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March 2010

# MEDICARE CONTRACTING REFORM

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



GAO

Accountability \* Integrity \* Reliability

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Highlights of [GAO-10-71](#), a report to the Committee on Finance, U.S. Senate

## Why GAO Did This Study

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

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

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

View [GAO-10-71](#) or [key components](#). For more information, contact Kathleen King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

## MEDICARE CONTRACTING REFORM

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

#### What GAO Found

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

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

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

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

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## Abbreviations

CMM	Center for Medicare Management
CMS	Centers for Medicare & Medicaid Services
CNI	Chickasaw Nation Industries
DME	durable medical equipment
EDC	Enterprise Data Center
FAR	Federal Acquisition Regulation
HHS	Department of Health and Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
JOA	Joint Operating Agreements
MAC	Medicare Administrative Contractor
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NPI	National Provider Identifier
OAGM	Office of Acquisition and Grants Management
QASP	Quality Assurance Surveillance Plan
SOW	statement of work

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United States Government Accountability Office  
Washington, DC 20548

March 25, 2010

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

Since the enactment of Medicare in 1965, claims administration contractors have played a vital role in the program. The program was designed so that the federal government could contract with health insurers or similar companies experienced in handling physician and hospital claims to pay Medicare claims. These Medicare claims administration contractors process and pay claims, handle the first-level appeals of denied claims, and serve as providers' primary contact with Medicare. In addition, they answer complex inquiries from beneficiaries related to Medicare claims-processing or coverage rules. In fiscal year 2008, these contractors processed almost 1.2 billion fee-for-service claims and issued about \$310 billion in payments for Medicare health services.

Medicare claims administration contracting prior to 2003 had unique features in statute that differed from most other federal contracting. Before 2003, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program<sup>1</sup>—awarded Medicare claims administration contracts to entities now referred to as legacy contractors that were not selected through a competitive process. The agency's

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<sup>1</sup>The Secretary of Health and Human Services delegated the authority vested in that position under the Medicare provisions of the Social Security Act to the Administrator of CMS.

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authority to terminate these contracts also was limited.<sup>2</sup> Beginning in the 1980s, HHS asked Congress for changes in authority regarding the selection of claims administration contractors. HHS cited several reasons for such reform, including providing the agency with greater flexibility to administer the program, promoting competition, improving services to beneficiaries and providers, achieving cost savings, and increasing CMS's ability to reward Medicare contractors that performed well.

In 2003, Congress included such reform in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Specifically, the MMA repealed limitations on the types of contractors CMS could use and required CMS to use competitive procedures to select new contracting entities to process medical claims, provide incentives for them to provide quality service, develop performance standards including standards for customer satisfaction, and comply with the Federal Acquisition Regulation (FAR),<sup>3</sup> except where inconsistent with specific MMA provisions. The MMA also required CMS to complete implementation of the reform by October 2011 and to recompetete the contracts at least once every 5 years.<sup>4</sup> Additionally, the MMA required the Secretary of HHS to submit an implementation plan report on contracting reform to Congress in 2004 and an interim report on the reform's progress in October 2008.<sup>5</sup>

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<sup>2</sup>CMS officials use the term "legacy contractors" to describe both carriers and fiscal intermediaries that administered claims under contracts established before 2003. Carriers handled the majority of Medicare Part B claims for the services of physicians and other providers, including suppliers of durable medical equipment; and fiscal intermediaries administered Medicare Part A and Part B claims to hospitals, other institutions, and home health agencies. Rather than requiring CMS to select contractors competitively, Medicare law prior to 2003 required CMS to select health insurers or similar companies to be carriers and to choose fiscal intermediaries from among organizations that were first selected by associations representing providers. CMS could not terminate legacy contracts unless the contractors were first provided with an opportunity for a hearing, and the contractors themselves could terminate their contracts.

<sup>3</sup>The FAR establishes uniform policies for acquisition of supplies and services by executive agencies. 48 C.F.R. ch.1.

<sup>4</sup>The MMA provided that contracts with Medicare Administrative Contractors (MAC) could be renewed from term to term without the application of competitive procedures if the contractors met or exceeded performance requirements, but required CMS to provide for the application of competitive procedures at least every 5 years.

<sup>5</sup>In August 2009, CMS officials told us the agency had not submitted the interim report to Congress.

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CMS is in the process of implementing MMA contracting reform requirements by transferring all claims administration tasks from the 51 legacy contractors to 19 new entities known as Medicare Administrative Contractors (MAC).<sup>6</sup> Specifically, 15 MACs will process both Part A and Part B Medicare claims (A/B MAC),<sup>7</sup> and 4 MACs will process durable medical equipment (DME) claims (DME MAC).<sup>8</sup> (Apps. I and II provide maps of the MAC contract regions, known as jurisdictions.) The agency chose to implement the MAC transition in three cycles: the Start-Up Cycle, including all 4 DME MACs and 1 A/B MAC, and Cycle 1 and Cycle 2, each consisting of 7 A/B MACs. As of September 2009, CMS had fully implemented 9 A/B MACs and 4 DME MACs.<sup>9</sup> The contracts for the remaining 6 A/B MACs were awarded, but the awards were protested.<sup>10</sup> CMS is taking corrective actions on these remaining awards.

CMS initially anticipated that it could complete the claims administration transfer from legacy contractors to MACs by July 2009, before the October 1, 2011, MMA deadline. In August 2005,<sup>11</sup> we highlighted CMS's accelerated timeline as a concern because it did not leave time for adjustments to be made for unforeseen obstacles, such as bid protests by unsuccessful offerers, which generally halt implementation until they are resolved. In that report, we indicated that the accelerated implementation

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<sup>6</sup>As of 2005, when the Secretary of HHS released the report to Congress on the implementation plan for Medicare contracting reform, CMS reported there were 51 legacy contractors: 22 carriers and 29 fiscal intermediaries.

<sup>7</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, prosthetics, orthotics, and supplies.

<sup>8</sup>These include claims for DME, prosthetics, orthotics, and supplies.

<sup>9</sup>As of September 2009, CMS had fully implemented the 4 DME MAC jurisdictions and 1 A/B MAC jurisdiction in the Start-Up Cycle, 5 of the 7 A/B MAC jurisdictions in Cycle 1, and 3 of the 7 A/B MAC jurisdictions in Cycle 2.

<sup>10</sup>Unsuccessful and prospective offerors (companies seeking contracts with the federal government) may file protests of the award or solicitation of federal contracts with GAO or the contracting agency. They may also protest to the United States Court of Federal Claims. A division of GAO, separate from the division conducting this study, resolves the protests filed with GAO within 100 days of the protest filing. Until the protest is resolved, the agency generally cannot proceed with performance of the contract.

<sup>11</sup>GAO, *Medicare Contracting Reform: CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain*, [GAO-05-873](#) (Washington, D.C.: Aug. 17, 2005).

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schedule and other risks such as the volume and complexity of anticipated claims-processing workload transitions, and the potential for contractor withdrawals, had the potential to disrupt claims administration services, possibly resulting in delayed or improper payments to providers.<sup>12</sup> Although CMS did not agree with our 2005 recommendation to extend its MAC implementation schedule to allow more time for planning and midcourse adjustments, the agency did acknowledge it needed to develop certain critical areas in its plan to help it manage the transition.<sup>13</sup> In our 2005 report, we also questioned the likelihood of CMS's achieving the predicted cost savings that it had used as one rationale for the accelerated timeline.<sup>14</sup>

You asked us to evaluate and report on Medicare contracting reform efforts. We examined (1) how CMS has implemented Medicare contracting reform, (2) how CMS assessed the performance of the MACs and what the results of its assessments have been, and (3) what CMS's costs and savings have been for Medicare contracting reform.

To determine how CMS has implemented Medicare contracting reform, and specifically how it has implemented the MAC program, we examined CMS and MAC documents and conducted interviews with CMS officials. In particular, we selected 6 MAC jurisdictions from among the 10 where a final contract award had been made by June 2008, analyzed documents from the implementation of the MMA provisions in each jurisdiction, and interviewed CMS staff responsible for coordinating MAC contract awards and transition from legacy contractors to the MACs.<sup>15</sup> Our sample was designed to ensure diversity in geographic region, claims workload, complexity of transition, bid protest experience, and CMS's assessment of a jurisdiction's risk for fraud. In addition, for the 6 jurisdictions we selected, we interviewed incoming MACs and certain legacy contractors. We also interviewed health care provider associations located in the jurisdictions covered by 2 of the 6 MACs to understand how CMS

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<sup>12</sup>GAO-05-873, p. 13.

<sup>13</sup>GAO-05-873, p. 37. In the report we noted that CMS officials had identified some factors that might pose a risk to MAC implementation. For example, CMS's comments on the report noted that the agency was very concerned about the risks involved in the complex transitions of claims workload and was planning mitigating actions.

<sup>14</sup>GAO-05-873, pp. 33, 35.

<sup>15</sup>The six MACs we studied assumed responsibility for Medicare operations in their jurisdictions from July 2006 through December 2008.

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implemented Medicare contracting reform. Finally, we analyzed documents and conducted interviews to understand what lessons CMS may have learned that may help inform future award cycles.

To determine how CMS has assessed the performance of the MACs and to determine the results of its assessments, we reviewed sections of the FAR related to performance-based contracting and cost-plus-award-fee contracts, the type of contract CMS is using for the MACs. We also analyzed CMS documents to understand the agency's performance assessment process for the MACs. In addition, we interviewed officials in CMS's Medicare Contractor Management Group responsible for MACs and legacy contractor oversight to understand the agency's performance assessment framework and activities. To report on CMS's assessments of the MACs, we analyzed performance results for the three MACs in our sample that had completed all components of their performance assessment reviews by March 2009.<sup>16</sup>

To determine what CMS's costs and savings have been for Medicare contracting reform, we reviewed and analyzed relevant documents, including CMS's budget and estimates of potential costs and savings. We also interviewed CMS officials responsible for development and oversight of contracting reform budgets and estimates of potential costs and savings to understand CMS's process for tracking and reporting the financial status of contracting reform. We found the CMS-reported internal and external cost data for contracting reform and CMS-reported spending data for selected Medicare operational activities sufficiently reliable for the purposes of this report, based on relevant interviews and document reviews.

We conducted this performance audit from May 2008 through March 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Appendix III includes a more detailed discussion of our scope and methodology.

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<sup>16</sup>The three MACs we studied particularly to report on CMS's MAC assessments all assumed responsibility for Medicare operations from July 2006 through June 2007.

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## Background

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### Medicare Claims Administration Contracting before 2003

Prior to 2003, CMS was required by statute to select the two types of Medicare contractors it used at the time—fiscal intermediaries and carriers—from particular organization types. Congress limited the type of contractors CMS could use for claims administration activities when Medicare was enacted in 1965, in part because providers were concerned that the program would give the government too much control over health care. To increase providers' acceptance of the new program and to assuage their concerns, Congress required that health insurers that already served as payers of health care services to physicians and hospitals become the Medicare claims administration contractors. Specifically, prior to 2003, CMS was required by law to select the first type of claims administration contractor, fiscal intermediaries—contractors that paid Part A and Part B claims for institutions such as hospitals—from among companies that were nominated by health care provider associations.<sup>17</sup> Medicare law further required CMS to select the other type of contractor, carriers—contractors that paid the majority of Part B claims, such as for services provided by physicians and other providers—from among health insurers or similar companies.

During this period, Medicare claims administration contracts were typically renewed every year, and CMS could not terminate the contracts unless the contractors were first provided with an opportunity for a public hearing. The contractors themselves could terminate their contracts and have their termination costs reimbursed by CMS irrespective of which party terminated the contract. In addition, the claims administration contractors were paid on the basis of their allowable costs, generally without financial incentives to encourage superior performance.<sup>18</sup>

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<sup>17</sup>Section 1816 of the Social Security Act governed the administration of Part A, and section 1842 governed the administration of Part B. The MMA added new section 1874A, which now governs the administration of Parts A and B, and made conforming changes to the other sections.

<sup>18</sup>Prior to 2003, the Social Security Act generally provided that Medicare use cost-reimbursement contracts, under which contractors were reimbursed for necessary and proper costs of carrying out program activities.

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## Changes in Contracting following Enactment of MMA

The MMA requirement that CMS follow competitive procedures and the FAR in awarding contracts to MACs—except where MMA provisions explicitly differed—introduced key differences in how the agency would have to conduct its MAC contracting compared to how it had conducted its legacy contracting prior to 2003. Notably, under the FAR,

- agencies are generally required to conduct full and open competition for contracts and are permitted to contract with any qualified entity for any authorized purpose, with some exceptions;
- agencies are permitted to terminate contracts either for the government’s convenience or if they determine that the contractor is in default; and
- agencies are permitted to include financial incentives to contractors for meeting or exceeding performance goals.<sup>19</sup>

The MMA provided more specificity on certain aspects of CMS’s Medicare claims administration contracting processes. For example, CMS is to

- conduct a competition for MACs at least every 5 years,
- develop performance requirements and measurement standards for MACs,
- set forth the performance requirements<sup>20</sup> in the MAC contracts,
- ensure the performance requirements and standards are used to evaluate MAC performance and are consistent with the MACs’ statement of work (SOW),<sup>21</sup> and
- develop a measurement standard for provider and beneficiary satisfaction.

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<sup>19</sup>Under the requirements for Medicare administrative contracting added by the MMA, incentives are to be provided to MACs to provide quality services and to promote efficiency.

<sup>20</sup>These performance requirements are grouped according to functionality and generally are followed by specific standards against which MAC performance, that is, the quality of MAC services, may be assessed.

<sup>21</sup>SOWs are those documents generally incorporated in contract solicitations and, subsequently, contracts that specify, either directly or with reference to other documents, the work the government expects the contractors to perform.

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CMS selected a contract type for the MACs that allows it to provide incentives tied to service and efficiency of operations. CMS opted to establish MAC contracts as cost-plus-award-fee contracts, a type of cost-reimbursement contract that allows an agency to provide financial incentives to contractors if they achieve performance goals.<sup>22</sup> A MAC may earn an incentive, known as an award fee, based on performance, in addition to reimbursement for allowable costs<sup>23</sup> and a base fee for the contract, which is fixed at the inception of the contract.<sup>24</sup>

The FAR provides additional guidance for performance-based contracts.<sup>25</sup> If such a contract is used, the FAR requires that the agency establish methods that enable it to assess work performance against measurable performance standards.<sup>26</sup> In addition, the FAR requires that the agency conduct performance evaluations and inform contractors about their performance and the areas in which improvement is expected. The FAR further states that agencies should prepare a quality assurance surveillance plan in conjunction with the SOW, which documents the agency's approach to evaluating performance, and a review of the contractor's quality control program.

