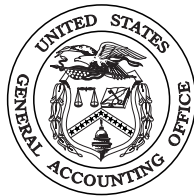


July 2001

# MEDICARE MANAGEMENT

## CMS Faces Challenges to Sustain Progress and Address Weaknesses



G A O

Accountability \* Integrity \* Reliability

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## Abbreviations

BBA	Balanced Budget Act
CMS	Centers for Medicare and Medicaid Services
DOJ	Department of Justice
HCFA	Health Care Financing Administration
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHS	Department of Health and Human Services
IT	information technology
MIP	Medicare Integrity Program
OIG	Office of Inspector General
PPS	prospective payment system
PSC	program safeguard contractor
SCHIP	State Children's Health Insurance Program
SNF	skilled nursing facility
Y2K	Year 2000



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United States General Accounting Office  
Washington, DC 20548

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July 31, 2001

The Honorable John D. Dingell  
Ranking Minority Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Sherrod Brown  
Ranking Minority Member  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

The Honorable Peter Deutsch  
Ranking Minority Member  
Subcommittee on Oversight  
and Investigations  
Committee on Energy and Commerce  
House of Representatives

Recently, the Congress has been examining reforms to address the Medicare program's uncertain, long-term fiscal sustainability. Discussions have focused on strengthening and modernizing the program—one whose size, complexity, and importance make it very challenging to manage. Medicare is the nation's largest health insurer, with nearly 1 million hospitals, physicians, and other health care providers billing the program. Together with tens of millions of beneficiaries, these providers and suppliers constitute a vast universe of program stakeholders that are directly affected by the way the program is administered.

As pressure mounts to ensure that the program will be well-managed now and in the future, questions have been raised about the ability of the Health Care Financing Administration (HCFA)—recently renamed the Centers for Medicare and Medicaid Services (CMS)—to administer the program and implement programmatic changes effectively.<sup>1</sup> These include questions as to whether HCFA has adequately implemented payment method changes mandated by the Congress, worked effectively to

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

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safeguard program payments, and provided adequate oversight of the quality of care furnished to Medicare beneficiaries in nursing homes and through other providers. Because of your interest in these issues, you asked us to assess (1) HCFA's record of managing certain key aspects of the Medicare program and (2) factors that limit the agency's ability to improve operations. To respond to this request, we relied primarily on our published studies and ongoing reviews of the agency's operations and Medicare program components. A list of related products is included in this report.

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## Results in Brief

Managing Medicare entails performing a broad range of complicated activities, such as setting payment rates for Medicare-covered services; overseeing companies that review, process, and pay about 900 million claims annually; and contracting with and overseeing health plans to provide beneficiaries choices in how they access their Medicare benefits. Because Medicare is a highly visible public program touching the lives of millions of citizens and directly affecting the health care marketplace, CMS' actions face close scrutiny. With such challenges, the agency's record of success has been mixed. On the plus side, HCFA has performed some of its core missions well. It has developed payment systems that were difficult to design and implement and that have helped constrain program expenditures while ensuring beneficiary access to care. Further, it has succeeded in ensuring that providers are paid promptly for the bulk of submitted claims and at a low administrative cost. On the minus side, however, the agency has experienced some difficulties in refining payment methods that were developed to control Medicare spending, paying claims properly, overseeing Medicare claims administration contractors, and ensuring the quality of care delivered to Medicare beneficiaries. Further, providers have become increasingly vocal about what they perceive as an excessive regulatory burden placed on them by the Medicare program.

HCFA's record of performance must be considered in light of factors that may impede its progress in improving Medicare operations. These include its lack of a performance-based approach to management. We recently reported that, compared with other federal managers, relatively few HCFA managers had performance measures to hold them accountable for achieving results. In connection with its available resources and statutory requirements, HCFA has worked to carry out its Medicare responsibilities and to improve existing operations with an administrative budget that has not increased in proportion to its growing workload. In addition, it is faced with taking on new and challenging tasks with an aging workforce whose skills do not always match the requirements of such new responsibilities.

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Furthermore, the agency has 49 senior executives to manage the two biggest insurance programs in the country and activities accounting for hundreds of billions of dollars in annual spending. In addition to its resource challenges, the agency faces statutory constraints that inhibit it from modernizing its management of fee-for-service claims administration—the bulk of its Medicare business. Mismatches between resources, authorities, and the agency’s responsibilities have hindered HCFA’s efforts to acquire appropriate expertise, modernize outdated and inefficient information systems, and conduct oversight activities.

In commenting on a draft of this report, CMS said it was pleased that we had recognized its progress in a number of key areas. CMS agreed that more could be done to strengthen the management of the Medicare program.

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## Background

CMS (formerly HCFA), an agency within the Department of Health and Human Services (HHS), is responsible for administering much of the federal government’s multibillion dollar investment in health care—including the Medicare program. Medicare is a health insurance program for people aged 65 years and older, some disabled people under 65 years of age, and people with end-stage renal disease—which is permanent kidney failure treated with dialysis or a transplant. Medicare covers a variety of services. Part A services include inpatient hospital, skilled nursing facilities (SNF), certain home health, and hospice care, while part B services include physician and outpatient hospital services, diagnostic tests, mental health services, and outpatient physical and occupational therapy, including speech-language therapy, ambulance and other medical services and supplies. Each year, Medicare serves about 40 million elderly and disabled Americans and processes about 900 million claims submitted by nearly 1 million hospitals, physicians, and other health care providers. In fiscal year 2000, the program spent over \$200 billion—about 11 percent of the federal budget.

The Medicare program has two components—the traditional fee-for-service program and Medicare+Choice—its managed care option. Most Medicare beneficiaries participate in the traditional program and receive their health care on a fee-for-service basis, in which providers are reimbursed for each covered service they deliver. CMS contracts with about 50 insurance companies to process and pay these claims. The other principal component—Medicare+Choice—covers about 14 percent of beneficiaries who have enrolled in about 180 prepaid health plans that

contract with the government to receive monthly payments in exchange for providing needed Medicare services for enrollees.

As the agency that administers Medicare, CMS performs a wide array of management activities. Principal among these are setting prices for services and health plans based on legislatively prescribed guidelines, ensuring prompt and accurate payment to providers and health plans, educating beneficiaries and providers about the Medicare program, ensuring the quality of fee-for-service and managed care services paid by the program, and operating the Medicare+Choice program. See table 1 for examples of these activities.

