

August 2005

**MEDICARE  
CONTRACTING  
REFORM**

**CMS's Plan Has Gaps  
and Its Anticipated  
Savings Are Uncertain**



GAO  
Accountability · Integrity · Reliability

# Highlights

Highlights of [GAO-05-873](#), a report to congressional committees

## Why GAO Did This Study

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly reformed contracting for the administration of claims for Part A, Medicare's hospital insurance, and Part B, which covers outpatient services such as physicians' care. The MMA required the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers Medicare—to conduct full and open competition for all of its claims administration contracts and to transfer the work to Medicare administrative contractors (MAC) by October 2011. The MMA required the Secretary of HHS to submit a report to the Congress and GAO on the plan for implementing Medicare contracting reform and for GAO to evaluate the plan. To address this mandate, GAO reviewed the extent to which (1) the plan provides an appropriate framework for implementing Medicare contracting reform and (2) the plan's cost and savings estimates are sound enough to support decisions on implementation.

## What GAO Recommends

GAO recommends that CMS extend its implementation schedule from 2009 to 2011, to be better prepared to manage contracting reform. CMS did not concur with the recommendation, but GAO believes that extending the time frame is the most prudent approach to manage contracting reform risks.

[www.gao.gov/cgi-bin/getrpt?GAO-05-873](http://www.gao.gov/cgi-bin/getrpt?GAO-05-873).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or [aronovitzl@gao.gov](mailto:aronovitzl@gao.gov).

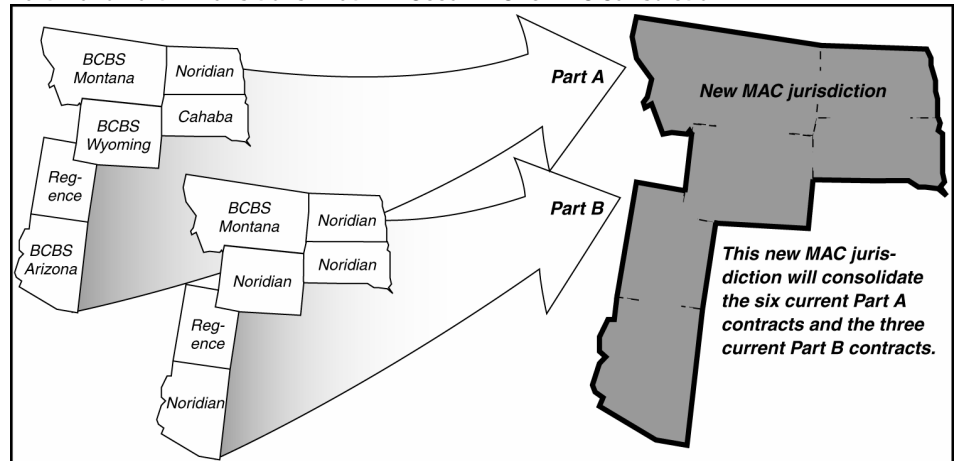
# MEDICARE CONTRACTING REFORM

## CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain

### What GAO Found

CMS's plan provides an appropriate framework to implement contracting reform in some critical areas but not in others. For example, the plan indicates the rationale for reform but lacks a detailed schedule to coordinate reform activities with other major initiatives CMS intends to implement at the MACs during the same period. Further, CMS's plan does not comprehensively detail steps to address potential risks during the transitions of the claims workload from the current contractors, such as failing to pay providers or paying them improperly. These transitions will be complex to manage because they require moving multiple claims workloads from current contractors to a single MAC with new jurisdictional lines. As the figure shows, as many as nine separate segments of current contractors' workload will be moved to the first A/B MAC. CMS has accelerated its schedule to transfer the current contractor claims workload to MACs by 2009, more than 2 years ahead of the MMA's time frame. This schedule leaves little time for CMS to adjust for any problems encountered.

Part A and Part B Transitions That Will Occur in One MAC Jurisdiction



Source: GAO.

CMS's estimates of costs and savings are too uncertain to support decisions on contracting reform implementation. First, CMS's internal cost estimate for a 6-year implementation period of about \$666 million is based on reasonable data but questionable assumptions about contract awards. Second, its estimate of \$1.4 billion in savings from reductions in improper payment by MACs depends on questionable evidence and assumptions that were never validated by knowledgeable CMS staff. However, the \$1.4 billion estimate prompted CMS to accelerate its implementation schedule to accrue savings as rapidly as possible. While it is reasonable to assume that contracting reform will result in savings, the actual amount could differ greatly from the estimate. Basing an accelerated implementation schedule on uncertain savings raises concerns that CMS has unnecessarily created additional challenges to effectively managing the risk of these transitions.

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## Abbreviations

BCC	beneficiary contact centers
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
DOD	Department of Defense
FAR	Federal Acquisition Regulation
HH	home health and hospice
HHS	Department of Health and Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
IT	information technology
MAC	Medicare administrative contractor
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
PSC	program safeguard contractor

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United States Government Accountability Office  
Washington, DC 20548

August 17, 2005

The Honorable Charles E. Grassley  
Chairman  
The Honorable Max Baucus  
Ranking Minority Member  
Committee on Finance  
United States Senate

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

The Honorable William M. Thomas  
Chairman  
The Honorable Charles B. Rangel  
Ranking Minority Member  
Committee on Ways and Means  
House of Representatives

Since the inception of the Medicare program in 1965, the contractors that process and administer medical claims have played a critical role in serving both beneficiaries and providers. For example, in fiscal year 2004, these contractors processed over 1 billion health care claims and provided customer service to about 36 million beneficiaries and over 1 million health care providers. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)<sup>1</sup> significantly changed Medicare law covering contracting for claims administration services by the Centers for Medicare & Medicaid Services (CMS)<sup>2</sup>—the agency within the Department of Health and Human Services (HHS) that administers the program. CMS

<sup>1</sup>Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378—2386 (to be codified at 42 U.S.C. § 1395kk-1).

<sup>2</sup>Until July 1, 2001, CMS was called the Health Care Financing Administration. We use the name CMS throughout this report.

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refers to these changes, which are intended to improve service to beneficiaries and health care providers, as Medicare contracting reform.

The implementation of contracting reform will fundamentally change Medicare claims administration contracting practices. Since the beginning of the Medicare program, CMS has generally been exempt from requirements to competitively select claims administration contractors or follow certain other procedures that usually apply to the selection and management of government contractors. However, the MMA required CMS to use competitive procedures to select Medicare administrative contractors (MAC) and to follow the Federal Acquisition Regulation (FAR),<sup>3</sup> except where specific MMA provisions differ. The MMA required CMS to transfer the work of current claims administration contractors to MACs by October 2011. It also required the Secretary of HHS to submit a report to the Congress and GAO on HHS's plan to implement the Medicare contracting reform provisions by October 1, 2004. This report was submitted on February 7, 2005.<sup>4</sup> CMS has designated the *Report to Congress* and related documents, taken together, as its plan for implementing Medicare contracting reform. These documents are listed in appendix I.

The MMA also required GAO to evaluate and report on CMS's contracting reform plan no later than 6 months after the date that CMS's report was received. To address this mandate, as discussed with the committees of jurisdiction, we reviewed (1) the extent to which the plan provides an appropriate framework for implementing Medicare contracting reform and (2) the extent to which the plan's cost and savings estimates are sound enough to support decisions on contracting reform implementation.

In preparing this report, we reviewed relevant sections of the MMA, documents prepared to help CMS plan for contracting reform, and GAO guidance on assessing federal agencies' procurement functions and improving how mission-critical work is accomplished. These documents are listed in appendix II. From these documents, we developed evaluation criteria and used them to review CMS's contracting reform plan.<sup>5</sup> Our

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<sup>3</sup>48 C.F.R. ch. 1 (2004).

<sup>4</sup>Department of Health and Human Services, *Report to Congress: Medicare Contracting Reform: A Blueprint for a Better Medicare* (Washington, D.C.: Feb. 7, 2005).

<sup>5</sup>We reviewed the *Report to Congress* and additional documents that CMS designated as part of its contracting reform plan that the agency provided to us by June 3, 2005.

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evaluation criteria are presented in appendix III. We also reviewed the information and assumptions on which the plan's cost and savings estimates were based. In addition, we interviewed officials at CMS's headquarters and regional offices, four current Medicare claims administration contractors, and CMS's actuarial contractor about the contracting reform plan and how it was developed. Appendix IV includes a more detailed discussion of our scope and methodology. We performed our work from November 2004 through July 2005 in accordance with generally accepted government auditing standards.

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## Results in Brief

CMS's plan for contracting reform provides detailed information and an appropriate implementation framework in some critical areas but not in others. For example, the plan provides detailed information on the reasons for, and benefits expected from, contracting reform; the organization of current and future Medicare claims administration contractors; the MAC contracting implementation schedule; and CMS's strategy for communicating information to potential contractors, providers, and beneficiaries. On the other hand, the plan does not provide detailed information on the risks of contracting reform and steps to mitigate them. Implementation of contracting reform is an inherently high-risk activity because it will involve complex transitions of claims workloads from current contractors to MACs. CMS has experience in transferring up to 10 percent of the claims administration workload in a year. In 13 of the past 15 years, CMS has transferred at least one contractor's workload, during transitions that took an average of 6 to 9 months, with some lasting as long as a year. However, the scale of the proposed transitions is much greater, since CMS plans to transfer as much as 91 percent of the annual Medicare claims processing workload—which represents an estimated \$250 billion in payments to providers—to MACs in less than 2 years. Furthermore, CMS is proposing to transfer all work to MACs by July 2009, which is more than 2 years ahead of the MMA's specified time frame. If these transitions go awry, physicians and other providers could experience payment delays and errors. Further, the plan does not fully detail how CMS intends to implement MAC contracting. For example, the plan does not fully explain CMS's strategy for monitoring MACs' performance. In addition, the plan does not fully explain how CMS will manage contracting reform while also implementing the Medicare prescription drug benefit and the expansion of options available to Medicare beneficiaries who enroll in private plans. Finally, it does not detail how CMS will coordinate the scheduling of contracting reform activities with other interrelated initiatives that must be implemented concurrently at the MACs, such as upgrades to CMS's information and



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accounting systems. Having a schedule for implementing the interrelated initiatives is critical, because delays in one initiative could easily affect others. CMS officials have taken initial steps to deal with critical areas that are not fully developed, but they have not completed planning for them. For example, officials have identified some factors that may pose a risk to MAC implementation, but they have not decided on steps to mitigate them.

The plan's cost and savings estimates are too uncertain to support decisions on contracting reform implementation because they are based on future developments that are difficult to predict. CMS estimates that contracting reform would cost about \$666 million to implement during a 6-year period, a much higher amount than the one indicated in the *Report to Congress*, because that document did not include funding anticipated to be needed beyond 2006. CMS used its data on the costs of previous transitions of claims workloads from one contractor to another as a basis to develop a transition cost amount. However, to develop an overall cost estimate, CMS had to make assumptions about how many contractors will take on new claims workloads and the size of these workload transitions. Because CMS does not know which contractors will compete and win contracts for specific workloads, it is difficult to predict how much contracting reform implementation will cost. Second, the total savings estimate of over \$1.9 billion for a 6-year implementation period relies on the expectation that MACs will reduce improper payments by over \$1.4 billion through more effective medical reviews of claims. The \$1.4 billion savings estimate, which was developed by an external consultant, is based on questionable evidence and assumptions that were not validated by the CMS staff who oversee medical reviews. While it is reasonable to assume that contracting reform will eventually lead to program savings, the exact level of savings is impossible to predict and could differ greatly from the consultant's estimates. Despite this, in order to benefit from the projected savings as soon as possible, CMS accelerated its implementation schedule for contracting reform. Basing an accelerated implementation schedule on such uncertain savings raises concerns that CMS has unnecessarily created additional challenges to effectively managing the risks and complexities of contracting reform. As a result, we recommend that CMS extend its implementation schedule to complete its workload transitions by October 2011, so that the agency can be better prepared to manage its contracting reform activities.

In its written comments on a draft of this report, CMS did not concur with our recommendation. (See app. V). CMS stated that it would be able to achieve savings to the Medicare trust funds and operational efficiencies more quickly by fully implementing MAC contracting in 2009. We believe

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that our recommendation to extend the time frame for implementation represents a prudent approach that would allow more time for planning and better enable CMS to manage complex transitions and make needed midcourse adjustments.

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## Background

Federal agencies are generally permitted to contract with any qualified entity for any authorized purpose so long as that entity is not prohibited from receiving government contracts and the contract is not for an inherently governmental function. Agencies are required to use contractors that have a satisfactory record of integrity and business ethics, a record of successful past performance, and the financial and other resources needed to perform the contract. The FAR generally requires agencies to conduct full and open competition for contracts. Under the FAR, a federal agency may terminate a contract either for the government's convenience or if the agency determines that the contractor is in default. The contractor does not have similar rights to terminate its contract with the government. The FAR also provides agencies with several methods to pay contractors—some of which allow for financial incentives for meeting performance goals.

Because of provisions in the Social Security Act, Medicare claims administration contracting had unique features that differed from most other federal contracting. Before Medicare was enacted in 1965, providers had been concerned that the program would give the government too much control over health care. To increase providers' acceptance of the new program, the Congress ensured that health insurers like Blue Cross and Blue Shield, which already served as payers of health care services to physicians and hospitals, became the contractors paying providers for Medicare services. Medicare's authorizing legislation specified that contractors called fiscal intermediaries would administer Part A and Part B claims paid to hospitals and other institutions, such as home health agencies.<sup>6</sup> Contractors called carriers would administer the majority of Part B claims for the services of physicians and other providers. By law, Medicare was required to choose its fiscal intermediaries from among organizations that were first selected by associations representing

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<sup>6</sup>Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health care services, and hospice care. Part B services include physician and outpatient hospital services, diagnostic tests, mental health services, outpatient physical and occupational therapy, ambulance services, some home health services, and medical equipment and supplies.

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providers, a process called provider nomination. Medicare was also required to choose health insurers or similar companies to serve as its carriers and, by statute, did not have to award the contracts through competition. In addition, Medicare contracts were generally renewed each year. As a result, since the inception of the program, most Medicare claims administration contracts have been awarded and renewed on a noncompetitive basis, with limited exceptions.<sup>7</sup> Contractors could not be terminated from the program unless they were first provided with an opportunity for a public hearing—a process not afforded under the FAR. Unlike other federal contractors, claims administration contractors could terminate their contracts. In addition, the contractors were paid on the basis of their allowable costs, generally without financial incentives to encourage superior performance.<sup>8</sup>

The MMA required CMS to significantly change its contracting arrangements and follow the FAR, except to the extent inconsistent with a specific requirement of the MMA. The MMA removed the specific procedures for selecting fiscal intermediaries and carriers, and unlike CMS's existing contracts, MAC contracts must be fully and openly recompeted at least every 5 years. In addition, the new contracts will also contain performance incentives for contractors. Finally, MACs will not be permitted to default on their contracts or terminate their contracts as allowed under current contracting practices. Contract termination will follow the requirements of the FAR, which allow the government to terminate contracts for its convenience or for contractor default.

MACs will assume work that is currently performed by 51 claims administration contractors. At present, there are 25 fiscal intermediaries and 18 carriers. In addition, four durable medical equipment (DME) regional carriers pay claims submitted by suppliers of DME, prosthetics,

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<sup>7</sup>For example, from 1977 through 1986, eight competitive contracts, which were designed to consolidate the workload of two or more small contractors, were established on an experimental basis. More recently, in 2004, CMS conducted a competitive procurement to replace the fiscal intermediary for Washington and Alaska. However, the competition was limited to Medicare fiscal intermediaries and carriers.

<sup>8</sup>The Social Security Act generally provided that Medicare use cost-based reimbursement contracts, under which contractors are reimbursed for necessary and proper costs of carrying out program activities. These contracts did not expressly provide for profit. Nevertheless, since the 1980s, CMS has had some limited authority to build financial incentives into contracts. See 42 U.S.C. § 1395h note (2000).

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orthotics, and supplies, and four regional home health intermediaries process home health and hospice (HH) claims.

CMS plans to select 23 MACs to serve specific jurisdictions, including 15 A/B MACs, which will process both Part A and Part B claims; 4 DME MACs, which will process claims for DME, prosthetics, orthotics, and supplies; and 4 HH MACs, which will process claims for HH care. CMS's current schedule calls for the full fee-for-service contracting workload<sup>9</sup> to be transferred to MACs by July 2009.<sup>10</sup> CMS plans to conduct competitions for existing Medicare contractor workloads beginning with a start-up acquisition and transition cycle for the 4 DME MACs and 1 A/B MAC. The start-up cycle will be followed by two additional acquisition and transition cycles. Appendix VI shows CMS's schedule and timing for competing all of the MAC contracts.

MACs will be responsible for most of the functions currently performed by fiscal intermediaries and carriers. They will process and pay claims, handle first-level appeals of denied claims,<sup>11</sup> and serve as providers' primary contact with Medicare. In addition, they will coordinate with CMS's functional Medicare contractors that perform limited Medicare functions on a national or regional basis, such as answering the 1-800-MEDICARE help line, coordinating Medicare and other insurance benefits, and conducting program safeguard activities. For example, the functional Program Safeguard Contractors (PSC) conduct activities to prevent or address improper payments—such as investigating potential fraudulent billing related to the claims paid by the claims administration contractors.<sup>12</sup>

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<sup>9</sup>Workload is the total work performed by a Medicare claims administration contractor, with the amount usually expressed as the number of claims processed annually.

<sup>10</sup>After the MAC contracts are awarded, the work performed by the outgoing Medicare claims administration contractors will be transferred to MACs. These transition activities include transferring data, records, and other functions to MACs.

<sup>11</sup>Beneficiaries and Medicare providers, on behalf of their beneficiaries, can appeal denied claims for services. At the first appeal level, the Medicare claims administration contractor reexamines the claim along with any additional documentation provided by the appellant. If the contractor upholds the decision to deny the claim, the appellant may appeal the decision further.