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## MAC Responsibilities

In the new contracting environment, MACs are responsible for most of the functions previously performed by the legacy contractors. They are responsible for processing and paying claims, handling the first level of appeal—redeterminations of denied claims, conducting medical review of

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<sup>22</sup>Under the FAR, agencies generally select from two broad categories of contract types: fixed-price and cost-reimbursement, which includes cost-plus-award-fee contracts.

<sup>23</sup>Cost allowability is defined in 48 C.F.R. ch. 31 as complying with all of the following requirements: reasonableness, allocability, cost accounting standards, terms of the contract, and other limitations in the FAR.

<sup>24</sup>Award-fee pools are established as a percentage of the total estimated contract amount. The actual fees paid are based on assessments made by CMS using criteria in Award Fee Plans.

<sup>25</sup>Performance-based contracting structures all aspects of an acquisition around the purpose of the work to be performed, as opposed to the manner by which the work is to be performed, with the contract requirements set forth in clear, specific, and objective terms with measurable outcomes.

<sup>26</sup>The FAR requires performance-based contracts to use measurable contractor performance standards that describe contractor performance in terms of quality, timeliness, and quantity.

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claims,<sup>27</sup> putting computerized edits into their portion of the claims-processing system to help ensure proper payment, serving as providers' primary contact with Medicare by enrolling providers, conducting provider outreach and education, responding to provider inquiries, and auditing provider cost reports. In addition, MACs are responsible for coordinating with other CMS contractors that perform limited Medicare functions that serve beneficiaries and providers. For example, the 1-800-MEDICARE help line answers calls for general and claims-specific beneficiary inquiries and forwards a relatively small number of complex beneficiary inquiries to the MACs to respond. The MACs also are required to provide required reports and other documents, known as deliverables, to CMS within generally specified time frames.

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## CMS's Plans for Contracting Reform

In its February 2005 report to Congress, *Medicare Contracting Reform: A Blueprint for a Better Medicare*, HHS outlined CMS's plans for implementing contracting reform and highlighted anticipated improvements, including improved customer service, streamlined service delivery by integrating claims-processing functions, and savings from reducing program costs (see fig. 1).

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<sup>27</sup>Medical review is performed by Medicare contractors, before or after payment, to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Most medical review is conducted through computerized claims edits—instructions programmed into the claims-processing system that identify a set of claims meeting specified characteristics—with a limited number of claims reviewed by clinically-trained staff. Claims are reviewed to see if beneficiaries' conditions meet Medicare coverage criteria. If medical reviews identify claims that should not have been paid, the contractor that paid the claim is responsible for collecting overpayments. The MACs will conduct medical review of any claims they process.

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**Figure 1: CMS's Reported Goals for and Anticipated Improvements from Contracting Reform**

**CMS's reported goals for implementing contracting reform:**

- minimizing disruption to beneficiaries, providers, physicians, and suppliers;
- preventing disruption of claims processing and Medicare operations;
- completing transition activities within the required time period;
- ensuring that costs represent effective and efficient use of resources; and
- ensuring that all parties with an interest in the transition are kept informed of the transition's status and progress.

**CMS's anticipated improvements from contracting reform:**

- improving customer service for beneficiaries and health care providers;
- improving delivery of comprehensive services by integrating claims processing for Medicare Parts A and B under the MACs;
- opening competition to a wider pool of contractors to encourage innovation and higher performance;
- creating a modernized administrative information technology platform to support the MACs and provide a central location for the storage and management of Medicare data; and
- achieving savings beginning in fiscal year 2008, and achieving estimated cumulative savings of \$900 million through fiscal year 2010.<sup>a</sup>

Source: GAO analysis of CMS data.

Notes: Information is from the 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>a</sup>In our 2005 report, we found that the basis for these savings estimates was uncertain. For related information, see [GAO-05-873](#).

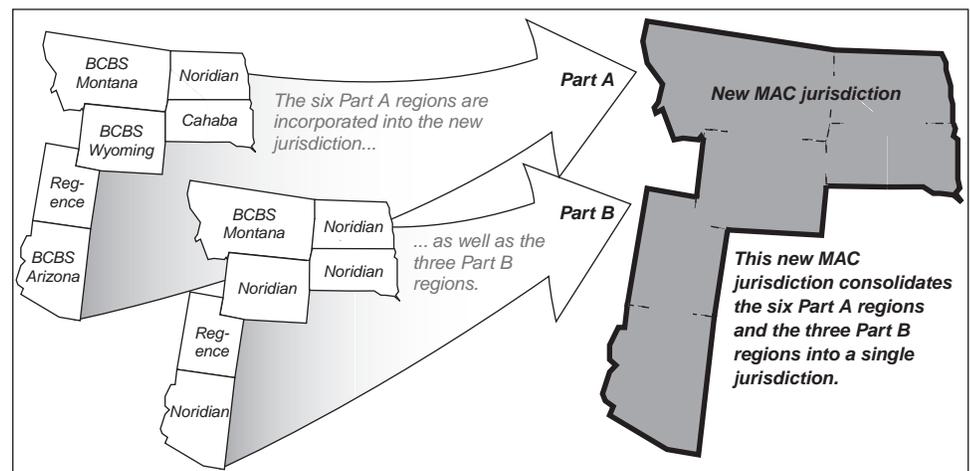
CMS designed the new MAC jurisdictions to achieve operational efficiencies by consolidating the number and types of contractors and better balancing workloads. In the legacy contracting environment, different contractors handled Part A and Part B claims in the majority of states, and multiple contractors were responsible for regions in which they processed claims across several—sometimes noncontiguous—states.<sup>28</sup> In its 2005 report to Congress, CMS called the varying legacy contractors that

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<sup>28</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.

processed Part A and Part B claims “a patchwork of responsibility and service,”<sup>29</sup> a problem it hoped to solve with consolidation. Whereas in the legacy environment, a single state might have been served by multiple contractors handling Part A and B claims in their separate regions, in the MAC environment, CMS established MAC jurisdictions, which were based on contiguous state boundaries, such that a single A/B MAC handled all Part A and B claims—other than DME claims—in its jurisdiction. (See fig. 2.)

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



Source: GAO.

Note: Data are adapted from [GAO-05-873](#).

As of September 2009, CMS told us it had awarded and implemented 13 MAC contracts, worth at least \$3 billion. Each contract is for 1 year (referred to as a base year), with up to 4 “option years,” should CMS choose to exercise them.<sup>30</sup> During the MAC’s base year, the legacy contractors transitioned their workload over a period that generally lasted about 7 months for the 6 MACs in our study, ranging from 4 to 10 months. CMS instructed the MACs and legacy contractors to work together to

<sup>29</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>30</sup>CMS could choose to exercise its option for an additional year annually for up to 4 years. As of September 2009, it had exercised this option for all DME MACs and A/B MACs that completed a base year.

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transfer data and records and required the MACs to educate providers about the change.<sup>31</sup> CMS also assigned responsibility to the MACs for consolidating computerized claims edits (used during processing to determine whether to accept, adjust, or reject a claim) that may have differed among the multiple legacy contractors into one consistent set of edits for each newly consolidated MAC jurisdiction. Furthermore, within their respective jurisdictions, A/B MACs were required to consolidate the legacy contractors' policies that determine what services Medicare covers in a jurisdiction—called local coverage determinations<sup>32</sup>—into one consistent set of policies within each jurisdiction.<sup>33</sup>

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## CMS Components Principally Responsible for Contracting Reform

Two CMS components are principally responsible for Medicare contracting reform: the Office of Acquisition and Grants Management (OAGM) and the Center for Medicare Management (CMM). While the OAGM is responsible for awarding Medicare administrative contracts, divisions within the CMM are responsible for MAC program and operations management, development, and performance assessment, as well as for developing and executing both the Medicare contracting reform budget and the MAC operating budgets. (See app. IV for a CMS organizational chart of the components involved in Medicare contracting reform.) Other parts of CMS coordinate with these two components, such as the Office of Financial Management, which establishes many program requirements for MACs, including, but not limited to, financial reporting. To manage the complex transition and to conduct oversight of the MACs, CMS assembled a staff with experience in acquisitions, contract management, and program management, as well as technical advisors in areas such as information technology and claims processing.

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<sup>31</sup>The MACs are required to assess the educational needs of the providers they serve in their respective jurisdictions and deliver appropriate educational activities to meet those needs.

<sup>32</sup>While each MAC or legacy contractor may establish its own local coverage determinations based on whether services are reasonable and necessary, all must implement any national coverage determinations, which are made by CMS. Unlike A/B contractors, the legacy contractors that paid DME claims already had nationally consistent coverage policies prior to MAC implementation.

<sup>33</sup>For example, a MAC jurisdiction might include areas where one legacy contractor had covered treatment for actinic keratosis, a skin condition, without documentation restrictions, whereas the MAC now requires detailed documentation of the lesions' physical characteristics before it will approve payment for treatment.

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## CMS Has Taken Steps to Facilitate the Complex Implementation of Medicare Contracting Reform, but Certain Decisions Have Led to Challenges

While CMS officials took numerous steps to facilitate Medicare contracting reform, we identified several CMS decisions that led to challenges. For example, we found that CMS underestimated the volume of appeals the MACs would inherit, which led to claims-payment delays and additional workload for incoming MACs. In some cases, CMS was able to make midcourse adjustments by incorporating lessons learned.

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## CMS Has Taken Steps to Facilitate the Complex Implementation of Medicare Contracting Reform

CMS has taken steps to facilitate the complex process of implementing Medicare contracting reform, which we described as an inherently high-risk activity in our 2005 report.<sup>34</sup> Medicare contracting reform represents the largest transition of claims administration workload since the inception of the Medicare program and was more complex than smaller-scale transitions CMS conducted in the past with legacy contractors. These earlier transitions were often “turnkey” operations, with incoming contractors retaining outgoing contractors’ staff and equipment. Furthermore, past transitions did not involve the transfer of as many Medicare Part A and B claims or the significant reconfiguration of the associated functional contractors and jurisdictions.<sup>35</sup>

This was also the first time that CMS awarded claims administration contracts under requirements for full and open competition. The agency faced the challenge of selecting contractors able to carry out complex activities critical to Medicare administration using procedures consistent with the FAR. In doing so, the agency decided to emphasize past experience and past performance with similar work of organizations that

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<sup>34</sup> [GAO-05-873](#), p. 3.

<sup>35</sup> Examples of functional contractors include Zone Program Integrity Contractors, which conduct benefit integrity activities involving the investigation of suspected fraud, and Recovery Audit Contractors, which identify improper Medicare payments and recoup overpayments.

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sought to become MACs.<sup>36</sup> For the initial competition for 19 MAC contracts, only three of the organizations seeking contracts lacked Medicare experience. All awards as of September 2009 were made to organizations with previous Medicare experience.<sup>37</sup>

Recognizing its challenge to manage the complex transitions, CMS took steps to facilitate implementation activities in a number of areas, including developing an integrated implementation schedule, developing training, hiring support staff, documenting lessons learned, and making midcourse adjustments. In particular:

**CMS established a “cross-component” team to facilitate communication across the agency and developed an integrated implementation schedule.** CMS reported that this team developed integrated schedule for the MAC implementation and other major Medicare initiatives, monitored implementation of cross-cutting initiatives, and identified effects that cut across initiatives. For example, CMS provided us with an integrated timeline the agency had developed that detailed important dates for each of these initiatives. This technical team was responsible for providing weekly updates to the directors of their respective components, who would then elevate issues as needed to CMS’s executive leadership.

**CMS developed training and manuals for agency staff, MACs, and legacy contractors.** CMS held training classes to define the roles and responsibilities of contract administration staff, such as contracting officers and project officers, involved in the award and management of MAC contracts.<sup>38</sup> The agency published a contract administration manual

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<sup>36</sup>The FAR generally requires past performance to be evaluated in award decisions. Past performance is considered one of multiple indicators of ability to successfully perform a contract, and the relative weight of past performance as an evaluation factor falls within the discretion of the awarding agency. CMS varied the weight it assigned to past performance in the three award cycles from 8 to 20 percent of the evaluation.

<sup>37</sup>Of the 19 MAC awards, 6 were in corrective action following bid protests as of September 2009.

<sup>38</sup>Contracting officers enter into, administer, or terminate government contracts. They negotiate and prepare MAC contract documents, modify terms or conditions of the contract, and approve payment vouchers, among other tasks. Project officers serve as the technical representative of the contracting officers, and provide technical direction to the MAC for all business functions described in the MAC contract. In addition, they monitor MAC performance and review payment vouchers.

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for staff with guidance on processing MAC deliverables and cost reports. In addition, CMS developed educational materials for MACs and legacy contractors, including handbooks that outlined CMS's policies on issues, such as required meetings and deliverables, and interaction with functional contractors.

**CMS hired an Implementation Support Contractor to assist in A/B MAC implementation.** CMS contracted with Chickasaw Nation Industries (CNI) to conduct various tasks such as monitoring implementation status, performing risk assessments, reviewing the completeness and timeliness of the MACs' status reports and meeting minutes, and bringing issues and suggestions to CMS regarding the implementation.

**CMS required the MACs to provide detailed plans and reports to facilitate implementation in each jurisdiction and to submit reports of lessons learned.** CMS required that each A/B MAC submit a Jurisdiction Implementation Project Plan to detail overall transition plans and a Segment Implementation Project Plan to delineate transition work more specifically for each part of the transition,<sup>39</sup> and that each DME MAC submit an Implementation Project Plan. The MACs were required to update these plans on a biweekly basis during the transition, including details of how each MAC would accomplish the requirements in their SOWs and the time frames for taking these steps. The agency also required that the MACs and CNI submit reports of lessons learned to provide insight on how to improve future transitions, and it requested that legacy contractors submit such reports.