**Table 1: Examples of CMS' Responsibilities in Managing Selected Medicare Program Activities**

<b>Program activity</b>	<b>Example</b>
Setting prices	<p>In accordance with legislatively prescribed guidelines, CMS sets tens of thousands of fees or prices to pay suppliers for Medicare-covered items and to pay providers—including physicians, hospitals, rehabilitation and nursing facilities, and home health agencies—for Medicare-covered services. For example, CMS must</p> <ul style="list-style-type: none"> <li>• develop rates for physicians that reflect the resources involved in providing individual services as well as variations in their costs across local markets and</li> <li>• set rates for acute care hospitals reflecting services beneficiaries will need based on diagnoses and adjust payments to reflect geographic cost differences.</li> </ul>
Overseeing fee-for-service claims administration	<p>In monitoring about 50 Medicare claims administration contractors, CMS must determine whether the contractors, among other things,</p> <ul style="list-style-type: none"> <li>• meet performance standards for timeliness and accuracy of claims processing;</li> <li>• identify insurers that should have paid claims that were mistakenly billed to Medicare;</li> <li>• operate fraud units that explore leads and develop and refer cases to law enforcement agencies;</li> <li>• identify and investigate instances or patterns of inappropriate billing that could result in unnecessary payments and serious financial losses to the program; and</li> <li>• collect overpayments.</li> </ul>
Educating beneficiaries	<p>CMS is responsible for improving beneficiary understanding of the Medicare program. To do this, CMS has launched a national education campaign, <i>Medicare &amp; You</i>, to provide Medicare beneficiaries with information about Medicare and their health plan choices. Information is made available to beneficiaries through a variety of channels, including print materials mailed to all beneficiaries, toll-free telephone service, and an Internet site.</p>

Program activity	Example
Ensuring that institutional care meets Medicare requirements	<p>To help ensure that Medicare beneficiaries receive quality care, CMS</p> <ul style="list-style-type: none"> <li>contracts with state agencies to survey institutional providers, such as SNFs, home health agencies, and dialysis facilities, and certify that they meet Medicare's conditions of participation and associated standards;</li> <li>conducts training activities to help ensure that state surveyors are qualified to enforce the federal quality standards for care; and</li> <li>is required, for certain providers, such as hospitals, to accept accreditation by the Joint Commission on the Accreditation of Health Care Organizations or other accrediting bodies.</li> </ul>
Overseeing Medicare+Choice	<p>CMS contracts with managed care plans, requiring, among other things, that they</p> <ul style="list-style-type: none"> <li>provide basic benefits to enrollees;</li> <li>comply with applicable provider requirements, including those relating to certification and participation; and</li> <li>operate quality assessment and performance improvement programs.</li> </ul> <p>CMS must</p> <ul style="list-style-type: none"> <li>review for accuracy the promotional literature and membership materials that each plan distributes to beneficiaries and</li> <li>ensure that plans have adequately informed beneficiaries of their right to appeal adverse coverage or payment decisions.</li> </ul>

## HCFA Has Had Mixed Success in Managing Medicare

Tasked with administering a highly complex program, HCFA has earned mixed reviews from us and others on its performance in managing Medicare. On one hand, the agency presides over a program that is unparalleled in its popularity with beneficiaries and the general public. HCFA has implemented a variety of payment methods that have helped constrain the growth of program costs. It has also succeeded in ensuring that Medicare claims are paid quickly and at little administrative cost. On the other hand, HCFA has had difficulty making needed refinements to its payment methods. The agency has also fallen short in its efforts to oversee its Medicare claims administration contractors and to ensure that claims are paid accurately and beneficiaries receive quality services. While in the early 1990s HCFA came under increasing criticism for not adequately protecting program payments, some providers have complained recently that its safeguard efforts are unduly burdensome.

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## HCFA Succeeded in Implementing Improved Payment Methods, but Refinements Are Still Needed

The size and nature of the Medicare program make it inherently challenging to develop payment methods that prudently reimburse providers while protecting beneficiary access to services. As Medicare's steward, CMS cannot passively accept what providers want to charge the program. However, because of its size, Medicare profoundly influences health care markets. The agency is often the dominant payer for services or products, and in such cases, it cannot rely on market prices to determine appropriate payment amounts because its share of payments distorts the market. In addition, HCFA has had difficulty relying on competition to determine prices, because finding ways of encouraging competition without excluding some providers has been problematic.<sup>2</sup> This means that HCFA has had to administratively set payment amounts for thousands of services in ways that encourage efficient delivery of, and ensure beneficiary access to, needed health care services and equipment.

Adding to the complexity of setting payment amounts is Medicare's status as a highly visible public program with certain obligations that may not be consistent with efficient business practices. For example, the agency is constrained from acting swiftly to reprice services and supplies even when prevailing market rates suggest that payments should be modified. As Medicare is a public program, its enabling legislation provides that any changes require public input. This minimizes the potential for policymaking to have unintended consequences. However, seeking and responding to public interests, including various provider and supplier groups, can be a time-consuming process that can sometimes thwart efficient program management.<sup>3</sup>

Recent changes in provider payment methods, as mandated by the Congress, have constrained rates paid to some providers and slowed the growth of payments to others. This has raised provider concerns about payment adequacy. As Medicare's payments have become less generous in the aggregate, payment adjustments for cost differences of providers and services become more important. HCFA's successes in more closely aligning payments to these differences have sometimes been obscured by the concerns of those providers affected, who are adapting to a new payment environment.

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<sup>2</sup>Statutory constraints on excluding providers from participating in Medicare have resulted in the program traditionally including all qualified providers who want to participate.

<sup>3</sup>*Medicare Payments: Use of Revised "Inherent Reasonableness" Process Generally Appropriate* (GAO/HEHS-00-79, July 5, 2000).



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Despite these challenges, over the last two decades HCFA has had broad experience, and significant success, in developing payment methods that seek to control spending by rewarding provider efficiency and discouraging excessive service use. HCFA's experience began in 1983 when the Congress passed legislation requiring the development of a hospital inpatient prospective payment system (PPS), a method that pays providers, regardless of their costs, fixed, predetermined amounts that vary according to patient need.<sup>4</sup> This approach, designed to reward hospitals that could deliver care at lower cost than the predetermined payment, succeeded in slowing the growth of Medicare's inpatient hospital expenditures. Growth in Medicare inpatient hospital expenditures averaged over 15 percent per year prior to 1983, but was generally under 10 percent in subsequent years. HCFA's next major effort to break the link between providers' charges and Medicare payments was implementing a fee schedule for physicians, which was phased in during the 1990s. This schedule was not designed to reduce the overall expenditure level, but to redistribute payments for services based on the relative resources used by physicians to provide different types of care. Its development and implementation was complex because HCFA had to calculate payment amounts for over 7,000 procedures, accounting for the three categories of resources used to perform each procedure—physician work, practice expenses, and malpractice insurance expenses.<sup>5</sup> While beneficiary access to physician care was generally not affected, the fee schedule, as intended, led to a shift in payments from surgical and nonsurgical services to primary care and other evaluation and management services.

HCFA's next challenge was to expand use of prospective payment methods for postacute care services, such as those provided by SNFs and home health agencies. In 1997, the Balanced Budget Act (BBA) mandated that HCFA develop and implement four new PPS<sup>6</sup> from fiscal year 1998 through fiscal year 2001—a heavy workload for the agency. For each new

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<sup>4</sup>Older payment methods reimbursed care providers for their costs (within certain limits) for all services delivered.

<sup>5</sup>Each medical procedure is ranked on a scale based on three categories of resources used to perform it—practice expense, physician work, and malpractice expenses. Practice expenses include the costs of resources such as personnel (other than physicians), equipment, supplies, and office space required to deliver a procedure. Physician work resources are measured in terms of a physician's time, intensity of effort, level of skill required, and stress from risk of harm to the patient.

<sup>6</sup>These include prospective payment methods for SNFs, hospital outpatient departments, home health agencies, and inpatient rehabilitation facilities.

