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Good morning Mr. Chairmen and members of the Subcommittees. I appreciate the invitation to testify today on the important issue of improving Medicare contractor operations.

Medicare contractors are the heart of the Medicare program. When they function well, providers are paid promptly, beneficiaries receive the health care services they need, and the Trust Fund is protected against wasteful spending. When they don't function properly, the entire program is jeopardized -- those who benefit from it, those who provide care, and those who pay for it all suffer the consequences.

Since the inception of Medicare, numerous legislative changes have been made and amendments added to the Social Security Act which have led to substantial changes in the Medicare program. For example, the way Medicare pays for health care has changed through time, from primarily cost/charge based payment systems to new fee-schedule and prospective based arrangements. While the Medicare program as a whole has seen significant change, the way that the Centers for Medicare and Medicaid Services (CMS) is allowed to select and organize its contractors has remained much the same as it has since the inception of the program.

CMS needs to be given greater flexibility in the methods it uses to select, organize, and supervise the contractors who handle the day-to-day operations of the Medicare program. This includes authorities to use entities other than insurance companies, select them competitively, pay them on other than a cost basis, organize them according to functions or benefits areas, and hold them accountable for performance.

BACKGROUND

The Medicare program provides health insurance for 39.5 million elderly and disabled Americans at a cost of over $220 billion in fiscal year 2001. Although beneficiaries have a growing number of options under the Medicare+Choice program, the majority of beneficiaries are still covered by traditional fee-for-service Medicare. The fee-for-service program is administered by the CMS with the help of approximately 50 contractors that handle claims processing and administration.

Since the Medicare program was created, the government has contracted with private health insurance companies for claims processing and related administrative services. There are two primary types of contractors. Fiscal intermediaries (FIs) process claims filed under Part A of the Medicare program by institutions, such as hospitals and skilled nursing facilities. Carriers process claims under Part B of the program filed by other health care providers such as physicians and medical equipment suppliers. In addition to these two types, Durable Medical Equipment Regional Carriers (DMERCs) pay suppliers of durable medical equipment, prosthetics, and orthotics; and, Regional Home Health Intermediaries (RHHIs) process home health claims.

Contractor tasks for the Medicare program fall into 5 functional areas: 1) claims processing, 2) payment safeguards, 3) fiscal responsibility, 4) beneficiary services, and 5) administrative activities. Claims processing involves receiving claims, promptly paying those that are appropriate, taking necessary action to identify inappropriate or potentially fraudulent claims and either withholding payment or recovering overpayments. Payment safeguard activities require additional actions to further safeguard the integrity of the Medicare program and protect against fraudulent and abusive billing. Safeguard activities include medical review to determine the medical necessity of procedures and services, Medicare Secondary Payer (MSP) review[1], audits, and investigations by fraud units. Fiscal responsibilities by the contractors include all actions to ensure a full and accurate reporting of Medicare accounts receivable and financial reconciliations.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) enacted the Medicare Integrity Program, which provided CMS with new authorities to contract with entities beyond, but also including, current carriers and fiscal intermediaries to perform specific payment safeguard functions. Such contractors can take on some, all, or any subset of the work associated with current contractor payment safeguard functions including medical and utilization review, cost report audits and provider education.

Unfortunately, we have identified numerous problems in contractor operations over the last few years. I will highlight some of these problems for you now.

INTEGRITY PROBLEMS

Perhaps the most troubling of all the problems that the Office of the Inspector General (OIG) has observed has involved lapses in contractors' own integrity -- misusing government funds and actively trying to conceal their actions, or altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars.

Since 1993, a number of criminal and civil actions have been taken against carriers and intermediaries in connection with their performance under CMS contracts, and we have entered into civil settlements with 14 Medicare contractors with total settlements exceeding $350 million. OIG has imposed 8 corporate integrity agreements in connection with these settlements. Corporate integrity agreements are mandatory compliance and reporting requirements agreed to by the contractor to avoid exclusion or debarment. In addition, two contractors have entered into guilty pleas to the charge of obstruction of a federal audit.

[1] Medicare Secondary Payer activities identify other sources of payment, such as employer-sponsored insurance or other third-party payer that may cover health claims for Medicare beneficiaries. These payers are primary and Medicare is secondary with respect to responsibility for paying a claim.