<sup>12</sup>CMS contracted for the PSCs as part of the Medicare Integrity Program, created by the Health Insurance Portability and Accountability Act of 1996. In addition to the activities cited above, PSCs conduct cost report audits and provider education related to program safeguard activities.

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MACs' responsibilities for medical reviews of claims;<sup>13</sup> benefit integrity, which involves the investigation of suspected fraud;<sup>14</sup> and beneficiary inquiries will differ in some respects from those of the current claims administration contractors. Currently, three of the four DME regional carriers conduct their own medical reviews and benefit integrity activities for the claims they process.<sup>15</sup> Under contracting reform, PSCs will be responsible for performing all medical reviews and benefit integrity activities related to the claims processed by the DME MACs. These responsibilities will be allocated differently for A/B MACs. All A/B MACs will conduct medical reviews of the Part A and Part B claims they will process, while PSCs will be responsible for conducting benefit integrity activities related to these claims.<sup>16</sup> The current Medicare claims administration contractors respond to beneficiaries' questions that are specific to their claims, while staff from 1-800-MEDICARE answer general questions on the telephone help line. In the future, staff at beneficiary contact centers (BCC) will answer calls placed to 1-800-MEDICARE and assume the role of responding to general and claims-specific questions. MACs will be responsible for responding to more complex inquiries from beneficiaries that require a more advanced understanding of Medicare claims processing or coverage rules.

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## CMS's Plan Does Not Provide an Appropriate Implementation Framework in All Critical Areas

CMS's plan for contracting reform provides detailed information—and an appropriate framework for implementation—in some, but not all, critical areas. For example, the plan presents detail on the proposed schedule for MAC implementation. Nevertheless, as figure 1 shows, the plan does not provide detailed information on the risks associated with contracting

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<sup>13</sup>Medical reviews of submitted claims are conducted either before or after payment to determine if the claims should be, or should have been, paid. Claims are reviewed to see if the beneficiaries' conditions meet the Medicare coverage criteria. If medical reviews identify claims that should not have been paid, the Medicare claims administration contractor that paid the claim is responsible for collecting overpayments.

<sup>14</sup>Investigation of suspected fraud can involve conducting a more detailed analysis of claims and other investigative steps. Once a case has been developed, it is referred to HHS's Office of Inspector General or to other law enforcement agencies for investigation or prosecution.

<sup>15</sup>One PSC currently conducts medical reviews and benefit integrity activities for the claims processed by the remaining DME regional carrier.

<sup>16</sup>PSCs currently conduct medical reviews of claims processed by 2 fiscal intermediaries and 2 carriers. The remaining 23 fiscal intermediaries and 16 carriers conduct their own medical reviews of the claims they process.

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reform, some aspects of CMS's implementation approach, and the integration of reform activities with other initiatives. CMS has recently taken steps to address areas of the plan where details and complete information were lacking, as part of its ongoing planning efforts. However, key decisions relating to critical areas are yet to be made and incorporated into its plan.

**Figure 1: Areas of Detailed Information in CMS's Contracting Reform Plan**

<p><b>The plan provides detailed information on</b></p> <ul style="list-style-type: none"><li>• the rationale for implementing contracting reform;</li><li>• the organization of current and future claims administration services, including the types of claims current claims administration contractors process and the geographic areas they serve;</li><li>• the proposed MAC implementation schedule; and</li><li>• CMS's strategy for communicating information about contracting reform.</li></ul> <p><b>The plan does not provide detailed information on</b></p> <ul style="list-style-type: none"><li>• the risks associated with implementing contracting reform and planned risk mitigation steps;</li><li>• some aspects of CMS's approach to implementing the MAC contracting environment, including how MACs will coordinate their functions with those of other contractors; and</li><li>• CMS's integration of ongoing contracting reform activities with other complex and interrelated ongoing initiatives, such as modernizing CMS's information and accounting systems.</li></ul>
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Source: GAO analysis of CMS's plan for contracting reform.

**CMS's Plan Provides Useful Information about Some Aspects of Implementation**

CMS's plan provides a clear discussion of the reasons for implementing contracting reform, including the restrictions and weaknesses in the current system, as shown in table 1. The plan also recognizes the benefits of improving Medicare contracting for beneficiaries and providers, such as providing a single point of contact for providers' claims-related inquiries.

**Table 1: CMS's Analysis of Restrictions or Weaknesses in Medicare Claims Administration Contracting and Their Associated Effects**

<b>Restriction or weakness in current system</b>	<b>Effects of current restriction or weakness</b>
Lack of full and open competition	CMS lacks the flexibility to choose qualified organizations to process Medicare claims through full and open competition. Provider institutions, such as hospitals, nominate fiscal intermediaries to process Part A claims, which limits CMS's ability to manage the program effectively. The Secretary of HHS is required, by law, to choose Part B carriers from health insurers or similar companies and did not have to compete these contracts.
Separate processing of Part A and Part B claims	Part A and Part B claims are generally processed by separate claims administration contractors and claims processing systems. For example, a beneficiary with a hospital stay followed by home health care will have hospital and some home health claims paid by a fiscal intermediary, while other home health and physician claims will be paid by a carrier. This division of responsibilities for claims payment sometimes makes it difficult for beneficiaries and providers to have their questions answered quickly. Providers also face increased expenses due to separate processing and are limited in their ability to understand and coordinate services on behalf of their patients.
Specialization restrictions	CMS is limited in its ability to award separate contracts for individual claims administration activities in which certain companies may excel, such as operating data centers or educating providers about program rules.
Absence of performance-based incentives	Contractors work under cost-based reimbursement contracts through which they are reimbursed for the necessary and proper costs of carrying out Medicare activities, but do not have financial incentives to improve their performance.
Cumbersome termination procedures	Contractors are allowed to terminate their contracts without cause, simply by providing 180 days notice. CMS, on the other hand, has to demonstrate that a poorly performing or unresponsive contractor has failed substantially to carry out its contract, or that continuation of the contract is disadvantageous or inconsistent with the effective administration of Medicare before it is able to terminate a contract. CMS is also required to provide the contractor an opportunity for a hearing before termination.
Outdated information technology (IT)	Medicare's IT infrastructure is inadequate for the program's expanding needs and does not take advantage of current technologies (e.g., use of the Internet to submit and track claims) that would improve customer service and result in additional cost savings.

Source: GAO analysis of CMS's *Report to Congress*.

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The plan also provides maps of the current jurisdictions of Medicare contractors and future jurisdictions of MACs. A CMS official told us that the agency took beneficiaries' patterns of care into account when drawing jurisdictional lines. In addition, according to the plan, CMS designed the new MAC jurisdictions, which were based on state boundaries, to achieve operational efficiencies, promote competition, and better balance the allocation of workloads. For example, there are one fiscal intermediary and three carriers currently serving New York, as well as two fiscal intermediaries and one carrier serving Connecticut. Under contracting reform, one A/B MAC will administer Part A and Part B claims for beneficiaries residing in these two states.

Currently, different claims administration contractors handle Part A and Part B claims in the majority of states.<sup>17</sup> For example, in Michigan, United Government Services processes Part A claims, and Wisconsin Physicians Service Insurance Company processes Part B claims. In addition, while some current contractors serve one state, others serve several—sometimes noncontiguous—states. For example, Blue Cross Blue Shield of Arizona processes Part A claims exclusively in Arizona, while National Heritage Insurance Company processes Part B claims on the East Coast in Maine, New Hampshire, Vermont, and Massachusetts and, on the West Coast, in California. The varying jurisdictions for contractors that process Part A and Part B claims have resulted in what CMS's plan terms "a patchwork of responsibility and service."<sup>18</sup> CMS has developed 15 distinct, nonoverlapping geographic jurisdictions for the A/B MACs.<sup>19</sup> Appendixes VII, VIII, IX, X, XI, and XII show the jurisdictional maps for the current fiscal intermediaries, the current carriers, the current regional home health intermediaries, the current DME regional carriers, the 15 new A/B MACs, and the 4 new DME MACs and 4 new HH MACs. A CMS official stated that while the A/B MACs' jurisdictions continue to vary somewhat in size and workload, they are reasonably balanced in terms of the numbers of fee-for-service beneficiaries and providers served.<sup>20</sup> However,

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<sup>17</sup>As of October 1, 2004, different contractors processed Part A and Part B claims in 39 states and the District of Columbia, and the same contractor processed both Part A and Part B claims in 11 states.

<sup>18</sup>Department of Health and Human Services, *Report to Congress*, I-2.

<sup>19</sup>CMS aligned the jurisdictions so that the 15 A/B MAC jurisdictions fit within the boundaries of the 4 DME MACs and the 4 HH MACs. Jurisdictions are identical for the DME MACs and the HH MACs.

<sup>20</sup>According to CMS, the new MAC jurisdictions will include from 1.1 million to 3.4 million beneficiaries and from 21,000 to 76,000 physicians.



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CMS officials have stated that companies might be able to win more than one MAC contract, and, if so, their workloads in multiple jurisdictions would potentially be greater than those of companies that win contracts for a single jurisdiction.

In addition to providing information on MACs' jurisdictions, CMS's plan provides timelines for implementing MAC contracting, including anticipated contract award dates for the start-up cycle and two subsequent cycles. CMS plans to monitor each cycle, including transitions, and to adjust the implementation schedule if necessary. The start-up cycle, which will result in the award of four contracts to DME MACs and one contract to an A/B MAC, should provide CMS with experience that can be applied to the next two cycles. For example, the start-up cycle will allow new CMS personnel to obtain additional expertise, if needed, on contracting activities. It will also allow CMS to examine its acquisition and transition efforts and apply lessons learned to future cycles.

Recognizing that open communication with stakeholders is important to the successful implementation of contracting reform, CMS's plan incorporates a written strategy to provide information and solicit questions, comments, and feedback on Medicare contracting reform from potential MACs, providers, and beneficiaries. This communication strategy includes periodically holding open meetings and establishing a Medicare contracting reform Web site.<sup>21</sup> For example, CMS hosted a series of open meetings in 2004 and 2005 to share information and seek input on aspects of its contracting reform plan, including MAC jurisdictions, draft statements of work,<sup>22</sup> and proposed performance standards.<sup>23</sup> In addition, CMS's Web site is routinely updated to provide answers to questions about contracting reform and provide access to important documents, such as its *Report to Congress*. The Web site also provides a link to a federal procurement Web site,<sup>24</sup> where draft and final versions of MAC statements of work can be found. Interested parties, including organizations

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<sup>21</sup>The Web site's address is [www.cms.hhs.gov/medicarereform/contractingreform/](http://www.cms.hhs.gov/medicarereform/contractingreform/). It was established on March 15, 2004.

<sup>22</sup>A statement of work is the portion of a contract that describes the actual work to be done by the contractor by means of specifications, performance dates, and quality requirements.

<sup>23</sup>The MMA required that CMS consult with providers, beneficiary organizations, and others on the development of performance requirements and standards for MACs.

<sup>24</sup>The Web site's address is <http://www.fedbizopps.gov/>. It provides information on federal government procurement opportunities over \$25,000.

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interested in competing for MAC contracts, provided feedback on these drafts through CMS's open meetings and its Web site. In developing certain areas of the contracting reform plan, CMS also sought input from its headquarters and regional office staff. For example, CMS teams worked collaboratively to develop the draft statements of work for A/B MACs and DME MACs.

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### CMS's Contracting Reform Plan Does Not Fully Address Three Critical Implementation Areas

While CMS's contracting reform plan provides detailed information in some areas, it does not comprehensively address (1) contracting reform risks and how the agency plans to mitigate them; (2) the intended approach for implementing certain aspects of MAC contracting, including details on how CMS will monitor MACs' performance; and (3) coordination of contracting reform activities with other complex initiatives that CMS is implementing. While a comprehensive contracting reform plan was due in October 2004, we found that the plan was still incomplete as of June 2005. The agency has begun to develop, but has not completed, a more detailed plan in critical implementation areas. Nevertheless, without having all of the critical elements of its plan in place, the agency is undertaking an accelerated schedule and intends to transfer all claims processing work to MACs by July 2009, more than 2 years ahead of the MMA's time frame.

### Plan Does Not Fully Address Implementation Risks

CMS's plan does not comprehensively address three major risks and indicate the steps that the agency plans to take to mitigate them. These are CMS's proposed implementation schedule, the volume and complexity of anticipated claims processing workload transitions, and the potential for voluntary contractor withdrawals. Each of these risks has the potential to disrupt claims administration services, resulting in delayed or improper payments to providers.

The *Report to Congress*—one of the documents in CMS's contracting reform plan—briefly noted that the anticipated implementation schedule “will require substantial risk management and schedule precision to minimize possible operational disruption.”<sup>25</sup> CMS's proposed implementation schedule calls for all work to be transferred to MACs by July 2009—more than 2 years ahead of the MMA's time frame. The initial

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<sup>25</sup>Department of Health and Human Services, *Report to Congress*, III-3.

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start-up acquisition cycle<sup>26</sup> is taking place in a 27-month period—from April 2005 to July 2007—during which about 9 percent of the national claims processing workload will be transferred to MACs. If CMS chooses current contractors that are administering claims in the MAC jurisdictions, the percentage of the workload transferred would be less. In the first phase of the start-up cycle, CMS will select and transfer workload to 4 DME MACs. In the second phase, CMS will select and transfer workload to 1 A/B MAC. Following the initial start-up cycle, CMS is planning two acquisition cycles, which will last from September 2006 to July 2009, during which it will select and transfer the remaining current contractors' work to 14 A/B MACs and 4 HH MACs. As part of these two cycles, in the 22 months from September 2007 to July 2009, CMS plans to manage transitions of as much as 91 percent of the annual Medicare claims processing workload, which represent an estimated \$250 billion in payments to providers.<sup>27</sup> The transition period for cycle one is 1 year, from September 2007 to September 2008, and the transition period for cycle two is 10 months, from September 2008 to July 2009. In 13 of the past 15 years, CMS has transferred at least one contractor's workload. These transitions took an average of 6 to 9 months, with some lasting as long as a year.

CMS decided on a more compressed schedule after initially considering a longer implementation period. In November 2004, CMS officials told us that they were planning to move to MAC contracting using six acquisition cycles to be completed around April 2011. According to the *Report to Congress*, CMS officials believed that the potential savings from contracting reform suggested that transferring larger portions of the workload to MACs in a shorter time frame would allow savings to accrue more quickly to the Medicare program.

Despite the ambitious time frame for implementation, CMS's plan does not provide detailed information on the risks involved in transferring large segments of Medicare's claims processing workload on an accelerated

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<sup>26</sup>Each acquisition cycle begins with the issuance of the request for proposals, which announces CMS's intent to award a contract. The cycle also includes a transition period, which begins with the award of the contract and ends when all work has been transferred to the MAC from the prior claims administration contractor.

<sup>27</sup>The first acquisition cycle will affect about 44 percent of the claims processing workload and the second acquisition cycle will affect about 47 percent. However, a smaller percentage of the claims workload may need to be transferred, since some of the current contractors may become MACs for jurisdictions that include part of their current service areas.

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schedule or outline contingency plans for the transitions to MACs. CMS's accelerated schedule for cycles one and two leaves little time for CMS to examine its acquisition and transition efforts, apply lessons learned, and resolve disagreements about the agency's award process with companies that were not selected. Furthermore, due to the accelerated cycle, interested companies—some of which may be among the best qualified to perform as MACs—may decide not to compete to win multiple MAC contracts because developing concurrent proposals or assuming the workload for more than one jurisdiction simultaneously might strain their resources. In addition, it may prove difficult for CMS staff to evaluate proposals, award contracts, and manage concurrent transitions within the proposed time frame.

CMS's plan does not provide details on its strategy for managing these compressed transitions with its anticipated staff resources. CMS officials expressed concerns to us that many of the staff most experienced in handling transitions were, or were close to being, eligible to retire and that CMS might have to manage these transitions with less experienced staff. In addition, CMS staff have never had to manage as many simultaneous transitions, which is likely to add to the challenge of managing them so that they are as smooth as possible for providers. As we reported previously, the lack of sufficient staff resources has hampered other transitions.<sup>28</sup>

The volume and complexity of claims workload transitions is a second risk that CMS's plan does not adequately address. Although CMS has regularly managed the transitions of claims administration contractors' workloads and functions and has much experience in doing so, recent transitions have affected only about 10 percent of the claims for Part A and Part B in any year. Nevertheless, CMS is planning to transfer 91 percent of current contractors' workload to MACs in less than 2 years. Furthermore, the MAC transitions will be more complex than past contractor transitions because both Part A and Part B workloads will be transferred from multiple contractors to a single MAC in a new jurisdiction. These changes mean, for example, that under the initial A/B MAC contract that is awarded—one that involves less than 3 percent of the national workload in a six-state

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<sup>28</sup>For example, lack of staff resources dedicated to transition efforts contributed to a slow implementation of updated telecommunications services to federal agencies, which led to increased costs and difficulties in holding service contractors accountable for their performance. See GAO, *FTS2001: Contract Transition Delays and Their Impact on Program Goals*, [GAO-01-544T](#) (Washington, D.C.: Apr. 26, 2001).

