

March 2000

# MEDICARE CONTRACTORS

## Further Improvement Needed in Headquarters and Regional Office Oversight



G A O

Accountability \* Integrity \* Reliability

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## Abbreviations

CPE	Contractor Performance Evaluation
HCFA	Health Care Financing Administration
OIG	Office of Inspector General

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United States General Accounting Office  
Washington, D.C. 20548

Health, Education, and  
Human Services Division

B-282691

March 23, 2000

The Honorable Thomas J. Bliley, Jr.  
Chairman, Committee on Commerce  
House of Representatives

Dear Mr. Chairman:

Overseeing Medicare claims administration contractors is one of the Health Care Financing Administration's (HCFA) most important responsibilities in administering the Medicare program. Medicare is the federal health insurance program serving over 39 million elderly and disabled Americans. Each business day, HCFA's contractors process about 3.5 million Medicare fee-for-service claims worth an average of more than \$700 million.

As we have reported, Medicare funds hundreds of billions of dollars in critical health care services and is vulnerable to fraud, abuse, and mismanagement.<sup>1</sup> Beginning in the early 1990s, we designated the Medicare program as a high-risk area, and so it remains.<sup>2</sup> For years, we and the Office of Inspector General (OIG) in the Department of Health and Human Services have been concerned about appropriate oversight by HCFA of Medicare contractors to ensure they pay claims accurately and prevent fraud and abuse.<sup>3</sup> Concerns about the effectiveness of HCFA's monitoring efforts have been heightened by recent evidence that some contractors—who are responsible for checking and auditing claims to ensure that providers do not defraud Medicare—have themselves defrauded the program.<sup>4</sup> In a recent report, we identified a number of problems with

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<sup>1</sup> *Major Management Challenges and Program Risks: Department of Health and Human Services* (GAO/OCG-99-7, Jan. 1999).

<sup>2</sup> *High-Risk Series: An Update* (GAO/HR-99-1, Jan. 1999).

<sup>3</sup> For examples, see *More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing* (HRD-79-76, June 29, 1979) and *Medicare: Contractor Services to Beneficiaries and Providers* (GAO/HRD-88-76BR, Mar. 16, 1988).

<sup>4</sup> *Medicare: Improprieties by Contractors Compromised Medicare Program Integrity* (GAO/OSI-99-7, July 14, 1999).

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HCFA's oversight of Medicare contractors—including weaknesses in how the central and regional offices conducted oversight—and recommended changes.<sup>5</sup>

As a follow-up to our testimony on this topic before the Subcommittee on Oversight and Investigations, you asked us to further assist you in your ongoing monitoring of HCFA's management of Medicare claims administration contractors.<sup>6</sup> Specifically, you asked us to review how coordination between the agency's central office and its regional offices affects contractor oversight. This report discusses HCFA's recent efforts to address weaknesses in how the central office and regional offices work together to oversee contractors, and the continuing management challenges HCFA faces.

For this report, we updated and further developed information related to our prior work on HCFA's oversight of Medicare contractors. Specifically, we reviewed and updated information on HCFA's response to our July 1999 report and interviewed HCFA central office officials and three Regional Administrators, who head groups of regional offices that are organized into consortia. We also discussed these matters with staff in two regions and reviewed key agency documents, such as HCFA's plan for strengthening the fiscal year 1999 contractor performance evaluation process and an assessment by HCFA's Office of Strategic Planning that identified central office/regional office problems with communications and contractor oversight. Finally, we examined the ongoing efforts of two central/regional teams charged with reviewing the relationship between HCFA's central and regional offices to develop options to improve communications and contractor oversight. Our work was performed between August 1999 and January 2000 in accordance with generally accepted government auditing standards.

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## Results in Brief

HCFA is taking a number of steps to strengthen contractor oversight by its central office and 10 regional offices. These include

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<sup>5</sup> *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

<sup>6</sup> *Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors* (GAO/T-HEHS/OSI-99-167, July 14, 1999); *Medicare: HCFA Oversight Allows Contractor Improprieties to Continue Undetected* (GAO/T-HEHS/OSI-99-174, Sept. 9, 1999).

- clarifying accountability for contractor oversight at the central office;
- establishing national review teams, which combine the expertise of central and regional office staff, to conduct evaluations of contractor performance; and
- providing detailed direction to regional office overseers to improve the consistency of contractor reviews and reporting.

Although central and regional office officials have stated that these changes will enhance contractor oversight, most of these actions are still in the planning or early implementation stages. Therefore, it is too early to assess their effects.

Even if these efforts are successful, HCFA's central and regional offices are still likely to face difficulties in working together effectively to oversee Medicare contractors. Until very recently, HCFA regional overseers were not directly accountable to the central office group responsible for contractor oversight activities. While HCFA was reviewing a draft version of this report, the agency announced that, to improve regional accountability, it is establishing a position within each consortium to consolidate responsibility for contractor management. We did not have time to evaluate the impact of this initiative on strengthening headquarters and regional oversight.

Other weaknesses in its oversight management have not yet been addressed. Specifically, HCFA (1) lacks adequate management information on regional office resources used or needed for evaluating contractors; (2) since 1995, has provided late annual instructions (or none at all) on what oversight must be conducted by regional office reviewers; and (3) does not effectively employ available management tools—such as routine feedback to regional offices—to ensure that adequate contractor oversight is performed. To enhance management of contractor oversight and improve accountability and communications, we are making several recommendations in this report.

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## Background

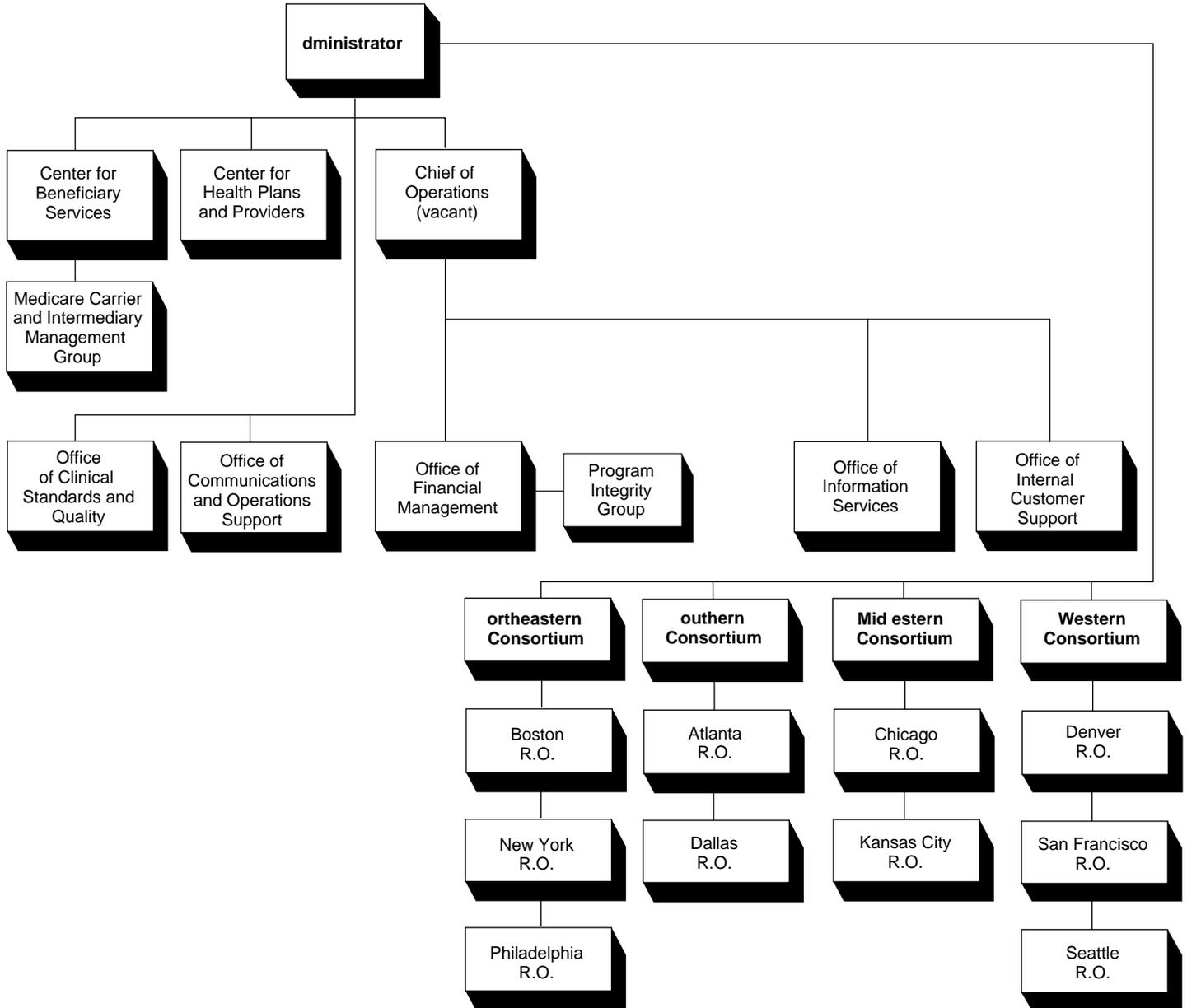
HCFA contracts with intermediaries and carriers to administer Medicare fee-for-service claims. Intermediaries review and pay claims from hospitals and other institutional providers, while carriers review and pay claims that are submitted by physicians and other outpatient providers. HCFA is responsible for ensuring that these contractors appropriately and efficiently administer claims, protect Medicare from fraud and abuse, and provide education and service to beneficiaries and providers.