The following examples illustrate the egregiousness of the problems which can occur and the consequent exposure to financial losses. Unfortunately, they are not isolated cases. At any given time, several contractors may be under investigation by our office. Presently, we have 24 former or current contractors actively under investigation.

Health Care Service Corporation
In July of 1998, Health Care Service Corporation, the Medicare carrier for Illinois and Michigan, agreed to pay $140 million to resolve its civil liability under the Civil False Claims Act and the Civil Monetary Penalties Law. On an annual basis, CMS evaluates the performance of its carriers, relying, in large part, on information, data and certifications provided by the carriers. Carriers that demonstrate poor performance on these annual reviews are subject to contract termination or other adverse action by CMS. Between 1985 and 1997, Health Care Service Corporation altered documents and manipulated data in order to improve its score on these annual reviews. During our investigation, we found the following problems: improper processing of Medicare Secondary Payer claims, bypassing the system generated audits and edits during the processing of Part B claims, and improper deletion of claims from the system.

In addition to the civil settlement, the corporation pleaded guilty to obstructing a federal audit, conspiracy to obstruct a federal audit and six counts of making false statements to CMS. Health Care Service Corporation paid a $4 million criminal fine in connection with these charges. Two of the corporation's managers pleaded guilty and five others were indicted on various criminal charges related to this scheme. CMS terminated the Medicare contracts with Health Care Service Corporation as of September 30, 1998. This case resulted in the largest civil fraud settlement against a Medicare contractor to date.

XACT Medicare Services of Pennsylvania
In August of 1998, a Medicare carrier located in Pennsylvania agreed to pay $38.5 million to resolve its liability for misconduct in its performance as a carrier. A joint investigation by the OIG and other Federal agencies found that during the years 1988 through 1996, the carrier engaged in the following misconduct: failing to properly process or take appropriate action to recover improper payments related to Medicare secondary payer claims; obstructing the carrier performance evaluation program by rigging samples for CMS audits; failing to recover overpayments; failing to monitor End Stage Renal Disease laboratory claims; and overriding payment safeguards to by-pass electronic audits or edits when processing Part B claims. As part of the settlement, the carrier agreed to enter into an extensive corporate integrity program to ensure proper training for its employees and external reviews of its performance under its contract with Medicare.

Blue Cross/Blue Shield of Michigan
On January 10, 1995, Blue Cross/Blue Shield of Michigan, a Medicare carrier, agreed to pay $27.6 million to settle a qui tam suit under the False Claims Act initiated by a former employee. At the time that the suit was filed, in June 1993, Blue Cross/Blue Shield of Michigan was also the fiscal intermediary for the Medicare Part A program in Michigan and was the carrier for the Medicare Part B program. As of September 30, 1994, CMS terminated both contracts and Blue

Cross/Blue Shield of Michigan no longer serves as intermediary or carrier. As the intermediary, Blue Cross/Blue Shield of Michigan was responsible for auditing participating hospitals' cost reports to ensure accuracy. An Office of Inspector General (OIG) investigation showed that they performed inadequate, cursory audits in which they disregarded significant overpayments. They later gave CMS fraudulent work papers in an attempt to show that complete and accurate audits were performed. The precise amount of loss to the Government could not be determined because it would have required auditing more than 200 hospitals. As part of the settlement, the Blue Cross/Blue Shield of Michigan agreed to repay the entire amount CMS had paid to perform audits over a 4 year time period, approximately $13 million.

Blue Cross/Blue Shield of Michigan also agreed to pay an additional $24 million to settle charges of violating Medicare secondary payer laws. Under these laws, private insurers are required to act as the primary benefits payer under certain circumstances when an individual has medical insurance under both Medicare and an employer health plan. An OIG audit determined that in its capacity as the Medicare contractor in Michigan, Blue Cross/Blue Shield of Michigan paid thousands of dual coverage claims from Medicare trust funds rather than from its own funds in cases where there was overlapping coverage.

