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MEDICARE

HCFA Should Exercise Greater Oversight of Claims Administration Contractors

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Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you discuss the Health Care Financing Administration's (HCFA) oversight of its Medicare fee-for-service claims administration contractors. HCFA paid these contractors $1.6 billion in fiscal year 1998 to serve as Medicare's first line of defense against inappropriate and fraudulent claims made on Medicare funds. They pay out over $700 million each business day—making it a business whose size and nature require careful scrutiny. Revelations of inappropriate Medicare payments to providers totaling billions of dollars each year have heightened concerns about the program's management, as have cases in which contractors themselves have defrauded Medicare.

Mr. Chairman, by holding this hearing, we appreciate the interest you have shown in ensuring that HCFA's Medicare contractors are earnest stewards of the trust fund. We also acknowledge the long-standing concerns expressed by the Ranking Minority Member, especially in the area of HCFA's selection, oversight, and evaluation of the fiscal intermediaries. We hope that our testimony today provides some information regarding the concerns he expressed on this topic to us last year. We will be initiating additional related work when needed data become available.

Today we are releasing our report, prepared for the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, on the weaknesses in HCFA's contractor oversight activities that could make Medicare more vulnerable to fraud, waste, or abuse. We also considered whether any changes in HCFA's contracting authority might improve its ability to manage contractors.[1] We are also releasing a separate report today that provides more detail on Medicare contractor integrity cases in which there have been convictions, fines, or civil settlements.[2] That report

- identifies recently completed cases of criminal conduct or False Claims Act violations committed by Medicare contractors,
- describes the deceptive contractor activities set forth in those cases or alleged by investigating agents and former contractor employees, and
- describes how these activities were carried out without detection by HCFA.

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

[2]Medicare: Improprieties by Contractors Compromised Medicare Program Integrity (GAO/OSI-99-7, July 14, 1999).

Our comments today are based upon both our report of HCFA's oversight and our investigative report. Although you are focusing primarily on the activities of the fiscal intermediaries, our reports cover both part A fiscal intermediaries and part B carriers.

In brief, although HCFA has taken recent steps to improve its oversight of claims administration contractors, HCFA's oversight process has weaknesses that leave the agency without assurance that contractors are fulfilling their contractual obligations, including paying providers appropriately. Since 1993, at least six contractors have settled civil and criminal charges following allegations that they were not checking claims to ensure proper payment, were allowing Medicare to pay claims that should have been paid by other insurers, or were committing other improprieties. For years HCFA left decisions about oversight priorities entirely in the hands of regional reviewers, did not evaluate regional oversight to achieve consistency, and set few performance standards for contractors to aid in holding them accountable. This has led to uneven review of key program safeguards designed to prevent payment errors. Our report contains several recommendations to correct identified weaknesses and improve HCFA's oversight of its claims administration contractors.

HCFA is also seeking new contracting authority that could help the agency increase competition and better ensure contractor performance. We believe the Congress may wish to consider amending the Social Security Act to allow the Secretary of the Department of Health and Human Services (HHS) explicit authority to more freely contract with appropriate types of companies for claims administration. Even if such legislation were enacted, however, HCFA would need several years to carefully plan and properly implement any new contracting initiatives to avoid the types of problems it encountered in the past when it tried to make changes to its contracting methods. We further believe that HCFA should be required to report to the Congress with an independent evaluation on the impact of any new authorities on the Medicare program.

Weak Contractor Oversight Increases the Vulnerability of Medicare

Our work indicates that HCFA has had numerous cases in which questions about contractor integrity have surfaced, but HCFA has yet to incorporate the lessons from these cases into its oversight. Since 1990, nearly one in four claims administration contractors have been alleged, usually by whistle-blowers inside the company, to be conducting improper or

fraudulent activities. We identified at least 17 contractors that have been either the target of qui tam suits or that have been the subject of HCFA integrity reviews. At the time of our review, at least 7 of the 58 current contractors were being actively investigated by the Department of Justice or by HHS' Office of Inspector General (OIG). Since 1993, over $235 million has been assessed in civil and criminal penalties against six current or former contractors. Among the charges involved in these cases are that contractor employees