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Claims administration contractors conduct several types of activities to help safeguard the Medicare program from fraud and abuse. They conduct medical review, which includes both automated and manual reviews of claims. This is done either prior to or after payment to identify claims that should not be or should not have been paid because services are not covered; are medically unnecessary or unreasonable; or for other reasons, such as duplicate claims. Contractors also seek to identify situations where other insurance should pay a claim before Medicare—for example, when a Medicare beneficiary is covered by the private insurance of a working spouse. Identifying such situations requires contractors to match recipient data to Internal Revenue Service and Social Security Administration information. Contractors also audit cost reports submitted by institutions, such as hospitals, nursing homes, and home health agencies. The cost reports these providers submit are used in determining the amount of their Medicare reimbursement. Finally, contractor fraud units identify, investigate, and refer potential cases of fraud and abuse to law enforcement agencies that prosecute fraud.

HCFA's central office and its 10 regional offices have distinct responsibilities for overseeing contractor performance. Within the central office, contractor management and oversight activities are dispersed among seven major components. Ten regional offices, organized into four consortia, each have direct contractor management and oversight responsibilities, although some regional offices manage and oversee more contractors than others (see fig. 1).

Figure 1: Central Office and Regional Office Components With Responsibilities for Medicare Contractor Management and Oversight Issues



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One component, the Center for Beneficiary Services, coordinates all aspects of program direction, contract management, and oversight of Medicare contractors.<sup>7</sup> Within the center, the Medicare Carrier and Intermediary Management Group is the focal point for contractor performance issues and has oversight responsibility for the contractors. This group is charged with developing and implementing evaluation programs to monitor contractor performance and making recommendations to agency management to address contractor performance deficiencies. Table 1 summarizes information on contractor responsibilities of key components agencywide.

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<sup>7</sup> HCFA's 1997 reorganization established the Center for Beneficiary Services. The statement of organization, at that time, envisioned the center's role in coordinating contractor activities as extending only through the period of transition to the Medicare Transaction System. This effort was expected to substantially reduce the number of Medicare contractors and to develop a single claims processing system. The effort was unsuccessful, and the Medicare Transaction System project was canceled in August 1997.

**Table 1: HCFA Organizational Components With Responsibilities for Medicare Contractor Management and Oversight Issues**

HCFA organizational component	Component responsibilities
Central office	
Center for Beneficiary Services	Contractor management focal point, contractor performance evaluations, transitions, customer service, beneficiary enrollment, coordination of benefits, and appeals
Center for Health Plans and Providers	Claims processing and payment issues
Office of Financial Management	Accounting operations, budget, cost reporting, and cash management/letter of credit, Medicare Integrity Program, other payment safeguards, and internal controls, provider/supplier enrollment
Office of Information Services	Contractor information systems, system changes, and systems security as well as managing internal HCFA information systems that interface with contractor systems, administrative transaction standards
Office of Internal Customer Support	Procurement issues and contract award services
Office of Clinical Standards and Quality	Coordination and development of medical coverage policies
Office of Communications and Operations Support	Coordination and dissemination of manual and program guidance
Ten regional offices	Direct contractor oversight

In its 1997 reorganization, HCFA established four consortia to provide leadership to the regional offices and coordination of regional activities, including contractor performance oversight, within the consortia and with the central office. The consortia are structured by geographic location and headed by an administrator who also serves as a Regional Administrator. The Northeastern Consortium, for example, directs Medicare programs within the three regional offices that make up the consortium—Boston, New York, and Philadelphia. The current Northeastern Consortium Administrator is also the New York Regional Office Administrator. Consortium Administrators are responsible for allocating regional resources.

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The regional offices directly monitor contractor performance using guidance prepared by the Medicare Carrier and Intermediary Management Group. Since 1995, HCFA has relied on its Contractor Performance Evaluation (CPE) process as the basic tool used in performing contractor reviews. The CPE process allows regional staff to review any aspect of contractually required duties in five general areas: claims processing, customer service, payment safeguards, fiscal responsibility, and administrative activities.<sup>8</sup> When HCFA reviewers identify a serious problem, contractors can be required to take corrective actions under a performance improvement plan. The regional office is responsible for ensuring that the necessary contractor action is taken. The region must report the results of its evaluation reviews and corrective action monitoring to the Medicare Carrier and Intermediary Management Group.

In the past, we reported that HCFA's oversight of Medicare claims administration contractors had significant weaknesses that left the agency without assurance that contractors were paying providers appropriately.<sup>9</sup> Some of the weaknesses we identified were related to the nature of the relationship between the central office and regional offices. Regional office staff, although they are the front line for overseeing contractors, do not report directly to central office units responsible for contractor performance. Instead, they report to the HCFA Administrator through the Consortium and Regional Administrators. We found that this structural relationship, along with dispersion of responsibility for contractor activities across multiple central office components, blurred accountability for evaluating the regional offices' effectiveness in overseeing contractors, enforcing minimum standards for oversight activities, and having regions adopt best oversight practices. In addition, when HCFA began using the CPE process in 1995, the agency gave its 10 regional offices a high degree of flexibility, while providing limited guidance on the level and type of contractor reviews that should be performed. We found that HCFA's flexible evaluation process led to a number of problems, such as key program safeguard activities not being reviewed at all contractors, inconsistent handling of contractor performance problems, and variations in regional review reports, which made analysis difficult and cross-contractor comparisons impossible.

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<sup>8</sup> In fiscal year 1999, HCFA established a number of national review teams composed of central office and regional office staff to conduct performance reviews of some contractors.

<sup>9</sup> GAO/HEHS-99-115, July 14, 1999.

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## HCFA Has Taken Steps to Improve Contractor Oversight

HCFA has taken—and is planning to take—a number of steps, including several that address weaknesses in the central and regional office relationship. To improve its oversight of contractors, HCFA (1) has appointed a high-level central office official to consolidate responsibility for contractor management within the agency, (2) has established a high-level board to make decisions about contractor issues, (3) has established national teams made up of staff from the central and regional offices to review selected contractors in specific review areas, (4) is initiating systems to gather more oversight information, (5) is providing more centralized direction, and (6) has required that each Regional Administrator's performance agreement specify contractor oversight as a distinct responsibility. Central and regional office officials and staff generally believe these actions will improve the effectiveness and consistency of contractor oversight.

In November 1998, HCFA established the position of Deputy Director for Contractor Management in the Center for Beneficiary Services in the central office. The Deputy Director is responsible for managing and overseeing contractor operations across the central and regional offices. The Deputy Director presents contractor management issues to the agency's Executive Council, a management council made up of senior HCFA executives and chaired by the Administrator. Several regional officials we spoke with reported that the creation of this new position has clarified central office responsibilities for contractor functions.