Anthem Blue Cross and Blue Shield of Connecticut

In December of 1999, Anthem Blue Cross and Blue Shield of Connecticut (Anthem), Connecticut's former Medicare fiscal intermediary, agreed to pay the Government $74.3 million to resolve allegations of wrongdoing by its predecessor corporation. The company allegedly falsified hospital cost reports to meet Government performance standards as a Medicare fiscal intermediary. The company's misconduct led several Connecticut hospitals to improperly receive Medicare overpayments and enabled the company to obtain a better performance evaluation from CMS than it would have otherwise received. This settlement represents the largest civil settlement in a health care fraud case in the State and the second largest Medicare contractor settlement nationwide. As part of the settlement, the company, which is no longer an intermediary, agreed to the imposition of a corporate integrity agreement for 5 years for its Medicare+Choice health maintenance organization contract, which it still operates.

FRAUD UNIT PERFORMANCE

As part of their payment safeguard activities, Medicare contractors are required to have Fraud Units which are designed to detect and deal with problems of fraud and abuse within the provider community. The types of problems detected range from individual cases of suspected fraud, to patterns of fraud or questionable activity which may represent a broader program vulnerability.

As we work closely with these units, we in the OIG are keenly interested in their operations and effectiveness. In 1996, we reviewed the functions of the carrier fraud units, and in 1998 we reviewed the fiscal intermediary fraud units. Overall, we found that their effectiveness varies considerably and often their performance is not directly related to the size of the unit or the total number of resources allocated. Total case loads among the Fraud Units varied considerably, from

zero to over 600 for the intermediaries. In reviewing carrier case files, we also found that some allegations of fraud were being lost during the overpayment adjustment process and were not properly developed as potential fraud cases. In addition to complaints received, Fraud Units are encouraged to proactively develop their own cases for potential referral to our office. Unfortunately, we found that less than one-half were actively engaged in developing their own cases. Similarly, less than one-half of the fraud units were active in identifying program vulnerabilities.

A key factor is a contractor management's commitment and attention to fraud matters overall. The most successful Fraud Units are those given significant prominence in the contractor's organizational structure, reporting to the highest levels of corporate management. Overall, however, effectiveness of the Fraud Units has been hampered by staff turnover, lack of proper background and training, and an overall lack of uniformity and understanding of key fraud terms and definitions.

As mentioned earlier, HIPPA provided CMS with new authorities to contract with entities separate from current carriers and fiscal intermediaries to perform specific program integrity functions. These new Program Safeguard Contractors will supplement, and in some cases replace, the work of fiscal intermediary and carrier fraud units. It is too early to evaluate the performance of these safeguard contractors; however, as I will discuss in more detail later, their structure provides a model on which to base broader contractor reforms.

FINANCIAL MANAGEMENT PROBLEMS

We have also encountered problems associated with financial management and accounting procedures and longstanding weaknesses in internal controls, including deficiencies related to the receivable amounts reported in CMS' financial statements and electronic data processing.

Financial Systems and Processes

Along with its Medicare contractors, CMS is responsible for managing and collecting many billions of accounts receivable each year. Medicare accounts receivable are primarily overpayments made to health care providers by contractors that must be repaid to Medicare, and funds due from other entities when Medicare is the secondary payer. For FY 2000, the contractors reported about $30 billion in accounts receivable activity which resulted in an ending gross balance of approximately $7.1 billion -- over 87 percent of CMS' total receivable balance.

For several years, we have reported serious errors in contractor reporting of accounts receivable that resulted from weak financial controls. Control weaknesses were noted again in our FY 2000 audit. Because the claim processing systems used by the contractors lacked general ledger capabilities, obtaining and analyzing financial data was a labor-intensive exercise requiring significant manual input and reconciliations between various systems and ad hoc spreadsheet applications. This situation increases the risk that contractors could report inconsistent,

incomplete, or erroneous information.

To address previously identified problems in documenting and reporting accounts receivable and to accurately determine receivable balances, CMS began contracting with independent public accountants in FY 1999. This year, the accountants noted significant improvement in the CMS central office's analysis of information included in its financial statements, along with the improvement in contractors' processing and reporting of receivables. Over the 2-year period, however, the independent public accountants identified about $590 million in non-Medicare Secondary Payer recorded debt that the Medicare contractors could not document. While all of these receivables were written off because of the lack of documentation, some may have represented actually debt due to Medicare that should have been collected.