- improperly screened, processed, and paid claims, resulting in additional costs to the Medicare program;
- destroyed or deleted backlogged claims;
- failed to recoup within the prescribed time moneys owed by providers, and failed to collect required interest payments;
- manufactured documentation to support paying claims that otherwise would have been rejected as medically unnecessary;
- switched off customer service telephone lines when staff could not answer incoming calls within the prescribed time limit;
- arbitrarily turned off computer edits that would have subjected questionable claims to more intensive review;
- altered or hid files that involved claims that had been incorrectly processed or paid and altered contractor audits of Medicare providers before HCFA reviews; and
- falsified documentation and reports to HCFA regarding their performance.

Our investigative report focuses on three Medicare fee-for-service contractors with cited integrity problems. In these three cases, the contractors entered into civil settlements totaling about $180 million. Also, in two of the cases, contractors pleaded guilty to multiple counts of criminal fraud.

The following illustrates the types of problems alleged at some contractors. A qui tam complaint filed in June 1993 alleged that from 1988 through 1993, Blue Cross and Blue Shield (BCBS) of Michigan (1) routinely altered its audit work papers in order to fix deficiencies and then forwarded the altered papers to HCFA for review, rather than forwarding the original work papers as required; (2) concealed its "clean up" efforts from HCFA and the participating hospitals; (3) lied to HCFA about the status of certain of its audits of providers to steer HCFA away from audits that were so poorly done that they could not be fixed before submission to HCFA; and (4) circumvented a requirement to collect overpayments within

30 days by using various evasive means to make it appear that payments were collected on time when, in fact, they were not.

In January 1995, this case was settled for $27.6 million. In the settlement agreement, the contractor denied the allegations contained in the qui tam complaint. Nevertheless, as a result of the allegations and resulting investigations, the Medicare fiscal intermediary and carrier contracts of BCBS of Michigan were not renewed. HCFA chose BCBS of Illinois as the replacement for both contracts. In 1998, BCBS of Illinois settled criminal and civil allegations of wrongdoing for $144 million and withdrew from the Medicare program.

Unfortunately, few contractor integrity problems have been detected through HCFA's oversight. Of the 17 contractors we identified as having had integrity problems, only 3 were first identified by HCFA. Despite this record of contractor problems, HCFA's oversight is not designed to detect deliberate contractor fraud. Information from whistle-blowers, federal investigators, former contractor employees, and HCFA officials familiar with integrity investigations suggests that the way HCFA conducted on-site verification of contractors' work allowed problems to go undetected. For example, for many years, HCFA notified contractor officials in advance of the review dates and the specific or probable records that would be reviewed. In addition, HCFA reviewers sometimes relied on contractor officials to pull claims or files for review, and sometimes reviewed copies of information made by the contractors rather than the original documents. HCFA's reviews were so predictable that companies were able to identify the areas in their audit operations that could be improperly altered to achieve favorable reviews. Based on our interviews with investigators and former contractor employees, we believe that HCFA may have placed too much trust in its contractors.

HCFA Oversight Is Uneven and Inconsistent

One of the key problems is that HCFA's current oversight process does not ensure that contractors are efficiently and effectively paying claims and protecting the integrity of the program. Poor management controls and falsified data have been common in the integrity cases, yet HCFA continues to rely on contractor self-certifications of management controls and contractors' self-reported performance data that it rarely validates. HCFA currently has few performance standards to measure contractors, has been uneven in setting priorities, and has given regional oversight staff broad discretion over what aspects of contractor performance to review and how to review them. Furthermore, HCFA does not check on the quality

of regional oversight. Not surprisingly, important program safeguards have received little scrutiny at some contractors, and regions have been inconsistent in dealing with contractor performance problems.