The Deputy Director for Contractor Management serves as the Executive Director of the Medicare Contractor Oversight Board. The board was established in December 1998 to provide high-level oversight to contractor activity and to help develop a strategy to manage and monitor contractors. The board, which reports directly to the Administrator, includes one Consortium Administrator to represent the regional offices and representatives from seven central office units with responsibilities for Medicare contractor issues.<sup>10</sup>

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<sup>10</sup> The seven central office units represented are the Center for Beneficiary Services, Center for Health Plans and Providers, Office of Clinical Standards and Quality, Office of Communications and Operations Support, Office of Financial Management, Office of Information Services, and Office of Chief of Operations (vacant). The Office of Internal Customer Support serves as a board consultant.

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To further encourage consistency in oversight efforts, in fiscal year 1999, HCFA established national review teams made up of central office and regional office staff to conduct reviews of selected contractors.<sup>11</sup> HCFA provided training in CPE policies and procedures to national team members, who were selected for their expertise in various review areas. In fiscal year 2000, HCFA plans to expand its use of national teams for reviewing contractor performance. HCFA officials believe that the use of national teams will facilitate consistency and cross-contractor performance comparisons because the same staff participate on teams and because these teams, by virtue of their membership, help bring a broader perspective to their reviews. Using national review teams also helps address concerns that the regional staff responsible for day-to-day operational guidance may become too familiar with the contractors that they manage and thus unable to evaluate their contractors' performance with independence and objectivity. During interviews for our recent report on contractor improprieties, we were told one of the reasons HCFA failed to detect fraudulent activities by contractors was that HCFA officials with long-term relationships to contractors also provided oversight.

HCFA is also gathering more oversight information, including initiating systems to monitor the status of CPEs done by regional offices in order to better manage oversight efforts and to collect information on contractor performance. An official told us that monitoring the status of regional office CPEs in 1999 allowed central office staff to identify potential problems in meeting the schedule for issuing end-of-year annual performance reports for selected contractors. HCFA provides this annual report, which summarizes a contractor's overall performance, to the company's top executive, and HCFA officials may use it in awarding additional work to contractors if others leave the program. In addition, the central office is providing regional offices with more guidance and instruction, such as standardized review protocols and detailed CPE information via e-mail bulletins that HCFA calls "CPEExtras." Finally, HCFA recently awarded two contracts to improve the CPE process. (For more detail on these and other actions, see app. II.)

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<sup>11</sup> In fiscal year 1999, national teams conducted reviews at all five Regional Home Health Intermediaries; all four Durable Medical Equipment Regional Carriers; and Mutual of Omaha, a contractor servicing providers in nearly every state.

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HCFA's Administrator is now able to use performance agreements as a management tool to hold HCFA senior executives, including Consortium and Regional Administrators, accountable for critical tasks, including contractor oversight. In fiscal 1999, 7 of 10 Regional Administrators had incorporated responsibility for contractor oversight into their agreements with the HCFA Administrator and tied it to Government Performance and Results Act goals for the agency.<sup>12</sup> For fiscal 2000, performance agreements for all Consortium and Regional Administrators will recognize contractor oversight as a distinct responsibility. However, because HCFA has not yet identified various aspects of oversight responsibilities that can be evaluated, the fiscal year 2000 agreements do not include objective indicators of success, such as standards for conducting oversight activities or data against which performance can be benchmarked.

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## HCFA Faces Continuing Difficulties in Managing Its Agencywide Program to Oversee Contractors

Despite these initiatives, HCFA's central and regional offices' staff are likely to face continuing difficulties in working effectively together to oversee Medicare claims administration contractors. HCFA's regional overseers are not directly accountable to the central office group responsible for contractor oversight activities. Instead, HCFA places oversight responsibilities in both the central office and regional offices without creating sufficient management mechanisms to ensure effective coordination and oversight. Although HCFA has taken recent steps to address this issue by creating a new contractor management position in each consortium, it is too early to assess whether this step will succeed in strengthening headquarters and regional oversight. Other weaknesses in its oversight management have not yet been addressed. HCFA's central office has inadequate management information on oversight resources; provides late instructions on review priorities and outdated guidance; and has not yet begun systematic evaluation of, or feedback on, regional oversight activities.

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<sup>12</sup> The Government Performance and Results Act of 1993 requires federal agencies to define their mission and align their activities and resources to support mission-related outcomes. The Act requires agencies to measure their performance against program-driven criteria to ensure that they are meeting agency goals.

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**Organizational Structure  
Does Not Directly Link  
Central and Regional  
Components Responsible  
for Contractor Oversight**

HCFA's regional office staff directly oversee Medicare claims administration contractors and report to their respective Regional and Consortium Administrators who, in turn, report to the HCFA Administrator. Regional staff responsible for contractor oversight are not under the direct authority of the central office component responsible for leading contractor management and oversight (see fig. 1). These reporting lines may complicate communications and coordination related to contractor oversight.

As we reported in our July 1999 report, HCFA gave wide latitude to its regions for managing and overseeing contractors, without taking steps to ensure the quality or consistency of that oversight. We also reported that HCFA has few measurable performance standards for claims administration contractors. As a result, key activities directed toward safeguarding program dollars received limited scrutiny at some contractors. For example, we found that regional reviewers were not routinely checking how effective contractors were in identifying insurers other than Medicare with responsibility for claims payment or in recouping payments contractors had mistakenly made. Similarly, the OIG found that contractors had significant disparities in the performance of their fraud detection units, with weaknesses in HCFA's oversight that allowed poor performance to go uncorrected.

We also reported in July 1999 that the structural relationship between regions reporting to the HCFA Administrator and the dispersion of responsibility for contractor activities across multiple central office components exacerbated the weakness of HCFA's oversight process. It also blurred accountability for having regions adopt best oversight practices, routinely evaluating the quality of regional oversight, and enforcing minimum standards for conducting oversight activities, including taking action when a particular region was not providing effective oversight.<sup>13</sup>

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<sup>13</sup> See GAO/HEHS-99-115, July 14, 1999.

Before HCFA's 1997 reorganization, central office responsibility for managing and overseeing Medicare contractors fell to the Bureau of Program Operations, and the regional offices carried out the day-to-day oversight of specific contractors. The Bureau provided guidance to regional offices and was responsible for almost every aspect of contractor management at the central office, including contractor selection, budgeting, and ensuring proper monitoring of contractor performance. Both the Director of the Bureau of Program Operations and the regions reported to the HCFA Administrator through the Associate Administrator for Operations and Resource Management. Under this organizational structure, HCFA experienced problems with contractor oversight and contractor performance.<sup>14</sup>

HCFA's implementation of its new management organization in 1997, however, did not fully address (and may have exacerbated) communication and accountability problems. HCFA based its new organization on a matrix management model.<sup>15</sup> A successful matrix organization requires strong communication and coordination links within units and across the agency. However, when HCFA was considering using a matrix management structure, it did not focus on effectively managing central and regional office accountability and communication under the revised structure. The former HCFA Administrator told his reorganization design team that it should not consider major changes in regional reporting lines, according to an official who served on the team. He had decided that Regional Administrators would report to him through Consortium Administrators, and directed the team not to make decisions regarding regional accountability.

Under the reorganization, responsibility for contractor functions was dispersed among seven central office components. This was done to separate responsibilities for contracting, budgeting, and oversight because HCFA was concerned that, under the prior organizational structure, one

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<sup>14</sup> *Medicare: HCFA's Contracting Authority for Processing Medicare Claims* (GAO/HEHS-94-171, Aug. 2, 1994); *Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments* (GAO/HEHS-95-210, Sept. 19, 1995); *Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements* (GAO/HEHS-95-171, Aug. 8, 1995); *Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs* (GAO/HRD-91-67, May 15, 1991).

<sup>15</sup> A matrix organization provides for two channels of command and performance responsibility. It is an organizational form intended to provide and control skills and resources where and when they are most useful.

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office had had too much concentrated responsibility for contractor activities. However, we found in our July 1999 report that this dispersion of responsibility left contractors without an effective focal point at the central office and contributed to poor communication of key HCFA directives to contractors.