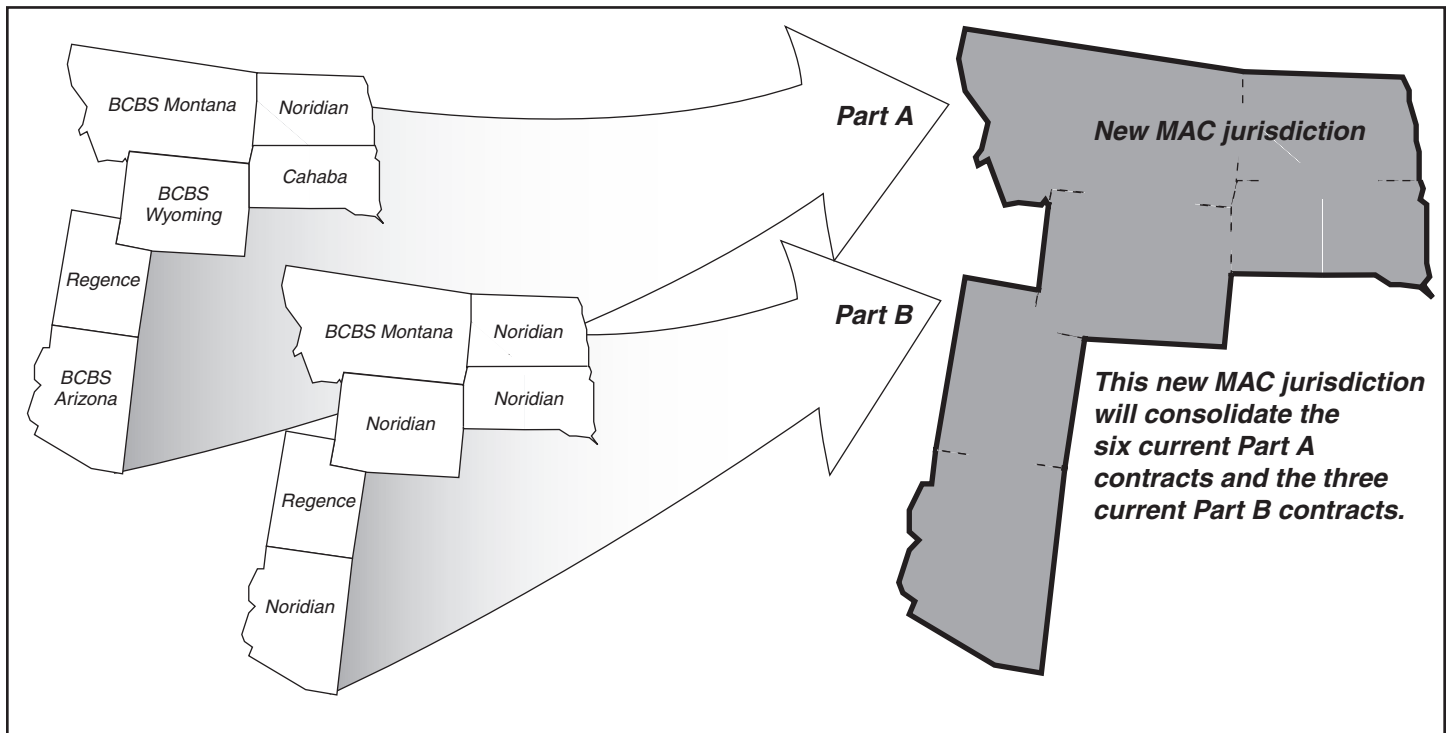
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jurisdiction—CMS will simultaneously transfer as many as nine separate segments of current contractors' workload to the new MAC.<sup>29</sup> Figure 2 illustrates the transitions that will occur to consolidate the Part A and Part B workload in the first contract to be awarded for an A/B MAC jurisdiction. These transitions will also involve transferring some portions of the work currently being done by the carriers and fiscal intermediaries to functional contractors. For example, CMS will be transferring medical review and benefit integrity work from DME regional carriers to PSCs at the same time that the claims workload transfers to DME MACs. While the start-up cycle transitions are complex, they are planned to affect only 1 A/B MAC and the 4 DME MACs. CMS will be conducting a much greater number of transitions for cycles one and two, as the rest of claims administration work is transferred from current contractors to 14 A/B MACs and 4 HH MACs.

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<sup>29</sup>Subsequent transitions in the next two cycles will transfer workload to the new MACs from two to as many as seven current fiscal intermediaries and carriers. Furthermore, transitions may involve transferring some work to functional contractors, such as the contractor that will be responsible for handling beneficiary inquiries.

**Figure 2: Part A and Part B Transitions That Will Occur in One MAC Jurisdiction**



Source: GAO.

Additional factors may add to the complexity of the transitions. For example, if current fiscal intermediaries and carriers choose not to compete or lose competitions for MAC contracts in the jurisdictions where they currently process claims, they may have little incentive to be highly cooperative in the transition activities. In these cases, their knowledgeable staff who would facilitate transitions may seek employment elsewhere. Further, MAC transitions may involve the transfer of workloads to companies new to Medicare operations, which would add complexity to the process.

Another risk that CMS's plan has not fully addressed is the potential impact that voluntary contractor withdrawals may have on the planned transition schedule. CMS has not developed mitigation strategies to deal with these potential withdrawals. Several CMS officials told us that they were concerned that some contractors might voluntarily withdraw before the agency's planned competition for jurisdictions that included their

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current service areas because the contractors did not intend to compete as MACs. In addition, contractors that lose competitions may opt to leave the Medicare program before transitions to new MACs have been completed. CMS has the option of paying contractors' staff retention bonuses, so that key contractor staff can work through transitions, but that may not be enough to convince contractors to stay in the program. Voluntary withdrawals could force CMS to conduct competitions and manage transitions for the affected jurisdictions on a different or more accelerated schedule than originally planned. CMS could elect to choose a Medicare claims administration contractor to briefly perform the withdrawing contractor's work until a MAC is chosen for the affected jurisdiction, but this could be perceived as limiting competition by favoring one company over others.

The ultimate risk from transitions that do not proceed smoothly or on schedule is that providers might not receive payment for the items or services they furnished to beneficiaries or could be paid inappropriately. Interrupting providers' cash flow by failing to pay them can create significant problems in their operations. On the other hand, any increase in improper payments would create a further drain on the Medicare trust funds. In fiscal year 2004, CMS estimated that Medicare claims administration contractors' net improper payments amounted to \$19.9 billion.

CMS has not completed a comprehensive risk mitigation plan to address the risks associated with contracting reform, but the agency has taken some initial steps to manage the risks. CMS has developed a procedure for identifying, analyzing, responding to, and monitoring and controlling risks. As part of this procedure, CMS has identified certain risks that may have an impact on implementation, including the availability of resources to complete scheduled procurement tasks and the difficulty of developing a clear, complete statement of work that minimizes the need for future contract modifications. The agency is currently working on developing a document that lists proposed actions that could mitigate these and other identified risks. However, CMS's descriptions of proposed mitigation actions lack specificity. For example, to address the risk that CMS may not have the funding to conduct transition activities as scheduled, the proposed mitigation action is to "monitor federal appropriations," but the document does not indicate how the agency might redeploy resources or restructure its transitions, should a funding gap occur. Further, CMS has not developed mitigation actions for some serious risks, including the failure to create internal processes for managing MACs. Without such

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Plan Lacks Detailed  
Information on MAC  
Contracting Strategy and  
Management and Oversight  
Approach

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internal processes, CMS may not be able to effectively administer MAC contracts.

Although CMS has done extensive work toward developing a strategy that outlines how it intends to implement MAC contracting, the agency's plan lacks important implementation information in some areas. For example, CMS has made final decisions concerning certain elements of the MAC contracting strategy, such as paying performance incentives to encourage contractor innovation, efficiency, and cost effectiveness. However, for A/B MACs, the plan does not provide complete and definitive information on the contract type, performance measures and incentive structure, proposal evaluation criteria, and methods for maintaining a competitive environment and conducting market research to gather information on the number and size of companies that may submit proposals. CMS's MAC acquisition strategy, which will provide information on these areas, is not yet complete. The agency planned to finalize this strategy in July 2005 and to issue the A/B MAC request for proposals in September 2005.<sup>30</sup> Knowing such critical contracting information well in advance of the issuance of the request for proposals would make it easier for interested parties to develop specific plans for competing to win A/B MAC contracts. Having a robust pool of potential contractors with good proposals would make it easier for CMS to choose applicants likely to be effective as MACs.

CMS's contracting reform plan states that some MAC functions will be integrated with those of other types of Medicare contractors, but the agency has not fully developed the details of this integration. For example, the plan states that CMS expects that PSCs will continue to perform activities such as medical reviews and fraud investigations in the future and will coordinate closely with MACs. In addition, the statements of work for DME MACs and A/B MACs require that they sign agreements with PSCs to define respective roles and responsibilities. Among their responsibilities, DME MACs and A/B MACs will be expected to coordinate with PSCs in referring potential fraud cases when, for example, MACs identify claim forms that have been altered to obtain a higher payment or when it appears that a supplier or provider may have attempted to obtain duplicate payments. MACs' coordination with PSCs is critical because findings of fraud could affect payments to providers. Coordination with

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<sup>30</sup>The request for proposals announces CMS's intent to award a contract and specifies the service or product to be delivered, the criteria to be used, applicant qualifications, deadline, and other relevant information.



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PSCs is also discussed in “concept of operations” documents for DME MACs and A/B MACs. These documents provide high-level information on how MACs will be expected to work with PSCs and other contractors that focus on particular Medicare program functions, such as claims appeals. However, CMS has yet to develop many details, including information on the specific steps that will be used to facilitate contractor coordination.

In addition, CMS’s plan does not fully outline how the agency intends to evaluate and manage MACs. CMS’s plan incorporates a strategy paper on evaluating MACs’ performance, which was developed for the agency by a support services contractor. The strategy paper makes a number of recommendations, including establishing a specific office within CMS to gather, validate, and score contractor performance data and to share this information with agency management. CMS officials are currently considering these and other recommendations that were contained in the strategy paper. However, as of June 2005, they had not decided whether to implement any of these recommendations and had not completed their design of an approach for overseeing and evaluating MAC performance. Contractor oversight is an area of considerable concern, because, in the past, CMS’s failure to monitor Medicare claims administration contractors left the Medicare program vulnerable to fraud, waste, and abuse.<sup>31</sup> For example, CMS did not always detect activities, such as the falsification of reports on contractor performance and the improper screening, processing, and paying of claims, that led to additional costs to the Medicare program.

In developing the MAC oversight strategy paper, CMS’s contractor drew on the work of a cross-component work group within CMS that was established in April 2003.<sup>32</sup> The work group reported in June 2004 that CMS lacked an integrated and coordinated framework to guide a wide range of evaluation activities and that the agency had difficulty in compiling a

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<sup>31</sup>GAO, *Medicare: HCFA Oversight Allows Contractor Improprieties to Continue Undetected*, [GAO/T-HEHS/OSI-99-174](#) (Washington, D.C.: Sept. 9, 1999); *Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors*, [GAO/T-HEHS/OSI-99-167](#) (Washington, D.C.: July 14, 1999); *Medicare: Improprieties by Contractors Compromised Medicare Program Integrity*, [GAO/OSI-99-7](#) (Washington, D.C.: July 14, 1999); and *Medicare Contractors: Despite its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity*, [GAO/HEHS-99-115](#) (Washington, D.C.: July 14, 1999).

<sup>32</sup>CMS’s Medicare fee-for-service contractor evaluation work group was established to compile an inventory of all internal and external contractor assessments and to research alternative frameworks to integrate contractor evaluation, reporting, and follow-up activities.

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comprehensive view of individual contractor performance.<sup>33</sup> The work group also noted that complete and accurate information on contractor performance will be imperative as contracts for MACs are periodically recompeted and determinations about their records of performance become part of the qualification criteria. This information could also be critical in determining the amounts CMS pays to MACs as performance incentives.

The plan also lacks detailed information on organizational changes to better realign agency personnel to support the management and oversight of new MAC contracts because CMS has not made final decisions in this area. While CMS currently administers some types of contracts that are governed by the FAR,<sup>34</sup> MAC contracts generally will be larger, more complex, and more challenging to administer. CMS's past oversight of claims administration contractors was hindered by organizational weaknesses,<sup>35</sup> and at present, multiple central office components and regional offices have responsibilities to help oversee and manage claims administration contractors.<sup>36</sup> Having an organizational structure that is appropriately aligned for CMS to manage and oversee MACs will make it easier for the agency to routinely evaluate its contractors on the basis of a

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<sup>33</sup>We found similar problems in 1999. We reported that CMS's headquarters office had not set contractor oversight priorities, leaving such decisions almost entirely to regional office reviewers. This led to inconsistent contractor evaluations by regional reviewers, which made it more difficult for CMS to determine which contractors were performing effectively. See [GAO/HEHS-99-115](#).

<sup>34</sup>CMS's contracts that are governed by the FAR include those with quality improvement organizations and PSCs and for Medicare systems maintenance and data centers.

<sup>35</sup>We reported in 2000 that while responsibility for overseeing contractor performance was dispersed among central office components and the agency's 10 regional offices, lines of accountability had not been clearly established. The regional office staff who were responsible for overseeing contractors were not directly accountable to the central office group responsible for contractor oversight activities. GAO, *Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight*, [GAO/HEHS-00-46](#) (Washington, D.C.: Mar. 23, 2000). CMS took steps to address this issue. While the agency was reviewing a draft version of our report, it announced that it was making organizational changes to improve regional accountability.

<sup>36</sup>For example, while the Center for Medicare Management's Medicare Contractor Management Group has overall responsibility for managing claims administration contractors, the Office of Financial Management has significant responsibilities for the contractors' financial and program integrity activities, and the Office of Information Systems is responsible for oversight and security of the information systems used to pay claims. In addition, regional staff are currently responsible for monitoring the claims administration contractors' activities and helping to evaluate their performance.

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Plan Does Not Fully Integrate  
Scheduling of Contracting  
Reform Activities with Other  
Initiatives

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variety of newly established performance measures. CMS has reorganized the central office component that will be responsible for awarding MAC contracts and has been considering ways to use regional offices' staff expertise to support MAC contracting efforts. However, CMS has not completed its plan for organizational changes, including the division of labor and responsibilities for management and oversight of Medicare contractors among CMS components and between the central and regional offices.

CMS has not developed an approach that fully integrates the planning and scheduling of Medicare contracting reform with other initiatives that will affect Medicare contractors, beneficiaries, and providers over the next several years. As CMS works toward implementing contracting reform, it is also focusing on several critical initiatives that must be integrated, or implemented concurrently, with Medicare contracting reform. These include the Medicare prescription drug benefit and the expansion of the existing options available to Medicare beneficiaries who enroll in private health plans. According to CMS officials, these initiatives may compete with contracting reform for agency resources. Other key planned initiatives, such as major systems upgrades or replacement, will directly affect Medicare claims administration operations and are anticipated to be fully or partially implemented between now and 2009 in conjunction with contracting reform. Information on these interrelated initiatives is provided in table 2. As we have previously reported, planning for IT system transitions has often been problematic in federal agencies.<sup>37</sup> Coordinating the schedule for implementing these initiatives in conjunction with Medicare contracting reform is crucial to ensuring that claims administration operates smoothly during the transition to MACs.

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<sup>37</sup>GAO, *Business Systems Modernization: Internal Revenue Service Needs to Further Strengthen Program Management*, [GAO-04-438T](#) (Washington, D.C.: Feb. 12, 2004), and *Information Technology: DOD's Acquisition Policies and Guidance Need to Incorporate Additional Best Practices and Controls*, [GAO-04-722](#) (Washington, D.C.: July 30, 2004).

**Table 2: Key Initiatives Affecting MAC Implementation**

Initiative	Description	Implementation schedule and integration issues related to MAC implementation
Standard front end	This initiative will standardize the way that electronic claims enter the automated processing system.	Implementation of this initiative will occur within the DME MACs and the A/B MACs at the same time they are implemented. Changing claims administration contractors can require providers and billing agents to adapt to a new front end, which is why standardizing the front end as part of MAC implementation could minimize future disruption for providers and billers.
Data center consolidation	CMS plans to consolidate its current 14 operational data centers that conduct claims processing functions into 2 data centers.	CMS had initially planned to begin consolidating the data centers in fiscal year 2006 to overlap with MAC implementation, but in May 2005, the agency postponed the initiative for about 2 months, due to the extent of public comments received on the draft request for proposals for data center contracts. Future consolidation of data centers will affect MACs because they are required to work with their respective data centers to maintain electronic information. As a result, delays or difficulties in transferring workload to the chosen data centers could increase the risks of claims payment problems during MAC transitions.
BCCs	CMS plans to establish two to three BCC contracts, which will be responsible for handling beneficiaries' telephone and written inquiries.	BCC implementation overlaps with MAC implementation. CMS plans to award the first BCC contract in the summer of 2006 and transfer the workload in the summer of 2007. The second BCC contract will be awarded in fall 2007, and the workload will be transferred in 2008. While BCCs will assist beneficiaries by answering claims-related inquiries, they will need to coordinate with MACs because MACs will be responsible for answering more complex questions.
Healthcare Integrated General Ledger Accounting System (HIGLAS)	HIGLAS is a major CMS initiative to modernize Medicare's accounting and financial management systems. CMS's current accounting systems are fragmented and overlapping and will be replaced with HIGLAS—a single, integrated financial accounting system.	HIGLAS implementation overlaps with MAC implementation. HIGLAS is expected to be fully operational in 2007. In the future, all MACs will be required to use HIGLAS. However, several current contractors have begun to use HIGLAS, and other fiscal intermediaries and carriers will have begun to use HIGLAS before MAC competitions get under way. For jurisdictions where transitions to HIGLAS are not complete, CMS will need to coordinate its scheduling of MAC and HIGLAS implementation because CMS wants all MACs to use HIGLAS as their financial accounting system.
PSCs	PSCs focus on program safeguard activities, such as the review of provider activities, including medical, utilization, and fraud reviews; cost report audits; Medicare secondary payer determinations; and provider and beneficiary education.	PSC transitions overlap with MAC implementation. The medical review and benefit integrity work will transfer from three DME regions to PSCs simultaneously with the transition to DME MACs. The work conducted under three PSC medical review contracts for A/B claims will transfer to the A/B MACs in the affected jurisdictions at the same time that the A/B MACs assume their other contractual responsibilities.
Recovery Audit Contractor initiative	This initiative is a demonstration initiative required by the MMA. It includes two Medicare secondary payer recovery audit contractors and three claims review recovery audit contractors.	The implementation of this initiative overlaps with MAC implementation. This demonstration will run through mid-2008 and will affect California, New York, and Florida. MACs will not perform any postpay medical reviews for prior fiscal years for claims paid to providers in these states, but must coordinate with the contractors tasked with this assignment. MACs processing claims for these three states must also complete some additional administrative work related to debt collection.

