scoring for fiscal year 1984 as shown. Because the contract became operational in mid-year, we have changed the report to identify the actual quarter in which the performance evaluation was based. We have also updated the report with recently obtained data, which show HCSC's payment error rate decreased to 4.5 percent for the year ending June 1985 (the most recent data available). However, this error rate—after over a year of operation—was the highest of any Medicare carrier and was almost three times the national average of 1.8.

Page	HHS comments	GAO Evaluation
Competitive Contracts Require More HCFA Resources		
24	It should be noted that all transitions require more resources during the transition phase for monitoring purposes.	We agree that transitions generally require increased resources to insure a successful transition phase. Also, we believe that the regular use of competition in Medicare would increase the number of required transitions, thus putting a strain on HCFA's declining resources.
25	There may have been some additional staff required for earlier fixed-price contracts because they were experimental and HCFA monitored them closely with higher standards and semiannual rather than annual reviews.	All the fixed-price contracts in Medicare were considered experimental. Also, the additional staff requirements were not limited to the "earlier" experiments. The Illinois II contract is one of the most recent experiments to be awarded but required a significant amount of HCFA staff resources during the transition and early operational phase. The most recent fixed- price contract, the tri-state, encountered problems when it became operational in October 1985 and will probably require close HCFA monitoring until the difficulties are resolved.
DEFRA Gave HCFA Additional Authority to Reduce Administrative Costs		
26	The point here is that DEFRA authority has resulted in reductions of administrative costs for all contractors which suggests that no contractor was optimally efficient. Medicare contractors continued to make unprecedented break-throughs not only in unit cost reductions but payment safeguard performance. It should be kept in mind that fixed-price contracting has had a salutary effect on the entire contractor community's unit cost as it indicates an appropriate "market price."	See page 63 for a discussion of this and related comments. Also, we disagree that the claims processing unit costs for the fixed-price contracts should be used as an indicator of "an appropriate market price" for cost contractors. As discussed in chapter 2, the contract award price in the fixed-price contracts can be artificially low because (1) it may represent a "buy-in" price rather than the true cost of quality claims processing, (2) it may represent incremental rather than total cost, and (3) it does not reflect the cost of subsequent change orders. Thus, to use fixed-price contract prices as standards for the cost contractors, without careful analyses, could be detrimental to the accuracy of program payments and the quality of services.
Most Recent Experiment May Be Less Attractive Than HCFA Believes		
30	HCFA does not dispute that most fixed- price bidding is on the basis of incremental cost. However, the savings are nonetheless real and, as the draft report notes, are even better than the marginal rate would predict. We believe this additional savings comes from marketplace pressures. We do not accept the analytical construct of combining the two Massachusetts contracts into one. Moreover we will not allow the tri-state contractor to allocate costs based on the total workload. Any future bid will be determined by both the current economic conditions and the contractor's perception of possible competition.	Massachusetts Blue Shield is processing the claims of four states—Maine, Massachusetts, New Hampshire, and Vermont—using one claims processing system; thus, viewing this as one operation seems reasonable. By viewing this situation as two separate contracts, HCFA could miss an important opportunity with this experiment—the opportunity to evaluate the operation of the only regional claims processing center in the Medicare program.