HCFA has recognized that the dispersion of responsibility for contractor operations in the central office created problems, and it has taken some actions to deal with this issue. HCFA established a high-level, central office position to provide consistent policy direction and leadership to contractor oversight activities. However, the new position has no direct organizational link to the regional staff that perform contractor review activities. Consequently, it is not always clear where accountability for these oversight activities resides.

The reorganization also resulted in dispersed responsibility for contractor oversight in the regions. Although regions retained their role as primary contract monitors, the reorganization resulted in dispersion of responsibility for contractor oversight into two or more divisions at each regional office, with one division given the lead. The division given primary responsibility for contractor oversight varies from region to region. For example, in the Boston Regional Office, the Associate Regional Administrator for the Division of Beneficiaries, Health Plans, and Providers has primary responsibility for contractor oversight. In the Kansas City Regional Office, on the other hand, the Associate Regional Administrator for Financial Management has this responsibility.

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Central and regional office officials did not agree on whether reporting, communication, and accountability were complicated by the headquarters and regional structure. Some central office officials believe organizational variation in the regions has complicated communication and coordination. For example, it is not always clear to central office officials with responsibility for contractor oversight which particular Associate Regional Administrator is responsible for contractor issues. This makes it more difficult for central office officials to ensure that appropriate regional action is taken as quickly as possible. However, regional staff we spoke with stated that lines of accountability between the central and regional offices are clear and well understood, and that communication has improved. They point to the consortia structure, Medicare Contractor Oversight Board, and the new position of Deputy Director for Contractor Management as primary reasons for this improvement. Although regional staff generally believe that communication has improved, some regional staff told us that they still did not know whom to call to discuss specific contractor oversight issues.<sup>16</sup>

A recent contract award serves as an example of how serious communication weaknesses can lead to uninformed decisions. A HCFA official told us that the central office selected a program safeguard contractor whose previous performance in this area was weak.<sup>17</sup> Central office staff were unaware of the contractor's previous poor performance because the region's annual oversight report on this contractor did not contain this critical information. The Regional Administrator, although aware of the performance problem, did not realize it was not in the report, and therefore this information was not communicated to central office officials who would be deciding which contractors would be selected to perform additional program safeguard tasks. This year, in an attempt to avoid similar communication breakdowns between Regional

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<sup>16</sup> We identified similar communication problems among both regional and central office staff in different parts of the organization since the 1997 reorganization—*Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/T-HEHS-98-85, Jan. 29, 1998); and *HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century* (GAO/T-HEHS-99-58, Feb. 11, 1999).

<sup>17</sup> Section 202 of the Health Insurance Portability and Accountability Act of 1996 gave HCFA the authority to contract separately for program safeguard activities, which help ensure that only appropriate claims are paid and that providers participating in Medicare comply with program rules. In May 1999, HCFA announced the award of 12 contracts under this authority.

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Administrators and central office decisionmakers, Regional Administrators will sign the final annual reports of contractor performance.

In mid-1999, HCFA formed study teams to examine contractor oversight and communication. These teams are expected to address the possibility of “re-engineering” the relationship between HCFA’s central and regional offices. For example, they are addressing how the increasing use of central office personnel to oversee multiregional contractors affects oversight and communication and how central/regional office relationships could be more effective. They are also addressing the need for consistency in contractor operations and the prospect of consolidating certain aspects of contractor oversight in selected regions.

In February 2000, while HCFA was reviewing a draft version of this report, the agency announced its plans for establishing four consortium contractor management officer positions in HCFA’s regional offices. These officers will be responsible for directing and leading Medicare contractor management in each consortium and will report both to the central office official accountable for contractor management and to their respective Consortium Administrators. Within their consortia, these individuals will be responsible for managing assigned contractors and will oversee contractor management staff. HCFA believes that consolidating responsibility for contractor management within each consortium will improve regional accountability and strengthen the reporting relationship between the central office and regional offices. However, because plans for establishing these positions were only recently announced, it is too soon to tell whether this step will succeed in strengthening agencywide management of contractor oversight.

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## HCFA Still Lacks Information and Resource Targeting to Ensure Effective Oversight

Although HCFA has made the Medicare Carrier and Intermediary Management Group responsible for ensuring that regional offices are meeting their contractor oversight responsibilities, the agency does not have all of the information and management mechanisms needed for the group to carry out its responsibilities. For example, HCFA has not systematically assessed the skills and personnel needed for oversight, nor has it determined where those resources could best be deployed. The Deputy Director's office, however, is beginning to develop a formal risk assessment process to help ensure that scarce oversight resources are used effectively.<sup>18</sup> HCFA is taking steps to improve its management information (see app. II).

Our previous study on contractor oversight pointed out HCFA's lack of management information. For example, we reported that HCFA did not collect, analyze, or evaluate information on regional oversight across the country. We noted that HCFA was giving its regions wide discretion over what aspects of contractor performance to review, without requiring regions to conduct a formal risk assessment and without collecting management information on regional oversight activities.

There are still gaps in management information, including limited data about the resources HCFA has been devoting to contractor oversight. The central office unit with substantial responsibilities for managing the contractor oversight program does not have a systematic process for determining the level of resources used for implementing the program. During our prior review, when we requested data on staff and travel funds devoted to contractor oversight, HCFA was not able to provide it expeditiously. Instead, a regional representative located in the central office asked each regional office to develop estimates of resources used for oversight. However, because of apparent inconsistencies in regional offices' estimates, the central office was not satisfied with the reliability of the estimates.

In addition to having only limited information about how many resources are used, HCFA has not systematically evaluated the level of resources and skills needed to adequately oversee contractors. HCFA officials told us that contractor oversight activities had not been adequately funded or staffed in prior years. In the past, regional offices had not always invested an

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<sup>18</sup> A risk assessment process would employ a methodology that would help HCFA identify contractors and specific activities that should be reviewed as part of its oversight process.

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appropriate level of resources in contractor oversight, funneling resources away from contractor oversight activities into competing priorities, including managed care outreach efforts, nursing home surveys, and implementation of the Balanced Budget Act of 1997. Staff told us that they plan their regional oversight activities, including on-site visits, based on the resources available, rather than on what is needed to adequately oversee contractors. Several regional officials concurred that overseeing contractors in fiscal year 1999 was particularly challenging because many of their most qualified oversight staff had been diverted to HCFA's efforts to deal with its year 2000 computer systems problem.

Further, as some contractors left the Medicare program, their claims administration work shifted to contractors in other parts of the country. Agency officials told us that substantial resource imbalances now exist among regions, with some regions being underfunded for the number of contracts they oversee. One regional official told us that, although the regional office faced increasing responsibility for overseeing more contracts, the office's budget was not adjusted accordingly. We could not evaluate these concerns because HCFA has insufficient information on the resources it devotes to contractor oversight. Without comprehensive and reliable data, HCFA cannot compare resources devoted to contractor oversight on a region-by-region basis based upon each region's responsibilities.

Although the Deputy Director for Contractor Management has overall responsibility for the contractor oversight program, she does not directly influence how resources are allocated among and within regions. Using regional office estimates developed by the four consortia, HCFA's Financial Management and Investment Board develops a budget and makes recommendations to the Executive Council, which determines the level of funding for each consortium. Each consortium has a voting representative on the Financial Management Investment Board. The four Consortium Administrators are members of the council, bringing a regional perspective to the agency's top deliberative body. Consortium and Regional Administrators then decide how funds will be distributed to regional offices within the consortia. Regional Administrators, without direct input from the central office, make the final decision about the level of resources and staff devoted to contractor oversight. Regional office officials with whom we spoke generally stated that the consortia arrangement has led to the regions having a stronger voice and receiving a more equitable distribution of resources, including travel resources for conducting CPEs.

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HCFA is planning some changes that may provide central office with more information about and control over regional office use of resources. For example, HCFA is in the initial stages of developing a system to monitor regional resources used for conducting CPEs. Also, for fiscal year 2000, the central office contractor oversight unit will manage the resources for travel for regional office staff on national CPE review teams. For fiscal year 1999, the travel dollars for regional office staff on national reviews came directly from regional office resources. One regional official told us that the change was made to eliminate problems stemming from competing priorities at the regional office level.