Source: GAO analysis of CMS documents.

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HIGLAS, in particular, provides an example of why effective integration is essential. Most outgoing contractors will not be utilizing HIGLAS at the time their workloads are transferred to MACs. Therefore, CMS will have to coordinate HIGLAS transition activities, including data preparation and data conversion testing, between the MACs that will be using HIGLAS and the outgoing contractors that have been using the existing financial management systems. Given that the HIGLAS implementation strategy calls for “just in time” data conversion to HIGLAS format by outgoing contractors at the time the work is transferred to the MACs, problems or delays in this conversion could delay MAC transitions. Therefore, the scheduling for HIGLAS will have to be carefully managed to allow sufficient time for the data conversion.

Although CMS has begun initial efforts to integrate the planning and scheduling of several major initiatives that will affect contractors, an agency official told us that there are no planning documents to provide a detailed integration framework and that he did not know when such documents would be available.<sup>38</sup> He said that CMS is attempting to determine the appropriate sequencing and interdependencies of the multiple initiatives occurring in the agency. To focus its sequencing efforts, CMS has designated the contracting reform implementation schedule as the anchor around which it will schedule the implementation of HIGLAS and other critical initiatives. For example, since CMS plans call for MACs moving to HIGLAS either before or with MAC claims workload transitions, the MAC implementation plan will be pivotal in determining when the HIGLAS transitions will be accomplished. CMS is also examining each project’s resource requirements to help ensure that the agency is able to fund the initiatives in the sequence planned.

Delays in the implementation of MAC-related initiatives could potentially have a significant impact on the timing, scope of work, costs, and ultimate success of MAC implementation. For example, CMS has already begun to experience schedule slippage for its initiative to consolidate the contractors’ data centers. These data centers, which are provided by current carriers and fiscal intermediaries, conduct the physical processing of Medicare claims and as a result, play a crucial role in efficient and accurate claims administration. The agency had intended to award

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<sup>38</sup>The official told us that the agency’s integration planning efforts had been delayed until the agency’s *Report to Congress* was issued in February 2005, in part because of the concern that procurement-sensitive information might be prematurely made public.

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contracts for four data centers that would consolidate the work of 14 current centers before awarding the DME MAC contracts, which are anticipated to be awarded in December 2005. However, it suspended the request for proposals on May 3, 2005, because it was unable to consider the large number of comments that were received on its draft request. It reissued its solicitation on June 27, 2005, for two, instead of four, data centers. Delays or other problems in implementing the consolidation of its data centers could affect the efficiency and effectiveness of MACs' claims processing transitions. CMS's *Report to Congress* stated that having the new data centers would be critical to achieving the greatest efficiency from the MAC transitions, in part because some of the information services and support to be provided by MACs would depend on the modernized platform.<sup>39</sup> Currently, CMS expects that one of the new DME MACs will be managing a data center for all of the DME MACs as a stopgap measure and plans to award the contract for the two data centers in February 2006. Implementation of the data centers is planned to coincide with implementation of the first A/B MAC selected.

The data center consolidation effort faces some of the same complexities that might occur during the transition of the claims processing contracts. If claims administration contractors operating data centers opt to leave the program before the conclusion of their contracts, CMS will have to find other data center contractors to temporarily take over that workload. Furthermore, because the data center consolidation is planned to occur during the MAC transition period, the two data center contractors will have to support claims administration contractors moving in or out of the program, while also integrating some of the prior data center contract work into their new data center responsibilities. CMS generally envisioned multiple data center transitions overlapping, but the schedule for data center consolidation is uncertain. CMS has not indicated how it intends to handle the risks associated with moving data center work at the same time claims processing workload is being transferred to MACs.

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<sup>39</sup>Department of Health and Human Services, *Report to Congress*, III-7 and III-8.

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## Plan's Cost and Savings Estimates Do Not Provide a Reasonable Basis for Decision Making

CMS's plan includes estimated costs and savings for Medicare as a result of contracting reform, but the estimates are too uncertain to provide a reasonable basis for making implementation decisions. Because CMS has never undertaken an effort comparable to full-scale contracting reform, the plan's cost and savings projections were based on questionable evidence and assumptions about a contracting environment that differs considerably from its current one. As a result, the costs to implement contracting reform and the savings generated from it could be significantly greater or less than CMS has anticipated.

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## Cost Estimates Depend on Uncertain Outcomes

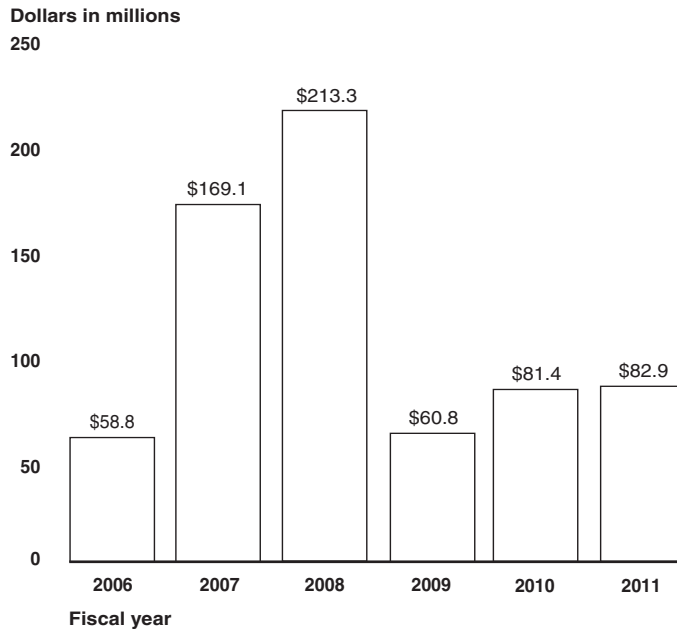
In its plan, CMS estimated that the costs to implement contracting reform from 2006 to 2011 would total about \$666 million.<sup>40</sup> The plan's cost estimate is higher than indicated in the *Report to Congress*, which included only the fiscal year 2006 budget request of \$58.8 million to support a single year of contracting reform implementation costs. CMS opted not to include its estimates for funds that would likely be requested in its budgets for fiscal years 2007 through 2011. The *Report to Congress* indicated that contracting reform would require "substantial additional investment in subsequent years."<sup>41</sup> The costs CMS anticipates incurring each year are shown in figure 3.

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<sup>40</sup>To be able to negotiate yearly costs with the MACs prior to the beginning of the contract period, CMS plans to request adjustments to its budget authority to change the period of performance for MACs to coincide with the calendar year, instead of the current fiscal year basis. Changing the period of performance will not increase or decrease overall or net administrative outlays and is not included in the administrative cost estimate.

<sup>41</sup>Department of Health and Human Services, *Report to Congress*, IV-3.

**Figure 3: Estimated Costs of Medicare Contracting Reform, Fiscal Years 2006-2011, as of February 2005**



Source: GAO analysis of CMS cost estimates.

Note: The costs for each year are adjusted for inflation, using 2004 as the base year.

The estimated \$666 million in costs is divided into four categories, as noted in table 3.<sup>42</sup> The largest cost component is for the termination and transition of the current Medicare contractors, which CMS has estimated at \$331.5 million. When a Medicare contract is terminated, contractors can have costs for items such as lease termination, equipment depreciation, and severance pay for contractors' employees. The current Medicare contracts may require CMS to pay many of these termination costs when contractors leave the Medicare program. Similarly, when a Medicare contract workload is transferred from an outgoing contractor to another one, transition costs are incurred. Such transition costs include expenses related to transferring Medicare records and updating records related to

<sup>42</sup>The MMA mandates that contracting reform be completed before October 1, 2011, the first day of fiscal year 2012. Although all of the transitions to MACs are planned to be completed by July 2009, some of the costs—such as IT enhancement and oversight—will be incurred through fiscal year 2011.



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Medicare benefit payments, including overpayments and other accounts receivable, so they are ready for the incoming contractor to use.

**Table 3: CMS's Estimates of Administrative Costs for Medicare Contracting Reform, Fiscal Years 2006-2011, as of February 2005**

Dollars in millions	
Type of cost	Estimated cost
Termination and transition costs	\$331.5
Performance incentives	190.6
IT and other costs <sup>a</sup>	132.5
Provider satisfaction surveys	11.7
<b>Total</b>	<b>\$666.3</b>

Source: GAO analysis of CMS cost estimates.

<sup>a</sup>CMS informed us on July 29, 2005, that it had updated this cost estimate, but the updated estimate was not available to be included in this report.

Although CMS's estimate for termination and transition costs is based on cost data from prior years, it is impossible to predict with certainty the termination or transition costs that will be incurred through implementing contracting reform. CMS's estimate for termination and transition costs is based on the agency's experience with both types of costs from 1995 to 2001. The estimate assumes that current contractors will win the majority of the MAC contracts and retain about 60 percent of their current workload. However, CMS officials do not know how many of the existing contractors will win MAC contracts for particular jurisdictions, so this assumption is speculative. Additionally, some of CMS's prior contractor transitions were "turnkey" operations, in which an incoming contractor simply assumed the prior contractor's business arrangement and staff without needing to incur some of the usual start-up costs, such as equipment purchases. Likewise, in turnkey transitions, CMS did not have to cover severance pay, because the outgoing contractor's existing staff could be employed by the incoming contractor. As a result, the prior transitions may have cost less than the transitions that will occur during contracting reform because CMS is not requiring MACs to retain outgoing contractors' work sites or staff.

Contracting reform will allow CMS to pay performance incentives that are designed to reward MACs with exceptional performance. However, it is impossible to know the amount of incentive fees contractors will earn in the full-scale MAC environment until the contracts are awarded and CMS has more experience with contractor performance. These performance

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incentives are projected to cost 5.5 percent of the total estimated costs of the MAC contracts, or \$190.6 million for fiscal years 2006 through 2011. CMS based this estimate on its prior experience in managing contractor incentive programs on a much smaller scale.

Several IT modernization projects designed to support MACs by facilitating electronic claims processing are included in CMS's estimate of contracting reform costs.<sup>43</sup> These IT project costs include CMS's planned consolidation of its current data centers. However, delays in the data consolidation initiative may affect the amount of these costs.<sup>44</sup> The IT modernization costs also include plans to standardize the front end, or the way that electronic claims enter the DME MACs' automated processing systems. CMS did not include similar costs for A/B MACs, because the agency had not made a decision to standardize the A/B MAC front ends at the time these estimates were made.<sup>45</sup> CMS's \$132.5 million estimate for IT and other costs included \$78.7 million in IT costs needed to support Medicare contracting reform, primarily the cost of data center consolidations.<sup>46</sup>

The final type of costs CMS estimated was for surveys of providers to assess their opinions about MAC performance. The MMA required that MAC performance be assessed in part based on provider satisfaction. CMS plans to begin surveying providers to measure their satisfaction with their MAC's performance after MACs begin operating. The cost estimate for these surveys is \$11.7 million and was based on an internal CMS analysis.

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<sup>43</sup>CMS is simultaneously implementing other IT-related initiatives, which are not considered to be part of contracting reform and are not included in the contracting reform costs.

<sup>44</sup>CMS had planned to begin consolidating the data centers in fiscal year 2006, so this cost is reflected in its estimated costs for contracting reform. However, in May 2005, the data center consolidation initiative was postponed for about 2 months. CMS anticipates awarding the data center contracts in February 2006, about 5 months later than originally planned.

<sup>45</sup>CMS currently plans to consolidate the A/B MACs' front ends, to coincide with the beginning of the cycle one A/B MAC implementation. The agency is developing requirements for the A/B MAC standardized front end. It plans to award a contract in early fiscal 2007 and be ready to implement the standardized front end by the fall of 2007.

<sup>46</sup>In its technical comments on a draft of this report, CMS stated that it has updated its IT cost estimate to reflect the adjustments to the data center consolidation initiative and to include the standard front end initiative. This updated estimate is somewhat higher than CMS's original estimate and was not available as of July 29, 2005. CMS plans to make its estimate final and public through the official budget process.

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A potential operational cost not part of CMS's implementation estimate is funding for MAC contract modifications. Under the current contract arrangements, CMS is able to develop new tasks for contractors to complete. The agency may pay more for these tasks to be completed, regardless of the initial requirements set for the year, or may direct the contractor to do the work within its existing budget, if CMS's review of the contractor's spending pattern indicates that new funding is not needed to complete the new tasks. In the MAC environment, unless they become part of the statement of work, CMS will not be able to add new tasks to the MAC contracts without negotiating payment for them. Because contractors will submit proposals based on the tasks described in the original statement of work, work required after the contract is awarded could require CMS to negotiate with MACs. This could be the case, for example, if new legislation requires CMS to implement a major program change that was not anticipated in the established MAC contract costs. For example, in 2001, we reported that the Department of Defense (DOD) was not including contract adjustments when budgeting for its contracts with the insurers delivering health care to DOD employees.<sup>47</sup> We warned that this approach could become quite costly, because in fiscal year 2001, it led to a \$500 million shortfall in the DOD budget. When an agency is negotiating changes with an existing contractor, the competitive aspect of the negotiations is lost. As a result, the federal government may not always receive the best price. If CMS has to negotiate new tasks with the MACs for greater payment, contracting costs could rise above the agency's estimates. To address this concern, CMS has instructed companies interested in becoming DME MACs to assume a level of effort for a specific number of changes. As long as the extra work to implement program changes does not exceed the level of effort in the statement of work, the Medicare program would not incur additional operational expenses.

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### Savings Estimates Depend on Contractor Performance in Reducing Improper Payments

Based on estimates generated both internally and by a consultant, CMS expects that contracting reform will generate significant savings to Medicare's administrative budget and to the Medicare trust funds. While it is rational to assume some level of savings, these estimates are highly uncertain because they project the outcome of contracting processes and protocols that CMS has not used before. Furthermore, the consultant's

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<sup>47</sup>GAO, *Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly*, [GAO-01-513](#) (Washington, D.C.: Apr. 30, 2001).

estimates relied on questionable evidence and were not reviewed by CMS program staff with the expertise to confirm whether the assumptions upon which they are based are realistic.

CMS's estimate of savings from 2006 to 2011 for the administrative budget totals \$459.5 million, as shown in table 4. These savings are estimated to come from two sources. First, CMS anticipates that the competed MAC contracts will cost less than the current agreements and encourage more innovative efforts among contractors, which will allow them to operate at lower cost. CMS estimates that the introduction of competition will lower the contractor budget for awarded MAC contracts by 6 percent in the first year and 12 percent in each succeeding year. Second, CMS anticipates that the consolidation of its 14 Medicare data centers will lower operating costs.<sup>48</sup> Both of the savings estimates shown in table 4 will be highly dependent upon contractor performance and the outcome of the competitive process. For instance, any savings CMS incurs from competing the MAC contracts will substantially depend on their final costs.

**Table 4: CMS's Estimates of Administrative Savings from Medicare Contracting Reform, Fiscal Years 2006-2011, as of February 2005**

Dollars in millions	
Source of savings	Estimated savings
Competition for MAC contracts	\$376.3
Consolidation of Medicare data centers <sup>a</sup>	83.2
<b>Total</b>	<b>\$459.5</b>

Source: GAO analysis of CMS savings estimates.

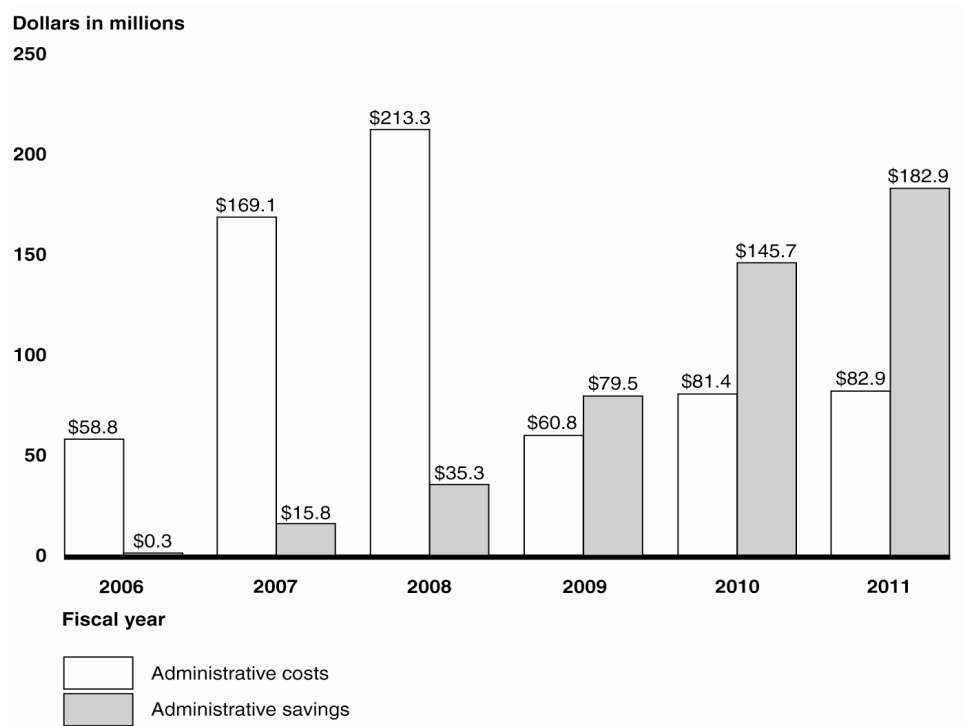
<sup>a</sup>CMS informed us on July 29, 2005, that it had updated this savings estimate and it is now higher, but the updated estimate was not available to be included in this report.