HCFA Does Not Validate Contractors' Internal Management Controls or Workload Data

HCFA's first critical weakness is that it accepts Medicare contractors' self-certification of management controls without routinely checking that controls are working as intended. Medicare contractors are required to certify annually that they have established a system of internal management controls over all aspects of their operations. This helps ensure that they meet program objectives, comply with laws and regulations, and are able to provide HCFA with reliable financial and management information concerning their operations. In April 1998, the HHS OIG reported that the regional offices were not evaluating the accuracy and reliability of contractor internal control certifications. In response, HCFA headquarters sent guidance to the regional offices reminding them to validate contractors' self-reports within the 1998 evaluation review cycle. Our analysis of fiscal year 1998 reviews performed for seven contractors found no case in which a self-report of internal controls was validated. We believe systematic validations of contractor internal controls would significantly contribute to reducing the likelihood of contractor fraud.

An equally fundamental activity in overseeing contractor performance is obtaining reasonable assurance that performance and financial data self-reported by the contractor are accurate. We analyzed 170 contractor reviews for fiscal years 1995 through 1997 for the seven contracts we studied; only two of these reviews documented efforts to validate contractor-supplied performance data. For 1998, staff in one of the three regions we visited validated contractor data in five reviews. Staffs of the other two regions did not validate performance data over the 4-year period for the contractors we examined.

To address these weaknesses, we have recommended that the HCFA Administrator establish a contractor management policy that requires the verification that each contractor has the internal controls necessary to ensure the adequacy of its operations. We have also recommended that HCFA require the systematic validation of statistically significant samples of contractor-reported data. HCFA agreed on the importance of validating contractors' internal controls and reported workload data. In its response to our draft report, HCFA stated that it was hiring a firm to develop procedures and methodologies to evaluate contractor self-certifications of internal controls. HCFA also plans to contract for the development of a

protocol to be used for data validation reviews that would begin in fiscal year 2001.

HCFA Sets Few Performance Standards for Contractors

Holding contractors accountable for meeting performance standards and measuring contractors on reaching these outcomes is one recognized way to improve performance quality. From 1980 to 1995, HCFA used an evaluation process for which performance standards were explicit but which focused on process rather than outcome. For example, it did not score contractors on the outcomes of their postpayment programs, such as whether their efforts resulted in recovering overpayments. Also, HCFA limited its review to standards published in the Federal Register at the beginning of each year, which, HCFA believed, caused contractors to mainly focus on those standards to ensure a high score. In response, in 1995, HCFA developed the Contractor Performance Evaluation (CPE) process to allow individual reviewers "greater flexibility in determining the appropriate types and levels of review for each contractor."[3] Under the CPE model, HCFA's reviewers have broad discretion to examine any aspect of contractor operations. Until fiscal year 1998, HCFA headquarters did not, however, issue guidance for reviewers to evaluate a minimum set of essential operations and did not require CPE reports to follow a standard format.

Except for standards mandated by legislation, regulation, or judicial decision, HCFA's current CPE process is more descriptive than outcome oriented. There are only a few mandated standards, such as processing certain types of claims within specific time periods. There are no standards required for HCFA reviewers to ensure that contractors adequately perform the most important program safeguards—such as medical review of claims. The lack of standards is worrisome because HCFA has made more effective medical review part of its plan to strengthen program integrity. In our opinion, the lack of clearly defined and measurable payment safeguard performance standards decreases the likelihood that HCFA will get maximum performance from contractors.

HCFA's mandated standards generally apply to contractors' claims processing—rather than program integrity—activities. We found, however, that HCFA has not ensured that regional reviewers check contractor performance on these standards. Reviewers are only required to evaluate whether contractors meet the mandated standards when the reviewers choose that specific area of contractor performance to review. Our

[3]HCFA, Regional Office Manual, Section 1100, "Contractor Performance Evaluation" (Washington, D.C.: HCFA).

analysis of CPE reports for three regional offices found that when HCFA reviewers did assess claims processing activities, they only checked about half of the applicable mandated standards. The three regions varied considerably in their reviews, with one region checking less than 15 percent of the standards, while another region checked over 80 percent.

To address these weaknesses, we have made a number of recommendations, including the development of a comprehensive set of clearly defined and measurable performance standards, the regular assessment of all contractors on core performance standards, and the development of performance reports that allow contractor comparisons on the core performance standards across regions. HCFA agreed with these recommendations and, in response to our draft report, outlined a number of steps it is taking to implement them including the development of a contractor-specific claim payment error rate as well as a contractor-specific fraud rate, which should facilitate contractor comparisons.