Although it is quite clear that the root cause of the accounts receivable problem is the lack of an integrated, dual-entry accounting system, better oversight or implementation of compensating internal controls could ensure that the receivables will be properly accounted for and reflected in their future financial reports. For instance, had CMS regional offices been required to conduct reviews similar to those conducted by the independent public accountants, many problems could have been detected earlier or prevented and the need to hire outside accountants would have been obviated. Similarly, stronger regional office oversight of the contractors would have helped to ensure that essential controls, such as reconciliations, were in place to prepare accurate and complete financial reports. Of the 10 contractors in our sample, 9 did not reconcile the monthly expenditures reported to CMS to the actual paid claims tape as CMS requires. Failing to conduct this reconciliation increases the risk of material misstatements in the financial statements.

To address its systems problem, CMS plans to develop a state-of-the-art Integrated General Ledger Accounting System. However, the system will not be fully operational until 2007. Until then, stronger internal controls and oversight of the Medicare contractors are critically needed.

Electronic Data Processing

The CMS relies on extensive electronic data processing (EDP) operations at both its central office and Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data and sensitive information while reducing the risk of improper Medicare payments disruption of critical operations, and malicious changes that could interrupt data processing or destroy data files.

However, we again found numerous EDP general control weaknesses, primarily at the Medicare contractors. About 80 percent of the 124 weaknesses that we noted involved three types of controls:

- **Access controls** ensure that critical systems assets are physically safeguarded, that logical (e.g. electronic) access to sensitive computer programs and data is granted only when authorized and appropriate, and that only authorized staff and computer

processes access sensitive data in an appropriate manner. Weaknesses in these controls represented the largest problem area. At several contractors, for example, programers had inappropriate access to beneficiary history files, and passwords were not properly administered.

- **Entry-wide security programs** ensure that security threats are identified, risks are assessed, control techniques are developed, and management oversight is applied to ensure the overall effectiveness of security measures. At several sites, we found that contractors lacked fully documented, comprehensive entity-wide security plans.

- **Systems software controls** help to prevent unauthorized individuals from using software to read, modify, or delete critical information and programs. We noted problems in managing routine changes to systems software to ensure their appropriate implementation and in configuring operating system controls to ensure their effectiveness.

In addition, the prior control weaknesses concerning the Medicare data centers' access to the software program coding of the "shared" system used by certain Medicare contractors remains unresolved. This weakness has been expanded to include the Common Working File system, which all shared systems use to obtain authorization to pay claims and to coordinate Medicare Parts A and B. Access to source code renders the Medicare claim processing system vulnerable to abuse, such as the implementation of unauthorized programs.

CURRENT STRUCTURAL BASIS FOR MEDICARE CONTRACTING

The ability to prevent or correct the problems just described stem in part from the way CMS is required to contract with its claims administrators. The Medicare statute places substantial limits on how CMS may obtain contractor assistance to administer the Medicare program, including limiting CMS to choosing only certain types of companies to process claims and restricting them to a cost-based reimbursement method.

I will describe how Medicare currently contracts with its carriers and fiscal intermediaries and contrast that with the flexibility in contracting authority already available to most other government agencies.

Medicare Contracting Entities

Carrier, Fiscal Intermediary, DMERC and RHHI Contracts. The legislative authorities under which CMS contracts with carriers and fiscal intermediaries are found in Title 42 of the United States Code (U.S.C.).[2] Currently, these contracts are governed by laws that are more restrictive

[2] Social Security Act, Sections 1842 (42 U.S.C. 1395u) and 1816 (42 U.S.C. 1395h).

than general federal contract laws. These contracts are not subject to the general government contracting authorities which are found in Title 41 of the United States Code, nor are they subject to the Federal Acquisition Regulation (FAR).

Program Safeguard Contracts. Contracts with program safeguard contractors are subject to FAR and Title 41 of the U.S.C.[3] The contracts must be awarded using full and open competition with few prohibitions on who can hold these contracts. These contracts can be entered into for up to 5 years and can be reimbursed using either fixed price or cost-reimbursement methodologies. In addition, the program safeguard contracts can be terminated at the Government's "convenience."