CMS's annual estimates of savings for the administrative budget increase significantly from fiscal year 2006 to fiscal year 2011. As shown in figure 4, these estimated savings would begin to outpace CMS's estimated

<sup>48</sup>In its technical comments on a draft of this report, CMS stated that it has updated its IT savings estimate to reflect the adjustments to the data center consolidation initiative and to include the standard front end initiative. This updated estimate is somewhat higher than CMS's original estimate and was not available as of July 29, 2005. CMS plans to make its estimate final and public through the official budget process.

administrative costs in 2009, and by 2011, they would exceed estimated costs by \$100 million.

**Figure 4: CMS’s Annual Estimates of Administrative Costs and Savings from Medicare Contracting Reform, Fiscal Years 2006-2011, as of February 2005**



Source: GAO analysis of CMS data.

CMS anticipates that the bulk of the savings from Medicare contracting reform will occur through funds it can avoid spending from the Medicare trust funds, but the basis for this estimate is uncertain. CMS’s consultant estimated the total projected savings to the trust funds through fiscal year 2011 to be over \$1.4 billion.<sup>49</sup> The savings to the trust funds are expected to come from the three main sources shown in table 5. The consultant who created these savings estimates explained that while it is logical to assume some level of savings to the Medicare program, there are “enormous uncertainties” at this stage of the implementation process, which make it

<sup>49</sup>The *Report to Congress* noted an estimated savings of \$900 million to the Medicare trust funds by the end of fiscal year 2010.

difficult to project the savings with much accuracy. Ultimately, each of these sources of savings assumes that contracting reform will lead to a lower rate of improperly paid claims. Further, while the estimate for each of the three sources is based on a different methodology and formula, the basis for each is similar enough that the savings accrued through each may overlap, resulting in possible double counting. Therefore, whether contracting reform will actually achieve the \$1.4 billion savings is highly uncertain.

**Table 5: CMS’s Consultant’s Estimates of Savings to the Trust Funds from Medicare Contracting Reform, Fiscal Years 2006-2011**

Dollars in millions

Source of savings	Fiscal year 2006-2010 estimated savings	Fiscal year 2011 estimated savings	Total fiscal years 2006-2011 estimated savings
Combining Medicare contracts for Part A and Part B, resulting in more comprehensive medical reviews of claims	\$350	\$220	\$570
Higher claims denial rates, because MACs will perform more effective medical reviews, to remain competitive <sup>a</sup>	160	100	\$260
Greater incentive for MACs to operate efficiently and adopt industry innovations in automated review of claims to remain competitive	390	260	\$650
<b>Total estimated savings</b>	<b>\$900</b>	<b>\$580</b>	<b>\$1,480</b>

Source: GAO analysis of CMS’s consultant’s savings estimates.

Note: The *Report to Congress* stated savings for 2006 through 2010, but the consultant’s complete estimates were calculated through 2011.

<sup>a</sup>The consultant assumed that a portion of claims denial rates can be associated with contractor performance and that contractors would have an incentive for higher performance in the new competitive contracting environment. As a result, the savings estimate includes projected savings from higher claims denial rates.

The consultant’s estimate anticipates that MACs could detect a larger amount of improper payments because they will be examining both Part A and Part B claims, but there is little evidence to support the amount of savings assumed. Currently, Part A and Part B medical reviews are generally conducted by different contractors, which lessens their focus on

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problematic billing that spans both parts. The consultant estimated that having MACs conduct joint Part A and Part B medical reviews would lower the amount of improperly paid Medicare claims by 0.08 percent. However, CMS's senior medical review staff indicated that they had no prior knowledge of this actuarial estimate until we showed it to them. The staff told us that there is no evidence to realistically estimate the amount of savings that may result from consolidating the medical review responsibility for both parts. Furthermore, according to CMS staff, the greatest savings would likely come through computerizing medical reviews to automatically examine and compare Part A and Part B claims before they are paid. However, this capability is not currently possible, because Part A and Part B claims are processed on different payment systems, and developing a combined Part A and Part B claims processing system that could automatically compare Part A and Part B claims before payment would take years to complete.<sup>50</sup>

Potential savings from improved fraud detection are also impossible to quantify, based on current information. The PSCs currently conduct fraud detection activities for both Part A and Part B in 40 states, the District of Columbia, Puerto Rico, and the Virgin Islands. As CMS implements contracting reform, the jurisdictions in which PSCs will conduct fraud detection for both parts may change. While CMS considers having a single PSC handling both Part A and Part B fraud detection a way to make its contractors more efficient, a senior official acknowledged that the agency had no evidence with which to determine whether having the PSCs conduct combined fraud reviews has been more effective in detecting fraud than having these reviews conducted by separate contractors for Part A and Part B.

The consultant's estimate also anticipated that MACs will be able to pay claims more accurately than the current Medicare contractors, due to more effective medical review of claims, thus increasing claims denial rates. While noting that some elements of claim denials are not associated with contractor performance, the consultant assumed that better contractor performance could be equated with increased claims denial rates. The calculation for this assumption was based on the projection that

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<sup>50</sup>CMS's goal is to have a unified claims processing system in 2011, but the consultant's estimate assumes that savings will be generated from combined medical reviews much sooner.

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contractor denial rates would increase<sup>51</sup> and that half of these increased denials would lead to program savings. However, CMS program staff told us that they do not consider denial rates in their evaluation of contractor performance but instead evaluate claims administration contractors' rates of paying claims properly. The CMS program staff told us that they were not sure of the basis for the consultant's calculations, and one senior official stated that it was unclear whether more denials would occur with new MACs.

Finally, the consultant projected that if CMS awards contracts competitively, contractors will have an incentive to operate more efficiently and to adopt the leading industry innovations that improve performance. The consultant expected these efforts to result in lower levels of improperly paid claims. This projection was based on a 1995 GAO report that estimated that if Medicare contractors adopted the technology and capabilities used by private insurers to detect improper payments through automated claims reviews, Medicare payments for physicians' services and supplies could be reduced by 1.8 percent. Since that report was issued, CMS has made additional efforts to reduce improper payments. In addition, CMS was not certain that GAO's assumed savings were achievable. Recognizing this, the consultant reduced this portion of the savings estimate to a 0.09 percent reduction in Medicare fee-for-service payments. In the consultant's opinion, this adjusted for current error rates and CMS's opinion that the initial 1995 GAO estimate was too high. However, when we followed up with CMS in April 2005, a senior official stated that while it would be realistic to expect some level of savings in the new competitive contracting environment, she did not know how the amount could be accurately quantified.

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## Conclusions

The millions of dollars in savings that CMS envisions achieving through contracting reform in the early years of implementation are largely based on questionable estimates. However, these anticipated savings have been the driving force behind the agency's decision to accelerate its schedule for contracting with MACs. The agency has opted to transfer the entire current contractor workload to MACs 2 years ahead of the MMA time frame, in the hope of garnering savings to Medicare as quickly as possible.

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<sup>51</sup>The consultant calculated this expected increase in denials by dividing all current carriers and fiscal intermediaries into quartiles, based on their current claims denial rate. Then, the consultant assumed that the denial rate for the bottom half of contractors in each quartile could be expected to increase to the median denial rate for that quartile.



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The accelerated schedule raises concerns for a number of reasons. First, CMS has never before undertaken a project of this scope and magnitude—one that affects more than 35 million beneficiaries and 1 million health care providers. If transitions do not run smoothly, operational disruptions could lead to delayed payments to providers and increased improper payments by contractors. With Medicare net improper payments estimated to be almost \$20 billion annually, any potential increase is cause for concern. Second, while CMS's plan provides detailed information in some areas, other critical areas of the agency's plan are still being developed. Although the agency is employing a start-up cycle that will provide an opportunity to gain valuable FAR contracting experience, the ambitious schedule for the subsequent two cycles leaves little time for the agency to learn from the experience and resolve problems that might arise. Finally, attempting complex transitions of almost all of the claims administration workload in less than 2 years, in conjunction with changes in the data centers and financial management systems, significantly increases the risk that providers' claims will be paid improperly or not be paid at all. As CMS undertakes this important challenge, it is critical that the agency proceed at a prudent pace in order to apply lessons learned from early implementation experiences to future contracting cycles.

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## Recommendation for Executive Action

To better ensure the effective implementation of Medicare contracting reform, we recommend that CMS extend its implementation schedule to complete its workload transitions by October 2011, so that the agency can be better prepared to manage this initiative.

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## Agency Comments and Our Evaluation

In its written comments on a draft of this report, CMS noted that implementing Medicare contracting reform would enable the agency to improve the efficiency of the services delivered to Medicare beneficiaries and providers. CMS agreed that implementing contracting reform was a significant undertaking, but did not concur with our recommendation to extend its implementation schedule. CMS stated that by fully implementing MAC contracting 2 years earlier than required, it would achieve savings to the trust funds and operational efficiencies more quickly. In addition, CMS stated that extending the transition schedule would increase the risk of current contractors leaving the program before MAC contracts are awarded and eliminate the agency's flexibility to adjust its schedule in response to unforeseen changes and still meet the mandated implementation date. We believe that by accelerating its implementation schedule to transfer the entire Medicare claims processing workload to MACs by July 2009, CMS is assuming an unnecessary risk.

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While it is true that lengthening the implementation schedule could increase the possibility that one or more contractors might withdraw from Medicare prematurely, we see greater risk in attempting complex transitions without sufficient time for adequate planning and midcourse adjustments. When the considerable risk associated with accelerated implementation is considered in light of uncertain savings, a more prudent approach would be to use the time frame established in the MMA to fully develop implementation plans, evaluate lessons learned, and apply them to future acquisition cycles. In recommending that CMS extend its implementation schedule, we assume that the agency would allow sufficient time at the end of the final transition to adjust for problems and unforeseen circumstances and still meet the mandated implementation date of October 1, 2011. CMS agreed that it would need sufficient time for this kind of adjustment and has not developed plans for all contingencies. For example, CMS responded to a relatively short schedule slippage for its enterprise data center implementation by including in contract language the option for one of the DME MACs to run a data center on an interim basis. However, CMS will still have to develop the details of the contract and choose the most appropriate company to perform this work. This is one example of the many adjustments that will undoubtedly have to be made before all of the transitions are finished.

CMS also stated that it disagreed with our conclusion about its readiness to conduct transitions to MACs. Our report did not conclude that CMS would not be ready to conduct transitions according to its proposed schedule. However, having a fully developed plan in place would assist CMS in conducting these transitions as smoothly as possible. As we stated in the report, CMS has recognized that it needs to develop certain critical areas in its plan and is taking steps to address them. For example, it is clear from its comments that the agency is very concerned about the risks involved in the complex transitions of claims workload and is planning mitigation actions—such as hiring a contractor to help manage the effort. CMS's comments provide additional information on other steps that it is taking to reduce or mitigate significant risks, coordinate the schedule for MAC implementation with other agency fee-for-service initiatives, develop detailed integrated implementation schedules, and address other GAO concerns. Nevertheless, the additional information provided by the agency generally reinforces our point that the agency's implementation plan, which was due to the Congress and to us in October 2004, is still a work in progress. For example, as we pointed out in the report, CMS's comments indicate that it has not completed its integrated implementation schedule and that it is leaving details concerning contractor coordination to MACs and other contractors. In addition, CMS has not finalized important

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implementation information, such as key performance measures or its MAC evaluation strategy and evaluation criteria for A/B MACs, or completed its proposal for a new organizational structure to oversee and manage the MACs. While CMS does have a risk management process, its current identification of risks and mitigation strategies lacks specificity and the agency has not completed a comprehensive risk mitigation plan.

CMS also disagreed with our assessment of the quality of its cost and savings estimates. CMS said that its estimates of implementation costs were well informed by program experience and were the best available predictions of future costs. As we reported, CMS used information from previous transitions of contractor workload to help estimate its administrative costs. This grounded the estimate in the agency's past experience. However, CMS had to make assumptions about the amount of claims workload to be transferred and transition costs to be paid, which might turn out to be inaccurate. Unlike previous workload transitions, CMS is not requiring MACs to maintain staff and facilities from the former contractors. This should allow the MACs to gain efficiencies in operations, but CMS may end up paying more in severance pay or for start-up costs than estimated. Similarly, CMS's experience informed its estimate of administrative savings, but the estimate depends on assumptions about the efficiencies MACs will achieve that are difficult to predict with certainty. While CMS's assumptions about administrative costs and savings might appear reasonable, if the assumptions are inaccurate, the estimates will not reflect the real costs and savings over time. In addition, CMS indicated that because the costs of contract modifications were for operations after the transfer of claims workload, they should not be included in the implementation cost estimate. As CMS noted, its DME statement of work includes a provision for implementing a specific number of programmatic changes after the contract is awarded, to reduce the possibility that CMS would have to negotiate contract modifications that incurred additional costs. We modified our draft to clarify our discussion of the potential costs of contract modifications.

Our greatest concern relates to CMS's consultant's estimate of savings to the trust funds. As we indicated in our report, the estimate of savings to the trust funds is generally based on little evidence and its underlying assumptions may not be reasonable, yet it played a significant role in CMS's decision to compress its implementation schedule. While CMS suggested that the savings estimate is conservative, the consultant who generated this estimate indicated that there were "enormous uncertainties" in estimating savings at this point in the implementation process. In its comments, CMS noted that our report highlighted the lack

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of direct evidence to support the amount of estimated savings. In response, CMS stated that the savings estimate was the best available, given that the changes proposed are unprecedented. CMS indicated that each of the three elements of the estimate of savings to the trust funds addresses a different aspect of the claims process. However, each of the three elements actually addresses the same aspect—MACs improving their medical and other claims review to increase denials of improper claims. CMS's comments indicate that its technical staff agree that the assumptions underlying this estimate are reasonable. We discussed these estimates with CMS officials most knowledgeable about medical and other claims review and they did not agree that the assumptions were based on evidence and were reasonable. Further, because each element in the savings estimate assumes improvement in claims review and improper claims denial, we think it is likely that CMS is double counting its potential savings. For example, the consultant estimated that the MACs would have higher claims denial rates, but also separately estimated savings from other aspects of claims review that—if conducted more efficiently—would lead back to higher claims denial rates.

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We are sending copies of this report to the Secretary of HHS, the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (312) 220-7600 or [aronovitzl@gao.gov](mailto:aronovitzl@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are Sheila K. Avruch, Assistant Director; Sandra D. Gove; Joy L. Kraybill; Kenneth Patton; and Craig Winslow.



Leslie G. Aronovitz  
Director, Health Care

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# Appendix I: Documents CMS Officials Have Identified as Constituting the Agency's Plan for Implementing Contracting Reform

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The Centers for Medicare & Medicaid Services (CMS) has designated its report, entitled *Report to Congress: Medicare Contracting Reform: A Blueprint for a Better Medicare*, and the documents underlying this report as its plan for implementing Medicare fee-for-service contracting reform. Documents include the following:<sup>1</sup>

- maps of jurisdictions for A/B Medicare administrative contractors (MAC), durable medical equipment (DME) MACs, and home health and hospice MACs;
- CMS's estimates for savings to the Medicare trust funds, administrative costs and savings, provider and beneficiary savings, and supporting narrative and information;
- MAC transition timelines;
- DME and A/B MAC project schedules;
- requests for information for A/B MACs and DME MACs, as published on FedBizOpps, including concepts of operations, draft statements of work, draft performance standards, and workload implementation handbooks;
- DME MAC request for proposals and related documents, including the final statement of work, as published on FedBizOpps;
- materials on beneficiary and provider customer service;
- materials concerning work on reengineering Medicare fee-for-service contract management processes;
- BearingPoint, Inc., Health Services Research & Management Group, *Contractor Evaluation Improvement Project (CEIP) Strategy Paper, Final Report* (McLean, Va.: Mar. 18, 2005);
- Centers for Medicare & Medicaid Services, *Medicare Contracting Reform: Acquisition Strategy for Medicare Administrative Contractors*, draft (Baltimore, Md.: Feb. 28, 2005);
- Centers for Medicare & Medicaid Services, *MAC Implementation Project, Risk and Issue Management Process, Schematic* (Baltimore, Md.: Jan. 24, 2005);
- Centers for Medicare & Medicaid Service, *MCMG Risk Management Plan for the Medicare Administrative Contractor Implementation Project*, draft (Baltimore, Md.: Dec. 7, 2004);
- Centers for Medicare & Medicaid Services, *Medicare Contracting Reform, Communication Plan* (Baltimore, Md.: Nov. 10, 2004);
- LMI Government Consulting, *Medicare FFS Contracting Reform: Level Five Work Breakdown Structure and Master Project Plan* (McLean, Va.: October 2004);

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<sup>1</sup>Where documents were prepared by support services contractors and contain recommendations, CMS may have chosen not to adopt all recommendations or not to adopt them in full.

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**Appendix I: Documents CMS Officials Have Identified as Constituting the Agency's Plan for Implementing Contracting Reform**

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- LMI Government Consulting, *Medicare Fee-for-Service Contracting Reform: Assessment of Planning Needs* (McLean, Va.: August 2004);
- Centers for Medicare & Medicaid Services, *Report to the Medicare Contractor Oversight Board: Integration Issues in Modernizing Medicare, Final Report*, submitted by CMS's fee-for-service project integration team (Baltimore, Md.: July 2, 2004), and related briefing documents; and
- Logistics Management Institute, Sensitive Assessment Center, *Medicare Fee-for-Service Contracting Reform: Key Challenges* (McLean, Va.: December 2003).