Page	HHS comments	GAO Evaluation
Savings May Diminish With Recompetition		
32	HCFA is aware of the potentially diminished returns of recompetition. We do not want to be required to compete or recompete. We want management flexibility. The Government's interests are not harmed by buying-in and it is a phenomenon which exists only in competitive contracting.	GAO has issued a number of reports pointing out the dangers to the government when a contractor "buys-in" to a competitive contract. For example, the experience of the Civilian Health and Medical Program of the Uniformed Services with fixed-price contracting has shown that when new contractors "buy-in" and experience problems, they are sometimes financially unable to correct the problems and satisfy the contract requirements. Some of these contractors left the program or were terminated, necessitating additional transitions and further disruption of services to providers and beneficiaries. Another potential problem to the government occurs when contractors "buy-in" but attempt to increase payments they receive through subsequent change orders, thus requiring careful administration of the change order process.
32	Another significant reason for the decline in competition is the advantage of incumbent contractors as evidenced in lower transition costs. HCFA is attempting to deal with this in several ways, most prominently by eliminating requirements for data entry and claims processing within the competed territory.	We agree that incumbent contractors generally have an advantage in a recompetition.
Program Improvements Under Existing Authority		
34	I ast Sentence should read ". . . where three intermediaries and two carriers jointly use one bill processing system and one claims processing system."	We have changed the sentence to reflect that intermediaries also participate in the consolidated claims processing system.
Medicare Contractors Generally Oppose Competition		
35	Periodic competition permits HCFA to validate its cost control management through identification of the current marketplace price for contractor services.	We agree with the comment, if the winning bid in a fixed-price contract represents the true market price. However, the contract award price can be artificially low because (1) it may represent a "buy-in" price rather than the true cost of quality claims processing, (2) it may represent incremental rather than total cost, and (3) it does not reflect the cost of subsequent change orders.
35	HCFA's experience, most recently in Colorado, reveals that there are significant limits on the results of negotiations where a contractor believes itself to be irreplaceable in the short run.	None.
35	We do not agree that high quality service to beneficiaries and providers is inevitably at odds with the concept of fixed-price contracting. We see a clear advantage in competitive fixed-price contracting from three advantage points: —it allows HCFA to determine the market price for claims processing; —it facilitates the consolidation of territories in order to achieve greater economies of scale; and, —it allows for improved services to our beneficiaries.	As discussed, fixed-price competition does not necessarily determine true market prices. Also, the consolidation of territories can be done under existing authority. We agree that fixed-price competition could allow for improved service. However, the fixed-price contracts awarded to date have not been used to remove poor performers, therefore, HCFA has not demonstrated that performance will improve.

Page	HHS comments	GAO Evaluation
Conclusions		
35-36	Administrative cost savings are not the sole reason for entering into an experiment. In the combined Colorado A/B experiment it was not even a significant reason. Further, the provisions for profit and incentive payments where high level performance is achieved make a rigid comparison with cost contractors difficult. HCFA, also, profits from sharing in the knowledge of various efficiencies developed by fixed-price contractors attempting to maximize their profit.	We did not state that administrative cost savings was the sole reason for fixed-price experiments but only that it was an important consideration for HCFA.
HCFA Inappropriately Used DEFRA Authority		
48	HCFA recognized individual differences in the contractor budget development process. Our process included adjustments for area wages, bill mix and levels of reconsiderations. In addition, HCFA regional offices were given the authority to negotiate shifts in the suggested individual contractor budgets.	While HCFA considered the three factors mentioned in this comment in setting the individual contractor claims processing cost caps, there were many other important circumstances that legitimately vary among contractors that were not considered. As discussed on page 48, the formula that HCFA used to establish the claims processing cost caps did not account for contractor differences in workload growth rates, levels of paperless claims processed, or percentages of claims submitted by physicians. Further, the authority given to the HCFA regional offices to negotiate shifts in the cost caps was limited. HCFA's fiscal year 1985 budget guidelines to the regional offices stated that the regions could negotiate (1) budget caps below the level established by central office and (2) a cost per claim above that proposed by central office "so long as it does not exceed 2 percent more than the central office cap and total of the regional FOP [budget] for claims processing is not exceeded." When one HCFA regional office questioned the fiscal year 1985 claims processing cost caps set for the regional contractors, HCFA central office officials responded in a memo that, "While we appreciate your conceptual problems with the reimbursement levels, we are unwilling to grant exceptions unless a most extraordinary circumstance exists."
52	The GAO argument that cost caps should be applied only to inefficient contractors is not our reading of the law. The conference report does not state that reduction of costs applies only to poor performers.	As discussed on page 47, we believe that the law and accompanying conference report show that the Congress was primarily concerned about the costs of inefficient contractors. More importantly, however, we are concerned about the way the cost reductions were made—HCFA's cost cutting did not adequately consider individual contractor circumstances (see p. 48) nor was it based on a true standard of efficiency (see p. 63).
Exact Shortfall for Fiscal Year 1985 Difficult to Determine		
50	Contractors were told that they should report their actual costs incurred. There was no intent on the part of HCFA to have contractors absorb the cost of operation.	As discussed on pages 50 and 51, we believe that contractors were encouraged to absorb costs. Regardless of the reason, however, it appears that contractors are absorbing costs.