HCFA Regions Provide Uneven and Inconsistent Reviews and Remedies

With limited headquarters guidance and little follow-up to ensure that guidance is followed, contractor oversight is highly variable across regions. Without a set of common performance standards or measures, reviewers and contractors lack clear expectations. This has resulted in both uneven review of critical program safeguards and inconsistencies in HCFA reviewers' handling of contractor performance problems. Besides the inequity for contractors, such uneven review leaves HCFA without an ability to discriminate between contractors' performance when assigning new workload.

One such critical program safeguard for which oversight has been limited and uneven is that of Medicare Secondary Payer—so-called MSP—activities. Contractor MSP activities seek to identify insurers that should pay claims mistakenly billed to Medicare and to recover payments made by Medicare that should have been paid by others. This program safeguard has saved about $3 billion annually from 1994 through 1998. Our review of three regions' CPE reports shows that many of the key MSP activities most germane to spotting claims covered by MSP provisions were not reviewed at the seven contractors in our study. Also, the three regions varied considerably in how much review they gave to MSP, with one region rarely checking MSP activities at any of its contractors whose CPEs we reviewed.

This paucity of review is particularly disturbing because the potential for contractor fraud regarding MSP activities is significant as a result of an inherent conflict of interest. According to a former contractor employee, one contractor with a private line of business in health insurance in the same geographic area as its contract sometimes failed to send out letters to newly enrolled beneficiaries to determine whether Medicare payments should be secondary to those of another health insurer. HCFA has had to pursue several insurance companies—some with related corporations that serve as Medicare contractors—in federal civil court for refusing to pay before Medicare when Medicare should have been the secondary payer. In such a case filed by HCFA against BCBS of Michigan, the company paid $24 million in settlement of the MSP case in addition to $27.6 million to settle fraud allegations lodged against it in another case. Since 1995, settlements in the civil cases filed by HCFA in which a company with related interests was also a Medicare carrier or intermediary have totaled almost $66 million. HCFA currently has an additional $98 million in claims filed against current and former contractors as a result of its MSP activities.

HCFA's regions differ in their identification of problem contractors. For example, one company held two contracts for two states—each overseen by a different region. As part of its program safeguard activities, the company analyzed paid claims at one central location to identify possible fraudulent or abusive provider billing trends. While the company conducted identical types of analyses for both contracts, one region found that the contractor's data analysis activities were not fulfilling HCFA's expectations, while the other region found the contractor to be in compliance with HCFA's analytic expectations. Although these regions had signed a memorandum of understanding to seek consistency in how they directed the contractor and to coordinate oversight to avoid duplication of effort, they did not work together to resolve their differences and guide the contractor with one voice.

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

HCFA reviewers differ about whether they require PIPs, even in cases in which contractor performance is clearly not satisfactory. For example, one region required Contractor A to develop and follow PIPs for deficiencies in its performance in fraud and abuse prevention and detection. In contrast, another region, reviewing Contractor B, found many more serious weaknesses with its fraud and abuse prevention and detection activities. Contractor B was spending little or no time actively detecting fraud and abuse, failing to use data to detect possible fraud, not developing large and complex cases, and not referring cases to the HHS OIG. Furthermore, Contractor B was inadequately recovering overpayments, failing to focus on the highest-priority cases, preparing no fraud alerts, and not suspending payments to questionable providers. The reviewer concluded that Contractor B failed to meet HCFA's performance expectations, yet the region did not require the contractor to be put on a PIP.

To address this weakness, we have recommended that the HCFA Administrator designate one of the agency's organizational units to be responsible for

- evaluating the effectiveness of contractor oversight policy and procedural direction that headquarters staff provide to the regions,
- evaluating regional office performance in conducting contractor oversight activities, and
- enforcing minimum standards for the conduct of oversight activities.

Again, HCFA agreed with these recommendations, stating that it is exploring the use of an independent evaluation of its oversight policy and procedures and is laying the groundwork for evaluating regional office performance and establishing uniform requirements for CPE reports.