Also see documents found at the following Web sites:

<http://www.cms.hhs.gov/medicarerereform/contractingreform/> and

[http://www.cms.hhs.gov/medicarerereform/contractingreform/whats\\_new/](http://www.cms.hhs.gov/medicarerereform/contractingreform/whats_new/)

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# Appendix II: Documents Used by GAO to Develop Criteria for Reviewing CMS's Plan for Contracting Reform

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Selected provisions of section 1874A of the Social Security Act, added by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2066, 2378—2386 (to be codified at 42 U.S.C. § 1395kk-1).

Centers for Medicare & Medicaid Services, *Contractor Reform—Update*, September 22, 2004.

Medicare fee-for-service contractor (unnamed), *Contractor Suggestions Regarding Implementation of Medicare Administrative Contracts*. Comments submitted to CMS by a current Medicare fee-for-service contractor. December 22, 2004.

GAO, *Business Process Reengineering Assessment Guide*, [GAO/AIMD-10.1.15](#) (Washington, D.C.: May 1997).

GAO, *An Evaluation Framework for Improving the Procurement Function: A Guide for Assessing Strengths and Weaknesses of Federal Agencies' Procurement (Exposure Draft)*, (Washington, D.C.: October 2003).

LMI Government Consulting, *Medicare Fee-for-Service Contracting Reform: Assessment of Planning Needs* (McLean, Va.: August 2004).

# Appendix III: GAO’s Criteria for Evaluating CMS’s Contracting Reform Plan

Element	Subelement	Criteria
Contracting reform planning and implementation	Contracting reform objectives	Does the plan explain contracting reform objectives, such as promoting competition and establishing better communication between contractors and beneficiaries?
	Scope	Does the plan present an overview of how MAC implementation fits into broader agency plans?
	Schedule	Does the plan state when major events will take place, including announcing MAC jurisdictions, issuing proposed performance measures for inclusion in A/B MAC contracts and requests for proposals, selecting DME MACs and A/B MACs, and completing the transition to MAC contracting?
	Budget	Does the plan provide key information on budget and costs for contracting reform, such as estimated termination costs for current contractors, MAC operational costs, and performance incentives?
	Performance measures for contracting reform	Does the plan provide high-level information on performance measures—that is, what constitutes success in contracting reform and how will progress be measured?
Contracting reform management and oversight	Risk management	Does the plan identify a contingency or risk mitigation strategy for potential problems as contracting reform is being implemented?
	Transition planning	Does the plan address transition concerns and contingency planning for the transitions?
	CMS staffing	Does the plan explain how CMS staff will be organized and who will have specific roles and responsibilities in managing contracting reform?
	Management and oversight structure	Does the plan provide information on CMS’s intended contractor management and oversight structure for MACs?
	Human capital	Does the plan provide an approach for ensuring that the agency has the right staff in the right numbers with the right skills in the right places to accomplish its mission effectively? This approach requires that an agency devote adequate resources to provide its acquisition workforce with the training and knowledge necessary to perform their jobs. It also requires long-range planning, including succession planning, to ensure the workforce has the necessary skills and qualifications to perform the procurement function into the future.
Implementation of MAC contracting	Jurisdictions	Does the plan provide information on MAC jurisdictions, including number and geographic areas?
	Rollout plan	Does the plan provide information on the jurisdictional rollout plan, and how this timeline might be affected by voluntary contractor withdrawals?
	A/B strategy	Does the plan discuss the strategy for combining Part A and Part B and associated implications or risks?
	Contract acquisition	Does the plan address the acquisition process for new contracts?
	Eligibility of contractors	Does the plan describe the eligibility criteria expected of MACs?



**Appendix III: GAO's Criteria for Evaluating  
CMS's Contracting Reform Plan**

<b>Element</b>	<b>Subelement</b>	<b>Criteria</b>
	MAC functions	Does the plan describe the functions that MACs will perform, such as developing local coverage decisions, determining payment amounts, making payments, educating beneficiaries, and communicating with providers?
	Non-MAC functions	Does the plan provide information on functions that will be assigned to non-MAC contracts?
	Coordination concerning program integrity functions	Is the plan clear in defining the roles of MACs and other contractors that conduct program integrity functions, so that program integrity efforts are not duplicative? Does the plan explain how MACs and other contractors will interface and coordinate their different program integrity activities?
	Chains	Does the plan provide information on how MACs will deal with chain providers, which is a concern for those with establishments in multiple MAC jurisdictions?
	Performance requirements	Does the plan address the establishment and definition of performance measures for MACs?
	Policies and processes	Does the plan provide clear, transparent, and consistent policies and processes that provide a basis for the planning, award, administration, and oversight of procurement efforts?

Source: GAO analysis of documents used to develop criteria for reviewing CMS's plan for contracting reform.

Note: Documents used to develop criteria are listed in app. II.

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# Appendix IV: Scope and Methodology

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To conduct this evaluation, we consulted CMS to determine the documents included in its plan for contracting reform. Appendix I lists the documents that were identified by agency officials as included in CMS's contracting reform plan, including its *Report to Congress*, that were provided to us through June 3, 2005. We developed evaluation criteria to assess the extent to which CMS's plan provides an appropriate framework to implement Medicare contracting reform. To develop these criteria, we analyzed the statutory provisions added by section 911 of the MMA, documents and related information prepared to help CMS plan for contracting reform, and GAO guidance on assessing federal agencies' procurement functions. We also reviewed GAO's guidance on changing the approach through which mission-critical work is accomplished. These documents are listed in appendix II. The evaluation criteria we developed address contracting reform planning and implementation, contracting reform management and oversight, and CMS's contracting strategy for MACs and are listed in appendix III. We used these criteria to evaluate CMS's plan. In addition to this assessment, we also conducted interviews with officials at CMS headquarters and regional offices concerning the process for developing the plan, the implementation schedule, the challenges that CMS faces in implementing contracting reform, lessons learned that have prepared CMS for moving to the MAC environment, and the risks and benefits involved in the transition to MAC contracting. We also interviewed officials from four current Medicare contractors to obtain their views on CMS's contracting reform plan and the challenges, risks, and benefits involved in undertaking this effort.

To assess the extent to which the plan's cost and savings estimates were sound enough to support decision making on implementation, we reviewed CMS's estimates for administrative costs and savings, savings to the Medicare trust funds, and supporting documentation. We evaluated the assumptions associated with the estimates. We conducted interviews with CMS officials who have been involved in developing estimates for the costs and savings related to Medicare contracting reform in order to understand the rationale upon which the estimates were based. We interviewed other CMS officials who work in program areas that will be affected by contracting reform to learn how they expect contracting reform to generate costs or savings in their program areas. We also interviewed a representative of CMS's actuarial contractor, which developed the savings estimates for the Medicare trust funds. We did not verify the reliability of CMS's data that were used to generate financial estimates. We performed our work from November 2004 through July 2005 in accordance with generally accepted government auditing standards.

# Appendix V: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 29 2005

Ms. Leslie G. Aronovitz  
Director, Health Care  
U.S. Government Accountability Office  
Washington, DC 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO's) draft report entitled, "MEDICARE CONTRACTING REFORM: CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain" (GAO-05-873). These comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Daniel R. Levinson".

Daniel R. Levinson  
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for U.S. Government Accountability Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

**HHS COMMENTS ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED, "MEDICARE CONTRACTING REFORM: CMS'S PLAN HAS GAPS AND ITS ANTICIPATED SAVINGS ARE UNCERTAIN" (GAO-05-873)**

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the U.S. Government Accountability Office's (GAO) draft report.

**General Comments**

The improvement of services for Medicare program beneficiaries and providers and the efficient delivery of these services is a primary objective for HHS, Centers for Medicare & Medicaid Services (CMS). The Medicare contracting reform provisions outlined in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allow us to make these improvements through changes to the Medicare claims administration contracting practices. CMS agrees with GAO on a fundamental point—achieving these envisioned improvements is not a trivial undertaking. However, CMS does not concur with GAO's recommendation and differs in conclusions regarding three broad areas addressed in its report: schedule suitability, transition readiness, and cost/savings estimate quality.

Regarding the implementation schedule, while CMS has never before undertaken a project of this scope and magnitude, it believes that the potential savings to the Medicare Trust Fund and the envisioned benefits to beneficiaries and providers compel us to maintain our implementation schedule. As discussed further below, CMS has adopted and are implementing a number of strategies to effectively manage this project while sustaining the continuity of Medicare Fee-for-Service (FFS) administrative operations.

All aspects of planning the details of the transition to the new environment are not yet final, and CMS is aggressively addressing the areas of concern noted in the report. Currently CMS is: (1) identifying and mitigating risks that may result from the transition to the new processes; (2) developing guidance on how the new Medicare administrative contractors (MACs) will coordinate with other contractors who are involved with ensuring that benefits and claims are paid; and (3) integrating and coordinating other CMS modernization initiatives that are being implemented concurrently with our contracting reform efforts. Addressing the areas of concern not only allows us to finalize the remaining transition planning details, but also provides us with a means by which to adjust quickly to any issues or situations that might force us to modify our plans.

Finally, with respect to cost/savings estimates for contracting reform, while CMS agrees that its current plan is based partly on predicted future cost and savings estimates, CMS contends that these estimates and planning factors represent the best possible information.

CMS appreciates GAO's acknowledgement of the elements of CMS's current implementation strategy that you believe CMS has fully addressed. In those cases in which CMS disagrees with the findings of the report, it has provided comments to address those concerns. Be assured that CMS is strongly committed to ensuring a transition to the new contracting environment for Medicare that is transparent to Medicare's beneficiaries and providers and confident that its current implementation strategy is fundamentally sound.

**GAO Recommendation**

*To better ensure the effective implementation of Medicare contracting reform, we recommend that CMS extend its implementation schedule to complete its workload transitions by October 2011, so that the agency can be better prepared to manage this initiative.*

**HHS Response**

While CMS acknowledges some of the points raised in this report, we do not concur with the GAO's recommendation. Since it is in the best interest of Medicare beneficiaries and providers, as well as the Government, to assertively procure and transition workload to the new MACs, CMS is taking the necessary steps to reduce or mitigate significant risks, align MAC implementation with other agency FFS initiatives, and create detailed baseline implementation schedules.

By achieving full MAC implementation in 2009, CMS will realize the benefits, both in terms of Trust Fund savings and operational efficiencies, more quickly than if the schedule were extended. The continuing development of modernized Information Technology (IT) systems will improve overall processing of claims, and implementing consolidated data centers will provide the necessary infrastructure to improve data collection and analysis while reducing costs.

CMS believes that extending the transition schedule past 2009 will increase the risk of current fiscal intermediaries (FIs) and carriers leaving the program before competitions are finalized. A number of contractors only intend to stay in the program until their jurisdiction is completed. An extension of the schedule could cause them to reevaluate their plans and leave sooner. This, in turn, would lead to the deterioration of Medicare services, as contractor staff attrition over any extended period may increase, leaving the existing contractor short-staffed in terms of experienced employees. In addition, it would be difficult to replace these departures with capable staff, as that contractor's remaining time in the program would be of short duration. The promise of short-term employment would likely not encourage the acquisition of the most capable personnel.

The schedule published in the 2005 report to Congress, *Medicare Contracting Reform: A Blueprint for a Better Medicare*, with a 2009 completion date, provides CMS the flexibility to adjust in response to any unforeseen changes in the marketplace or legislative environment and still meet the statutory implementation date. CMS would not have this flexibility should it extend its baseline plan to finish implementation on or near October 1, 2011.

**GAO Concern**

*“For example, CMS has already begun to experience schedule slippage for its initiative to consolidate the contractors’ data centers.” (p. 25)*

**HHS Response**

CMS still plans to begin consolidating the data centers in fiscal year (FY) 2006. The enterprise data center (EDC) procurement was moved by two months, while the implementation strategy was reviewed within CMS based on questions posed by industry to our draft request for proposal (RFP). The February 2006 award of EDC contracts will allow preliminary infrastructure work to be completed by June 2006, enabling the first EDC to be ready to coordinate with a Pilot A/B MAC contractor upon award. The EDC FFS Transition schedule is being fully integrated with the A/B MAC Cycle 1 and Cycle 2 procurement schedules.

CMS has determined that the most efficient and effective approach will include implementing two data centers instead of four. This will increase savings and improve standardization of the future data center environment. The only impact of the additional review at CMS was the potential availability of EDCs for durable medical equipment (DME) MACs. CMS had already recognized this risk and a data center option was included in the DME MAC RFP, which provides CMS the flexibility to consolidate DME MAC claims processing into one data center run by a DME MAC contractor if cost effective.

**GAO Concern**

*“For example, the plan lacks a detailed schedule to coordinate reform issues with other major initiatives CMS intends to implement at the same time period.” (Highlights)*

**HHS Response**

CMS is completing an integrated project schedule for the major initiatives it plans to accomplish during the same timeframe as implementation of section 911 of the MMA and will have a more detailed schedule soon. Most recently, CMS’s FFS project integration team has worked to align assumptions, schedules, and resource competitions among all projects for the first two MAC procurement rounds (DME and A/B start-up cycle). CMS has defined MAC implementation as the “anchor” project for integration purposes. While CMS components are working together to align projects, CMS believes the MAC implementation timeframe should be firmly anchored first, followed by alignment and coordination of other initiatives. These efforts have resulted in project plan modifications for some FFS functional activities, such as consolidated EDCs, the Standard Front-End, Qualified Independent Contractors (QICs), and Beneficiary Contact Centers (BCCs).

As CMS continues to refine its more near-term schedules, it continues to work to ensure integrated schedules for the first and second cycles of A/B MAC procurements and transitions. In addition, CMS is employing a commercial off-the-shelf software tool to more easily track its project schedules and information; CMS launched this tool for major projects in mid-July, 2005. These efforts will help CMS closely monitor its established schedules for changes and impacts to dependent projects.

**GAO Concern**

*“However, CMS has yet to develop many details, including information on the specific steps that will be used to facilitate contractor coordination.” (p. 20)*

**HHS Response**

It is clear that the roles played by the FFS functional contractors are inherently interwoven into the work of the MAC. Coordination among these entities is essential to the overall claims administration process, and it is CMS’s intent to closely oversee the functioning of these relationships in the context of monitoring the overall performance of each contract.

To facilitate this coordination, the A/B MAC statement of work (SOW) requires joint operating agreements (JOAs) between the MAC and key functional contractors that will interface with the MAC. These functional contractors include program safeguard contractors (PSCs), QICs, quality improvement organizations (QIOs), recovery audit contractors (RACs), and BCCs.

In the MAC SOW, it is recommended that MACs include the following topics in their JOAs with these functional contractors:

- Confidentiality
- Definitions
- Contract Roles and Responsibilities
- Dispute Resolution
- Connectivity
- Communication

CMS’s approach to the establishment of JOAs is nonprescriptive. CMS believes that the key parties to the JOA (the MAC and functional contractor) will best identify and agree on the specifics of their operational interactions if the responsibility for doing so is delegated to those entities. Each MAC and functional contractor must share responsibility for establishing, negotiating, and maintaining agreement in accord with achieving the expectations of their respective SOWs. At the same time, as part of performance-based contracting, CMS is working to create incentives that will motivate both MAC and functional contractors to operate effectively by ensuring that they coordinate among themselves.

**GAO Concern**

*“... CMS’ plan does not comprehensively detail steps to address potential risks during the transition of claims workload from current contractors ...” (Highlights)*

**HHS Response**

CMS agrees that contracting reform is a project that poses certain inherent risks and, as such, is fully aware of the need for a comprehensive risk management program. CMS staff have been building an ongoing risk management program, complete with a risk database that captures and manages risks as they are identified. Under the process of continuous risk management, risks will continue to be identified throughout the life of this project, and strategies to prioritize and mitigate high risks will continue to be developed and implemented. Risk owners are assigned to develop and implement risk responses, including mitigation plans, where appropriate. CMS is committed to successfully expanding and enhancing its MAC implementation risk management program and coordinating that with the risk management programs for the other segments of FFS contracting reform. For example, CMS staff is now combining the various risk responses into a comprehensive mitigation plan both for MAC implementation and for the larger integrated FFS contracting reform.

**GAO Concern**

*The GAO has identified concerns with a few specific risks of the contracting reform project. (p. 9)*

**HHS Response**

CMS agrees with GAO that continuity of payment operations for health care providers is one of CMS’ primary concerns (especially in a project such as this one), as is the assurance that those payments are made properly.

The number and scale of the proposed workload transitions under contracting reform is significantly greater than the numerous individual transitions CMS has successfully completed over the past decades. As such, this risk will be given appropriate attention by CMS leadership and contractors alike. CMS has extensive experience in managing transitions and the tasks required for a successful transition. These transition tasks for the movement of Medicare workload and operations have not changed because of contracting reform. However, to assist us in managing concurrent jurisdiction transitions, CMS will hire an experienced project management support contractor with Medicare-knowledgeable staff. This contractor will monitor individual segment transition activities and assist us in our integration and coordination efforts with multiple jurisdiction transitions.

CMS agrees that voluntary contractor withdrawals could have a significant impact on contracting reform implementation, and has developed a set of strategies for mitigating this risk. In fact, a recent contractor withdrawal was addressed using the plans CMS had prepared.



Inherent risks are associated with any transition, and the complexity of multiple data center transitions at one time may increase these risks. CMS staff have successfully moved data centers before in conjunction with contractor transitions. Additionally, CMS will gain lessons learned as it conducts the Start-up A/B MAC transitions. The hands-on experience with transitioning multiple workloads and data centers into the EDC environment will also provide a strong foundation for the oversight required for implementing MAC Cycle 1 and Cycle 2 transitions. Completion of transitions to EDCs will reduce future risk in MAC procurements, since data centers will not have to change at the same time.

CMS will leverage the expertise of a transition support contractor to provide separate teams for the overlapping Medicare data center transitions while employing an integrated schedule. CMS's intent is to ensure that current data centers leaving the program are transitioned within one year from the start of their transition. CMS has also fully included requirements for transition planning in the EDC RFP. This approach will allow CMS the opportunity to evaluate the expertise of the potential EDC vendors and ensure that the relevant transition expertise is available to further mitigate these risks.