Documenting lessons learned helped some aspects of later implementations. For example, lessons learned documents provided to CMS revealed challenges associated with transferring records from legacy contractors to the MACs. Two contractors we interviewed noted that they had to sort through over 100,000 boxes of paper files, as either a legacy contractor or the incoming MAC.<sup>40</sup> One of these contractors reported that

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<sup>39</sup>Each MAC jurisdiction implementation involves numerous segment implementations. Segment implementations consist of the movement of Medicare data, files, and functions from the legacy contractors to the MAC.

<sup>40</sup>CMS reported to us that while the standard retention period for claims records is 6 years and 3 months, due to ongoing investigations by the Department of Justice some contractors must retain paper records dating as far back as 1966.

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these files spanned multiple jurisdictions and estimated that it would cost \$11 million to sort and move these records, which they described as unlikely to ever be needed. CMS told us that based on lessons learned documents they recognized a need to begin planning for file transfer as soon as possible. CMS began suggesting that the MACs bring a file transfer plan to their first meeting with the outgoing contractor, and the outgoing contractor bring descriptions of its current files, organization and volume, and file search and retrieval methods.

**CMS made midcourse corrections to facilitate its response to bid protests.** As of July 2009, CMS reported that bid protests had been filed in 11 of the 19 jurisdictions and as of September 2009, 6 jurisdictions still had final award decisions pending. Bid protests delayed implementation of 3 of the 6 MAC jurisdictions that we reviewed. CMS indicated that responding to bid protests was very time consuming for staff. As CMS gained experience with MAC-related bid protests, the agency told us that it made changes to better respond to them. For example, because CMS initially assigned the same staff to work on procurements for several jurisdictions at a time, when a bid protest occurred in one jurisdiction, CMS shifted staff resources to manage the protest, ultimately delaying award decisions for other jurisdictions not under bid protest. In response, CMS established separate jurisdiction-based review panels, which allowed other staff to continue their work in jurisdictions that were not involved in bid protests. In addition, CMS identified a need to improve its management of MAC-related proposal evaluation documents. The agency has since hired an outside contractor that provided a tool to assist with managing the agency's documentation of proposal assessments in Cycles 1 and 2 to help the agency respond more quickly should a bid protest occur.

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### Certain CMS Decisions Have Led to Challenges during the Implementation of Medicare Contracting Reform

While MACs we interviewed generally described CMS's facilitation steps as helpful, we identified certain agency decisions that led to challenges for the implementation of Medicare contracting reform. Some of these decisions, for example, caused delays in payments to providers. CMS sometimes, but not always, used lessons learned from MACs and legacy contractors to make midcourse adjustments to decisions that initially led to challenges. The decisions we identified include the following:

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**CMS underestimated the number of appeals and provider call volumes, and the legacy contractors did not reduce their appeals workloads to target levels before the MAC transitions.** Three of the six MACs we interviewed and CMS reported that some legacy contractors turned over a larger-than-expected appeals workload,<sup>41</sup> resulting in delays in resolving appeals and, in some cases, higher customer service call volumes than CMS estimated. (See table 1.) CMS required all legacy contractors to set workload processing goals to reduce the number of appeals transferred to the MACs during the transition,<sup>42</sup> and to submit weekly and monthly workload reports. CMS reviewed these reports to check whether the legacy contractors were meeting their workload processing goals. Despite regular workload monitoring during the MAC transitions, CMS underestimated the appeals and provider call volumes. As a result, three MACs we interviewed and CMS reported large appeals workload backlogs for several months, leading to delays in resolving appeals, which in some cases led to more calls from providers with unresolved appeals.<sup>43</sup> CMS officials reported that, in some cases, they required the MACs to take corrective actions, such as hiring additional staff, which two contractors noted were most often temporary staff. The agency also reported having revised workload estimates for subsequent MAC transitions.

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<sup>41</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>42</sup>The legacy contractors are required to analyze their claims-processing workload—which CMS reported includes appeals, provider enrollment and inquiry, and other claims administration related workload, and develop a realistic plan—the Inventory Reduction Plan—for reducing the claims backlog so that a minimal amount of workload is transferred to the MAC.

<sup>43</sup>CMS reported that, although more appeals workload was turned over to the MACs than CMS initially anticipated, these legacy contractors technically met the agency’s timeliness requirements for most of the transition period.

**Table 1: Inaccurate Appeals and Customer Service Workload Estimates, Corrective Actions, and Resolutions for Three of the Six MAC Jurisdictions We Studied, 2007 and 2008**

Appeals workload <sup>a</sup>	Customer service workload	Corrective action	Resolution
One MAC that originally anticipated inheriting about 15,000 redetermination <sup>b</sup> claims cases from the legacy contractor actually received more than 46,500 cases, 25,000 of which were at least 30 days old and more than 1,100 of which were at least 60 days old. <sup>c</sup>	Appeals backlogs led to call wait times of 10 minutes or more in the first several weeks of operation. (MACs were expected to meet a performance standard of average wait times of 60 seconds or less.) <sup>d</sup>	CMS required the MAC to submit a workload-reduction plan. The MAC hired additional staff.	It took the MAC 1 year to meet its redetermination timeliness performance standard and 5 months to meet its call wait time standard.
A second MAC's appeals workload was twice what had been anticipated. Of about 13,000 appeals for claims inherited from the legacy contractor at cutover, <sup>e</sup> 2,000 had not been entered into the system by the legacy contractor, and one-third of the inventory transferred was more than 60 days old.	CMS reported to us significant call volumes and increased wait times on customer service telephone lines due to inventory backlogs. <sup>f</sup>	The MAC trained additional staff and was able to improve telephone wait times without significant CMS intervention.	CMS reported to us that the appeals workload issue was fully resolved within about 3 months of cutover. <sup>g</sup> Additionally, the MAC was able to improve customer service wait times.
After cutover, <sup>g</sup> a third MAC received more than 20,000 appeals for claims that had not been processed by the legacy contractor. In an average month, there are about 12,000 appeals for this MAC. <sup>h</sup>	The MAC reported to us higher call volumes from providers with delayed payments due to claims backlogs, including appeals backlogs. A provider organization reported to us that 1 month after cutover, the average call wait time was almost 40 minutes. <sup>d</sup>	The MAC has initiated an action plan. CMS required the MAC to submit daily reports on operations performance (on handling appeals, claims, advance payments, etc.) and provider enrollment.	As of June 2009, about 10 months after cutover, <sup>g</sup> CMS reported to us that the appeals workload issue for this MAC had not yet been fully resolved. However, CMS reported to us that the average call wait time was within the performance standard about 5 months after cutover.

Source: GAO analysis of CMS, provider association, and contractor data.

<sup>a</sup>These examples were reported to us as challenges in three of the six MAC jurisdictions we studied.

<sup>b</sup>Once an initial claim determination is made by the legacy contractor or the MAC, providers have the right to appeal Medicare coverage and payment decisions. A redetermination is the first of five escalating levels of the appeals process. The legacy contractor or MAC reexamines the claim to determine whether the claim for benefits is denied in whole or in part to the appellant. The four other levels of appeals include reconsideration by a Qualified Independent Contractor, a hearing by an Administrative Law Judge, review by the Medicare Appeals Council, and judicial review in U.S. District Court.

<sup>c</sup>The Social Security Act requires that redeterminations be processed within 60 days, which is reflected in the MAC SOW.

<sup>d</sup>According to the MAC SOW, the performance standard for the average speed of answer is 60 seconds and is calculated quarterly based upon all calls received during the quarter.

<sup>e</sup>The cutover date is when the new MAC assumes responsibility for Medicare operations.

<sup>f</sup>Along with appeals backlogs, other claims inventory backlogs contributed to these high call volumes.

<sup>g</sup>CMS reported a number of records transfer challenges that contributed to delays in processing appeals.

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According to CMS staff, concern that legacy contractors might terminate their contracts prior to the MAC transition and cause claims payment disruptions contributed to a decision by the agency to pay incentive bonuses<sup>44</sup> to 15 legacy contractors, which as of July 2009 were worth a total of about \$5 million. However, CMS officials reported that, as of July 2009, payment of these bonuses was not contingent upon legacy contractors meeting specific workload reduction metrics and therefore was not used as a mechanism to ensure that legacy contractors reduced their workloads to specified levels prior to the MAC transition. For example, a bonus was given to a legacy contractor in a jurisdiction we reviewed in which the new MAC reported inheriting larger-than-expected numbers of appeals from the legacy contractors.

**The concurrent implementation of the MAC transition with other Medicare initiatives caused payment delays and other operational challenges.** CMS reported that it accelerated MAC implementation to prevent potential disruptions in claims processing if legacy contractors that were not awarded MAC contracts terminated their operations prematurely. We first noted concerns about CMS's accelerated schedule in our 2005 report, including that CMS had not integrated the planning and scheduling of MAC implementations with other initiatives.<sup>45</sup> CMS did not agree with our 2005 recommendation to extend its MAC implementation schedule to allow more time for planning and midcourse adjustments. Instead, CMS reported to us that it had established a team that developed integrated schedules for the MAC implementation and other major Medicare initiatives across the agency. (See fig. 3.) Overlapping initiatives that posed particular challenges for the MAC transition included the establishment of a new standard unique provider identification number, the National Provider Identifier (NPI), which providers had to use to be paid;<sup>46</sup> CMS's establishment of Enterprise Data Centers (EDC) to house

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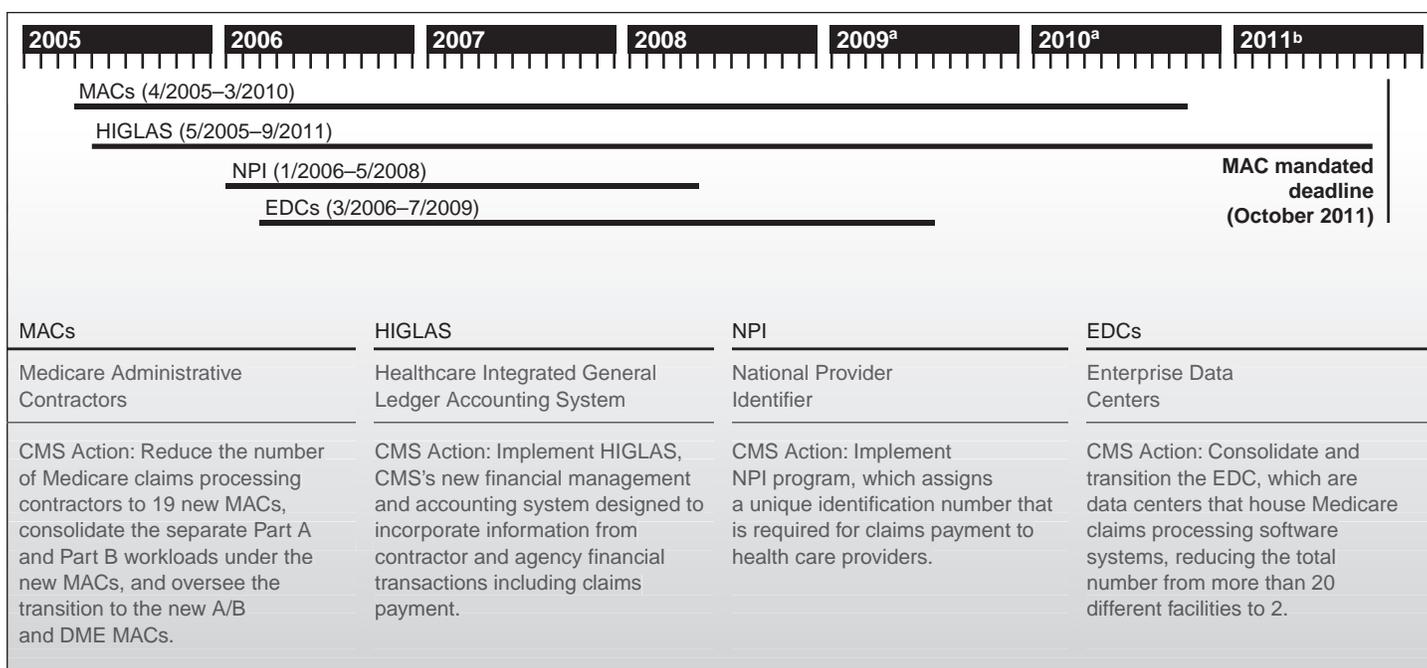
<sup>44</sup>Legacy contractors could qualify for two types of bonuses: (1) corporate retention bonuses paid to legacy contractors if the transition to the MAC is deemed by CMS as successful; and (2) employee retention bonuses for legacy contractors experiencing high staff attrition. Legacy contractors applied for one or both types of bonuses and CMS paid a bonus to each contractor that applied.

<sup>45</sup>[GAO-05-873](#).

<sup>46</sup>The HHS regulation to implement the administrative simplification standards of the Health Insurance Portability and Accountability Act of 1996 generally required NPI to be implemented by May 23, 2007 (except by small health plans, which had until May 23, 2008). However, CMS allowed a 1-year contingency period. Providers could not use their old identification numbers beginning May 23, 2008.

Medicare claims-processing software systems beginning in March 2006;<sup>47</sup> and CMS’s implementation of the Healthcare Integrated General Ledger Accounting System (HIGLAS), a new CMS financial management system designed to incorporate information from contractor and agency financial transactions, including claims payment, beginning in May 2005.<sup>48</sup>

**Figure 3: Implementation of MACs and Other New Initiatives**



Source: GAO.

<sup>a</sup>CMS's initial and revised targets for completing the implementation of Medicare contracting reform were 2009 and 2010.

<sup>b</sup>October 1, 2011, is the deadline mandated by the MMA for CMS to complete Medicare contracting reform.

<sup>47</sup>One of two EDCs serves each MAC, a consolidation from the past, when legacy contractors used as many as 20 data centers.

<sup>48</sup>HIGLAS is a major CMS initiative to modernize Medicare’s accounting and financial management systems by creating a single, integrated financial accounting system to be used by CMS and all Medicare contractors. CMS began planning the transition to HIGLAS in 2001 to satisfy the objectives of the Federal Financial Management Improvement Act and the Joint Financial Management Improvement Program, but implementation was delayed until the MAC implementation began in 2005.