However, HCFA has not systematically assessed the skills and number of personnel needed to effectively oversee contractors or where skills should be located in the agency. According to some central and regional office officials, lack of staff with sufficient expertise and experience creates problems in providing adequate oversight in some areas, including claims processing, financial management and audit, and systems analysis and security. HCFA's use of national and multiregional teams is one approach to developing and leveraging the skills and expertise of staff.

As we reported in previous testimonies, HCFA managers have expressed continuing concerns about having sufficient staff with needed skills and expertise to implement top-priority tasks because the agency had experienced a loss of institutional knowledge due to attrition.<sup>19</sup> This trend is expected to continue. Over the next 5 years, almost a quarter of HCFA's staff—a large part of the agency's management and technical expertise—will be eligible to retire. HCFA should focus on staff resources needed for contractor oversight and how they should be deployed in the future.

Making plans for skill needs and staff deployment will continue to be important as HCFA moves to heavier use of national review teams to oversee contractors. Using national review teams helps ensure that review by staff who manage day-to-day contractor activities is balanced with assessments by other staff members who have more of an outsider's perspective. It can also help HCFA balance oversight responsibilities in particular regions when work is transferred among contractors. In addition, a national team can apply a mixed set of skills to contractor reviews, helping to ensure that evaluations are thorough and consistent. However, the team approach is likely to require additional travel funding.

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<sup>19</sup> See GAO/T-HEHS-98-85, Jan. 29, 1998; and GAO/T-HEHS-99-58, Feb. 11, 1999.

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According to HCFA, this year's effort to be more thorough and to use a team approach increased the staff time needed for oversight.

In our July 1999 report, we recommended that HCFA review contractors based, in part, on a risk assessment of their vulnerabilities, to help ensure effective targeting of limited oversight resources. HCFA agreed that this was important, and stated that it was developing a structured risk assessment protocol. HCFA has not yet formalized a risk assessment methodology to set agencywide review priorities. In fiscal year 1999, HCFA did not use a structured risk assessment process or document the methodology it used to select contractors for reviews by national teams. Officials told us that contractor selection was based, to a large extent, on the judgments of knowledgeable central office managers, rather than a more structured risk assessment. In response to a House Committee on Commerce's September 1999 letter, HCFA said that it is developing a structured risk assessment protocol to be used at both the national and regional levels for the fiscal year 2000 evaluation cycle. In late December 1999, HCFA directed regional offices to begin using a risk assessment tool to prioritize potential choices for performing on-site contractor reviews within each regional office. HCFA stated that this risk assessment tool will also be used to help identify contractors for review by national teams. However, HCFA noted that other special factors, including high-level administration concerns about a contractor's activities, will play a key role in selecting contractors for national review. HCFA recently hired a contractor to refine its risk assessment tool.

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**Late Direction and Outdated Oversight Guidance Complicate Planning and Implementing Contractor Reviews**

HCFA's central office has been late in issuing annual instructions to regional offices on contractor oversight review activities in both of the last 2 fiscal years. The late instructions complicated regional planning for contractor oversight; forced regional reviewers to conduct mandatory reviews in compressed time frames, leaving insufficient time to conduct discretionary reviews; and limited the consistency of reviews because some individuals could not be scheduled to participate on multiple national teams. In addition, HCFA has not routinely updated the regional office manual, which contains important information on contractor performance evaluation in a consolidated format. Providing guidance in a piecemeal way leaves regional reviewers without assurance that they have all guidance and are properly following it.

Despite actions it has taken to provide more direction to the regions on contractor oversight activities, the central office continues to issue review

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instructions very late in the fiscal year. Between 1995 and 1997, HCFA's central office set no review priorities, leaving it entirely to regional staff to decide what to review. Beginning in fiscal year 1998, the central office set certain review priorities and issued specific instructions to regional review staff. However, the fiscal year 1998 instructions were issued in May 1998, and it was not until June 1999—8 months into the fiscal year—that the central office finally issued its fiscal year 1999 instructions to the regions.

More timely instructions on conducting CPEs would allow regional staff to better plan for and more effectively implement their oversight program. During our study, regional staff stated that receiving central office instructions so late in the fiscal year hampered their ability to perform both mandatory and discretionary CPE reviews. The compressed travel schedule caused by late instructions issued in 1999 also made it impossible to retain the same team members for national teams, and thus help ensure consistency in reviews. We were also told that HCFA plans to issue its instructions for fiscal year 2000 in early March. This should allow the regions to get an earlier start—as long as the necessary travel funds are also available—rather than compressing the CPE reviews into the latter part of the year.

We also found that regional staff do not have comprehensive oversight guidance to follow because HCFA has not routinely updated its regional office manual. The first chapter of this manual is devoted to contract administration and the evaluation of contractor performance, but regional contractor oversight staff with whom we spoke told us that the manual was not reliable or comprehensive. Lacking an up-to-date manual, staff depend on annual CPE instructions, e-mail, and teleconferences to provide them with current information about contractor oversight. One regional official said that, because the manual has not been updated on a routine basis, staff are uncertain that they have all information relevant to a subject. She noted that it would be very useful to consolidate up-to-date information and procedures in a single source, but that it may be preferable to do so electronically.

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**HCFA Does Not  
Consistently Use  
Management Tools to Help  
Ensure an Effective  
Oversight Program**

HCFA does not consistently employ tools that could enhance management of its contractor oversight program. For example, the central office unit in charge of managing contractors has not routinely evaluated regional offices on their performance or provided feedback on best practices in contractor oversight, although we have recommended that HCFA do so. Recently, HCFA undertook a number of steps to address these issues. For example,

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in late 1999, HCFA announced that it had hired a consultant to collect information on best oversight practices and develop performance feedback mechanisms.

One performance improvement tool available to managers is ongoing performance assessments. In our July 1999 report, we recommended that HCFA designate a unit responsible for evaluating the effectiveness of regional oversight of contractors and for enforcing minimum standards for the conduct of oversight activities to ensure quality and consistency. HCFA responded that the central office group headed by the Deputy Director for Contractor Management would have that responsibility.

However, HCFA has not yet established a system to provide regional offices with feedback on their oversight performance or that can be used to develop a comprehensive view of the relative performance and timeliness of regional offices in supporting the central office's oversight efforts. Regional offices we visited told us HCFA has not set formal expectations for regional offices overseeing contractors; developed standardized, objective criteria to evaluate regional office performance in overseeing contractors; or established a process to provide constructive performance information to regional offices and similar feedback to the HCFA Administrator. In addition, the Deputy Director for Contractor Management has not created a formal process for enforcing minimum standards for the conduct of oversight activities.

Although the central office does not provide feedback on regional offices' performance, it is beginning to provide regional staff with standardized feedback on individual CPEs. For example, for the fiscal year 1999 evaluation cycle, reviewers have been advised whether or not their reports clearly state the evaluation criteria and rationale. Until recently, according to regional office staff with whom we spoke, feedback from the central office on CPEs was sporadic and not timely. Staff in the regions we visited were generally receptive to the idea of feedback on their oversight efforts, but were concerned that no expectations were set at the beginning of their review process. They felt that reviews of their performance in conducting CPEs could be educational for individual reviewers, if the central office used a collegial approach and if experts familiar with the evaluation areas conducted the performance reviews.

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Until recently, HCFA has not employed a process to identify, share, and apply best practices to improve its regional contractor oversight program.<sup>20</sup> We recommended that it do so to help improve the program's efficiency and cost-effectiveness. HCFA's response to our July 1999 study stated that HCFA would be reviewing regional offices' efforts to oversee contractors and would be providing feedback to the regions concerning best practices. At that time, HCFA indicated that it intended to share best practices at the end of the fiscal year 1999 review cycle. In February 2000, HCFA held a 2-day CPE conference on national best practices and lessons learned. HCFA reported that staff from central and regional offices attended the conference, sharing information and discussing proposed improvements for fiscal year 2000 and 2001 reviews.

In October 1999, HCFA officials announced that they had hired a consultant to help improve the CPE process, including developing feedback mechanisms and collecting information on best oversight practices. Although work is ongoing, it is unlikely that many recommended changes could be implemented until fiscal year 2001.