Awarding the Contract

Although most government contracts require competitive bidding using full and open competition with very few prohibitions on who can be awarded a government contract, CMS is limited as to which entities it may contract with. Under Part A, the statute allows for a process under which hospitals and certain other institutional providers nominate an organization to serve as a representative for its members. Currently, the National Blue Cross/Blue Shield Association, designated by the providers, serves as the prime contractor with CMS. As such, it subcontracts with its local member plans to perform as fiscal intermediaries. Presently, all fiscal intermediaries are insurance companies. For home health and hospice providers, CMS has designated a small number of FIs to serve as Regional Home Health Intermediaries (RHHIs), based on its current authority to designate an intermediary to serve a class of providers.

Carriers are defined by statute to be non-governmental organizations engaged in "providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts," or other such group arrangements. This requirement has effectively limited such contracts to insurance companies. By statute, carrier contracts may be entered into without competition. CMS contracts with DMERCs under a separate authority and uses a competitive bidding process to award these contracts. (See Table 1 for a comparison of how and to whom contracts are normally awarded.)

[3] Social Security Act, Section 1893, 42 U.S.C.1395ddd.

Table 1 - Contract Award

Type of Contract	Competitive or non-competitive	Contractor
General Government Contracts	Competitive	Any organization
Program Safeguard Contractors	Competitive	Any organization
Fiscal Intermediaries	Non-competitive	Insurance co. nominated by a provider group
RHHI	Non-competitive	Fiscal intermediary designated by CMS
Carriers	Non-competitive	Company with health insurance experience
DMERC	Competitive	Company with health insurance experience

Contract Type

Generally, government contracts can be either fixed-price contracts or cost-reimbursement contracts. In a fixed-price contract, the contractor has the full responsibility for the performance costs and resulting profit or loss. Fixed-price contracts are preferred since the contractor guarantees performance of the work as a condition of getting paid. In a cost-based contract, the government assumes the risk for all allowable costs. The contractor is liable for delivering only its best effort, not successful performance. General government contracts can be up to 5 years.

On the other hand, Medicare's fiscal intermediary, carrier, RHHI and DMERC contracts are generally limited to cost-reimbursement contracts. For these contracts, CMS and the contractor negotiate an overall amount for the contract based on standards established by CMS. These contracts are only made for a year.

Table 2 - Contract Types

Type of Contract	Fixed-price or cost-reimbursement	Length
General Government Contract	Fixed-price or cost-reimbursement	Up to 5 years
Program Safeguard Contractors	Fixed-price or cost-reimbursement	Up to 5 years
Fiscal Intermediaries	Cost-reimbursement	1 year
RHHI	Cost-reimbursement	1 year
Carriers	Cost-reimbursement	1 year
DMERC	Cost-reimbursement	1 year

Contract Renewal and Termination

In general, government contracts can be renewed as long as the contractor meets or exceeds the performance requirements established in the current contract. Most contracts may be terminated by the government at any time for default of the contract or for the convenience of the government. If the government terminates the contract for its convenience, then the government must compensate the contractor for any preparations and for any completed and accepted work.

The CMS contracts with carriers and fiscal intermediaries, including RHHI and DMERC contracts, have automatic renewal clauses. As long as the contractors meet or exceed the standards that CMS publishes annually, the contracts are renewed. If CMS terminates the contract upon a determination that the contractor has failed to properly carry out its contracted duties or is not operating in an efficient and effective manner, the contractor has a right to a hearing. Because contracts with fiscal intermediaries and carriers are generally only one year in duration, these contracts are rarely terminated. Instead, CMS simply does not renew the contract at the end of the one year period. The contractor, on the other hand, can terminate at any time upon written notice to the government. Under CMS' prime contract with the National Blue Cross Association, when one of the local Blue plans does not renew its contract, the Association may choose the replacement contractor, thus further limiting CMS' choice of future contractors.