In particular, the concurrent MAC and NPI implementations led to provider enrollment workload backlogs and, subsequently, claims payment and processing challenges, as providers were not paid until provider enrollment applications were processed. According to CMS, three of the six MACs we studied inherited a backlog of unprocessed provider enrollment applications from the legacy contractors (see table 2), which led to claims payment delays. CMS officials told us they were aware that the mandated deadline for legacy contractors and MACs to enroll providers in the NPI program overlapped with the MAC transition schedule in five jurisdictions,<sup>49</sup> but acknowledged that they did not initially understand the full effect that the overlap with the NPI implementation would have on the MAC transitions.

**Table 2: Provider Enrollment Challenges Related to MAC and NPI Overlapping Schedules in Three of the Six MAC Jurisdictions We Studied, 2007 and 2008**

Challenge <sup>a</sup>	Corrective action	Resolution
According to CMS, one MAC inherited approximately 27,000 pending provider enrollment applications from its legacy contractor. According to a provider association, about 11,000 of these had been pending for 4 to 6 months. More than 1,600 providers and provider groups reported to us delays of 6 months or more for payments of \$40,000 to \$80,000, and in one case, as high as \$3.5 million.	CMS and the MAC negotiated a detailed inventory reduction plan and amended the contract to provide additional resources to the MAC. CMS also suspended implementation of a specific claims-processing edit that had been implemented in all other states until the provider enrollments were processed. The MAC hired additional staff and installed a customer service phone line dedicated to provider enrollment. CMS began monitoring the MAC on a daily basis.	The MAC reported resolving the provider enrollment application backlog inherited from its legacy contractor within 5 months of cutover. <sup>b</sup> CMS reported that approximately 92 advance payments worth approximately \$5.4 million had been issued to providers whose claims for services provided to beneficiaries were submitted but could not be paid due to NPI-related challenges.
A second MAC inherited 4,500 pending provider enrollment applications.	CMS reported to us that it began monitoring the MAC on a weekly basis.	CMS reported to us that the pending provider enrollment applications were processed within about 4 months of cutover. <sup>b</sup>
A third MAC had about 300,000 claims suspended due to NPI-related challenges. Additionally, one legacy contractor in its jurisdiction transferred 18,000 pending provider enrollment applications to the MAC.	To address both of these challenges, the MAC temporarily shifted staff resources from other areas. CMS increased the funding for provider enrollment, allowing the MAC to add staff.	According to CMS, the NPI-related claims suspension challenges were resolved within approximately 3 months of cutover <sup>b</sup> and the MAC began meeting timeliness standards for pending provider enrollment applications within approximately 9.5 months of cutover. <sup>b</sup>

Source: GAO analysis of CMS and provider association data.

<sup>a</sup>These examples were reported to us as challenges in three of the six MAC jurisdictions we studied.

<sup>b</sup>The cutover date is when the new MAC assumes responsibility for Medicare operations.

<sup>49</sup>The NPI deadline overlapped with MAC implementation in Jurisdictions 1, 4, 5, 12, and 13.

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To a lesser extent, CMS reported other MAC operational challenges implementing the EDCs and HIGLAS in conjunction with the MACs. According to CMS officials, implementing the EDCs in conjunction with the MACs was challenging, in part because each legacy contractor had unique claims-processing system features that either had to be consolidated in the broader MAC jurisdictions or discontinued. For example, a legacy contractor may have configured its claims-processing system with 150 to 200 unique computer applications, each with specialized functions. CMS reported establishing a workgroup that was responsible for reviewing these unique claims-processing system applications and determining whether or not the application would be transferred to the EDC for use by the new MAC.

CMS officials said implementing HIGLAS in conjunction with the MACs was most problematic in MAC jurisdictions where some legacy contractors had transitioned to HIGLAS prior to the MAC transition and others had not. For example, in one case a MAC had to maintain two financial management systems temporarily until the entire jurisdiction was converted to HIGLAS. CMS's HIGLAS timeline initially required legacy contractors to convert data into HIGLAS format just before cutover to the MAC.<sup>50</sup> In response to these and other challenges, officials reported that the agency is now implementing HIGLAS on a jurisdiction-by-jurisdiction basis after the transition to each MAC is complete.

**Prior to the MAC transition, CMS did not adequately monitor legacy contractors' implementation of mandated claims-payment policy changes, generating unanticipated work for the MACs and causing provider relations challenges.** In four of the six MAC jurisdictions we studied, CMS or the MAC told us that the MACs discovered and corrected claims-processing errors made by legacy contractors,<sup>51</sup> which, in some cases, had generated improper payments to

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<sup>50</sup>Cutover is the date when the new MAC assumes responsibility for Medicare operations.

<sup>51</sup>CMS officials explained that computer edits are entered into a contractor's claims-processing system to implement a specific coding rule that dictates whether the system accepts or rejects a claim. Each legacy contractor was required to routinely enter and maintain specific CMS-mandated edits in its claims-processing systems. In addition, legacy contractors also had discretion to enter other edits in their systems to improve the accuracy of claims they paid. Because each legacy contractor had a combination of CMS-mandated and contractor-specific edits, the action taken on a claim varied from region to region. CMS required the MACs to consolidate the existing contractor-specific edits in each legacy jurisdiction to ensure consistency across each MAC jurisdiction.

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providers and added additional work for the MACs in order to make the corrections themselves during the transition. These errors were largely due to legacy contractors not properly implementing certain CMS payment policies and revealed that CMS had not routinely checked to ensure that legacy contractors were making changes required by CMS to pay claims correctly. Although discovering and correcting these errors eventually led to more accurate Medicare payment, the errors generated unanticipated work for the MACs and caused provider relations challenges. For example, CMS reported that a legacy contractor had made improper payments to providers for scheduled, nonemergency ambulance transportation, a service covered by Medicare only under limited circumstances, which was discovered by the MAC. The MAC corrected the error, stopping improper payments to providers. A MAC in another jurisdiction told us that a legacy contractor had paid claims that should not have been paid for decades because it had not fully implemented requirements for certain edits related to rented equipment maintenance and service. In another example from the same jurisdiction, CMS reported that the MAC discovered the legacy contractor's system was ineffective in ensuring that a provider had submitted documents required for payment. The HHS Office of Inspector General estimated that, because of this claims-processing error, Medicare paid approximately \$127 million to providers who had not submitted the required documentation in 2006.<sup>52</sup> Although CMS officials told us the agency monitored the legacy contractors through periodic reviews of contractor edits, it did not discover or correct these particular errors; instead, the MACs did.

**CMS allowed local Medicare coverage policy to be consolidated to a stricter standard in a region and did not require MACs to make this change clear, causing payment denials providers did not anticipate.** Originally, CMS instructed MACs to select the “least restrictive” local coverage determination already in place in the jurisdiction. CMS later changed its guidance to advise MACs to implement the “most clinically appropriate” local coverage determination in place in the jurisdiction, because a legacy contractor may not have had a policy in place for some topics. This led some providers to face more restrictive coverage determinations than they had prior to the MAC transition. For example, one provider group we interviewed reported that the incoming

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<sup>52</sup>HHS, Office of Inspector General, *Review of Medicare Payments for Selected Durable Medical Equipment Claims with the KX Modifier for Calendar Year 2006* (Washington, D.C.: Jan. 2010).

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MAC instituted documentation criteria for treating a type of skin lesion that had not been required by the legacy contractor. Two of the three provider groups we interviewed reported that there was a lack of clear communication about this change in guidance, which caused confusion once the local coverage determinations were finalized and claims were rejected. In addition, in two jurisdictions we studied where the MACs invited providers to comment on more than 100 draft policies, two provider groups we interviewed said draft policies would be clearer if they identified which areas were changes from old policies, and one provider group said physicians' time constraints made it difficult to review such large volumes of information.

**CMS did not initially require Joint Operating Agreements (JOA) between MACs and all functional contractors, resulting in communication challenges between MACs and some key functional contractors.** Initially, CMS did not require JOAs—agreements that establish roles and responsibilities—between MACs and all related contractors. CMS officials noted that in considering JOA requirements, the agency determined whether a JOA was appropriate for each particular MAC relationship. Specifically, CMS initially did not require JOAs between MACs and the EDCs, but did require JOAs between MACs and certain other contractors, such as the Beneficiary Contact Center, which runs the 1-800-MEDICARE help line for beneficiaries. One MAC we interviewed noted that it was unsuccessful in communicating directly with the EDC in its jurisdiction because there was no JOA in place. Instead, it had to direct all communication to CMS officials, who would then contact the EDC on behalf of the MAC. CMS made a midcourse correction to address this inefficiency, and required JOAs between MACs and all functional contractors (including EDCs) in implemented jurisdictions. CMS informed us that as of February 2009, these JOAs had been executed or were in progress.

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## **CMS Has Begun Evaluating MACs Using an Assessment Program, and the MACs Whose Reviews We Examined Did Not Meet All Standards and Metrics**

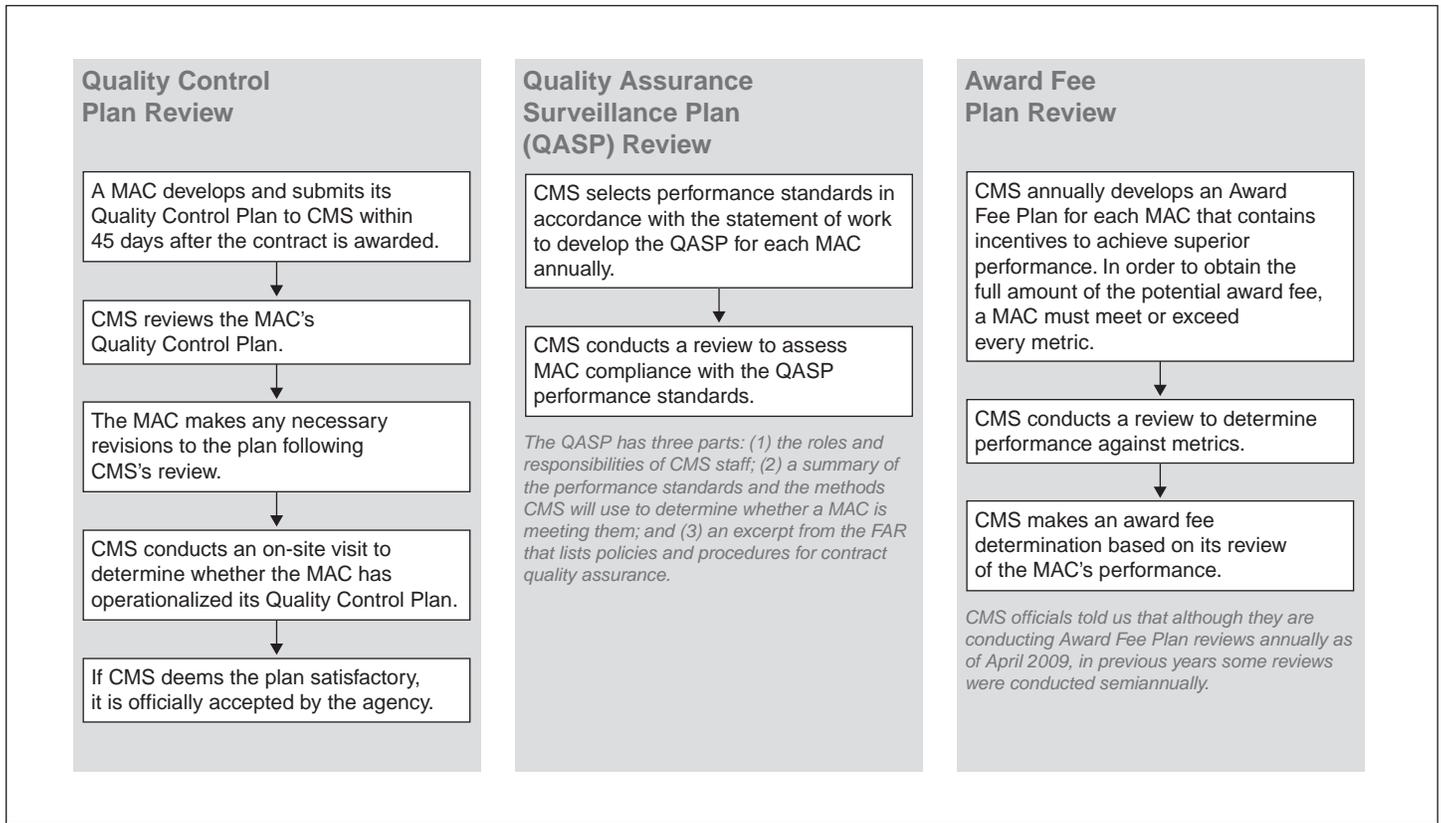
CMS has developed a performance assessment program for MACs that includes three reviews—the Quality Control Plan review, the Quality Assurance Surveillance Plan review (QASP), and the Award Fee Plan review. As of March 2009, CMS had completed all three reviews for three of the MACs in our sample. CMS’s on-site visits in 2007 and 2008 to review implementation of the MACs’ Quality Control Plans found that two of the three MACs’ plans required modification, which those MACs provided to CMS. Although CMS’s QASP evaluations indicated improvement from the first review period to the most recent review period we examined, the three MACs whose evaluations we examined did not meet all the QASP performance standards. Award Fee Plan reviews by CMS also indicated improved performance, based on the incentive metrics that the MACs met and the total award fee percentage they earned from the first review period to the most recent review period we examined. However, because the MACs did not meet all incentive metrics, they did not receive full award fees for which they were eligible.

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## **CMS’s Performance Assessment Program Comprises Three Reviews**

CMS developed the MAC Performance Assessment Program to include three reviews—the Quality Control Plan review, the QASP review, and the Award Fee Plan review. (See fig. 4.) CMS designed these reviews in part to reflect MMA and FAR requirements for assessing contractor performance. For example, CMS developed an annual Medicare Contractor Provider Satisfaction Survey in 2005 and used the survey results to develop a QASP performance standard in order to meet the MMA requirement for a performance standard related to provider satisfaction.

**Figure 4: Description of the MAC Performance Assessment Program Reviews**



Source: GAO.

The MAC Performance Assessment Program is supplemented by ongoing monitoring activities carried out by staff from various CMS divisions.<sup>53</sup> These activities include communicating with MAC staff, such as conducting biweekly telephone meetings with MACs, and reviewing MAC audits and monthly status reports to oversee contractor performance. As noted in each MAC's statement of work, MACs are required to submit monthly status reports that include information related to problems and risks encountered during the review period and the actions taken to address the problems.