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## Conclusions

HCFA has taken a number of positive steps to improve its oversight of Medicare claims administration contractors through more coordinated regional and central office efforts. In February 2000, HCFA established a position within each of its four consortia to consolidate responsibility for contractor management. Although it is too early to tell, establishing these positions could eventually prove to be a key step in agency efforts to improve regional accountability.

Other key actions were appointing a high-level central office focal point for contractor oversight and increasing emphasis on agencywide oversight activities. Both regional office and central office staff view the appointment and many of the other improvement efforts positively. With more centralized direction, detailed instructions, and training in the proper use of various protocols in 1999, expectations of individual reviewers were more clearly defined and understood. HCFA central and regional office staff found that the use of crosscutting teams contributed depth, objectivity, and quality to the oversight reviews. Using national teams

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<sup>20</sup> Best practices refer to the processes, practices, and systems identified by public and private organizations that can improve an organization's performance and efficiency in specific areas.

allows HCFA flexibility in its deployment of oversight staff. It could concentrate review staff with particular skills in a limited number of locations and use them on national teams, rather than expecting every region to have staff that oversee all aspects of contractor performance.

Nevertheless, significant problems remain. HCFA cannot ensure effective accountability within the organization without a formal process for evaluating regional office performance in conducting contractor oversight activities. To evaluate regional office performance, HCFA would need to set expectations and develop standards for assessing regional offices' oversight performance, provide constructive feedback to the regions, and make comparative performance information available to the HCFA Administrator. So far, none of these steps has been taken. Finally, HCFA has not yet determined what steps it will take to deal with regions that may have less than satisfactory performance, a difficult challenge at best.

For the 1999 review process, HCFA took a positive step by specifying the contractors and evaluation areas to be reviewed. This was based more on the judgment of central office staff than on any formal risk assessment. We have recommended that HCFA use a consistently applied risk assessment methodology to help ensure that limited agency resources are used effectively. Although it has taken some initial steps, HCFA still does not have a process for ensuring that an appropriate level of resources and staff with the right skills are available for the long term and are properly positioned within the organization to perform efficient and effective contractor oversight.

Finally, the instructions for the annual CPE reviews have improved because they provide more detailed and consistent direction for regional office reviewers. However, issuing instructions late in the fiscal year hampers effective continuous oversight. Communication tools such as teleconferences can facilitate central and regional office cooperation, but do not replace consolidated, up-to-date information for reviewers. Consolidating review information and keeping it up to date would give HCFA reviewers a single source to consult for all relevant information and help ensure that they are aware of all key guidance. Likewise, identifying and sharing best oversight practices among all reviewers is a step that HCFA agrees will enable it to more effectively oversee contractors.

## Recommendations to the Administrator, Health Care Financing Administration

To enhance HCFA's central and regional offices' effectiveness in overseeing Medicare claims administration contractors, we recommend that the HCFA Administrator take the following steps:

1. Improve accountability for contractor oversight by establishing a system to evaluate and hold regional staff accountable for their oversight activities.
2. Ensure that central and regional office resources are applied appropriately to the review process by
  - using a structured, documented risk assessment process for identifying specific contractors or evaluation areas to be reviewed each year, and
  - determining what resources are needed for effective contractor oversight and how they should be deployed for maximum effectiveness.
3. Improve intra-agency communication and information sharing by
  - ensuring that annual instructions to the regional offices for conducting CPEs are issued on a timely basis;
  - directing that regional offices be provided up-to-date, consolidated guidance in the regional manual, electronically, or through other means; and
  - establishing a formal program to identify and routinely communicate information on best oversight practices.

## Agency Comments and Our Evaluation

In written comments (which are reproduced in app. I) on a draft of this report, HCFA agreed with our recommendations and discussed steps it has begun or is planning to take to address the challenge of providing effective oversight. In its comments, HCFA reaffirmed its commitment to strengthening its oversight of Medicare contractors. It also provided technical comments, which we incorporated in this report as appropriate. In response to our previous report on contractor oversight, HCFA implemented a multifaceted plan to improve the oversight of Medicare contractors, which is detailed in this report and in HCFA's comments.

HCFA agreed with our recommendation to improve accountability for contractor oversight by establishing a system to evaluate and hold regional

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staff accountable for their oversight activities. Just recently, HCFA consolidated responsibility for contractor management within each consortium by establishing the position of Consortium Contractor Management Officer. Although we have not had sufficient time to evaluate this initiative, we believe it may help HCFA better meet its oversight challenges. In addition, HCFA is working with a contractor to design a formal evaluation process for regional office performance in implementing contractor oversight policies and procedures. HCFA is also planning to identify performance standards for contractor management that can be incorporated into the work plans for responsible staff.

With regard to using a risk assessment tool and resource targeting to help focus oversight efforts, HCFA agreed in principle on the use of a risk assessment to decide on oversight priorities. Nevertheless, HCFA cautioned that special factors—such as senior management concern about the integrity of a specific contractor—need to be considered when selecting specific contractors or business functions to review. HCFA is having a contractor evaluate its assessment tool to better address program risk, including how to integrate special factors into a structured assessment process. HCFA said that the Medicare Contractor Oversight Board has reviewed, and will continue to review, oversight plans to ensure that review efforts are appropriately ranked and funded. To assess human and financial resource needs for contractor oversight, HCFA has begun short- and long-term efforts. It is identifying staff in regional offices involved with contractor management and oversight and has also convened a work group to assess the resources needed—both human and financial. This will dovetail with an agencywide workforce planning project, intended to serve as the basis for tactical plans for recruitment, succession planning, training and development, and staffing or redeployment.

HCFA outlined a number of steps to address our third recommendation, which focused on steps to improve intra-agency communication and information sharing. As we and the agency have noted, HCFA has already taken a number of steps to improve the CPE process. HCFA anticipates providing its fiscal year 2000 oversight instructions to its regional review staff in March—earlier than in previous years—and plans to begin developing annual instructions even earlier for fiscal year 2001 in order to give review staff sufficient lead time for oversight visits. Further, HCFA plans to begin reviewing its regional office manual by late March to identify sections that need updating and will continue to use its “CPEExtras” as a formal means of providing regional offices with corrections, clarifications, and additions to prior guidance. Finally, in February 2000 HCFA conducted

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a national CPE best practices/lessons-learned conference, where staff from central and regional offices shared information and discussed proposed improvements for fiscal year 2000 and 2001 reviews.

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We will send copies of this report to the Honorable Nancy-Ann MinDeParle, Administrator of HCFA, and other interested congressional committees. We will also make copies available to other interested parties upon request.

Please contact me at (312) 220-7600 if you or your staff have questions about this report. Sandra Gove, Peter Oswald, and Don Walthall prepared this report under the direction of Sheila Avruch.



Leslie G. Aronovitz  
Associate Director, Health Financing and  
Public Health Issues

# Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

FEB 25 2000

Office of the Administrator  
Washington, D.C. 20201

**DATE:**

**TO:** William J. Scanlon  
Director, Health Financing and Public Health Issues

**FROM:** Nancy-Ann Min DeParle  
Administrator

**SUBJECT:** GAO Draft Report, "Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight"

Thank you for the opportunity to review and comment on your draft report to Congressman Bliley concerning the Health Care Financing Administration's work to increase oversight of Medicare contractors who process and pay Medicare claims. This report provides valuable information about the relationship in regard to our contractor oversight functions between the Regional Offices and Central Offices. We appreciate your acknowledgment of HCFA's efforts to address the challenges associated with effective oversight of Medicare contractors.

The law that created Medicare in 1965 required the program to use contracts with private insurance companies that already served as payers of health care services. These contractors, which in 1966 numbered more than 130, are responsible for all aspects of claims administration. Now only 55 Part A and Part B contractors handle nearly 1 billion claims for more than 1 million providers annually.

As noted in your report, in the past year, we took a number of important steps to strengthen oversight of the contractors who process and pay Medicare claims for nearly 40 million beneficiaries. Among the most significant steps taken were the establishment of the position of Deputy Director for Contractor Management within the Center for Beneficiary Services and the formation of a Medicare Contractor Oversight Board both of which have strengthened the Agency's contractor management and oversight activities.