**GAO Concern**

*“Although CMS has done extensive work toward developing a strategy that outlines how it intends to implement MAC contracting, the agency’s plan lacks important implementation information in some areas.” (p.19)*

**HHS Response**

CMS is making every effort to assure that stakeholders have received all appropriate information related to the MAC procurements and their implementation and will continue to do so. Requests for Information (RFIs) were released on [www.fedbizopps.com](http://www.fedbizopps.com) for both the DME and A/B MAC procurements. CMS released its performance measures for the A/B MAC in an RFI on April 11, 2005, and received 630 comments. Key performance measures will be incorporated in the incentive structure as defined in a mutually agreed upon award fee plan, with the winning offer (an initial award fee plan will be released in September with the RFP). In addition, the evaluation criteria for the A/B MAC were released in an RFI on June 3, 2005. CMS is currently reviewing the comments received on this RFI.

**GAO Concern**

*“For example, the plan does not fully explain CMS’ strategy for monitoring MACs’ performance.” (pp. 3-4)*

**HHS Response**

CMS has continuously worked to improve the oversight and evaluation of Medicare contractors under Title 18. While the structure for oversight under MAC contracting is not currently in place, CMS is implementing a new oversight methodology that it plans to have fully in place when MACs are operational.

Under the Title 18 authority, CMS implemented Contractor Performance Evaluations using national teams that conducted periodic onsite evaluations based on risk assessments. Under MAC implementation, CMS will begin a shift from inspections to surveillance by developing currently available data sources and new reporting capabilities. With Medicare contracting reform, CMS will transition to a new oversight model based on a centralized approach and real-time surveillance. This approach, labeled the Contractor Surveillance and Assessment Program, is built upon four elements of effective contractor oversight:

- Real-time surveillance of contractor operations using a performance dashboard,
- Data validation by CMS of contractor self-reported information,
- Analysis of contract deliverables, and
- Continued use of periodic onsite evaluations predicated upon risk assessments and legislative mandates.

These elements will support the development of contractor performance scorecards and will be integrated with oversight of contractor quality management systems.

**GAO Concern**

*“CMS has not completed its plan for organizational changes ...” (p. 22)*

**HHS Response**

CMS understands the criticality of having an organizational structure that will support contracting reform and has been working to develop such a structure. CMS has reorganized the two internal FFS governing bodies (the FFS Governance Council and the FFS Operations Board) to better function in the MAC environment. CMS also has engaged both central and regional office staff to develop a detailed structure and process that will oversee the new MAC contractors.

The organization of MAC oversight is addressed in an initial draft of the future MAC Administration and Contract Management structure that CMS has developed. This document outlines the reporting lines for an effective management team in the matrix-oriented organization. To control the number of “touch points” to the Project Officer (PO), this model establishes a limited number of PO contacts, while maintaining a flow of information from all critical functional areas and locations.

Additionally, CMS has developed a draft process flow diagram and supporting documents depicting the communication flow needed to monitor the new MAC contracts. The process shows the three most critical oversight areas: deliverables, invoices, and contractor performance. The model displays the interrelation among the various forms of contract monitoring and follows the same communication lines established in the previously mentioned administration and contract management structure.

**GAO Concern**

*The plan's savings estimates are too uncertain to support decisions on contracting reform implementation because they are based on future developments that are difficult to predict. (p. 4)*

**HHS Response**

CMS's Office of the Actuary (OACT) recognizes that the estimates of Trust Fund savings for activities such as this are uncertain. However, the estimated savings were intended to be somewhat conservative (low) because of the uncertainty involved. The Actuarial Research Corporation report points out that the Office of Inspector General estimates a Medicare claims processing error rate of 6 percent in 2002, although the financial loss is undoubtedly smaller than this since many of the errors do not result in permanent denial of the claim but require only technical corrections from the provider submitting the claim. The combined savings claimed for the three provisions is about 0.2 percent of program costs after being fully phased in after several years.<sup>1</sup>

The GAO draft report refers to the possibility of double counting of savings because similar methods were used in the three estimates. The OACT does not concur that there is double counting as the estimates apply to different parts of the claims process. The GAO report also calls attention to the lack of direct evidence that the proposed activities will result in savings of the order of magnitude claimed. Because the changes proposed are unprecedented, CMS has submitted estimates, which it believes are the best available, with appropriate caveats.

**GAO Concern**

*In its draft, GAO argues that it is "difficult," even "impossible," to accurately predict how much contracting reform implementation will cost. GAO further argues that the new contracting environment will differ considerably from the current one and that CMS' estimates are based on certain questionable evidence and assumptions. (pp. 27-32)*

<sup>1</sup> The estimates for:  
(a) requiring contractors serving as fiscal intermediaries to process both part A and part B claims is .08% for both Part A and Part B,  
(b) reducing the number of contractors to 15 plus the specialty contractors for DME and HHA claims is .05% for Part A and .02% for part B, and  
(c) selecting contractors by competitive bidding is .09% for both Part A and Part B.  
Probably due to a typo in the consultant's report, this last figure has been incorrectly quoted as 0.9% (.009 instead of .0009) but the derivation shown in the report and the value used and shown in the tables accompanying report are correct.

**HHS Response**

While any predictions of future costs will be uncertain, CMS maintains that its estimates of implementation costs are both well informed by program experience and the best available. CMS used statistical analysis of the historic relationship between workload size and transition/termination costs and its assumptions as to the probable general success rate of incumbent contractors, as well as the effects of the transition schedule. The GAO report gives the impression that the assumptions CMS used to develop its cost estimates are no more or less plausible than alternative assumptions that could have been applied. On the contrary, CMS formulated the assumptions used in its administrative costing model based on considerable analysis using historical data from actual Medicare operational workload conditions. Similarly, CMS's assumptions relating to contractor incentives and administrative efficiencies (savings) were developed based on extensive analysis and historic CMS experience. CMS believes that its estimating efforts have been very reasonable, but will improve them as this initiative unfolds and better data (including actual experience) becomes available.

**GAO Concern**

*The savings estimates were developed by an external consultant. (p. 32)*

**HHS Response**

OACT has reviewed the estimates and concurs with them. Estimates for these activities are inherently uncertain; however, the OACT consultant has provided the best, unbiased estimates possible. The estimates are intended to be somewhat conservative because of the uncertainty involved. The consultant, the Actuarial Research Corporation, has extensive experience in doing cost estimates for the Medicare program and has provided assistance to the OACT for many years. The OACT is confident these are the best estimates available.

The draft report suggests that the estimates did not receive as much internal CMS review as would be desirable. While individual CMS operating components, such as medical review, were not directly involved in the development of these cost estimates, CMS technical staff in this area agree that the contractor used reasonable assumptions in developing its cost savings estimates. For example, consolidating Part A and Part B operations claims processing functions, as well as medical review functions, will presumably lead to significant overall cost savings because of a more integrated data structure for Parts A and B.

**GAO Concern**

*"A potential cost omitted from CMS's estimates is funding for MAC contract modifications." (p. 30)*

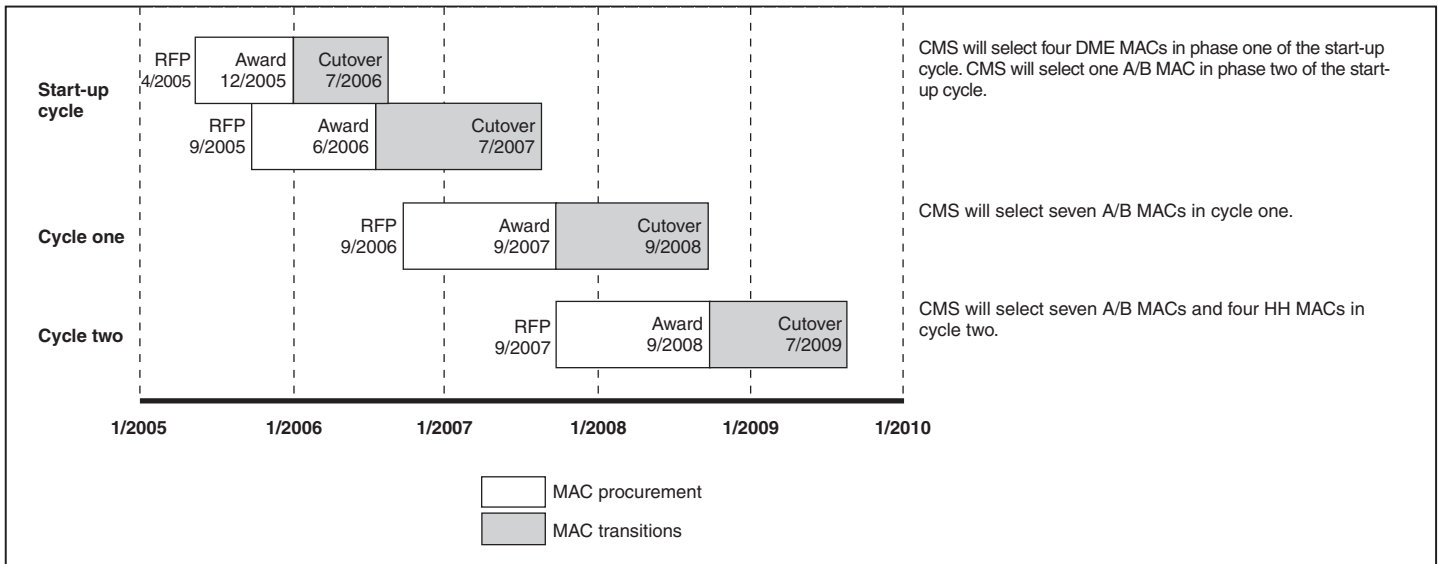
**HHS Response**

CMS does not agree with GAO's discussion on pages 30 and 31 about the potential cost of MAC contract modifications being omitted from its cost estimates. The cost of contract modifications is ongoing (i.e. operational) cost and it should not have been included in implementation cost estimates. Operational costs are those incurred by the MACs in performing the work specified in the SOW. The instructions issued to potential bidders for DME MAC work directed them to assume, for proposal purposes only, a level of effort for implementing a specified number of changes. Thus, the potential cost of routine work required after the contracts are awarded *has* been considered.

# Appendix VI: CMS's MAC Procurement and Transition Schedule

Figure 5 shows CMS's procurement and transition schedule for MACs, as of June 2005. During one start-up cycle and two additional transition cycles, CMS will conduct competitions to select a total of 23 MACs. In the first phase of the start-up cycle, CMS will select four MACs that will be administering claims for DME, prosthetics, orthotics, and supplies—called DME MACs. In the second phase of the start-up cycle, CMS will select one of the MACs that will be responsible for paying Part A and Part B claims—called A/B MACs. During cycle one, CMS will select seven A/B MACs. During cycle two, CMS will select seven A/B MACs and four MACs that will be responsible for administering claims for home health and hospice (HH) care, called HH MACs.

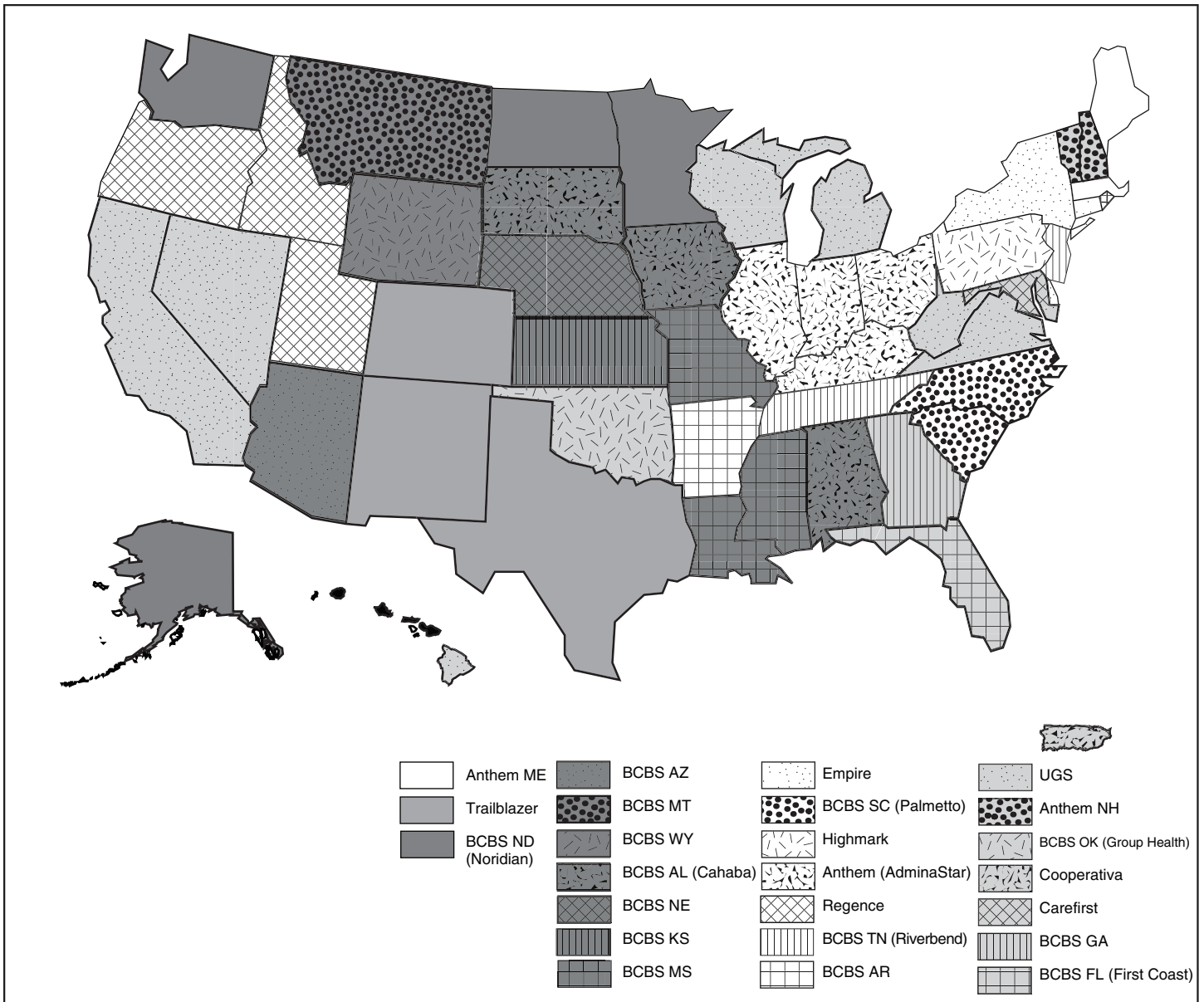
**Figure 5: CMS's MAC Procurement and Transition Schedule**



Source: GAO.

Notes: Based on information from CMS. The request for proposals (RFP) announces CMS's intent to award a contract and specifies the service or product to be delivered, the criteria to be used, applicant qualifications, deadline, and other relevant information. In this figure, the date under RFP indicates when it was, or will be, first issued. The date under award indicates when CMS intends to announce publicly that the contract has been awarded. Cutover occurs when all work has been transferred to the MAC from the prior claims administration contractors. The date under cutoff indicates when CMS anticipates the transfer of work for these contracts to be completed.

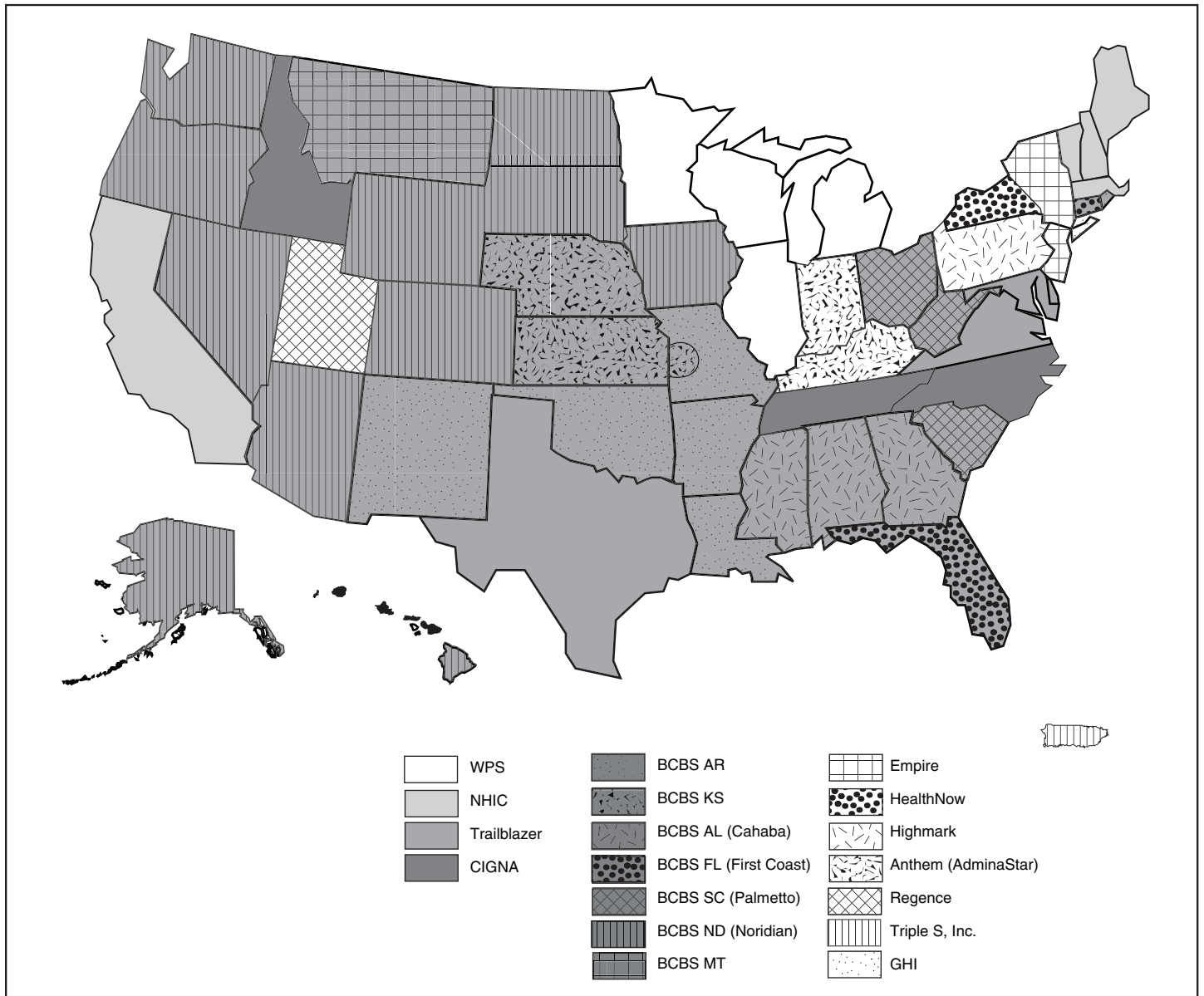
# Appendix VII: Jurisdictional Map of the Current Fiscal Intermediaries



Source: CMS.