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PPS, HCFA had to (1) design the payment system—which was based on data-intensive studies—including factors that adjust payments based on the health status of beneficiaries receiving care, (2) develop and issue regulations that incorporated public comment, and (3) plan and program computer system changes. Adding to its challenge, HCFA and its contractors needed to make significant systems changes to implement the new payment methods at the same time that they were renovating information technology (IT) systems for Year 2000 (Y2K) date changes. As a result of the priority HCFA had to give to Y2K systems changes, HCFA moved more slowly than the law required to phase in its new PPS methodologies for home health and hospital outpatient services.<sup>7</sup>

Each of these payment methods was an improvement over cost- and charge-based methods, which often rewarded inefficient delivery and excessive provision of unnecessarily costly services. PPS methods reward providers for keeping their costs down, which in turn has helped constrain the overall growth of Medicare payments. However, slower payment growth requires further adjustment to better account for differences in patient needs and the special circumstances of particular providers or facilities to ensure that the program is paying appropriately and adequately.

HCFA has had mixed success in refining some of its payment methods. For example, HCFA partially addressed problems with its initial methodology for introducing a resource-based practice expense component into the physicians' fee schedule when it issued a new methodology in 1998. Overall, we considered HCFA's new methodology to be acceptable. The new methodology better defined practice expenses by specialty and used a more straightforward and simple-to-understand approach. Although HCFA developed the new methodology using the best available data, the agency had limited data on resource use by some specialties, and HCFA made a series of assumptions and adjustments without confirming their reasonableness. As a result, questions remain about whether payment is appropriate for certain procedures. To address these issues, we recommended that HCFA refine its relative value payments by identifying and then focusing on the areas where the data and

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<sup>7</sup>HCFA implemented the PPS for SNFs on time—by July 1, 1998. The home health PPS was mandated to begin October 1, 1999, and was delayed by later legislation until October 1, 2000. The hospital outpatient PPS was mandated to begin by calendar year 1999 and was implemented in August 2000. The implementation of the inpatient rehabilitation PPS was mandated by fiscal year 2001, but has been delayed.

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methodology weaknesses have the greatest effect,<sup>8</sup> but HCFA has done little to target its refinement efforts. Similarly, we have pointed out design flaws in the new payment methodology for SNFs and home health agencies that could allow providers to increase payments by “gaming” these payment methods.<sup>9</sup> HCFA has begun to address some, but not all, of these weaknesses.

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### Fee-for-Service Claims Paid Promptly and Inexpensively, but Contractor-Related Concerns Continue

HCFA has been successful in performing one of its principal missions—ensuring that claims are generally paid quickly and at little administrative cost to the taxpayer. Medicare contractors process over 90 percent of Medicare claims electronically and pay “clean” claims<sup>10</sup> on average within 17 days after receipt.<sup>11</sup> In contrast, commercial insurers generally take longer to pay provider claims. Costs for processing Medicare claims are roughly \$1 to \$2 per claim—much less than \$6 to \$10 or more per claim for private insurers, or \$7.50 per claim paid by TRICARE—the Department of Defense’s managed health care program.<sup>12</sup>

Nevertheless, some Medicare contractors’ performance has been less than exemplary, and HCFA’s lax and uneven oversight allowed performance problems to continue undetected. In the 1990s, several contractors defrauded the government or settled cases alleging fraud for hundreds of millions of dollars, following allegations of serious problems. These included deleting or destroying claims, failing to conduct proper audits,

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<sup>8</sup>*Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term* (GAO/HEHS-99-30, Feb. 24, 1999).

<sup>9</sup>*Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments* (GAO/T-HEHS-00-160, July 19, 2000).

<sup>10</sup>These are claims that have been filled out properly and whose processing has not been stopped by any of the systems’ computerized edits designed to check whether the claim is appropriate to pay—for example, that it is a covered service for an eligible beneficiary. According to HCFA data on claims processed during fiscal year 1999, about 81 percent of Medicare part A and part B claims processed were paid, and, of those paid, over 99 percent were processed as clean claims.

<sup>11</sup>Much of this time is due to the mandatory claim payment delay provisions, which prohibit the payment of Medicare claims until after 13 days from the date received if electronically submitted and after 26 days for those submitted on paper.

<sup>12</sup>Much of the cost difference appears attributable to differences in program design and processing requirements, but we and others believe that TRICARE has opportunities to reduce this administrative cost. See *Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs* (GAO/T-HEHS-00-138, June 22, 2000).

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falsifying documentation needed to prove claims were for medically necessary services, and switching off the toll-free beneficiary inquiry lines when staff members were unavailable to answer calls within the prescribed amount of time. Many of these problems were discovered, not through HCFA's routine oversight efforts, but through whistleblowers whose information sparked federal investigations that led to criminal and civil settlements.

HCFA's oversight of its contractors' activities had several failings. The agency relied on unverified performance information provided by contractors and limited checking of each contractor's internal management controls. Furthermore, the agency's reviews of its contractors' performance and treatment of identified performance problems were inconsistent. To address these and other weaknesses, we made a number of recommendations to improve the rigor and consistency of HCFA's oversight.<sup>13</sup>

HCFA has taken steps to improve its management and oversight of contractors. It has adopted a more consistent and strategic approach for overseeing contractor performance, which is directed by a management board composed of senior executives.<sup>14</sup> In addition, the agency has clarified accountability for contractor oversight,<sup>15</sup> assigned additional staff to monitor and oversee contractors, and separated responsibility for contractor management from contractor evaluation. However, some of our recommendations for improvement have not been fully implemented, including those to establish a policy for systematic validation of essential contractor-reported data and to strengthen controls over accountability and financial management,<sup>16</sup> including improving debt collection activities.<sup>17</sup>

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<sup>13</sup>*Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

<sup>14</sup>The Medicare Contractor Oversight Board, which reports directly to the Administrator, was established in December 1998.

<sup>15</sup>*Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight* (GAO/HEHS-00-46, Mar. 23, 2000).

<sup>16</sup>*Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (GAO/AIMD-00-66, Mar. 15, 2000).

<sup>17</sup>*Medicare: HCFA Could Do More to Identify and Collect Overpayments* (GAO/HEHS/AIMD-00-304, Sept. 7, 2000).

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While HCFA has focused on specific contractor functions that it believes need improvement, others may also need attention. For example, Medicare contractors handle nearly 15 million telephone inquiries from beneficiaries annually, but HCFA has not been able to adequately oversee contractor performance in this area because it lacked performance data on beneficiaries' access to telephone customer service, the accuracy of responses to inquiries, and caller satisfaction. To better measure performance, the agency has begun to develop measures for telephone service, set standards, and monitor contractor performance.

In addition to sharing information with beneficiaries, contractors also play a major role in communicating with providers. How well they do this has become more of a concern, which is understandable given that providers have had to adjust to numerous program changes and increased attention is focused on potential improper payments. We have begun reviewing how CMS and other parts of HHS communicate with physicians to assess how Medicare program instructions are conveyed and whether communication efforts could be improved.

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### Safeguarding Program Payments Remains Challenging

Medicare is one of the federal government programs that we consider at high risk of improper payment because of its size and complex administrative structure.<sup>18</sup> Safeguarding Medicare program payments has become an increased focus of HCFA's activities in the last few years. Although HCFA and its contractors have taken a number of steps to address improper payment, program vulnerabilities remain. Recent concerns have focused on three program integrity issues—improperly paid claims, the integrity of HCFA's new payment methods, and difficulties that providers face in understanding and complying with payment rules.