<sup>53</sup>The MAC Performance Assessment Program is described in the agency's draft 2009 MAC Contract Administration Manual.

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**Quality Control Plan Review:** A Quality Control Plan is submitted to CMS and is designed to describe the plans, methods, and procedures—or internal controls—that a contractor will use to meet performance standards in the statement of work such as those related to quality, quantity, time frames, responsiveness, and customer satisfaction. The plan details how the MAC intends to meet CMS’s seven required quality-control program elements outlined in the statement of work: (1) maintaining an inspection and audit system; (2) establishing a method of identifying deficiencies in services performed; (3) developing a formal system to implement corrective action;<sup>54</sup> (4) documenting procedures and processes for services to ensure that services meet contractor performance requirements; (5) documenting a change-management program that ensures correct procedures and processes are followed when implementing CMS-required changes resulting from legislation, litigation, and policy; (6) providing a file to CMS of all quality records relating to inspections and audits conducted by the contractor and the corrective action implemented; and (7) providing for CMS inspections and audits. Lack of a fully functioning Quality Control Plan can potentially weaken a MAC’s internal controls.

A MAC is required to submit its Quality Control Plan to CMS for review no later than 45 days after the contract is awarded. CMS is to conduct an on-site visit to examine implementation of the Quality Control Plan after the MAC has become fully operational to determine whether the MAC’s internal controls are in place. CMS reports the results of its review in the Quality Control Plan Review Report, and if the plan is deemed satisfactory, it is officially accepted by the agency.

**Quality Assurance Surveillance Plan (QASP) Review:** The QASP has three parts: (1) an outline of the roles and responsibilities of CMS staff involved in the QASP review, (2) a summary of the QASP performance standards CMS developed in accordance with the statement of work and a description of the methods the agency will use to determine whether a MAC is meeting them,<sup>55</sup> and (3) an excerpt from the FAR that lists policies

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<sup>54</sup>Specifically, a MAC is required to develop action plans for all weaknesses, gaps, or security deficiencies identified by CMS audits, reviews, and evaluations and shall correct these issues.

<sup>55</sup>Many of the performance standards are the same standards identified in the SOW. CMS officials reported to us that some QASP standards are not explicitly stated in the SOW, but are derived from requirements that are incorporated by reference into the SOW.

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and procedures for contract quality assurance. CMS categorizes the QASP performance standards according to several “functional areas,” or areas of Medicare operation. CMS has flexibility in choosing functional areas with applicable performance standards to use for each of the review periods, which have ranged from 6 months to 1 year. For example, CMS may choose performance standards in financial management, a functional area that relates to a MAC’s financial reporting activity, including ensuring the effective and efficient use of Medicare funds.

CMS is to use the QASP review to evaluate a MAC’s performance against a subset of performance standards in accordance with the statement of work. According to CMS, if a MAC does not meet a performance standard, the agency requires an action plan to address the deficiency. The CMS project officer communicates the action plan request to the MAC. If the CMS project officer and other CMS staff agree that there are extenuating circumstances, the requirement for the action plan can be waived. However, a written justification for the waiver must be documented. (See app. V for additional information on the QASP review.)

**Award Fee Plan Review:** The Award Fee Plan is CMS’s method for providing financial incentives to MACs based on their performance. CMS creates an Award Fee Plan for each MAC annually, for review periods that have ranged from 6 to 12 months. For each MAC Award Fee Plan, CMS develops incentive metrics. CMS officials explained that MAC award-fee incentive metrics are generally designed to be more challenging than the standards outlined in the statement of work in order to provide incentives for the MACs to exceed those standards. For example, the claims-processing timeliness metric states that the MAC will process 97 percent of clean claims within statutorily specified time frames, a level that is set higher than the standard in the statement of work, which states that the MAC must process 95 percent of clean claims in these time frames.<sup>56</sup> CMS assigns a value to, or weights, each metric to determine what percentage of the award fee can be earned by the MAC for that metric. (See app. VI for a listing of the weights assigned to each incentive metric for the three MACs we studied.)

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<sup>56</sup>The claims-processing timeliness metric assesses whether a specific percentage of claims are processed by a MAC within statutorily specified time frames. A clean claim is one that does not contain a defect that prevents timely payment. This standard relates to requirements in sections 1816(c)(2) and 1842(c)(2) of the Social Security Act that require contractors to issue payment for at least 95 percent of clean claims within 30 days from the date when the claim is received.

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CMS uses the Award Fee Plan review to assess a MAC's performance against each metric to determine the amount of the award fee earned for that metric. If a MAC does not meet some of its incentive metrics, it may still receive an award fee for other metrics that it meets or partially meets.<sup>57</sup> For example, if CMS assigned a value of 8 percent to the claims-processing timeliness metric, and this was the only metric the MAC met, then the MAC would receive 8 percent of the total award fee. According to CMS, agency officials can change incentive metrics every review period, depending on which aspects of the MAC's performance need to be emphasized during that period. For example, CMS officials stated that one MAC may not initially have a provider enrollment incentive metric in its Award Fee Plan, but agency officials can incorporate it in a subsequent review period if they want the MAC to improve in this area.<sup>58</sup> In determining the award fee, CMS also considers overall contract performance, such as the QASP results and other CMS monitoring activities. (See apps. V and VI for additional information on the Award Fee Plan review.)

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**CMS Found that MACs' Quality Control Plans Required Modifications, which the MACs Provided**

In examining implementation of the Quality Control Plans during its on-site visits to the MACs in 2007 and 2008, CMS found that the plans of two of the three MACs whose reviews we examined required modifications. For example, CMS's Quality Control Plan Review Report for one MAC indicated an inconsistency in the contractor's process for closing action plans in its Part B Overpayments Recovery area.<sup>59</sup> The MAC management staff agreed to modify the action plan process and a CMS official confirmed that the MAC submitted a revised Quality Control Plan, which the agency accepted. CMS's Quality Control Plan Review Report for the other MAC indicated that modifications were needed to help mitigate risks to the agency and its beneficiaries. For example, there were problems with its process for identifying and reporting deficiencies and managing corrective actions, such as the lack of a formal system for implementing

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<sup>57</sup>CMS can offer all or a portion of an award fee for a metric that a MAC did not fully meet as determined by its evaluation of the MAC's performance. See 48 C.F.R § 16.405-2(a).

<sup>58</sup>The provider enrollment metric relates to MAC processing of provider enrollment applications.

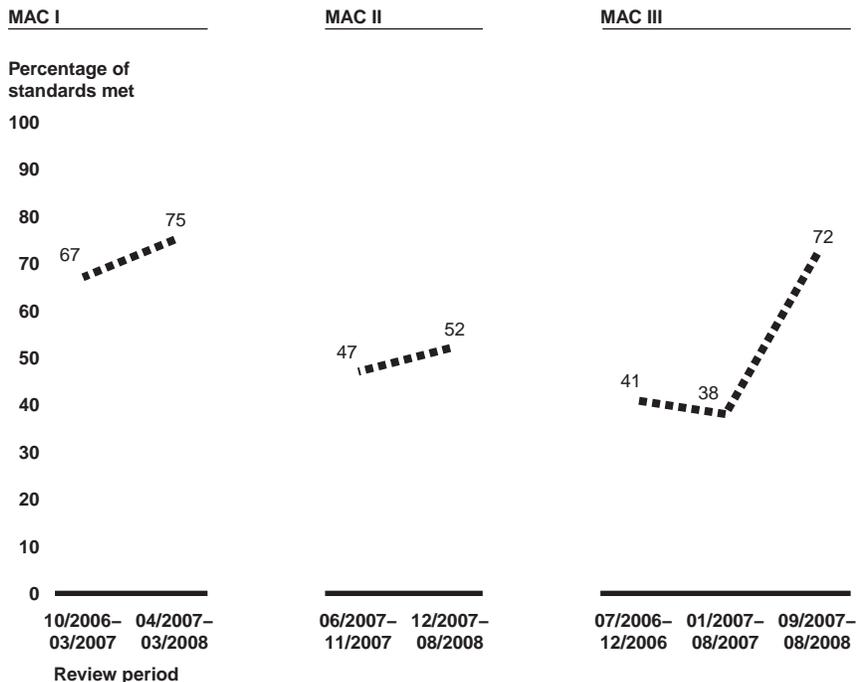
<sup>59</sup>Overpayments are Medicare funds that a provider, beneficiary, or other entity has received in excess of amounts due and payable under the Medicare statute and regulations. As part of Overpayments Recovery, MACs that discover an overpayment are required to notify the provider of the existence and amount of the overpayment and to request repayment.

corrective actions. A CMS official told us that the MAC submitted a revised Quality Control Plan, which the agency accepted.

### CMS's QASP Reviews Found the MACs Improved Their Performance but Did Not Meet All Standards

CMS's QASP reviews for the three MACs showed that they had improved their performance from the first review period to the most recent review period we reviewed but did not meet all standards in any one review period. As of March 2009, CMS had completed two or three QASP reviews for each of the three MACs we studied. While the three MACs met from 41 to 67 percent of their performance standards in their first review periods, by the later review periods, each MAC had met a higher number of performance standards, achieving 52 to 75 percent of standards met. (See fig. 5.)

**Figure 5: Percentage of QASP Performance Standards Met for Three MACs**



Source: GAO analysis of CMS data.

Note: The QASP review is used to evaluate MAC performance against the standards in accordance with the statement of work during a review period. The QASP reviews for the three MACs in our study were conducted during different time frames based on when the contract was awarded.

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None of the three MACs met all of its QASP performance standards in any review period, however.<sup>60</sup> Specifically, CMS found that these MACs did not meet a number of QASP performance standards in six of the nine functional areas reviewed during those periods.<sup>61</sup> (See app. VII for details on the QASP performance of the three MACs, including which functional areas were reviewed.) Performance was generally poorest in the functional areas of Appeals and Medicare Secondary Payer.<sup>62</sup> For example, CMS indicated that one MAC experienced challenges in some functional areas, such as Appeals, that hindered its ability to meet relevant performance standards. The project officer requested an action plan that outlined how the MAC intended to work down the appeals backlogs.

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### CMS Award Fee Plan Reviews Showed Improved Performance, but Because the MACs Did Not Meet All Incentive Metrics, They Did Not Receive Full Award Fees

CMS's Award Fee Plan reviews showed that each of the three MACs improved its performance on incentive metrics from its initial review period to its later review period. As is shown in figure 6, both the percentage of incentive metrics met and the percentage of the total award fee earned increased.<sup>63</sup> Each MAC was paid less than half of the full award fee for which it was eligible in its first review period, but earned a higher percentage in subsequent periods for metrics it met. For example, MAC III met two of seven metrics, or 29 percent, and received 47 percent of the full award fee in the first review period. For its second review period, it met four of seven metrics, or 57 percent, and received 60 percent of the full award fee. By its last review period, the MAC met seven of eight metrics, or 88 percent, and was paid 86 percent of the full award fee.

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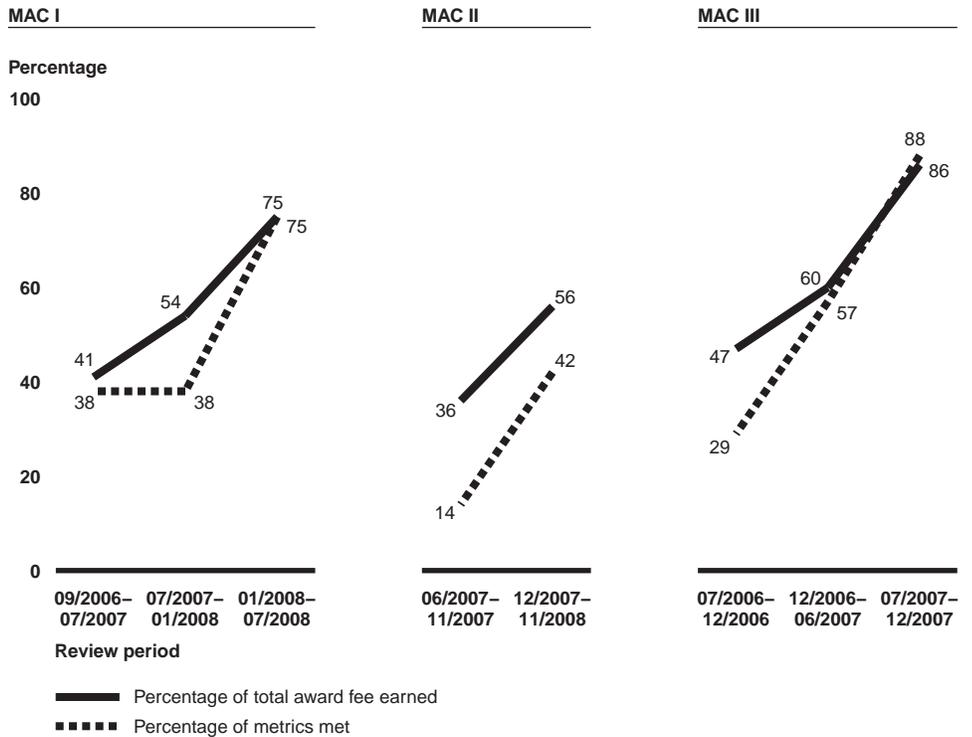
<sup>60</sup>According to CMS officials, while the QASP review is an indicator of a MAC's performance, there are other factors that must be considered, including external factors beyond the MAC's control, which may have contributed to poor performance in a particular area.

<sup>61</sup>CMS chose different functional areas to review for each MAC—for example, Provider Outreach and Education was only reviewed in one review period for one of the three MACs in our sample.

<sup>62</sup>Appeals measures a MAC's performance in managing cases when it is necessary to reopen an initial claim determination or redetermination. Medicare Secondary Payer measures a MAC's performance in managing and providing customer service on claims and inquiries for which Medicare is not the primary payer.

<sup>63</sup>For this review, we determined whether incentive metrics were not met, partially met, or met based on the percentage of an award fee a MAC received for a metric. If a MAC earned 0 percent of the award fee for a metric, we determined that the metric was not met. If a MAC earned 1 through 99 percent of the award fee for a metric, we determined that the metric was partially met. If a MAC earned 100 percent of the award fee for a metric, we determined that the metric was met.

**Figure 6: Percentage of Incentive Metrics Met and Total Award Fee Percentage Earned for Three MACs**



Source: GAO analysis of CMS data.

