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MEDICARE CONTRACTING REFORM

Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards

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Highlights

Highlights of GAO-10-71, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 significantly reformed contracting for payment of Medicare's $310 billion per year in fee-for-service claims. The Centers for Medicare & Medicaid Services (CMS) is transitioning claims administration to 19 new entities known as Medicare Administrative Contractors (MAC) and plans to complete the process ahead of October 1, 2011, the date required by law.

In 2005, GAO reported that CMS's plan to accelerate the transition could create challenges and was based on estimated costs and savings that were uncertain. In this report GAO examined (1) how CMS has implemented Medicare contracting reform; (2) how CMS assessed the performance of the MACs and what the results of its assessments have been; and (3) what CMS's costs and savings have been for Medicare contracting reform.

GAO selected a sample of 6 transitions to review from among the 10 MAC contracts awarded as of June 2008, based on factors such as geographic diversity, volume of claims workload, and transition complexity. GAO analyzed CMS documents related to the MAC transitions, including performance assessments for 3 of the 6 MACs in the sample that had results available for three types of reviews as of March 2009, and interviewed CMS officials, contractors, and provider groups.

View GAO-10-71 or key components.
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What GAO Found

CMS took numerous steps to facilitate the complex implementation of Medicare contracting reform, but certain decisions led to challenges during the six MAC transitions we reviewed, such as payment delays to providers. For example, CMS's accelerated implementation schedule overlapped with other Medicare initiatives that affected claims processing, such as requiring that providers re-enroll in order to be paid, which resulted in claims payment delays. In addition, despite regular workload monitoring of the former contractors during the MAC transitions, CMS gave the MACs inaccurate workload estimates. For example, one MAC originally planned on receiving 15,000 appeals cases but actually inherited 46,500 cases, which led to processing backlogs and delayed payments to providers. However, CMS also incorporated lessons learned and made midcourse adjustments to address some of these challenges.

CMS has assessed the MACs using a program it developed, and in the reviews we examined the MACs did not meet all standards and metrics. CMS's assessment program includes an initial review of each MAC's internal controls and two subsequent reviews to assess performance. One of these reviews compares a MAC's performance to standards in accordance with its contract and the other provides an incentive award fee if the MAC meets selected metrics that are designed to reflect high performance. Results available as of March 2009 from the assessments of three of the six MACs in GAO's sample show that the three MACs improved their performance over time but did not meet all metrics. For example, while the three MACs consistently met or partially met a metric that assesses contract management, they did not meet some beneficiary and provider service metrics. In addition, because they did not meet all incentive metrics, they did not receive full award fees.

CMS's total costs and savings to date for Medicare contracting reform are uncertain because CMS does not track and provide information on all related costs and savings. The agency provided information on costs associated with contracts, which totaled a little over $300 million for fiscal years 2004 through 2008. It also provided information on some internal agency costs for conducting contracting reform, but did not track others, such as agency staff salaries. Although CMS expected contracting reform to generate substantial savings from reduced spending on administrative functions and savings to the Medicare trust funds due to improved claims review to detect payments that should not be made, as of April 2009, CMS was unable to provide information on total savings. CMS provided some information on savings due to reductions in operational spending, but the extent to which these savings were attributable to contracting reform is uncertain. CMS did not track or provide information on savings to the Medicare trust funds due to reduced improper payments related to contracting reform activities.

CMS reviewed a draft of this report and generally agreed with GAO's findings.