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Overall Budget Cuts Limit Funds for Program Safeguards		
57-58	Because FY 85 was the first year of the MSP [Medicare Secondary Payer] Initiative, budgeting was a difficult process. We believed, however, it was best to give most of the initial MSP funds to the intermediaries rather than carriers because the expected return on investment was much higher (i.e., 35 to 1 versus 15 to 1). Because we found that some of our contractors, particularly carriers, were underfunded, HCFA requested (and received) an additional $8 million in contingency funds which was distributed to these contractors.	The additional $8 million in contingency funds was not released to HCFA until June 1985, leaving contractors little time to plan for and effectively use the additional funds before the fiscal year ended. Some contractors used the additional MSP funds to "pay back" other budget categories, such as claims processing, from which funds had been taken to support MSP activities.
Services to Beneficiaries and Providers Deteriorating		
59	The second indented phrase suggests that contractors have been unable to improve the quality of their written communications as required by the courts, due to budget cuts. We take exception to this finding: —Carriers completed a major improvement to the Explanation of Medicare Benefits (EOMB) in FY 1983. —Activities are underway to implement a court order in a Gray Panthers suit which has only recently been issued: (1) notice published in the Federal Register; (2) draft implementing instructions issued to carriers; (3) funding set aside in the FY 1986 budget; and (4) CPEP standards for readability in place. —HCFA has contracted for consultants services to improve document format and simplify messages for all forms that are sent to Medicare beneficiaries.	We believe the information presented on pages 60 and 61 supports the statement in question. In addition, as discussed on page 67, information available since our report was drafted shows that the quality of carriers' written communication is deficient according to HCFA's standards.
61	The carrier in question was given an opportunity to request funding in FY 1984, at the time the level of service requirements were imposed. No request was received. This indicated to HCFA that the P-20 standard could be achieved without additional funding. The incremental cost associated with increased inquiries generated by the participating physician program was adequately funded, as reflected in footnote 9.	The carrier also had the opportunity to request the funding needed to meet the P-20 level in fiscal year 1985 (see p. 61), but did not. This did not indicate that the P-20 standard could be met. Rather, a HCFA regional office memorandum indicates that, because of HCFA's emphasis on administration cost, the contractor was "more concerned with the consequence of exceeding the cost cap" than with the quality of services provided to beneficiaries (see p. 61).
Conclusions		
61-62	The draft report distorts the issue of payment safeguard funding by not focusing on the real funding increases of over 20 percent per year since FY 82.	See pages 64-66 for a discussion of this comment.
HCFA Has Improved Its Ability to Measure Contractor Performance		
68	We are pleased that GAO has recognized the improvement HCFA has made in its Contractor Performance Evaluation Program. With each year, CPEP has been strengthened, with continued improvement expected.	None.