Notes: The Award Fee Plan review includes selecting incentive metrics for each MAC and conducting assessments of each metric to determine what share of an award fee each MAC will earn in each review period. Different metrics may be selected for each MAC and for each review period. The Award Fee Plan reviews for the three MACs in our study were conducted during different time frames based on when the contract was awarded. For this review, we determined whether incentive metrics were not met, partially met, or met based on the percentage of an award fee a MAC received for a metric. For more information, see app. VI for the weights assigned to each award-fee incentive metric for the three MACs in our sample and app. VIII for information about the incentive metrics the MACs met.

While all three MACs received a portion of the award fees for which they were eligible as a result of the incentive metrics they met in their Award Fee Plan reviews, they did not meet some incentive metrics, particularly metrics in areas related to beneficiary and provider service. All three of the MACs consistently met or partially met the Contract Administration metric—a measure that assessed the contractors’ service to CMS in contract management, such as providing quality deliverables on time. However, in some cases, they did not meet some beneficiary and provider service metrics for superior performance in areas CMS assessed, such as

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(1) Provider Relations—Accuracy, which assessed the accuracy of responses to providers’ Medicare policy questions; (2) Claims Processing Timeliness; (3) Appeals; (4) Beneficiary Inquiries, which measured the timeliness of responses to beneficiaries; and (5) support to the Qualified Independent Contractor, a contractor that handles the second-level appeals of denied claims.<sup>64</sup> (See app. VIII for details on the award-fee performance of the three MACs, including which areas were reviewed.) For example, MAC II did not meet more than half of the incentive metrics it was assessed against in its first and second review periods in areas such as Appeals, Beneficiary Inquiries, and Provider Relations—Accuracy.

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## CMS’s Total Costs and Savings to Date for Medicare Contracting Reform Are Uncertain

CMS has not tracked and provided information on all of its costs and savings related to Medicare contracting reform, and so the total costs and savings for Medicare contracting reform are uncertain. The agency has provided information on its external costs associated with establishing and supporting contracts, but has not provided information on its internal costs for conducting contracting reform activities, such as salaries. Similarly, CMS has not provided information on the total savings related to contracting reform. The agency provided information on some savings due to reductions in operational spending that it attributes to contracting reform and other activities related to claims payment; however, it has not provided information on what it had previously estimated would be the major source of savings, reduced improper payments to providers resulting from contracting reform.

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<sup>64</sup>CMS chose different metrics for each MAC and for each review period—for example, MAC II was assessed against the Provider Relations—Web site and Medicare Contractor Provider Satisfaction Survey metrics in the second review period, but not the first one.

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**CMS Routinely Tracks  
Some, but Not All, Costs  
Associated with  
Contracting Reform,  
Leading to Uncertainty  
about Total Costs**

CMS tracked and provided information on contracting reform costs of about \$300 million from fiscal year 2004 through fiscal year 2008, but could not readily account for certain internal administrative costs for implementing the MAC program, such as agency staff salaries and overhead. In response to our request for total costs of Medicare contracting reform, CMS provided information on external costs beginning in fiscal year 2005 for areas such as contractor transition and termination costs,<sup>65</sup> provider surveys, contract support activities, and technology associated with contracting reform, including information management systems and developing the EDCs.<sup>66</sup>

Of the approximately \$300 million in external costs CMS indicated was spent for contracting reform from fiscal year 2004 through fiscal year 2008, most (approximately \$260 million) were incurred in fiscal year 2007 and fiscal year 2008. (See table 3.) From fiscal year 2004 through fiscal year 2006, CMS paid contracting reform costs out of a lump-sum appropriation for program management, as CMS did not receive appropriations specifically for contracting reform until fiscal year 2007. Funds that were appropriated for contracting reform for fiscal years 2007 and 2008 were available for 2 fiscal years,<sup>67</sup> instead of the usual 1 fiscal year; these are referred to in this report as “2-year funding.” For both fiscal year 2007 and fiscal year 2008, CMS indicated that it spent less than the amount appropriated for contracting reform and carried over the unused portion of the funding to the next fiscal year. The appropriations act for fiscal year 2009 made \$108.9 million available for contracting reform and designated it as 2-year funding.

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<sup>65</sup>CMS pays certain costs associated with contractors’ transition from a legacy contract to a MAC or the termination of a legacy contract. Specific costs include those associated with closing out legacy contracts, such as paying out lease agreements for a legacy contractor leaving the Medicare program.

<sup>66</sup>CMS did not report the breakout of costs for fiscal year 2004.

<sup>67</sup>The appropriations for program management for these two years identified specific amounts—or line items—for contracting reform.

**Table 3: Information from CMS on External Costs and Appropriations for Medicare Contracting Reform, Fiscal Year 2004 through Fiscal Year 2008**

Dollars in millions

Fiscal year	External costs for contracting reform	Appropriations specifically for contracting reform <sup>a</sup>
2004	\$5.6	Not applicable
2005	16.9	Not applicable
2006	18.2	Not applicable
2007 <sup>b</sup>	84.6	\$106.3
2008 <sup>b</sup>	175.1	189.6
<b>Total</b>	<b>\$300.4</b>	<b>\$295.9</b>

Source: CMS.

<sup>a</sup>From fiscal year 2004 through fiscal year 2006, CMS used a lump-sum appropriation for program management for the costs of contracting reform; for fiscal years 2007 and 2008, funds were appropriated specifically for contracting reform and were available for 2 years.

<sup>b</sup>In fiscal year 2007 and fiscal year 2008, CMS spent less than the amounts specifically appropriated for the purpose of contracting reform and carried over unspent funding for contracting reform to the next year.

CMS did not include certain internal expenses as part of its accounting of Medicare contracting reform costs, leading to uncertainty about the total cost of the effort. In response to our request, CMS was able to compile selected internal costs for contracting reform in fiscal year 2008 totaling almost \$661,000 and told us that, in general, the internal costs associated with contracting reform are small compared to the external costs. (See table 4.) The contracting-reform-related internal costs CMS provided information on for fiscal year 2008 included categories such as travel, overtime, training, and supplies, but did not include internal costs for agency staff salaries, including legal services to address bid protests, and overhead. CMS said that internal costs comparable to those it provided information on for fiscal year 2008 were not readily available for other years. In addition, CMS officials told us that the agency does not routinely track the internal costs such as staff salaries related to initiatives like contracting reform, mainly because CMS's accounting system does not allocate payroll costs by specific project.<sup>68</sup>

<sup>68</sup>We are not proposing that CMS track its costs specifically for contractor reform because it would require the agency to change its accounting practices regarding staff time. Given the resources that would be involved in implementing such a change across the entire agency, we did not find that a change of that magnitude is warranted in this circumstance.

**Table 4: CMS’s Selected Internal Costs for Medicare Contracting Reform, Fiscal Year 2008**

<b>Cost category<sup>a</sup></b>	<b>Selected internal costs for contracting reform</b>
Travel	\$577,929
Overtime	68,203
Training	9,771
Supplies	4,932
<b>Total</b>	<b>\$660,835</b>

Source: CMS.

<sup>a</sup>Internal costs were recorded as spent by the Medicare Contractor Management Group, the division of CMS responsible for the majority of Medicare contracting reform activities.

**CMS Did Not Provide Information on Total Savings, and the Extent to Which Identified Savings Can Be Attributed to Contracting Reform Is Uncertain**

Although CMS estimated that it would achieve savings from two sources—reduced spending on administrative functions and savings from the Medicare trust funds related to better claims review leading to reduced improper payments—the agency has provided information only on administrative savings, making the total amount of any savings and the extent to which they are due to contracting reform uncertain. In 2005, we reported that CMS expected contracting reform to generate savings totaling over \$1.9 billion from reduced spending on Medicare administration and from reduced improper payments. However, as of April 2009, CMS was unable to quantify and provide information on total savings realized. Most of the estimated savings were expected to occur from funds it could avoid spending from the Medicare trust funds by reducing improper payments for Medicare services, with fewer savings anticipated from reducing administrative spending.<sup>69</sup> As of April 2009, CMS had indicated to us reduced spending on operational activities that it considered administrative savings due to contracting reform. However, it had not provided information on any savings to the Medicare trust funds based on a reduction in improper payments due to contracting reform. As of November 2008, the estimated percentage of Medicare fee-for-service payments that were improper had been declining since fiscal year 2004 and CMS attributed some of the reduction in improper payments to

<sup>69</sup>CMS estimated in 2005 that from fiscal year 2006 through fiscal year 2011, these Medicare trust-fund savings would be \$1.48 billion and total administrative savings would be \$459.5 million. However, at that time, we found that the basis for these savings estimates was uncertain. [GAO-05-873](#).

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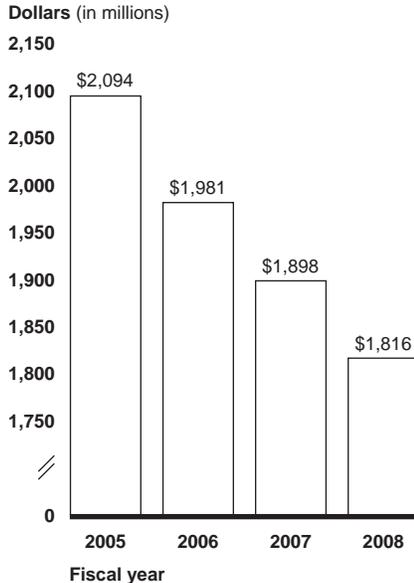
contracting reform activities. However, according to CMS, the agency is not tracking savings to the Medicare trust funds from contracting reform and therefore is unable to quantify total savings. Further, in November 2009, CMS reported that an estimated \$24.1 billion fee-for-service payments from April 2008 to March 2009 were improper, which was higher than its November 2008 estimate of \$10.4 billion for claims paid from April 2007 to March 2008. CMS also reported that it had changed its methodology for conducting the error-rate measurement, which could make a trend comparison with the past years' estimates unreliable. These changes make it more uncertain what savings to the Medicare trust funds, if any, may be due to contracting reform.

Incongruence between the spending categories CMS used in its estimated savings in 2005 and the categories CMS used to provide information on reduced spending for selected Medicare operational activities from fiscal year 2005 through fiscal year 2008 makes it impossible to directly compare CMS's estimated and actual savings to date. CMS indicated that spending for certain Medicare operational activities<sup>70</sup> began decreasing in fiscal year 2006 and continued decreasing through fiscal year 2008. (See fig. 7.) The agency provided information to show a decrease in the annual operating cost of these Medicare operational activities from fiscal year 2005 through fiscal year 2008, when spending reached just over \$1.8 billion. According to CMS, the agency spent nearly \$280 million less for these selected Medicare operational activities in fiscal year 2008 than it did in fiscal year 2005, the year with the highest level of spending for these activities during this period.

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<sup>70</sup>CMS provided information on the following operational activity spending categories: claims contractors, data processing, and other contractors such as Qualified Independent Contractors that perform second-level claims appeals formerly performed by legacy contractors; Medicare Secondary Payer Recovery Contractors that process recovery actions for Medicare Secondary Payer situations identified following initial payment; certain contractors that perform functions formerly reimbursed through the DME legacy contractors; Beneficiary Contact Centers that respond to beneficiary questions and casework needs; and Program Safeguard Contractors that perform specific benefit integrity functions that legacy contractors formerly performed.

**Figure 7: Information from CMS on Spending for Selected Medicare Operational Activities, Fiscal Year 2005 through Fiscal Year 2008**



Source: CMS.

Note: CMS provided information on spending for operational activities conducted by claims contractors, data processing, and other contractors such as Qualified Independent Contractors, Medicare Secondary Payer Recovery Contractors, Beneficiary Contact Centers, certain contractors that perform functions formerly reimbursed through the DME legacy contractors, and Program Safeguard Contractors.

CMS indicated that savings as a result of reduced spending for these selected Medicare operational activities are due to several factors, including efficiencies gained from Medicare contracting reform. For example, CMS officials said that consolidation of program functions as a result of contracting reform led to cost reductions. Specifically, the agency noted that consolidating data processing functions under the EDCs, which CMS includes as part of contracting reform, resulted in lower operating costs than data processing in the legacy environment. In addition, CMS noted that increased competition led contractors to implement cost-cutting measures, such as site closures, to achieve a competitive advantage in obtaining a MAC contract. However, the agency was unable to quantify these savings specifically and to isolate the effects of contracting reform on spending for operational activities from the effects of other activities related to claims payment. Therefore, it could not quantify the extent to which these and other examples of reduced

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spending were due to Medicare contracting reform, resulting in uncertainty about savings due specifically to contracting reform.

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## Agency and Medicare Administrative Contractor Comments

We provided a draft of this report to HHS for comment and received written comments from the agency, which are reproduced in appendix IX. We also solicited comments on our draft report from representatives of the six MACs in our sample as well as the three provider associations we interviewed. Of those invited to review the draft report, three MAC representatives accepted and provided oral comments to us. In addition to the overall comments discussed below, we received technical comments from HHS and MAC representatives, which we incorporated as appropriate.

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## HHS Comments

We obtained written comments on our draft report from HHS, on behalf of CMS. HHS generally agreed with our draft report findings and praised GAO for recognizing the progress CMS has made in implementing Medicare fee-for-service contracting reform.

In response to the draft report's discussion on the implementation of Medicare contracting reform, HHS indicated that it agreed with our finding that CMS took several steps to implement contracting reform, particularly noting that it was one of the most complex operational initiatives that the agency has ever undertaken. HHS also generally agreed with our finding regarding CMS's performance assessments of three MACs whose reviews we examined. In one of its technical comments, HHS noted that there are other performance-related reviews it considers when evaluating MAC performance that we did not highlight in the draft report. These reviews relate to a broader set of activities than those within the scope of the report; we focused specifically on the three key reviews administered through the MAC Performance Assessment Program because CMS officials reported to us that these reviews are the key components of the program. Finally, HHS generally agreed with our finding regarding the uncertainty of the total costs and savings for contracting reform. HHS noted, however, that CMS provided us with information supporting reduced spending on Medicare fee-for-service operations after 2005 that was not fully captured in the draft report. Our draft report included information that showed accrued savings due to reduced spending on Medicare fee-for-service operational activities after fiscal year 2005; however, we excluded fiscal year 2009 information because, at the time of our review, CMS reported fiscal year 2009 costs as estimates. We also noted that CMS was unable to

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isolate the effects of contracting reform spending for Medicare operational activities from the effects of other activities related to claims payment.