### Estimates of Large Improper Payments Underscore Importance of Integrity Efforts

Since 1996, the Office of Inspector General (OIG) in HHS has repeatedly estimated that Medicare contractors inappropriately paid claims worth billions of dollars annually. These claims successfully passed through Medicare's highly automated claims processing systems because the claims appeared valid on their face. Claims were disputed only after the OIG obtained the underlying patient medical records from providers and reviewed them in detail. The OIG and contractor staff could then determine that some services were not properly documented to support the claims, not medically necessary, coded improperly, or not covered.

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<sup>18</sup>*High-Risk Series: An Update* (GAO-01-263, Jan. 2001).

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Such labor-intensive and detailed review of even a significant fraction of the millions of fee-for-service claims is not practical or efficient. It would involve significant administrative cost and impose a considerable burden on providers required to submit patient medical records. As more than 90 percent of the improper payments the OIG identified were for claims that contained no visible errors and individual fee-for-service claims typically involve small amounts of money, the returns from an investment in such a review may not be cost effective.

Nevertheless, these large improper payment estimates reinforce the importance of having the agency and its contractors develop and implement effective strategies to prevent or detect such payments. The Congress aided HCFA in this effort by creating the Medicare Integrity Program (MIP) and giving HCFA a stable source of funding for program safeguard activities as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In fiscal year 2000, HCFA used its \$630 million in MIP funding to support a wide range of efforts. These included conducting antifraud activities, provider and managed care organization audits, targeted medical review of claims, and awarding a competitive contract to a coordination of benefits contractor, which will help safeguard Medicare dollars by identifying when other companies should pay claims as the primary insurer instead of Medicare. Concentrating audit efforts on providers and reimbursement areas in which program dollars are most at risk has been a cost-effective approach in identifying overpayments. Based on HCFA's estimates, in fiscal year 2000, MIP saved the Medicare program more than \$16 for each dollar spent. In addition to activities funded through the MIP program, HCFA has been conducting a range of other stewardship activities, such as revising its process for enrolling providers in Medicare to ensure that only legitimate providers are billing the program.

The agency now has additional options for conducting safeguard activities because HIPAA gave it new authority to contract with entities other than the Medicare claims administration contractors to perform specific payment safeguard functions. Through a competitive bidding process, HCFA selected 12 entities to act as its program safeguard contractors (PSC) and has assigned them a variety of tasks. These have ranged from doing specific focused assignments to supplement the work of the claims administration contractors to conducting most of the program safeguard

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activities for a contractor.<sup>19</sup> PSCs are also conducting nationwide safeguard activities. This incremental approach to assigning work to PSCs is a prudent first step that will allow the agency to test how best to integrate these specialized contractors into Medicare program integrity efforts.

The agency has faced difficulties, however, in determining where its safeguard activities could be improved. The reason is that it lacked detailed information on payment accuracy by claims administration contractor and by type of provider or service. To develop a more refined understanding of how and why payment errors occur, the agency has an initiative to measure the error rate for each claims administration contractor. A PSC “validation” contractor has begun to randomly sample claims paid by contractors and to recheck the processing and payment decisions made. From the results, CMS will be able to target contractors whose best practices should be emulated by others and those that need improvement.

#### Revised Payment Methods Raise New Integrity Challenges

Moving a larger share of program payments to methods that pay a global fee for a set of services creates new integrity challenges. Under global payment methods, providers face the risk of financial loss if their costs exceed their payments, while those who can furnish care for less than the global fee retain the difference. This provides incentives for providers to skimp on services, which may compromise patients’ quality of care. For example, managed care organizations participating in Medicare+Choice have incentives to inappropriately maximize the gains from their global payment by skimping on the delivery of services. Similarly, home health agencies are now paid a global payment for services provided during a 60-day episode of care, rather than being paid for each individual service. Thus, home health agencies can increase profits by reducing the number of visits provided during the payment period. In addition, no standards

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<sup>19</sup>For example, a PSC is supplementing the work of the claims administration contractors by conducting field audits at the home offices of large SNF and other provider chains. A PSC is also supporting the efforts of fraud unit activities for several claims administration contractors by performing postpayment data analysis. However, some PSCs have been given more extensive tasks, such as performing all of the program integrity functions for a durable medical equipment regional carrier. PSCs are also maintaining the system of automated edits used by all claims administration carriers to identify certain types of inappropriate claims, conducting a national needs assessment, and developing a comprehensive plan for educating Medicare providers. For a discussion of PSC contracting authority implementation, see *Medicare: Opportunities and Challenges in Contracting for Program Safeguards* (GAO-01-616, May 18, 2001).

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exist for what is the right amount of home health care for specific types of patients—particularly for home health aide care—a major share of home health visits. To reduce the system’s vulnerability to exploitation, we have recommended that HCFA adopt a risk-sharing provision, whereby the government shares in a home health agency’s excessive losses, but protects the program from an agency’s excessive gains.<sup>20</sup> However, HCFA was concerned that any additional change to payment policy would be too confusing for home health agencies and has not agreed to implement the recommendation.

Depending on their design, these global payment methods are not immune to being gamed by increasing services provided. This is because the link between amount of service provided—as determined by a provider—and payment has not been entirely broken. For example, payments to SNFs for serving beneficiaries are adjusted by a number of factors, including the amount of therapy services provided. This gives facilities incentives to raise their payment rates by providing more therapy services to beneficiaries than they would otherwise. Similarly, home health agencies have incentives to inappropriately increase the number of episodes of care provided, which could escalate, rather than constrain, Medicare spending.

To protect program dollars, CMS needs information to monitor provider responses to payment changes and their effect on beneficiaries. Monitoring global payment methods is particularly important to ensure that providers do not skimp on services in ways that could negatively affect beneficiaries’ health. However, HCFA’s efforts to systematically gather and evaluate program data to monitor the impact of its SNF and home health payment reforms on providers and beneficiaries have not been sufficient to identify desirable or undesirable consequences. Furthermore, in Medicare+Choice, rather than developing proactive methods to monitor beneficiaries’ access to services, HCFA sometimes relied on complaints as the main indicator that enrolled beneficiaries may be experiencing problems in getting access to needed care. This is a weak mechanism because beneficiaries do not always understand the benefits that plans are expected to provide. We have made several recommendations that HCFA improve plan marketing and the appeals process literature so beneficiaries can understand their benefits and

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<sup>20</sup> *Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available* (GAO/HEHS-00-9, Apr. 7, 2000).



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## Safeguard Efforts Have Raised Concerns by Providers

appeal rights.<sup>21</sup> The agency has implemented some of our recommendations and has established work groups to consider others.