HCFA has implemented a multi-faceted plan to improve the oversight of the Medicare contractors. Our plan for evaluating contractor's performance is detailed in our response to your previous report on Medicare Contractors (GAO/HEHS-99-115). In FY 1999, HCFA began development of standardized review protocols for important business functions such as program safeguards, developed national performance review teams comprised of Regional Office and Central Office staff, and improved training.

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In FY 2000 we will expand both the number of national review teams and standardized review protocols, and implement standardized management information reports for contractor management and oversight. We learned many valuable lessons from successfully achieving Y2K compliance at all our Medicare contractors and are incorporating many best practices into our ongoing contractor management program. We initiated a Continuous Improvement Program for contractor performance evaluation (CPE) which will evaluate the current process, identify best practices and provide feedback to management and staff involved in CPE.

The President's FY 2001 budget request builds upon these initiatives and asks Congress for additional resources to strengthen contractor oversight through evaluating and improving review protocols, developing clear and measurable contractor performance standards, developing a contractor performance management information system, and creating an integrated general ledger accounting system. In addition, the administration is again proposing contractor reform legislation, as we have a number of times. If enacted, this legislation would provide the Secretary with more contracting flexibility, bring Medicare contracting more in line with the standard contracting procedures used throughout the Federal government, and create an open marketplace so we do not have to rely on a steadily shrinking number of contractors. In the previous GAO report on Medicare Contractors, the GAO shared our view regarding the need to update our contracting authorities

In the past year, not only did we clarify accountability for contractor oversight in Central Office but we also began to examine the relationship between HCFA's Central Office and Regional Offices for the management and oversight of the Medicare contractors. Ten regional offices, organized into four consortia, each have direct contractor management and oversight responsibilities. To improve both the accountability within the regions and strengthen the reporting relationship between the Regional Offices and Central Office, HCFA is consolidating responsibility for contractor management within each consortium and establishing the Consortium Contractor Management Officer. We believe this change will substantially strengthen our oversight in the future.

Improving the management and oversight of HCFA's third-party contractors is a priority for this Agency as part of our commitment to taxpayers and beneficiaries who expect strong management of this important program.

An important initiative is our participation in the Council for Excellence in Government program. This program is designed to both teach our future leaders important management skills and to provide an opportunity to benchmark with private and public agencies to understand how other entities manage contractors. Approximately one half of the HCFA participants are from the Regional Offices and many are managers involved with the Medicare contractors.

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Attached are our comments on the specific recommendations in the report, a few general comments and our technical comments. Thank you, to you and your staff for the work put into producing this report, as well as the opportunity to review the draft report. We look forward to working closely with GAO on these and other issues in the future.

**Comments of the Health Care Financing Administration  
On the General Accounting Office Draft Report,  
“Medicare Contractors: Further Improvement Needed  
In Headquarters and Regional Office Oversight”**

**GAO Recommendation 1**

Improve accountability for contractor oversight by establishing a system to evaluate and hold regional staff accountable for their oversight activities.

**HCFA Comment**

We agree and as documented in the GAO report we have initiated steps to achieve these objectives.

Within the Central Office, although contractor management and oversight activities are dispersed among seven major components, the Deputy Director for Contractor Management in the Center for Beneficiary Services is the leader responsible for coordinating the management and oversight of the contractors. The Deputy Director for Contractor Management has consolidated responsibility for contractor management within the Agency and provides consistent policy direction and leadership to contractor oversight activities and provides support to the MCOB.

In the past year, we also began to examine the relationship between HCFA’s Central Office and Regional Offices for the management and oversight of the Medicare contractors. The 10 Regional Offices are organized into four consortia and the Consortium Administrator provides leadership to the Regional Offices and coordinates regional activities. To improve both the accountability within the Regional Offices and strengthen the reporting relationship between the Regional Offices and Central Office, HCFA is consolidating the leadership responsibility for the Regional Office management of contractors by establishing the position of Consortium Contractor Management Officer. Within each consortium, this individual will be accountable for the management of assigned contractors. To ensure consolidation of responsibility for contractor activities and provide central office program direction, this individual will report to both the Deputy Director for Contractor Management and the Consortium Administrator. The Consortium Contractor Management Office will also oversee the assigned staff. Any changes in the staffing complement for these duties will require concurrence by the Deputy Director and the respective Consortium Administrator.

HCFA agrees that an evaluation system can be established to emphasize the importance of HCFA staff being accountable for activities concerning the oversight of Medicare

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contractors. To evaluate Regional Offices, we need to set expectations and develop standards for assessing oversight performance and provide constructive feedback to the regions. In FY 1999, we began the training of Regional Office staff to ensure consistent application of rules and policies. Selected reports will be reviewed and feedback will be given to each Regional Office. As part of our Continuous Improvement Project for Contractor Performance Evaluation (CPE), in FY 2000 we are working with a contractor to design a formal evaluation process for Regional Office performance in implementing contractor oversight policies and procedures.

As noted in your report, for FY 2000, performance agreements for all Consortium and Regional Administrators recognize contractor oversight as a distinct responsibility and will be included in individual performance appraisals. We will identify various aspects of oversight responsibilities that can be evaluated, work with our Human Resources Management Group, and determine how best to incorporate these performance standards into the work plans of pertinent staff. As we place greater emphasis on national teams, we will work to establish an evaluation system that would apply both to Regional Office staff and Central Office staff involved in oversight.

A management information system is also critical for improved tracking of contractors. HCFA is initiating information systems to monitor critical activities related to the CPE process. This system will provide managers with the ability to monitor the plans of Regional Offices and the national teams for conducting CPEs, the status of these evaluations, and ensure timeliness and comparability of CPE reports across the regions. Information about the status of performance improvement plans based on findings in prior year evaluations will also be included.

**GAO Recommendation 2**

Ensure that Central and Regional Office resources are applied appropriately to the review process by:

- Using a structured, documented risk assessment process for identifying specific contractors or evaluation areas to be reviewed each year and,
- Determining what resources are needed for effective contractor oversight and how they should be deployed for maximum effectiveness.

**HCFA Comment**

We agree and as documented in the GAO report we have initiated steps to achieve these objectives. The Medicare Contractor Oversight Board (MCOB) has an important role in ensuring that resources are deployed for maximum effectiveness in the CPE process. In FY 2000, the MCOB identified business function units at our contractors requiring

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highest priority for review (i.e., financial internal controls, system security and program safeguard activities) and national team resources will be directed to these areas. Each business function unit is responsible for identifying issues for review and the development of necessary protocols. As we begin the formulation of the FY 2001 CPE, the MCOB will review the plans to ensure that the CPE process includes important HCFA initiatives, prioritize initiatives to maximize available staffing resources, and will review budget requests to ensure appropriate distribution of funding.

***Risk Assessment***

As already indicated, we developed and are using in FY 2000 a documented risk assessment tool. Risk assessments of all Medicare fee-for-service contractors in 11 different functional areas were conducted for the FY 2000 CPE process. We believe, however, other factors that are currently not quantified impact the yearly selection of contractors for national reviews and subject areas selected for review. Examples of such special factors or considerations are: awareness by senior management of concerns about the integrity of operations of a specific contractor or Medicare issue. Such factors need to be considered in addition to the risk assessment results. As part of our Continuous Improvement Program for CPE, we are having a contractor evaluate our risk assessment tool. With future refinements to the tool, we may be able to provide a numerical quantifier to some of the special factors.

***Resources***

Documenting both what resources -- human and financial-- are available and what are needed for effective contractor oversight has begun. Working with the Office of Internal Customer Support (OICS), we have initiated a short term project to identify the staff in the regional offices currently involved with contractor management and oversight. This information will be used to realign staff activities to a coordinated national and consortium approach instead of a regional office perspective. As the national team concept for CPE expands, staff will be assigned to teams to facilitate training, skills development and rapid deployment. Staffing information will also identify gaps for future work force planning.