HCFA Has Started to Move to a More Structured Evaluation Process

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

In May 1998, citing concerns raised by the HHS OIG and us regarding HCFA's level of contractor oversight, HCFA announced the "need to reengineer our current contractor monitoring and evaluation approach and develop a strategy demonstrating stronger commitment to this effort." As a result, HCFA issued a contractor performance evaluation plan specifying three

evaluation priorities for fiscal year 1998: (1) year 2000 compliance activities, (2) activities focusing on a subset of financial management operations—accounts receivable and payable, and (3) activities focusing on a subset of medical review activities.

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

Despite HCFA's intent to provide more direction to the regions on contractor oversight activities, it continues to issue review guidance late in the year. Agency officials recently told us that its plan for CPE reviews for fiscal year 1999 will include more headquarters involvement in the assessment process, review teams from headquarters and the regions, and multiregional reviews. However, it was not until 8 months into the fiscal year that HCFA finally issued its fiscal year 1999 guidance.

HCFA Lacks a Structure That Ensures Accountability

HCFA's structure is not designed to ensure oversight accountability, with two aspects creating particular problems. First, HCFA reorganized its headquarters operations in 1997, dispersing responsibility for contractor activities from one headquarters component to seven. Second, HCFA's 10 regional offices—the front line for overseeing contractors—do not have a direct reporting relationship to other headquarters units responsible for contractor performance. Instead, they report to the HCFA Administrator through their respective regional administrators and consortia directors. We found that this structural relationship and the dispersion of responsibility for contractor activities to multiple headquarters components contribute to communications problems with contractors, exacerbate the weaknesses of HCFA's oversight process, and blur accountability for (1) having regions adopt best practices; (2) routinely

evaluating the regional offices' performance of its oversight; and (3) enforcing minimum standards for conducting oversight activities, including taking action when a particular region may not be performing well in overseeing contractors. In an effort to establish more consistency and improve the quality of contractor management and oversight, HCFA has recently modified its organizational structure once again by consolidating responsibility for contractor management within the agency and creating a high-level contractor oversight board. It is too early, however, to tell whether these changes will be sufficient.

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

To address perceived barriers to effective contracting for Medicare claims administration services and to help attract new companies to become contractors, HCFA has proposed legislative changes. The proposals include obtaining repeal of the nomination provision—which allows institutional providers to select their intermediary—and authority to (1) contract with other than health insurers, (2) contract for specific functions, and (3) award other-than-cost-based contracts.

When Medicare was enacted, the Congress authorized HCFA to use health payers—almost all health insurance companies—to be its contractors. Because providers were fearful that the new program would give the government too much control over medicine, institutional providers such as hospitals were allowed to designate an intermediary between themselves and the government. The American Hospital Association picked the national Blue Cross Association to serve as the intermediary for its members. Today, the Association is one of Medicare's five intermediaries and serves as prime contractor for 32 local member plan subcontractors that together process over 85 percent of all benefits paid by intermediaries. Under the prime contract, when one of the local Blue Cross plans declines to renew its Medicare contract, the Association, rather than HCFA, chooses the replacement. While this may have made sense to ensure that the fledgling program became successfully launched, today it leaves HCFA with less ability to choose and manage its contractors.

Similarly, HCFA's regulations limit its ability to contract for specific functions, rather than have each contractor perform the full range of Medicare functions. As a result, with one recent exception, HCFA has not experimented with having one or two contractors performing consolidated functions to achieve economies of scale. The one area where HCFA has begun to try functional contracting is program safeguards, because in 1996 HCFA was given new authority to contract separately for these activities.

However, HCFA's experience in implementing its new payment safeguard contract authority attests to the need for significant time to explore and resolve feasibility issues. Implementing these functional contracts will provide useful experience in the advantages and possible pitfalls of such functional contracts.

Apart from program safeguards, other functions might be better performed if consolidated at a few contractors. For example, in the fee-for-service Medicare program, each contractor conducts hearings on provider and beneficiary appeals of its own claims decisions, despite the possible conflict of interest and inefficiency. While choosing certain functions and consolidating them in a limited number of contractors could benefit Medicare, current Medicare contractors have expressed concern that contracting by function would be disruptive to their operations and the program. After 30 years of integration, contractors' functions may not be easy to separate, and having multiple companies doing different tasks could create coordination difficulties. Which functions would be best suited for separate functional contracts has not yet been determined, suggesting that some experimentation would be a necessary step for the success of such an initiative.