While we and the OIG have continued to encourage the agency to close programmatic loopholes that can lead to improper payment, CMS' safeguard efforts are viewed differently by some provider groups. Providers whose claims are in dispute have complained about the burden of medical review audits and about the fairness of some specific steps the contractors follow. CMS faces a difficult task in finding an appropriate balance between ensuring that Medicare pays only for services allowed by law while making it as simple as possible for providers to treat Medicare beneficiaries and bill the program. While an extensive claims review is undoubtedly vexing for the provider involved, relatively few providers actually undergo them. In fiscal year 2000, HCFA's contractors conducted medical claims review audits of only three tenths of 1 percent of physicians—or 1,891 out of a total of more than 600,000 physicians who billed Medicare that year. We are beginning work to review several aspects of the agency's auditing and review procedures for physician claims.

Providers' concerns about fairness may also emanate from the actions of others who oversee federal health care—such as the HHS OIG and the Department of Justice (DOJ)—which, in the last several years, have become more aggressive in pursuing possible health care fraud and abuse. In the mid-1990s, the OIG initiated a series of audits that targeted the billing practices of physicians at teaching hospitals. As we reported, the OIG intended to audit the major teaching hospital or facility practice plan affiliated with each of the nation's 125 medical schools.<sup>22</sup> The OIG chose these institutions because, of the nation's 1,200 teaching hospitals, they had the largest number of residents and had received the most Medicare revenue—not because the OIG had reason to suspect that their billing activities were inappropriate. The medical community considered the audits costly and burdensome. We suggested to the OIG that a risk-based approach that focused on the most problem-prone institutions would be a more effective use of federal resources and less burdensome to compliant

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<sup>21</sup>*Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (GAO/HEHS-99-92, Apr. 12, 1999) and *Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights* (GAO/HEHS-99-68, Apr. 12, 1999).

<sup>22</sup>*Medicare: Concerns With Physicians at Teaching Hospitals (PATH) Audits* (GAO/HEHS-98-174, July 23, 1998).

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institutions.<sup>23</sup> The OIG agreed, but said that the office could not do so in its ongoing work because it did not have techniques for narrowing the selection to the most problem-prone institutions.

Providers have also charged that DOJ was overzealous in its use of the False Claims Act—a powerful enforcement tool with substantial damages and penalties. DOJ’s efforts included a series of nationwide investigations of hospitals known as national initiatives.<sup>24</sup> These initiatives—particularly the Laboratory Unbundling initiative<sup>25</sup>—which began in 1994, have provoked considerable controversy. For example, the hospital community alleged that DOJ subjected many of the nation’s hospitals to unwarranted investigations, resulting in large penalties for unintentional errors. Concerns with the Laboratory Unbundling initiative centered on the basis for selecting hospitals for audit, the reliability of the data used by the U.S. Attorneys’ Offices, and the manner in which hospitals were treated. Ultimately, several of these offices acknowledged that the data they had relied on contained errors that could not be corrected. As a result, these offices withdrew from the initiative, and all the hospitals in these areas that had entered into settlement agreements had their settlement amounts returned.

In June 1998, DOJ issued guidance to all its attorneys, including those in its U.S. Attorneys’ Offices, that emphasizes fair and responsible use of the act in all civil health care matters. It instructs DOJ attorneys to determine—before they allege violations of the act—that the facts and the law sufficiently establish that a claimant knowingly submitted false claims. At first, as we reported in August 1999, implementation of the guidance varied among U.S. Attorneys’ Offices and some had taken steps in their investigations prior to the issuance of DOJ guidance in June 1998 that were, to varying degrees, inconsistent with the issued guidance.<sup>26</sup> However, U.S. Attorneys’ Offices had largely addressed their shortcomings

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<sup>23</sup>See [GAO/HEHS-98-174](#).

<sup>24</sup>DOJ defines a national initiative as a nationwide investigation stemming from an analysis of national claims data, indicating that numerous similarly situated health care providers have engaged in similar conduct to improperly bill government health care programs.

<sup>25</sup>Unbundling is the practice of submitting bills piecemeal to maximize the reimbursement for various tests that are required to be billed together and therefore at a reduced cost.

<sup>26</sup>*Medicare Fraud and Abuse: DOJ’s Implementation of the False Claims Act Guidance in National Initiatives Varies* ([GAO/HEHS-99-170](#), Aug. 6, 1999).

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in implementing the guidance by 2000.<sup>27</sup> In our more recent March 2001 report, we found that DOJ's two newer initiatives are being conducted consistent with the guidance and that DOJ had improved its oversight of its U.S. Attorneys' Offices.<sup>28</sup>

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## Quality of Care Continues to Be a Concern

A major responsibility of CMS is to oversee federal quality standards for the services delivered to Medicare beneficiaries. Because many of these quality checks are actually carried out by the states, a key CMS mission is working with the states to oversee the care provided by nursing homes, home health agencies, end-stage renal dialysis centers, and psychiatric and certain Medicare-certified hospitals.<sup>29</sup> We and the OIG have been studying the effect of HCFA's oversight of nursing home quality for several years and have found significant weaknesses in federal and state survey and oversight activities designed to detect and correct quality problems in nursing homes. For example, in 1999, we reported that about 1 in 4 of the nation's 17,000 nursing homes—an unacceptably high number—had care problems that caused actual harm to residents or placed them at risk of death or serious injury.<sup>30</sup> Complaints by residents, family members, or staff alleging harm to residents remained uninvestigated for weeks or months. State surveys understated the extent of serious care problems, both because of procedural weaknesses in the surveys and their predictability. Federal mechanisms for overseeing state monitoring of nursing home quality were limited in their scope and effectiveness. In addition, when serious deficiencies were identified, federal and state enforcement policies did not ensure that they were corrected and remained corrected.

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<sup>27</sup>*Medicare Fraud and Abuse: DOJ Has Made Progress in Implementing False Claims Act Guidance* (GAO/HEHS-00-73, Mar. 31, 2000).

<sup>28</sup>*Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance* (GAO-01-506, Mar. 30, 2001).

<sup>29</sup>State surveyors review whether nursing homes, home health agencies, end-stage renal dialysis centers, and laboratories comply with applicable federal standards for health, safety, and quality of care. About 80 percent of Medicare-certified hospitals have their quality overseen through the Joint Commission on the Accreditation of Health Care Organizations—the others have their quality reviewed by state surveyors. Most psychiatric hospitals are accredited through the Joint Commission, but state surveyors must check whether they meet a few specific requirements.

<sup>30</sup>*Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards* (GAO/HEHS-99-46, Mar. 18, 1999).

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We have made a number of recommendations to address these problems.<sup>31</sup> HCFA generally concurred with our recommendations, and, in response, in 1998 the Administration introduced a series of initiatives focused on federal and state efforts to improve nursing home care quality. Certain initiatives seek to strengthen the rigor with which states conduct their required annual surveys of nursing homes. Others focus on the timeliness and reporting of complaint investigations and the use of management information to guide federal and state oversight efforts.