A workgroup of Agency staff has been convened to evaluate what resources are necessary for contractor management. As part of our Continuous Improvement Project, we are monitoring all the resources, including staff and travel, necessary for CPE. National review teams with standardized protocols require more resources. To conduct an on-site audit of a single business function at contractor currently takes 3-5 staff working approximately 2 weeks. In cases where the review universe from which the sample is drawn is not readily available, additional time must be added. The audit of a functional area such as medical review can take up to 5 staff working 2 full weeks. This information

will be expanded to develop a comprehensive analysis of resource requirements. In FY 1999, HCFA initiated an agency-wide workforce planning project. This project consists of a four phase model: analyzing current and future work functions; developing current and future competency frameworks; identifying existing workforce competencies; and conducting an analysis of the gap between what is required and what we currently have. This process is being supplemented with retirement and retention analyses. The resulting workforce planning data will serve as the basis for tactical plans for recruitment, succession planning, learning and training, and staffing or redeployment. We anticipate having baseline workforce planning data available for inclusion in our FY 2002 budget request. This time frame also enables us to use the information to formalize hiring, staffing, and learning plans for FY 2001.

**GAO Recommendation 3**

Improve intra-agency communication and information-sharing by:

- Ensuring that annual instructions to the Regional Offices for conducting CPEs are issued on a timely basis,
- Directing that Regional Offices be provided up-to-date, consolidated guidance in the regional manual, electronically, or through other means, and
- Establishing a formal program to identify and routinely communicate information on best oversight practices.

**HCFA Comment**

We agree and as documented in the GAO report, HCFA initiated many improvements in the CPE process in FY 1999 designed to provide centralized direction to the program and improve intra-agency communication. Important initiatives were standardized review protocols, standard templates for reporting CPE and final reports, and CPEExtras. (CPEExtras are formal notices issued to the Regional Offices to provide operational information needed for CPEs. The CPEExtras are issued as needed and will be incorporated into the Regional Office Manual.) These initiatives are being expanded in FY 2000 and will also incorporate information we obtain from our best practice conference.

***Timely Annual Instructions***

In any given fiscal year, HCFA is carrying out work on three separate FY's CPE. While a current FY's CPE plan is being implemented and conducted, the planning, policy, and

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procedure development for the subsequent FY is commencing, and the evaluation of nationwide results and the preparation of the official notification to contractors of their overall performance evaluation findings are being written and released by HCFA for the previous year. As part of our Continuous Improvement Process for CPE, we are identifying these activities as separate functions and are beginning to develop separate functional units in Central Office for the formulation and execution of CPE. We are developing a project plan to complement the budget cycle and plan the formulation of FY 2001 CPE during the summer of this year. This altered timing will provide additional time for providing annual instructions to the Regional offices.

While not as early as is anticipated in future years, HCFA's Medicare Carrier and Intermediary Management Group expects to issue to the regions by the first week in March the instructions for the FY 2000 CPE review strategy. This will be a marked improvement over the May release of the FY 1999 instructions. The additional two months will provide extra time for teams to plan and conduct reviews. This will enhance the consistency and comparability of CPE reviews.

***Guidance and Training***

As noted in the GAO report, in FY 1999 HCFA provided training in CPE policies and procedures to national team members. In FY 1999, HCFA also began to standardize the CPE process. Specifically, we required the use of standards definitions of adverse CPE findings ("program deficiency" and "program vulnerability") and issued clear instructions on when to require a Performance Improvement Plan. Regional Office staff were trained in the use of the new reports and report definitions. Training for FY 2000 has begun and is designed to include both general information and review of specific protocols.

By the end of March 2000, staff from our Medicare Carrier and Intermediary Management Group will begin needed review of the Regional Office Manual (ROM) to identify the pertinent sections that need to be updated concerning contractor performance evaluation guidelines. For immediate needs in FY 2000, staff will also review all CPEExtras issued during FY 1999 to identify which ones may be reissued in their entirety as instructions for the current year's reviews, which need revisions and updates, and where new ones will be needed until the ROM rewrite is completed. Even after the manual is updated, we plan to issue CPEExtras to serve as formal means of providing regional offices with notification of corrections, clarifications, and additions to prior guidance.

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***Best Practice/Lessons Learned Conference***

HCFA conducted a national CPE best practice/lessons learned conference February 15-16, 2000. In attendance were over 80 Regional Office and 30 Central Office staff involved in contractor oversight and evaluation. Information was shared through panel presentations by managers and staff who participated in the FY 1999 national team review process. The attendees also participated in a number of breakout sessions to propose improvements for FY 2000 and FY 2001 reviews.

An important component of these conferences is feedback about the individual business function review protocols. Review protocols will need annual evaluation appraisal for needed revisions or rewrites to reflect changing business priorities as well as lessons learned from the use of the protocol in the prior year. We are planning conferences for exchanging information in future years and are exploring other venues such as a web page for sharing information on an ongoing basis.

# Activities HCFA Is Involved in Address Management Weaknesses

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HCFA has taken a number of steps to improve agencywide efforts to oversee Medicare claims administration contractors. Key among these steps are gathering more oversight information, providing regional offices with more detailed direction, and awarding two contracts to improve the Contractor Performance Evaluation process.

To gather more oversight information, HCFA is initiating systems to monitor activities related to CPEs and to collect information on contractor performance. A new information system provides the central office managers with the ability to monitor the plans of regional offices for conducting CPEs and the status of those evaluations. The central office is also routinely collecting information on the status of performance improvement plans to address contractor weaknesses identified by regional offices in prior evaluations. HCFA is also developing a system to collect more information on contractor performance activities through a direct link with their claims processing data systems. The agency believes that this system will prove useful as a contractor workload and risk management tool.

In addition to gathering more management information, the central office is providing more detailed direction and has conducted training sessions for regional reviewers. For the fiscal year 1999 evaluation cycle, the central office directed regional offices to review all contractors in 10 core evaluation areas and provided standardized reporting requirements. It also developed and provided to regional office reviewers standardized plans or protocols for evaluating contractors in key areas, including accounts receivable, fraud and abuse, medical review, and the implementation of HCFA instructions. Regional office staff generally agreed that the standardized evaluation plans help promote greater consistency. HCFA believes that using protocols will facilitate comparisons of performance across contractors. The central office also sent regional reviewers instructions via e-mail, in what HCFA calls "CPEExtras," to notify them about modifications and clarifications to CPE guidance. Among other things, the central office told reviewers that they should not give contractors more than 3 business days' advance notice of a planned on-site visit or allow contractors to select review samples.

Although many of the steps HCFA has taken were focused on improving the fiscal year 1999 evaluation cycle, others are focused on the future. For example, HCFA recently awarded two contracts to help make CPE data more useful and to improve the review process. The first contract is to develop an agencywide database for contractor performance evaluation

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**Appendix II**  
**Activities HCFA Is Involved in Address**  
**Management Weaknesses**

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data, including review plans and evaluation reports. Currently, HCFA estimates that reviewers file about 800 CPE reports annually in a variety of software formats. The CPE report database is due to be completed in early 2000, followed by testing, training, and final implementation. Tasks included in the second contract include conducting a CPE lessons-learned conference, evaluating resource requirements for the CPE process, and refining and developing CPE protocols. The contractor is expected to recommend a number of ways to improve the CPE process. Specific areas to be addressed include national review teams, advance notice of reviews to contractors, sample selection, minimum training and requisite skills for CPE reviewers, the CPE reporting process, an evaluation program for assessing the performance of regional office CPE oversight activities, and the appropriate organizational components for managing the CPE program. The final phase of this project is expected in November 2000.

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# Related GAO Products

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*Medicare: HCFA Oversight Allows Contractor Improprieties to Continue Undetected* (GAO/T-HEHS/OSI-99-174, Sept. 9, 1999).

*Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors* (GAO/T-HEHS/OSI-99-167, July 14, 1999).

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

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

*HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century* (GAO/T-HEHS-99-58, Feb. 11, 1999).

*Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy* (GAO/AIMD-98-284, Sept. 28, 1998).

*Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities* (GAO/HEHS-98-160, June 1, 1998).

*Medicare: Control Over Fraud and Abuse Remains Elusive* (GAO/T-HEHS-97-165, June 26, 1997).

*High-Risk Series: Medicare* (GAO/HR-97-10, Feb. 1997).

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