Page	HHS comments	GAO Evaluation
The Development and Evolution of CPEP		
69-70	In order for an element to appear in CPEP, that element must be considered important enough to the mission of HCFA that nonperformance by a contractor should not be accepted. Accordingly, we believe that the reference that an element weighted 1 is "least important" and an element weighted 3 is "moderately important" can be misinterpreted.	In describing the weighting of the standards, we stated that the weights indicate the "relative importance" of each standard. We did not intend to imply that contractor nonperformance on any standards should be accepted by HCFA and have modified our text to make this clear.
Additional CPEP Improvements Are Possible		
71-72	GAO's findings are consistent with and support the increased emphasis placed on payment safeguards in the 2326 performance ranking methodology and our recommendation that the CPEP highlight payment safeguard performance over the past couple years. As stated earlier, we expect continued improvement of CPEP with each succeeding year. The standards/ elements we set are based on historical perspective and analysis of current facts. As such, we do not concur that ". . . CPEP does not encourage contractors to do more than the minimum required to save Medicare dollars, and in fact can penalize a contractor for expending more effort in such areas." The examples cited are utilization review and Medicare secondary payer, both requiring the contractors to expend 95 percent of their allotted funds. We believe that the argument advanced that if a contractor was always required to spend 95 percent of its funds it may reduce its return ratio to a failing level, is inaccurate. In both examples, our studies and analysis show that there are additional savings available and, at present, the return of those savings is only constrained by the funding limitation currently available to HCFA. Therefore, when a contractor requests funding for a specific objective, HCFA expects those funds to be expended as each expenditure results in sizeable return of program payments. This is extremely important in this day of tight monetary constraints. We will, however, continue to monitor each of our CPEP standards/elements to evaluate when we near the saturation point. When that occurs, we will modify the performance levels to prevent the potential problem cited from becoming a reality. We will continue to evaluate all potential payment safeguard elements and add to CPEP any which will increase savings. Payment safeguards, along with beneficiary services, have been our main objectives in 1985 and 1986 and will continue to be as we begin to develop our 1987 CPEP.	The examples given in the report are meant to illustrate potential anomalies that could arise. We did not state that they had actually arisen. The examples are meant only to illustrate an area that we believe HCFA should be aware of. HHS' comments state that HCFA is monitoring the area and that HHS agrees with our recommendation to increase contractor incentives for saving program dollars in future revisions of the CPEP standards.

Page	HHS comments	GAO Evaluation
HCFA Needs to Use Its Authority to Remove Poor Performing Contractors		
76	Evaluating poor performers in light of potential replacement action has been a part of the Medicare contract management process since its inception. It has been the driving force behind the evaluation process regardless of how often poor performers were actually replaced. In many instances, poor performers have voluntarily withdrawn from the program to save face and their reputation in the private sector before nonrenewal action was effectuated.	None.
Contractor Performance Varies		
76	GAO supports our contention that, regardless of evaluation tools (or formulas) used it is possible to identify "core" contractors who are consistent poor performers.	None.
HCFA Has Done Little to Terminate Poor Performers		
77	Credit should be given for contractors that "voluntarily left the program." As in Louisiana, the role of HCFA in helping contractors to understand our diverging interests is a major factor here.	None.
Fixed-Price Experiments Rarely Removed Poor Performers		
79-81	Removal of a poor performer per se was never a goal of fixed-price contracting because of its experimental nature. As to Colorado, the major facet of this experiment was the testing of truly integrated A/B operations, especially in the program safeguards area. Savings were desired but in no way essential.	The major point of this chapter of the report is that HCFA has the ability to identify consistently poor performing contractors, has the authority to remove them from the Medicare program, and has had a number of methods—including consolidations and the award of fixed-price contracts—that could have been used to replace poor performers. We point out, however, that HCFA has not used either consolidations or fixed-price contracting for the purpose. The HHS comment is consistent with our position. HHS states that a major facet of the Colorado experiment was the testing of an integrated A/B operations. We agree that this was a major consideration. However, as stated on page 79, another reason for initiating the fixed-price experiment was the deteriorating performance of the incumbent contractor which obtained the fixed-price contract.
Matter for Congressional Consideration		
82	Based on advice from our Office of the General Counsel, we have concluded that Section 2326 of DEFRA requires that the competitively awarded contracts be cost reimbursement contracts. Thus, DEFRA does not allow us to use a limited number of fixed-price competitions. If Congress extends the Section 2326 contracting authority it should provide that fixed-price contracting is permitted. (See the "Overview" section of our comments).	This issue is discussed in our analysis of HHS' comments on chapter 2 of the report (see pp. 36 and 37).

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