To realize the potential of these nursing home quality initiatives, sustained efforts by CMS and the states are essential. Because the agency is phasing in the initiatives and states began their efforts from different starting points, much unfinished work remains. In September 2000, we reported that—following state efforts to use new survey methods to better spot serious deficiencies—the proportion of nursing homes nationwide with such deficiencies increased slightly.<sup>32</sup> This could be due to better identification of problems by surveyors, but it could also be due to facility staff shortages during that period. Better detection and classification of serious deficiencies through the standard survey process will require further refinement of survey methods and more unpredictability in survey dates, which would limit the opportunities for nursing homes to prepare for them. States whose nursing home inspection activities we most recently reviewed<sup>33</sup> had improved investigation and follow-up to complaints, but were still not meeting HCFA's standard of investigating certain serious complaints within 10 days. These states also differed in how far they had progressed in establishing procedures to make it easier to file complaints or developing tracking systems to improve their oversight of investigations by local district offices. As for the application of strengthened federal enforcement policies, more time must elapse before progress in this area can be assessed, although referral of problem homes to the agency is on the rise. Similarly, with respect to improved federal oversight, the effectiveness of recent internal agency

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<sup>31</sup>*California Nursing Homes: Care Problems Persist Despite Federal and State Oversight* (GAO/HEHS-98-202, July 27, 1998); *GAO/HEHS-99-46; Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents* (GAO/HEHS-99-80, Mar. 22, 1999); and *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* (GAO/HEHS-00-6, Nov. 4, 1999).

<sup>32</sup>*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives* (GAO/HEHS-00-197, Sept. 28, 2000).

<sup>33</sup>These states were California, Missouri, Tennessee, and Washington.

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reorganizations to ensure more consistent oversight and management information reporting enhancements can only be judged in the months to come.

While recent attention has focused on quality of care in nursing homes, they generally get more scrutiny than other providers do. Nursing homes are generally surveyed at least yearly. Other facilities are surveyed much less frequently. For example, home health agencies were once reviewed annually, but now are reviewed every 3 years. The OIG has also documented gaps in surveillance of psychiatric hospitals and kidney dialysis facilities. In addition, our work has shown that the number of HCFA-funded inspections of dialysis facilities has declined significantly. These unannounced inspections, which are the agency's primary tool for ensuring that facilities meet standards protecting health and safety, were conducted at only 11 percent of the dialysis facilities eligible for Medicare recertification in 1999, compared with 52 percent in 1993. When such surveys were conducted, they showed that noncompliance was a problem. To illustrate, in 1999, 15 percent of the facilities surveyed had deficiencies severe enough, if uncorrected, to warrant terminating their participation in Medicare.

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## Management Approach, Resource Limitations, and Statutory Constraints Affect the Agency's Ability to Improve Medicare Operations

No examination of HCFA's record of Medicare management successes and shortcomings would be complete without recognizing the importance of the agency having the necessary tools to carry out its mission. Critical to the agency's success are an organizational focus on results and accountability, coupled with adequate resources and the flexibility to effectively deploy them.

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## Management Approach Lacks Strong Performance Focus

CMS has not yet developed an effective performance-based culture—a key factor that limits ongoing efforts to manage effectively. Managing for results is fundamental to an agency's ability to set meaningful goals for performance, measure performance against those goals, and hold managers accountable for their results. It is part of the direction set for federal agencies by the Congress through the Government Performance and Results Act of 1993.

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In May 2001, we reported on the results of our survey of federal managers at 28 departments and agencies on strategic management issues.<sup>34</sup> Overall, HCFA fared poorly on this survey. For example, HCFA was the second lowest among the agencies we surveyed in the percentage of managers who reported that they were held accountable for results to at least a great extent. In addition, the percentage of the agency’s managers who reported having performance measures for the programs they were involved with was significantly below that of other government managers. The agency ranked lowest in terms of the percentage of managers who reported having four key performance measures—output, efficiency, quality, and outcome measures—and it ranked second lowest in having a customer service measure. Measuring performance in assessing a program’s efforts to achieve its goals is essential to fostering a performance-based culture and managing for results. For example, such measures could be used to demonstrate whether intended results are being achieved and to gauge if programs are operating efficiently.

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### Resource Limitations Affect Medicare-Related Activities

In addition to an organizational focus on managing for results, sufficient resources—in terms of both dollars and human capital—are vital to fulfilling the agency’s multiple management responsibilities. These responsibilities include key oversight and stewardship activities and modernization of the agency’s IT systems. However, CMS faces many competing priorities when trying to fund and staff Medicare-related activities.

### Budget Constraints at the Agency

Over the years, HCFA’s administrative dollars have been stretched thinner as the agency’s mission has grown. For many years, budget pressures forced the Congress to make difficult decisions to limit discretionary spending. Like many other federal agencies, the agency has been operating with a discretionary administrative budget that has increased slowly. But, during the last decade, mandatory spending on Medicare benefit payments has doubled. Further, this was a period when the agency’s workload increased appreciably as it sought to fulfill BBA Medicare mandates and to take on new non-Medicare programmatic responsibilities, such as implementing the State Children’s Health Insurance Program (SCHIP).

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<sup>34</sup>*Managing for Results: Federal Managers’ Views on Key Management Issues Vary Widely Across Agencies* (GAO-01-592, May 25, 2001).

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We and others have contended that too great a mismatch between the agency's administrative capacity and its designated mandate has affected HCFA's responsiveness and will leave the agency unprepared to handle Medicare reforms and future enrollment growth. In fiscal year 2000, Medicare's operating costs represented less than 2 percent of the program's benefit outlays. Although private insurers seek to earn a profit and incur other costs, such as those for advertising, they would not attempt to manage such a large and complex program with so comparatively small an administrative budget.

Examples from the recent past show that sufficient resources are particularly important to support key oversight activities, such as ensuring proper payment of claims. In recent years, we have found that because of resource limits, claims administration contractors checked a smaller percentage of claims, audited a smaller percentage of cost reports from institutional providers, and were unable to identify and collect some overpayments promptly. In order to ensure that program safeguards were strengthened, the Congress created MIP, which provided—among other things—stable funding of safeguard activities. Although MIP began in fiscal year 1997, funding for safeguard activities did not increase until fiscal year 1998, when the MIP budget increased from \$440 million to \$550 million.<sup>35</sup> Total program safeguard appropriations are slated to increase annually until fiscal year 2003, when the appropriation will total \$720 million.

Resource issues have affected other oversight activities. In the area of nursing home quality, HCFA has made negligible use of its most effective oversight technique—an independent survey performed by HCFA employees following completion of a state's survey—for assessing state agencies' abilities to identify serious deficiencies in nursing homes. Conducting a sufficient number of these comparisons is important because of concerns that some state agencies may miss significant problems, but HCFA lacked sufficient staff and resources to perform these checks. In addition, limited resources affected HCFA's ability to oversee Medicare contractors. In fiscal year 2001, the agency requested and received funding for 100 additional positions to focus on key activities such as overseeing claims processing activities, monitoring payments to providers and suppliers, and using computer-based auditing techniques.

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<sup>35</sup>This included an additional \$50 million in supplemental program safeguard funds made available by the HHS fiscal year 1998 appropriation.

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Resource issues have also affected HCFA's ability to make capital investments in its information systems for managing Medicare.<sup>36</sup> For example, partly because resources were funneled to Y2K and other high-priority activities, HCFA has had to postpone much-needed IT enhancements that could help the agency and its contractors conduct Medicare program monitoring and policy development activities more efficiently. Resource limitations have delayed HCFA from developing a database using modern technology that could help the agency monitor health care quality and the appropriateness of provider payments. Some of Medicare's vital information systems are decades old and operate on software no longer commonly used. The agency has recently begun to focus on developing systems that are easier to maintain and that can increase the agency's ability to translate its data into useful management information. The agency's current and planned IT projects include developing a set of databases using more modern technology, consolidating Medicare's claims processing systems, and improving the systems that maintain the program's managed care enrollment and payment data. However, the immediate pressing priorities to maintain systems, keep the program operating, and respond to congressional mandates leave less to spare for IT investments that could help the agency better manage Medicare.