Table 3 - Contract Renewal and termination

Type of Contract	Renewal	Termination
General Government Contract	May renew	No hearing
Program Safeguard Contractors	May renew	No hearing
Fiscal Intermediaries	Automatic renewal	Hearing
RHHI	Automatic renewal	Hearing
Carriers	Automatic renewal	Hearing
DMERC	Automatic renewal	Hearing

MODELS FOR CONTRACTOR REFORM

As noted earlier, under the Health Insurance Portability and Accountability Act of 1996, CMS was granted new authority and flexibility in contracting separately for program integrity functions. It may enter into contracts or work orders for specific program safeguard functions, such as medical review, fraud detection, cost report audits, and reviews to identify primary payers to whom Medicare is the secondary payer.

To date, CMS has awarded 19 contracts to Program Safeguard Contractors (PSCs) to carry out a wide range of activities. These tasks include supplemental activities, such as an analysis of Y2K issues, which have not replaced regular contractor functions. Other tasks in part or in whole replace safeguard functions currently being done by contractors. For example one PSC is performing program integrity activities to target vulnerabilities in therapy services. Another PSC is tasked with conducting postpayment medical review fraud detection and data analysis for 12 Western states.

It is too soon to fully evaluate the success of this model; however, preliminary results are encouraging. We support this new authority and look forward to continued improvements in program operation and oversight that are taking place under the Medicare Integrity Program.

Another promising development is the designation of specialty contractors such as the Durable Medical Equipment Regional Carriers. They review and pay all claims for medical equipment and

supplies. There are only four of them, which appropriately concentrates their expertise in this complex area. They are bolstered by a data analysis unit, staffed by one of these carriers but supporting all four. This enables them to analyze payment and usage patterns which may suggest possible improper or questionable conduct. They are also able to effectively collaborate on the formulation of national coverage policies and payment control systems.

A recent OIG evaluation found that these entities are effective. We believe that specialty contractors, with a supporting analytic unit, would make sense for problematic areas and recommend that they be more widely used.

PROPOSED LEGISLATION

To promote innovations and efficiencies from the private sector, legislation is currently being developed that would increase CMS' flexibility in how it contracts with Medicare fiscal intermediaries and carriers by allowing it to award work competitively and use performance based contracts. Through this legislation, CMS hopes to accomplish the following:

- Provide flexibility to CMS and its contractors to better adapt to changes in the Medicare program.
- Promote competition, leading to more flexible efficiency and accountability.
- Establish better coordination and communication between CMS, its contractors and health care providers.
- Promote CMS' ability to negotiate incentives for Medicare contractors to perform well.
- Improve CMS' contractor performance evaluation processes, while maximizing objectivity in contractor evaluation.
- Stabilize and guide CMS' business relationship with its contractors.

CMS has proposed such broad and more flexible contracting authority in the past, and we have consistently testified in support. For instance, we have supported past proposals to allow CMS to enter into contracts with one entity to perform both carrier and intermediary functions, allow the Secretary to follow Federal Acquisition Regulations, and to reimburse contractors on a fixed price basis when needed. We believe such common sense approaches are long overdue. In fact, in recent work we found that Medicare's claims processing system did not prevent duplicate payments by multiple carriers for any of the 242 services in our audit sample. An ability to consolidate the number of contractors would help to prevent such types of duplicate payments from occurring.

More flexibility and specialization will, we believe, bring greater expertise and efficiency to contractor operations. This will, in turn, improve their relations with providers and facilitate provider education and understanding of Medicare rules and regulations. Further, the ability to pay contractors on a fixed-cost basis would offer the flexibility to award contracts for the best possible value.

CONCLUSION

Through our investigations, financial audits, and evaluations of management practices, we continue to identify problems at the Medicare contractors which run the gamut from operational inefficiencies to deliberate defrauding of the Medicare program. Taken as a whole, these problems underscore the critical need for immediate contracting reforms.

CMS needs to have sufficient flexibility in its authorities to contract with the companies best able to carry out the needed functions, to hold these companies accountable when they fall short, and to reward them when they perform well. Beneficiaries and providers will be better served, and CMS will get better value for its contracting dollars.

We fully support the need for Medicare contracting reform legislation. We also support a reduction in the number of private health insurance companies that process claims to a more manageable number. We look forward to the changes in Medicare contracting that are already taking place under the new Medicare Integrity Program and look forward to changes brought about by more global contracting reforms as well.