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## MAC Comments

The three MAC representatives who reviewed the draft report generally agreed that it accurately reflected challenges during the implementation of Medicare contracting reform. Two of the MAC representatives provided additional detail on the challenges created because CMS and the outgoing contractors did not accurately estimate workloads during the transitions. In addition, they elaborated on the challenges created by CMS's concurrent implementation of the MAC transition with other Medicare initiatives, such as NPI and HIGLAS. One representative attributed some of the workload increase to a failure by providers to apply for their new NPIs by the national deadline. Another MAC representative indicated that once the transition challenges began, CMS responded quickly and efficiently to address them. However, this representative also stated that he expected more discussion in the draft report of the MAC procurement process, particularly the delays and uncertainties resulting from the bid protests in some jurisdictions. Our report focused on the MAC jurisdictions where a final award had been made by June 2008 rather than on the procurement process leading up to the MAC awards.

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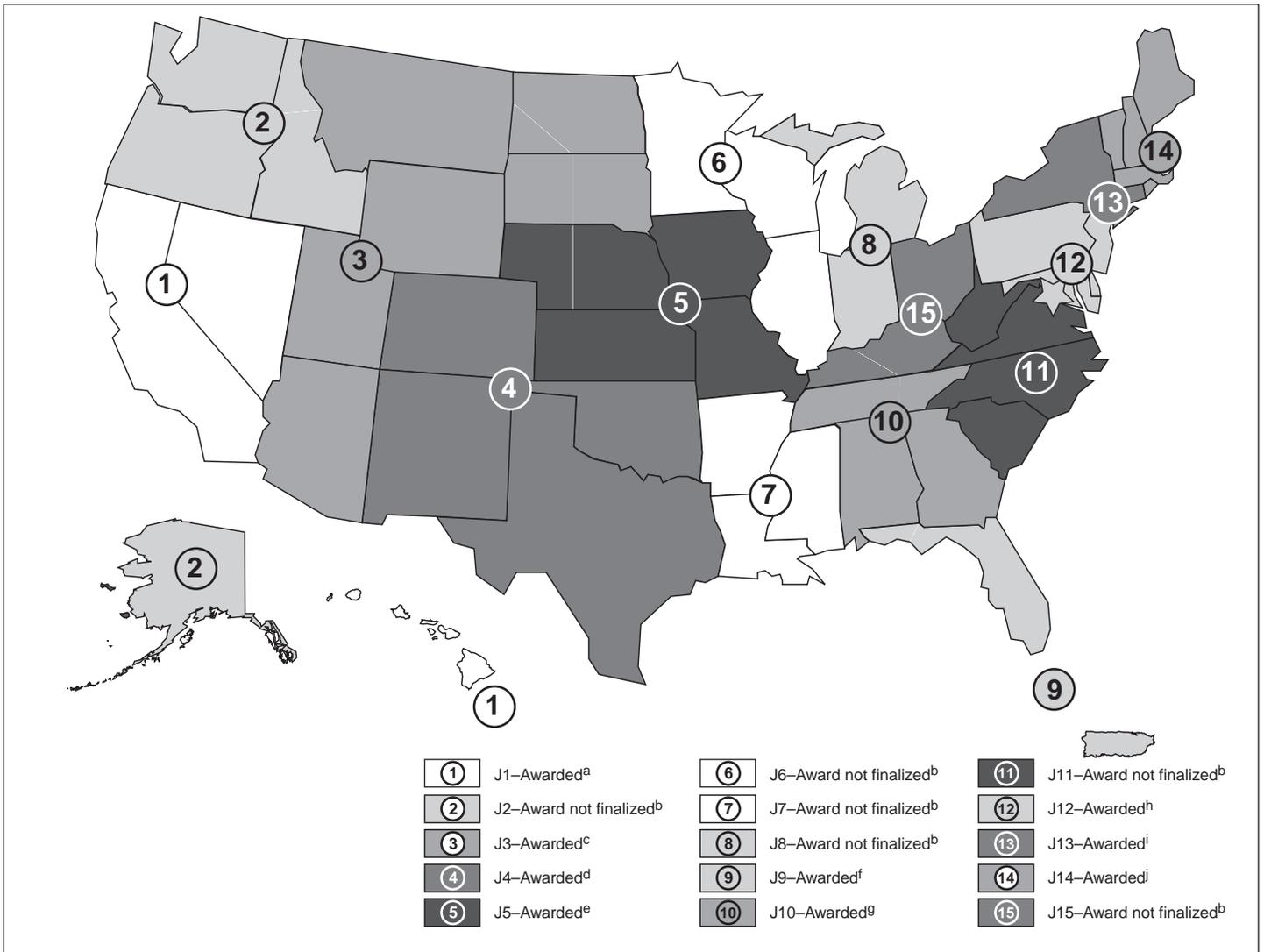
As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be 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 (202) 512-7114 or at [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix X.



Kathleen M. King  
Director, Health Care

# Appendix I: Jurisdictional Map for Part A/B Medicare Administrative Contractors, as of September 2009



Source: GAO analysis of CMS documentation (data). Copyright © Corel Corp. All rights reserved (map).

Notes: The contract jurisdictions are abbreviated as (J).

<sup>a</sup>Palmetto Government Benefits Administrators.

<sup>b</sup>Jurisdictions were awarded but were protested, and CMS is taking corrective action.

<sup>c</sup>Noridian Administrative Services.

<sup>d</sup>Trailblazer Health Enterprises.

<sup>e</sup>Wisconsin Physicians Health Insurance Corporation.

<sup>f</sup>First Coast Service Options.

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**Appendix I: Jurisdictional Map for Part A/B  
Medicare Administrative Contractors, as of  
September 2009**

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<sup>9</sup>Cahaba Government Benefits Administrators.

<sup>10</sup>Highmark Medicare Services.

<sup>11</sup>National Government Services.

<sup>12</sup>National Heritage Insurance Corporation.



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# Appendix III: Scope and Methodology

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To determine how the Centers for Medicare & Medicaid Services (CMS) implemented Medicare contracting reform, we selected a sample of 6 Medicare Administrative Contractor (MAC) jurisdictions for in-depth review from among the 10 where a final award had been made by June 2008. The 6 MAC jurisdictions that we selected for review in this engagement were among the earliest to be implemented, and thus had the longest experience from which we could learn about implementation and performance assessment.<sup>1</sup> Our criteria for selecting the 6 MAC jurisdictions were designed to ensure diversity in geographic region, in the volume of claims workload, in the complexity of transition (such as the number of legacy contractors in the region whose workloads had to be transitioned to a single MAC), bid protest experience, and CMS's assessment of a jurisdiction's risk for fraud. For example, we selected MAC jurisdictions based on areas CMS selected for its demonstration projects that targeted fraudulent business practices. The sample includes 2 MACs that process durable medical equipment claims (DME MAC) and 4 MACs that process both Part A and Part B Medicare claims (A/B MAC). We also examined documents and conducted interviews with CMS officials. Specifically, we reviewed documents including CMS's acquisition strategy, requests for proposals, implementation handbooks, MAC monthly status reports, and CMS's planning tools such as timelines and maps. We interviewed CMS staff responsible for coordinating the contract procurement for, and implementation of, the 6 MAC jurisdictions in our sample, as well as the Implementation Support Contractor CMS hired to assist it in implementing the A/B MACs. A division within GAO, separate from the division that conducted this review, is responsible for resolving certain federal contract protests. Given its role, we did not assess the solicitation or award of the MAC contracts. In addition, for the 6 jurisdictions we selected, we interviewed incoming MACs and certain legacy contractors. We also interviewed health care provider organizations located in three states within 2 of the 6 MAC jurisdictions in our sample, including three state medical organizations. We selected provider organizations for interviews based on whether contractors or CMS officials we interviewed specifically mentioned them as having raised concerns about the MAC implementation. In addition, to understand the national scope of contract reform implementation issues from the provider perspective, we gathered information from national medical, hospital, and other provider organizations, including the American Medical Association,

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<sup>1</sup>The six MACs assumed responsibility for Medicare operations from July 2006 through December 2008.

the American Hospital Association, and the American Health Care Association. Finally, we analyzed documents and conducted interviews to understand what lessons CMS may have learned that may help inform future award cycles.

To determine how CMS assessed the performance of the MACs and what the results of its assessments have been, we reviewed relevant sections of the Federal Acquisition Regulation (FAR) related to performance-based contracting and cost-plus-award-fee contracts and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requirements regarding MAC evaluations. We also reviewed CMS documents to understand the agency's performance assessment process for MACs. Specifically, we reviewed documents including CMS's 2009 draft MAC Contract Administration Manual, and agency documents that relate to the MAC Performance Assessment Program. We also reviewed MAC Performance Assessment Program results for three of the six MACs, those that had completed all three review components of the MAC Performance Assessment Program—the Quality Control Plan, Quality Assurance Surveillance Plan (QASP), and Award Fee Plan—as of March 2009. The Quality Control Plan, QASP, and Award Fee Plan reviews for the three MACs in our study were conducted during different time frames based on when their contract was awarded. These three MACs were awarded contracts in January 2006, July 2006, and September 2006. The three MACs assumed responsibility for Medicare operations, or cutover, on July 2006, March 2007, and June 2007, respectively. The on-site Quality Control Plan reviews for the three MACs were conducted in 2007 and 2008. The QASP and Award Fee Plan reviews covered periods of performance from 2006 through 2008 for the three MACs. In addition, we reviewed and analyzed CMS documentation about its Medicare Contractor Provider Satisfaction Survey.<sup>2</sup> Finally, we interviewed officials in CMS's Medicare Contractor Management Group responsible for MAC and legacy contractor oversight to understand the agency's performance assessment framework and activities. In conducting our work, we focused on the extent of implementation of the MAC Performance Assessment Program rather than the effectiveness of the program. We did not assess the appropriateness of the performance standards and incentive metrics CMS used to assess the

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<sup>2</sup>CMS completed its pilot of the annual provider satisfaction survey in 2005. The survey is designed to measure provider satisfaction with key services performed by Medicare fee-for-service contractors, such as the accessibility of provider education and training from a MAC.

MACs; however, we did analyze the results of CMS's reviews that had been conducted for DME and A/B MACs as of March 2009.

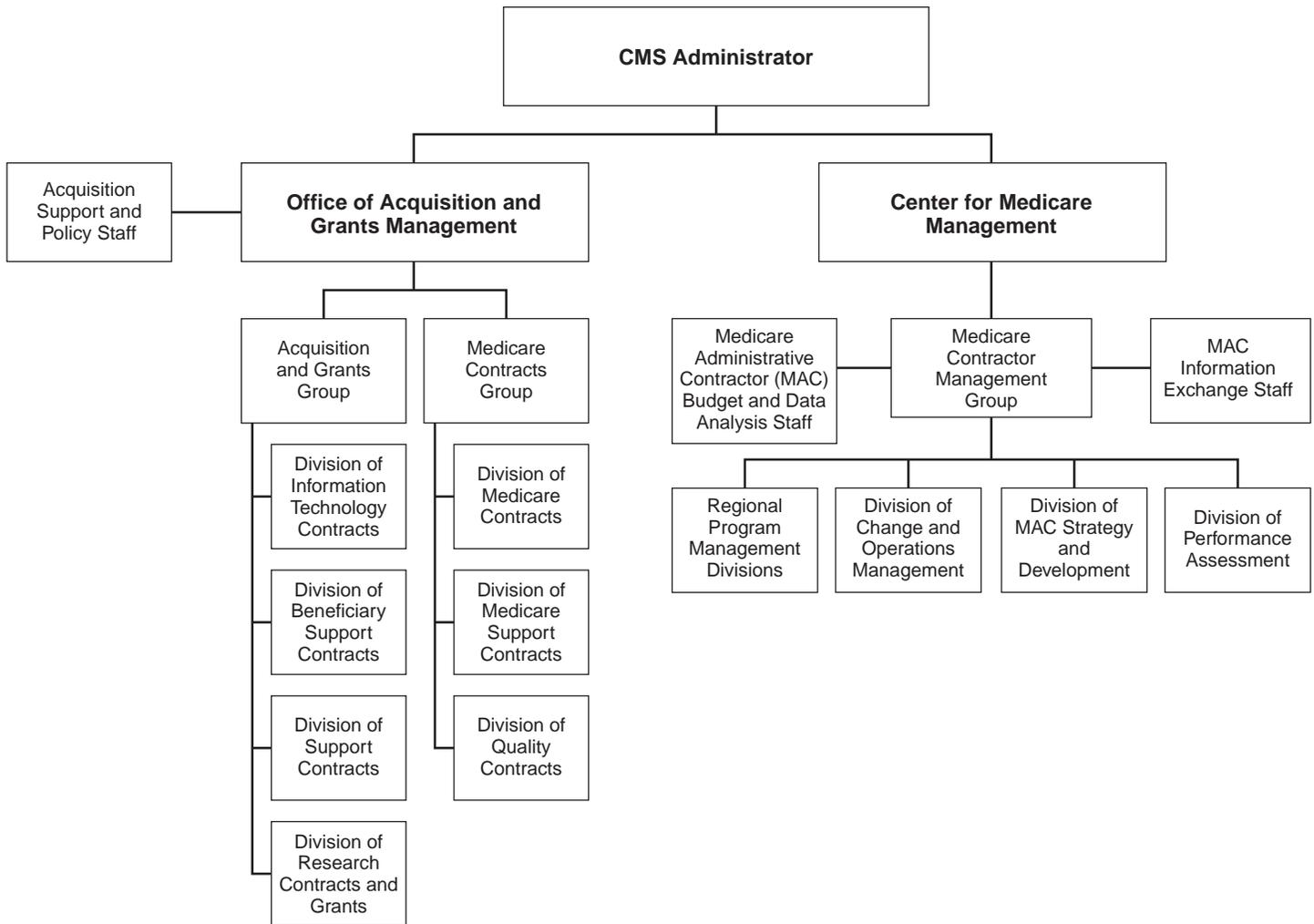
To determine CMS's costs and savings for Medicare contracting reform, we reviewed and analyzed documents related to CMS's budget, estimated costs, and estimated savings, and interviewed CMS officials. Specifically, we reviewed documents including CMS's budget justifications for fiscal years 2005 through 2009; appropriations acts for fiscal years 2004 through 2009; and CMS data on estimated savings, transition and termination costs, and other costs associated with contracting reform. We also interviewed CMS officials responsible for development and oversight of contracting reform budgets and estimates of potential costs and savings to understand CMS's process for tracking and reporting the financial status of contracting reform. Further, we reviewed criteria for good governance practices to determine the importance of complete information on the costs of federal programs and activities for the effective management of government operations and for assisting Congress and internal and external users in assessing the operating performance and stewardship of program activities.<sup>3</sup> To assess the reliability of CMS-reported internal and external cost data for contracting reform and CMS-reported spending data for selected Medicare operational activities, we conducted interviews with knowledgeable agency officials and reviewed for reasonableness the assumptions associated with the collection and compilation of the costs and savings data. Based on these reviews and discussions, we found the data reliable for the purposes of this report.