## CMS' Human Capital Challenges

CMS' capacity for managing Medicare is also closely tied to the quality and strength of the agency's human capital. CMS has a reservoir of staff who are highly skilled in many aspects of health care and its financing. However, our prior and current work suggests that the agency lacks sufficient staff with expertise in some key areas, such as managed care arrangements, financial management, data analysis, rate-setting methodology, and IT.<sup>37</sup> These shortages have affected the agency's ability to take on new and challenging tasks. For example, although GAO has identified information security as a governmentwide risk<sup>38</sup> that has been recognized as a particular problem for CMS, the agency's Chief Information Officer told us that some IT security projects have been delayed primarily because of a lack of staff with requisite skills.

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<sup>36</sup> *Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure* (GAO/T-HEHS-00-108, May 4, 2000).

<sup>37</sup> [GAO/T-HEHS-00-108](#), *HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century* (GAO/T-HEHS-99-58, Feb. 11, 1999), and [GAO/AIMD-00-66](#).

<sup>38</sup> [GAO-01-263](#).



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Furthermore, the agency has faced the challenge of dealing with increased responsibilities with fewer people. The BBA had 335 provisions requiring HCFA to make substantial changes to the Medicare program, and during 1998—a key implementation year<sup>39</sup>—the agency was doing this work with about 1,000 fewer employees than it had in 1980.

Compounding human capital concerns, CMS has a total of 49 senior executives to manage program activities accounting for billions of dollars in annual spending. In fiscal year 2002, federal benefit outlays for Medicare, Medicaid, and SCHIP are expected to reach approximately \$400 billion. In fact, CMS' corps of senior executives is smaller than that of most other civilian agencies that have significantly smaller annual expenditures. CMS' senior-level executives play a vital role in focusing staff on current mission priorities and guiding the agency on a strategic path to its future. They manage about 4,600 agency employees and also oversee the efforts of Medicare claims administration contractors, who have about 22,000 employees. However, despite Medicare's size and importance, there is no official whose sole responsibility is to run the program. In addition to Medicare, top-level managers have oversight, enforcement, and credentialing responsibilities for other major health-related programs and initiatives, such as the Medicaid and SCHIP programs, and for all of the nation's clinical laboratories. These other programmatic responsibilities naturally require time and attention that would otherwise be spent meeting the demands of the Medicare program.

Adding to concerns about current staffing, CMS is facing a potential loss of human capital with managerial and technical expertise through an impending wave of retirements. The agency has estimated that about 35 percent of its current workforce will be eligible to retire over the next 5 years.<sup>40</sup> Upcoming retirements heighten concerns we raised in both 1998 and 1999 about HCFA's loss of technical and managerial expertise due to its aging workforce.<sup>41</sup> For example, in the 5 years prior to 1998, almost 40 percent of HCFA's employees had left the agency. To its credit, to respond

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<sup>39</sup>In 1998, HCFA published 92 regulations and *Federal Register* notices implementing congressional directives in BBA.

<sup>40</sup>A retirement analysis by HCFA showed that about 22 percent of HCFA employees eligible to retire in a given year actually do so and that the average length of time between eligibility for regular retirement and actual retirement is 3 years.

<sup>41</sup>*Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/T-HEHS-98-85, Jan. 29, 1998) and [GAO/T-HEHS-99-58](#).

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to this human capital challenge, CMS is working on a human resources planning effort to support the agency in strategic staffing, development, and recruitment planning decisions. Part of CMS' challenge for planning its future workforce is to determine the right balance between work performed by CMS employees and work contracted out.

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### Constraints on Flexibility to Improve the Medicare Program

In addition to its resource challenges, CMS faces statutory constraints that inhibit the agency from modernizing its management of fee-for-service claims administration—the bulk of its Medicare business. At Medicare's inception in the mid-1960s, the Congress authorized the government to use existing health insurers to process and pay claims. It also permitted professional associations of hospitals and certain other institutional providers to “nominate” their claims administration contractors on behalf of their members. When the program began, the American Hospital Association nominated the national Blue Cross Association to serve as its fiscal intermediary.<sup>42</sup> Currently, the association is one of Medicare's three intermediaries and serves as a prime contractor for 26 local member plan subcontractors that process about 86 percent of all benefits paid by fiscal intermediaries. Under the prime contract, when one of the local Blue plans declines to renew its Medicare contract, the association—rather than CMS—nominates the replacement contractor. This process effectively limits CMS' flexibility to choose the contractors it considers most effective. The agency has also considered itself constrained from contracting with nonhealth insurers for the various functions involved in claims administration.

The Congress gave HCFA specific authority to contract separately for payment safeguard activities and for claims administration for home health and durable medical equipment. Nevertheless, for a number of years the agency has sought more general authority for functional contracting and other Medicare contracting reforms. We recently testified that Medicare could benefit from the Congress' removal of limitations on CMS' contracting authority and use of full and open competition in the selection of claims administration contractors.<sup>43</sup> We have also suggested

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<sup>42</sup>Fiscal intermediaries primarily review and pay claims from hospitals and other institutional providers covered under Medicare part A, while carriers review and pay part B claims, which are submitted by physicians and other outpatient providers.

<sup>43</sup>*Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services* (GAO-01-918T, June 28, 2001).

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that, should the Congress modify the Medicare claims administration contracting authorities, it should consider requiring that HCFA report on its progress in implementing these new authorities. Further, we recommended that HCFA develop a strategic plan for managing claims administration contractors in this new contracting environment.<sup>44</sup>

In June 2001, the Administration proposed legislation to modify the Medicare claims administration contracting authority that, among other things, would permit—but not require—full and open competition. The proposal would allow CMS to select any entity it chooses, award separate contracts to perform specific claims administration functions, and use other than cost contracts. However, CMS would not have to use competitive procedures to select initial claims administration contractors or to renew contracts under the proposal. We are concerned that if CMS is not required to use such competition, it may not identify and contract with the best entities to perform claims administration services.

Certain innovative approaches in contracting for services could be difficult to implement in a public program such as Medicare. Medicare was designed so that beneficiaries would have the freedom to choose among providers and that any qualified provider who was willing to serve Medicare's beneficiaries could do so. Even though approaches such as developing a network of providers chosen for their quality and willingness to accept discounted fees could be advantageous for beneficiaries and taxpayers, CMS would face obstacles in implementing them. In a 1998 study, an expert panel concluded that the agency could benefit from a more focused effort to test and adapt such innovations in the program. However, broadly implementing the experimental innovations that prove successful may require new statutory authority.<sup>45</sup>

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## Concluding Observations

Considering Medicare's complexity, size, and statutory constraints, some contend that HCFA's management of Medicare has—on balance—been satisfactory, while others argue that it has not been acceptable. There is evidence that HCFA's success has been mixed and that the agency's challenges are growing. Effective governance of Medicare depends on finding a balance between flexibility and accountability—that is, granting

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<sup>44</sup>GAO/HEHS-99-115.