Contractor payment is a third area where HCFA is seeking change. Medicare law generally requires intermediary and carrier contracts to be paid on the basis of cost. Though generally not able to earn profits, contractors benefit when Medicare pays a share of corporate overhead. Nevertheless, the adequacy of current funding to attract and retain contractors is being questioned and may be contributing to contractors' withdrawing from the program. Existing constraints on earning a profit make participation in the Medicare program less attractive to companies that have been part of the program for years.

Under HCFA's proposal to repeal the cost-based contract restrictions, HCFA would be free to award contracts that would permit contractors to earn profits. However, HCFA's past experiments with using financial incentives generally have not been successful and raise concerns about the success of any immediate implementation of such authority. HCFA has experimented with competitive fixed-price-plus-incentive-fee contracts and with adding financial incentives to cost-based contracts. Between 1977 and 1986, eight competitive fixed-price contracts were established as an experiment. Our 1986 report noted that three of the contracts generated

administrative savings,[4] but two resulted in over $130 million in benefit payment errors (both overpayments and underpayments) so that much of the administrative savings of the successful experiments was offset by program losses.

HCFA also had problems when, beginning in 1989, it was given limited authority to award other-than-cost contracts. HCFA provided financial incentives in several cost-based contracts, but some of the self-reported data that contractors used to claim incentive payments were inaccurate. In one case, the incentives would not have been paid had a contractor with integrity problems not cheated by "correcting" errors in about a quarter of the 60 claims reviewed by HCFA.

The problems in previous experiments suggest that any change from cost-based contracting will need to be carefully designed and thoughtfully monitored to prevent loss to the Medicare program. Testing different methods of contracting could help HCFA ensure that implementation would improve, rather than weaken, program administration.

Conclusions and Recommendations to HCFA

Medicare's fee-for-service program pays out the lion's share of program dollars expended by HCFA, making it a business that must be carefully monitored. However, we found that HCFA conducted limited scrutiny of contractor performance. Until HCFA starts regularly assessing the validity of contractor controls and data, it cannot be assured of contractors' integrity, the accuracy of their payments to providers, or contractors' fiscal responsibility in handling Medicare funds.

Contractor oversight could be strengthened if HCFA balanced an appropriate level of regional discretion with sufficient effort to establish measurable contractor performance standards, set programwide priorities for the assessment of all contractors, and developed a standardized report format facilitating contractor comparisons. HCFA needs to ensure that regions adopt best practices and incorporate lessons learned into its oversight—beginning with those learned from integrity cases. In addition, HCFA needs an organizational structure for contractor oversight that will ensure that there is evaluation of the quality of contractor oversight activities and of the effectiveness of contractor oversight policy and procedural direction.

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

Over the long term, HCFA could benefit from a strategic plan for managing claims administration contractors that could be used as a guide on the path from its current contracting mode to a new one. HCFA could design this plan to help it determine (1) the contractor activities that are most conducive to functional contracting, (2) the activities that could be performed by other than health insurance payers, (3) better cost information to facilitate the move to competitive contracting, (4) the functional contracts that might be conducive to other-than-cost payments, and (5) the feasibility of building financial incentives into the contracts.

In our oversight report, we make a number of specific recommendations to improve HCFA's oversight. Implementing these recommendations should help ensure that

- contractor internal controls are working;
- contractor-reported data are accurate and useful for management decision-making;
- contractor performance is evaluated against a comprehensive set of measurable standards;
- HCFA's treatment of contractors is more consistent; and
- HCFA has a strategic plan for implementing the legislative changes that it is seeking.

Mr. Chairman, this concludes my prepared statement. We would be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114 or Leslie G. Aronovitz at (312) 220-7600. Individuals who made key contributions to this testimony included Sheila Avruch, Mary Balberchak, Elizabeth Bradley, Stephen Iannucci, Bob Lappi, Don Walthall, and Don Wheeler.

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