Notes: Fiscal intermediaries administer Part A and Part B claims paid to hospitals and other institutions, such as home health agencies. The figure indicates jurisdictions of companies that serve as fiscal intermediaries. Mutual of Omaha also serves as a fiscal intermediary to providers in all states except New York and Puerto Rico.

# Appendix VIII: Jurisdictional Map of the Current Carriers

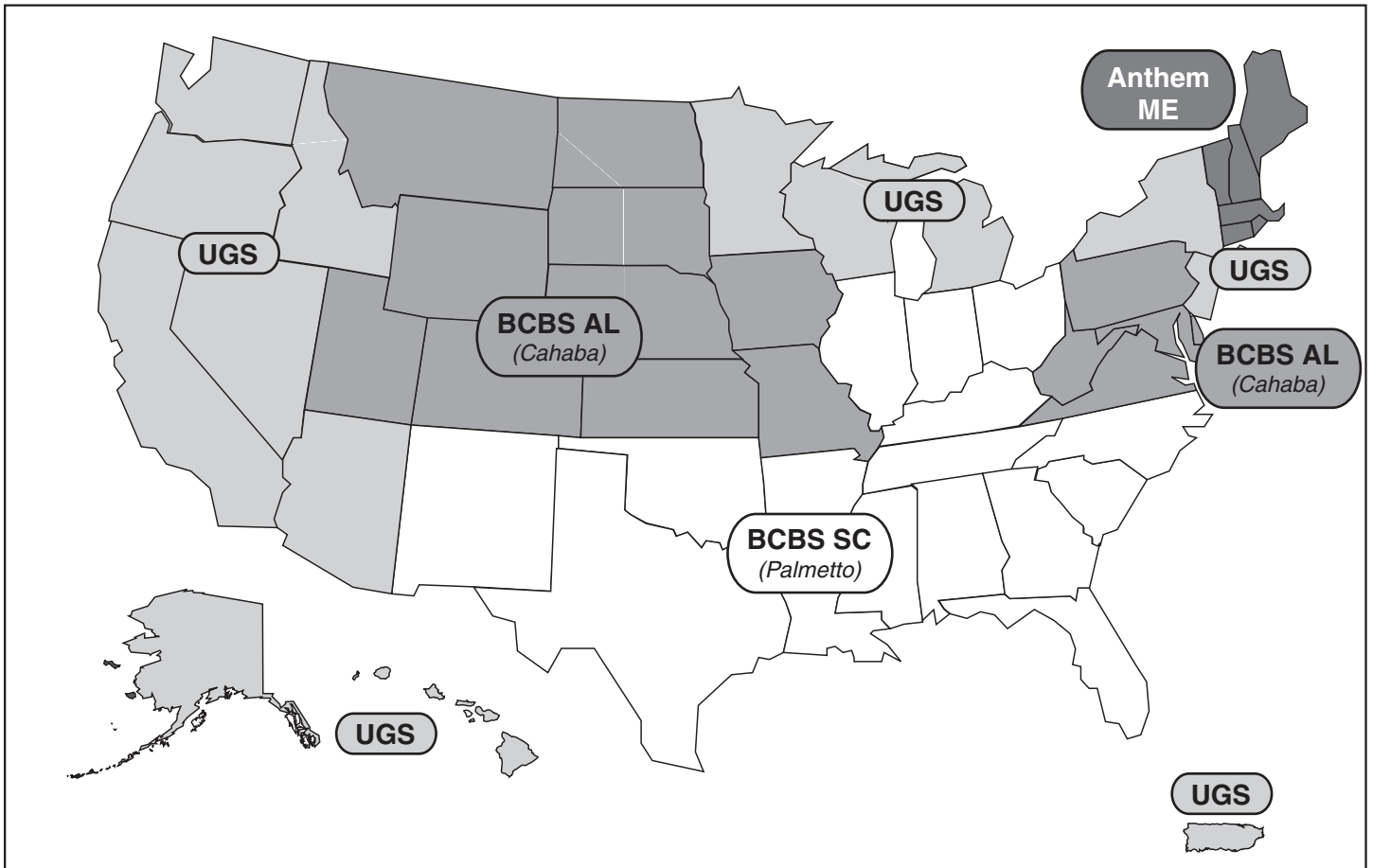


Source: CMS.

Note: Carriers administer the majority of Part B claims for the services of physicians and other providers.



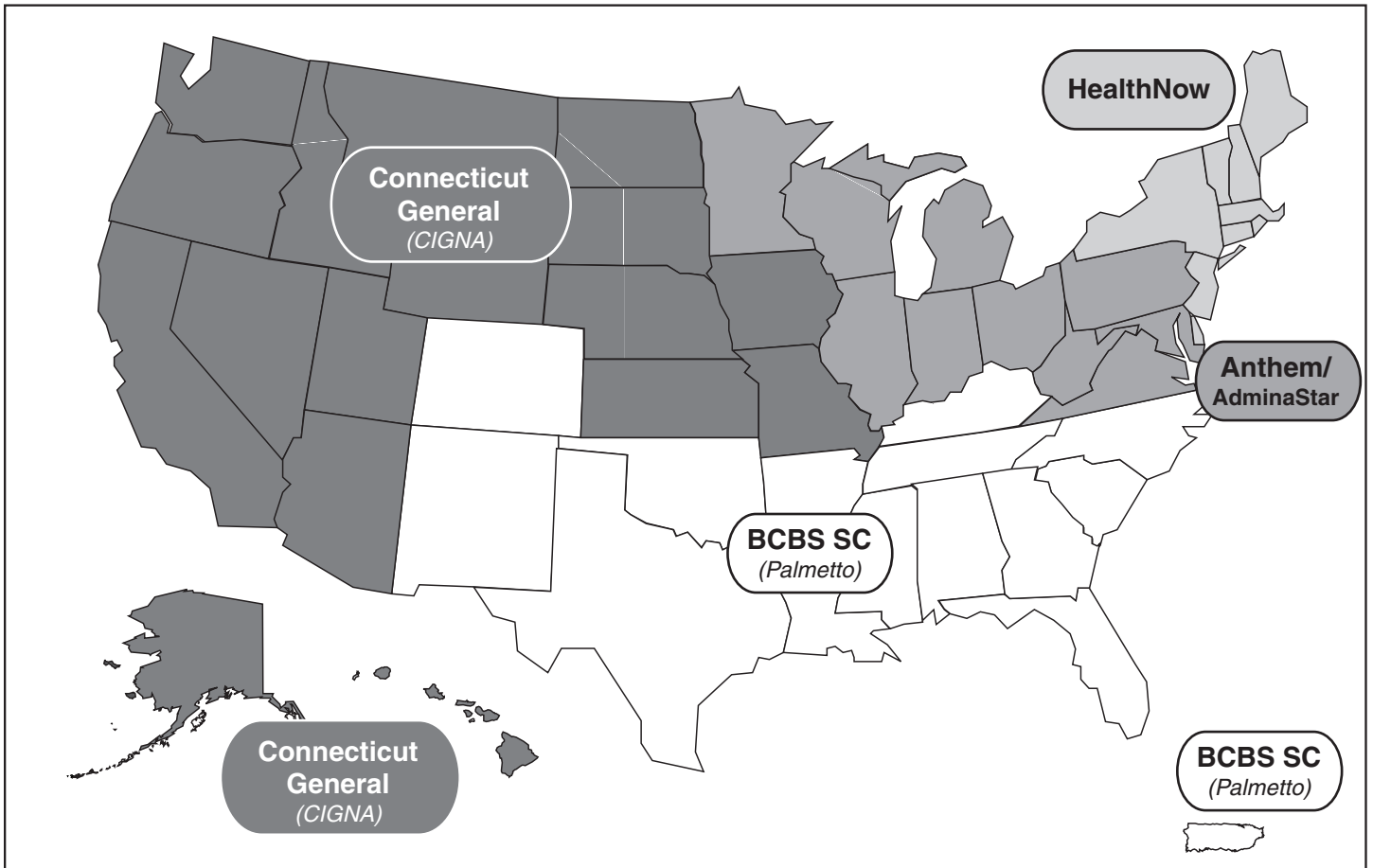
# Appendix IX: Jurisdictional Map of the Current Regional Home Health Intermediaries



Source: CMS.

Note: Regional home health intermediaries process Medicare home health and hospice claims.

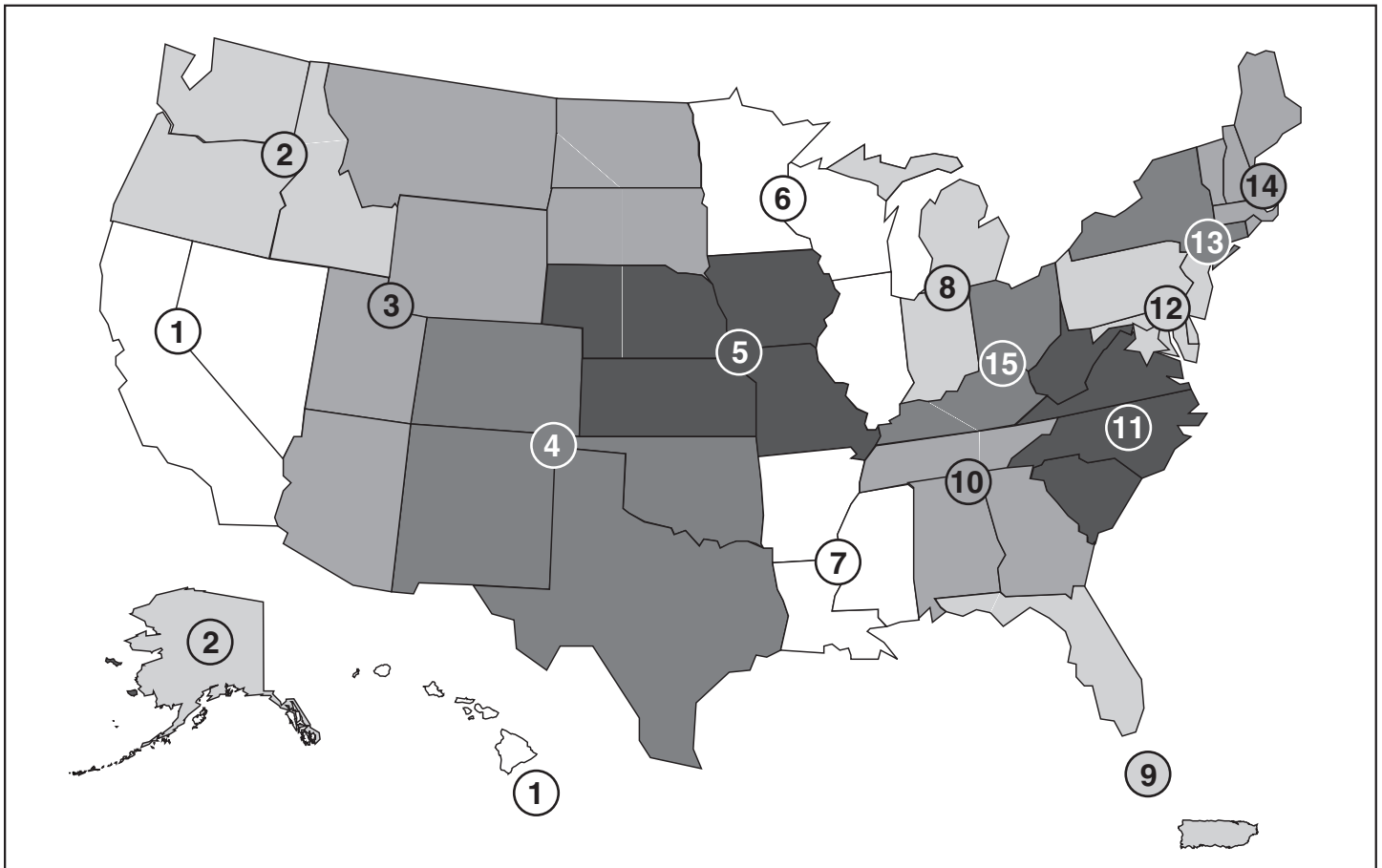
# Appendix X: Jurisdictional Map of the Current Durable Medical Equipment Regional Carriers



Source: CMS.

Note: DME regional carriers pay claims for DME, prosthetics, orthotics, and supplies.

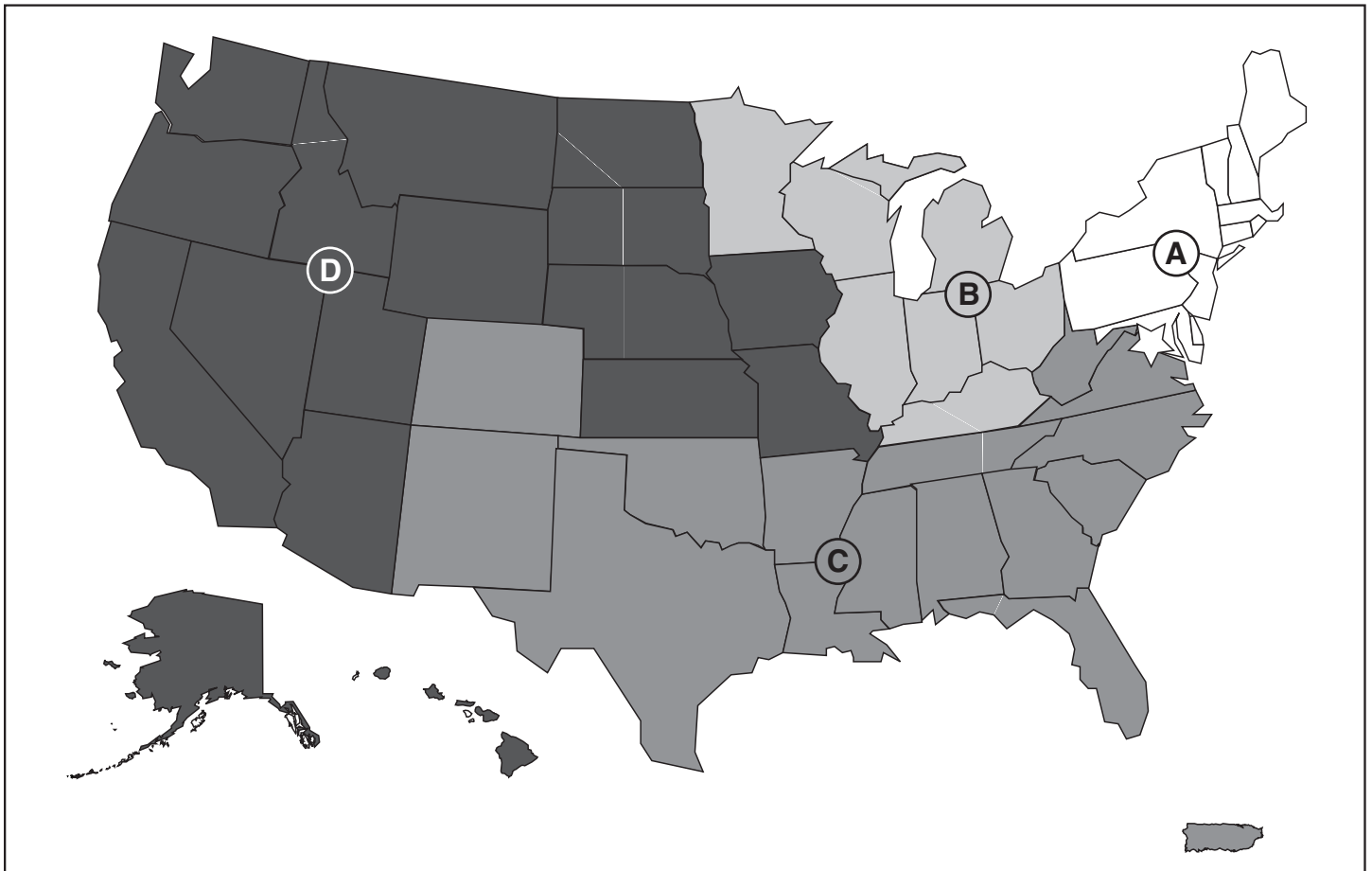
# Appendix XI: Jurisdictional Map of the 15 New Medicare Administrative Contractors



Source: CMS.

Notes: This map shows the jurisdictions for the MACs that will pay Part A and Part B claims, other than claims for HH care and for DME, prosthetics, orthotics, and supplies. These MACs will be called A/B MACs.

# Appendix XII: Jurisdictional Map of the Four DME MACs and the Four HH MACs



Source: CMS.

Note: This figure indicates the jurisdictions for MACs that will pay some specific types of claims. The DME MACs will pay claims for DME, prosthetics, orthotics, and supplies. The HH MACs will pay claims for HH care.

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