<sup>45</sup>*Medicare Reform: Modernization Requires Comprehensive Program View* (GAO-01-862T, June 14, 2001).

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the agency adequate flexibility to act prudently while ensuring that it can be held accountable for its decisions and actions.

Moreover, because Medicare's future will play such a significant role in the nation's fiscal future, we believe it prudent to make an adequate investment to ensure that Medicare is professionally and efficiently managed. Achieving such a goal will require that the day-to-day operations of Medicare's traditional program are modernized and maintained, and that achieving program efficiency and effectiveness remains paramount.

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## Agency Comments and Our Evaluation

In written comments on a draft of this report, CMS said it was pleased that we had recognized the agency's progress in a number of key areas, including developing and implementing payment systems and strengthening oversight of Medicare contractors. However, CMS disagreed with our contention that—despite Medicare's size and importance—there is no official whose sole responsibility it is to run the program. The agency noted that the Administrator of CMS has that responsibility. However, as we have pointed out, the Administrator also has many far-reaching responsibilities for oversight, enforcement, and credentialing for other major programs and initiatives. CMS has reorganized to centralize the management of the Medicare fee-for-service and managed care programs into two centers. Nevertheless, under the reorganization discussed in CMS' comments, CMS did not indicate that it planned to designate one senior official whose sole responsibility will be the management of the Medicare program.

In its comments, CMS agreed that more could be done to strengthen management of the Medicare program. CMS also discussed its plans for increasing emphasis on responding to beneficiaries and providers, improving the quality of care for Medicare and Medicaid beneficiaries, as well as how restructuring the agency based on the its major lines of business could help it achieve its mission. In addition, CMS provided technical comments, which we incorporated as appropriate. CMS' written comments are reprinted in appendix I.

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As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of the Department of Health and Human Services, the Administrator of the Centers for Medicare and Medicaid Services, appropriate congressional

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committees, and others who are interested. We will also make copies available to others on request.

If you or your staffs have any questions, please call me at (312) 220-7600 or Sheila Avruch at (202) 512-7277. Other key contributors to this report were Hannah Fein and Sandra Gove.

A handwritten signature in cursive script that reads "Leslie G. Aronovitz".

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

# Appendix I: Centers for Medicare and Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator  
Washington, D.C. 20201

DATE: JUL 26 2001

TO: Leslie G. Aronovitz, Director  
Health Care—Program Administration and Integrity Issues  
General Accounting Office

FROM: Ruben J. King-Shaw, Jr.  
Deputy Administrator/Chief Operating Officer  
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *MEDICARE MANAGEMENT: CMS Faces Challenges to Sustain Progress and Address Weaknesses* (GAO-01-817)

Thank you for the opportunity to comment on the above-referenced draft report. We are pleased that GAO has recognized the progress we have made in recent years developing and implementing payment systems; strengthening program integrity; financial management and contractor oversight; improving the oversight and reporting of quality of care in nursing homes; developing human capital management strategies; and ensuring prompt payment to providers for the bulk of submitted claims and at a low administrative cost.

However, we disagree with GAO that despite the size and importance of Medicare, there is no official whose sole responsibility is to run the program. The Administrator of CMS is the one person responsible for the Medicare program. In addition, CMS has a Chief Operating Officer that is charged with the management of CMS's day to day operations and implementation of new initiatives and policies. Further, we have centralized the management of Medicare fee-for-service (FFS) and of private health care programs and development of innovative choices for Medicare beneficiaries.

As you mentioned in your report, we have recently changed the name of the Agency from the Health Care Financing Administration to the Centers for Medicare & Medicaid Services (CMS). Much more was involved here than a simple name change. Our goal is to increase the emphasis on responsiveness to beneficiaries and providers as well as to improve the quality of care for Medicare and Medicaid beneficiaries. The reorganization that is following the name change serves to better align the FFS and managed care functions into two distinct centers, which clarifies and strengthens the lines of accountability for these important lines of business.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS).  
We are exercising fiscal restraint by exhausting our stock of stationery.

Page 2 – Leslie G. Aronovitz

To accomplish these goals CMS will:

- Launch a national media campaign to give seniors and other Medicare beneficiaries more information to help them make decisions about how they want to get their health care;
- Instill a new culture of responsiveness at CMS in serving beneficiaries, physicians, and other health care providers, states, and lawmakers;
- Enhance 1-800-MEDICARE to a 24-hour a day, 7 day a week service that will provide for more detailed information to help beneficiaries make Medicare decisions;
- Restructure the Agency around three centers that reflect the Agency's major lines of business; and
- Reform the contractor process to improve the quality and efficiency of the Medicare claims processing services.

The new Center for Medicare Management (CMM) now centralizes all of the management of the Medicare FFS program, while management of managed care programs has been moved to the Center for Beneficiary Choices (CBC). The Center for Medicaid and State Operations (CMSO) will focus on programs administered by the states, including Medicaid, SCHIP, and insurance regulation.

The CMM focuses on the management of the traditional FFS Medicare program including development and implementation of payment policy and management of the Medicare carriers and fiscal intermediaries. The CBC focuses on beneficiary education, and on providing beneficiaries with the information they need to make their health care decisions. This Center also manages the Medicare+Choice program, consumer research and demonstrations, as well as grievances and appeals. The CMSO, among its other functions, deals with survey and certification, and with working with the state survey agencies to ensure that the Medicare/Medicaid conditions of participation (or coverage) are met.

We agree that more can be done in each of these areas, and we are looking forward to working with GAO in years to come as we continue to strengthen the management of the Medicare program. We are confident these changes will enable us to move forward as quickly as possible with all of the recent initiatives you described in your report.

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# Related GAO Products

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*Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services* ([GAO-01-918T](#), June 28, 2001).

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

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

*Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance* ([GAO-01-506](#), Mar. 30, 2001).

*Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform* ([GAO-01-539T](#), Mar. 22, 2001).

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

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

*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives* ([GAO/HEHS-00-197](#), Sept. 28, 2000).

*Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending* ([GAO/HEHS-00-176](#), Sept. 8, 2000).

*Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings* ([GAO/HEHS-00-183](#), Sept. 7, 2000).

*Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments* ([GAO/T-HEHS-00-160](#), July 19, 2000).

*Medicare Payments: Use of Revised “Inherent Reasonableness” Process Generally Appropriate* ([GAO/HEHS-00-79](#), July 5, 2000).

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

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



*Medicare: HCFA Faces Challenges to Control Improper Payments* ([GAO/T-HEHS-00-74](#), Mar. 9, 2000).

*Medicare: Lessons Learned From HCFA's Implementation of Changes to Benefits* ([GAO/HEHS-00-31](#), Jan. 25, 2000).

*Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* ([GAO/HEHS-00-6](#), Nov. 4, 1999).

*Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* ([GAO/T-HEHS-99-192](#), Sept. 15, 1999).

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

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

*Balanced Budget Act: Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation* ([GAO/T-HEHS-99-139](#), June 10, 1999).

*Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* ([GAO/HEHS-99-92](#), Apr. 12, 1999).

*Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights* ([GAO/HEHS-99-68](#), Apr. 12, 1999).

*Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term* ([GAO/HEHS-99-30](#), Feb. 24, 1999).

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