We conducted this performance audit from May 2008 through March 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>3</sup>We reviewed Federal Accounting Standards Advisory Board, "Statement of Federal Financial Accounting Standards Number 4," Managerial Cost Accounting Concepts and Standards for the Federal Government (Washington, D.C.: July 31, 1995).

# Appendix IV: Centers for Medicare & Medicaid Services (CMS) Components Involved in Medicare Contracting Reform



Source: GAO analysis of CMS data.

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# Appendix V: Supplementary Information on the Quality Assurance Surveillance Plan and Award Fee Plan Reviews

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The Medicare Administrative Contractor (MAC) Performance Assessment Program comprises three reviews—the Quality Control Plan review, the Quality Assurance Surveillance Plan (QASP) review, and the Award Fee Plan review. This appendix provides supplementary information about the QASP and Award Fee Plan reviews.

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## Quality Assurance Surveillance Plan (QASP) Review

In implementing a QASP review, Centers for Medicare & Medicaid Services (CMS) staff who interact with the project officer include business function leads and technical monitors. Business function leads are responsible for determining the QASP performance standards and for deciding whether the review will consist of an on-site visit or a desk review. They are subject matter experts in Medicare functional areas, such as claims processing. They inform project officers of performance-related issues and identify areas that require closer inspection at on-site visits. CMS officials told us that, for a given MAC, if there is a significant amount of data to be reviewed at the contractor site, they will make an on-site visit, or if the MAC's performance information is available through a CMS system, they will do a desk review. Technical monitors are responsible for conducting the QASP reviews for their specialty functional area. According to CMS officials, technical monitors support project officers by assessing MAC performance and reporting their findings to the project officers. They summarize the results of their reviews in a report that outlines whether a MAC met the standards.

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## Award Fee Plan Review

The Award Fee Plans consist of subjective and objective incentive metrics.<sup>1</sup> Subjective metrics can be classified as met, partially met, or not met, whereas objective metrics can be classified as met or not met. For the first contract year, each Award Fee Plan included a contract-administration metric—the only subjective incentive metric in the plan. This metric assesses the MAC's efforts in contract management and providing service to CMS, such as maintenance of the appropriate level of staff to perform duties outlined in the statement of work, cost management, communication, and submission of deliverables like the

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<sup>1</sup>A subjective performance metric is a qualitative measure that is assessed based on an evaluator's judgment and impressions of performance quality, and an objective performance metric is a quantitative standard based on defined parameters for measuring performance. For more information, see GAO, *Federal Contracting: Guidance on Award Fees Has Led to Better Practices but Is Not Consistently Applied*, [GAO-09-630](#) (Washington, D.C.: May 29, 2009).

Quality Control Plan to the agency on time. For this metric, the MACs can receive all, some, or none of the award fee specifically allocated for it, using a point scale the agency developed. In addition, agency officials told us that they selected objective incentive metrics in functional areas they considered to be the most important for new MACs, such as claims-processing timeliness and beneficiary and provider relations. For each objective metric, a MAC can receive all or none of its award fee for that metric, but generally cannot receive a partial fee.<sup>2</sup>

The Award Fee Plan review takes place after a performance period has ended and involves various CMS staff.<sup>3</sup> CMS assembles a team to conduct Award Fee Plan reviews within 45 days after the end of the performance period and to report on the results. A CMS evaluation panel, which comprises the project officer, contracting officer, Director of the Medicare Contractor Management Group's Division of Performance Assessment, and other CMS officials, reviews the reports and recommends the portion of an award fee that should be given to each MAC in each review period. CMS's Director of the Medicare Contractor Management Group, the fee-determining official, takes into account the MAC's overall performance on the contract when making the final award fee determination and may adjust the amount of the award fee recommendation accordingly.

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<sup>2</sup>According to CMS, it may offer a portion of the award fee for objective metrics only in extraordinary circumstances as determined by the agency.

<sup>3</sup>CMS officials told us that the Award Fee Plan review was originally conducted up to twice a year, but that the agency had moved to conducting the reviews annually.

# Appendix VI: Weights Assigned to Award Fee Plan Incentive Metrics for Three Medicare Administrative Contractors

The Centers for Medicare & Medicaid Services (CMS) assigns a value to, or weights, each metric in an Award Fee Plan to determine what percentage of the award fee can be earned by a Medicare Administrative Contractor (MAC) for that metric. Figure 8 of this appendix highlights the weights assigned to the Award Fee Plan incentive metrics for three MACs CMS assessed from 2006 through 2008.

**Figure 8: Weights Assigned to Award Fee Plan Incentive Metrics for Three MACs Assessed from 2006 through 2008**

	MAC I			MAC II		MAC III		
	Review periods			Review periods		Review periods		
	09/2006 to 07/2007	07/2007 to 01/2008	01/2008 to 07/2008	06/2007 to 11/2007	12/2007 to 11/2008	07/2006 to 12/2006	12/2006 to 06/2007	07/2007 to 12/2007
<b>Incentive metrics</b>	<b>Weighted percentages for incentive metrics<sup>a</sup></b>							
Contract Administration <sup>b</sup>	40	32	22	45	26	46	40	40
Provider Relations—Accuracy <sup>c</sup>	8	8	8	14	9	17	23	14
Provider Relations—Listserv <sup>c</sup>	8	N/R						
Provider Relations—Web site <sup>c</sup>	N/R	8	8	N/R	9	N/R	N/R	9
Claims Processing Timeliness <sup>d</sup>	8	N/R	N/R	12	9	7	9	9
Appeals <sup>e</sup>	8	N/R	N/R	12	9	7	9	9
Qualified Independent Contractor Support <sup>f</sup>	8	8	8	10	9	10	9	9
Medicare Redetermination Notices <sup>g</sup>	N/R	8	8	N/R	N/R	N/R	N/R	N/R
Beneficiary Inquiries <sup>h</sup>	4	4	4	5	5	7	5	5
Program Safeguard Contractor Support <sup>i</sup>	14	15	11	2	N/R	5	6	6
Program Integrity Support—Overpayments <sup>j</sup>	N/R	N/R	N/R	N/R	3	N/R	N/R	N/R
Program Integrity Support—Law Enforcement <sup>k</sup>	N/R	N/R	N/R	N/R	3	N/R	N/R	N/R
Systems Security <sup>k</sup>	N/R	16	8	N/R	9	N/R	N/R	N/R
Medicare Contractor Provider Satisfaction Survey <sup>l</sup>	N/R	N/R	N/R	N/R	5	N/R	N/R	N/R
Enterprise Data Center (EDC) Collaboration <sup>m</sup>	N/R	N/R	N/R	N/R	5	N/R	N/R	N/R
Comprehensive Error Rate Testing (CERT) <sup>n</sup>	N/R	N/R	24	N/R	N/R	N/R	N/R	N/R

N/R = Incentive metric not reviewed during this review period

Source: GAO analysis of CMS data.

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**Appendix VI: Weights Assigned to Award Fee  
Plan Incentive Metrics for Three Medicare  
Administrative Contractors**

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Notes: The Award Fee Plan review includes selecting incentive metrics for each MAC and conducting assessments of each incentive metric to determine what share of an award fee each MAC will earn in each review period. The Award Fee Plan reviews for the three MACs in our study were conducted during different time frames based on when the contract was awarded. Percentages in columns may not add to 100 percent due to rounding.

<sup>a</sup>The Centers for Medicare & Medicaid Services (CMS) assigns a value to, or weights, each metric to determine how much of the award fee can be earned by the MAC for meeting that metric in a given review period. CMS can change the weight of the particular metric from review period to review period.

<sup>b</sup>Contract Administration assesses how well the contract is managed and administered and how well the MAC provides service to CMS.

<sup>c</sup>Provider Relations—Accuracy measures how accurately the MAC responds to Medicare policy questions. Provider Relations—Listserv measures the number of providers out of the total providers for the entire jurisdiction that are on its electronic provider Listserv. Provider Relations—Web site measures providers' satisfaction with the MAC provider Web site.

<sup>d</sup>Claims Processing Timeliness measures whether a specific percentage of claims are processed within specified time frames.

<sup>e</sup>Appeals measures whether the MAC processes and mails notices of appeals within a specified time frame.

<sup>f</sup>Qualified Independent Contractor Support measures whether the MAC forwards a percentage of requests to the Qualified Independent Contractor for case files within a specified time frame.

<sup>g</sup>Medicare Redetermination Notices measures whether a percentage of the Medicare redetermination notices contain clear and understandable support for the MAC's redetermination decision.

<sup>h</sup>Beneficiary Inquiries measures whether the MAC responds to telephone and written inquiries from beneficiaries within a specified time frame.

<sup>i</sup>Program Safeguard Contractor Support measures whether the MAC provides claims-related data to the Program Safeguard Contractor by a specified date.

<sup>j</sup>Program Integrity Support—Overpayments measures the timeliness for submitting overpayment information to the Program Safeguard Contractors. Program Integrity Support—Law Enforcement measures the MAC's responsiveness to requests for information by the Program Safeguard Contractor.

<sup>k</sup>System Security measures the MAC's compliance with CMS's system security standards.

<sup>l</sup>Medicare Contractor Provider Satisfaction Survey measures the MAC's overall provider satisfaction, as assessed by the Medicare Contractor Provider Satisfaction Survey.

<sup>m</sup>Enterprise Data Center (EDC) Collaboration measures the MAC's performance in collaborating with the EDC without affecting the EDC's shared system production environment.

<sup>n</sup>Comprehensive Error Rate Testing (CERT) involves CMS's assessment of a MAC's CERT error rate, which is the proportion of claims a MAC has improperly paid. At the time of this review, CMS had not made any award fee determinations for this metric. The metric will be evaluated when the November 2008 CERT error rate report is released.

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# Appendix VII: Three Medicare Administrative Contractors' Quality Assurance Surveillance Plan Performance

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The Centers for Medicare & Medicaid Services's (CMS) Quality Assurance Surveillance Plan (QASP) reviews for three Medicare Administrative Contractors (MAC) showed that they had improved their performance from the first review period to the most recent review period we reviewed but did not meet all standards in any one review period. Figure 9 of this appendix provides details on each MAC's QASP performance assessed from 2006 through 2008, including which functional areas were reviewed.

**Appendix VII: Three Medicare Administrative Contractors' Quality Assurance Surveillance Plan Performance**

**Figure 9: Three MACs' Performance Based on QASP Performance Standards CMS Assessed from 2006 through 2008**

Functional areas reviewed	MAC I		MAC II		MAC III		
	Review periods		Review periods		Review periods		
	10/2006 to 03/2007	04/2007 to 03/2008	06/2007 to 11/2007	12/2007 to 08/2008	07/2006 to 12/2006	01/2007 to 08/2007	09/2007 to 08/2008
	<b>QASP Review Performance Standards met/not met</b>						
Appeals <sup>a</sup>	●●●○ ○	●●○○	○○○○ ○○	●●○○ ○○	●●○○ ○○	●○○○ ○○○	●●○○ ○○
Claims Processing <sup>b</sup>	●●●● ●○	●●●○	●●●● ○	●●●● ○	●●●○ ○	●●●● ○	●●●● ●
Financial Management <sup>c</sup>	●●●● ○○○○	●●●● ●●●●	●●●	●●●●	N/R	●○	●●●●
Medicare Secondary Payer <sup>d</sup>	●	●●●● ●	●○○	●●●○ ○○○○	○○○	●○○○ ○	●●●● ○○○
Provider Customer Service— Provider Contact Center <sup>e</sup>	●●●● ○○○○	●●●● ○○○○	N/R	●●○○ ○○	●○	●○	●●●● ●○
Provider Outreach and Education <sup>f</sup>	N/R	N/R	N/R	N/R	●	N/R	N/R
Customer Service—Provider Satisfaction Survey <sup>g</sup>	N/R	N/R	N/R	N/R	N/R	N/R	●
Medical Review <sup>h</sup>	●	N/R	N/R	N/R	N/R	N/R	N/R
Audit and Reimbursement <sup>i</sup>	N/R	●●●● ●●●● ●○○○	N/R	N/R	N/R	N/R	N/R
<b>Standards met/total assessed (percentage), per review period</b>	<b>22/33 (67%)</b>	<b>30/40 (75%)</b>	<b>8/17 (47%)</b>	<b>15/29 (52%)</b>	<b>7/17 (41%)</b>	<b>8/21 (38%)</b>	<b>21/29 (72%)</b>
<b>Standards met/total assessed (percentage), for all review periods</b>	<b>52/73 (71%)</b>		<b>23/46 (50%)</b>		<b>36/67 (54%)</b>		

N/R QASP Functional Area not reviewed during this review period  
 ○ QASP Standard not met  
 ● QASP Standard met

Source: GAO analysis of CMS data.

Notes: The data are from QASP Review Reports. The QASP review is used to evaluate MAC performance against the standards in accordance with the statement of work, during a review period. The QASP reviews for the three MACs in our study were conducted during different time frames based on when the contract was awarded.

<sup>a</sup>Appeals measures a MAC's performance in managing cases when it is necessary to reopen an initial claim determination or redetermination.

<sup>b</sup>Claims Processing measures a MAC's ability to process a claim to the point of payment, denial, or other adjudicative action in a timely and accurate manner.

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**Appendix VII: Three Medicare Administrative  
Contractors' Quality Assurance Surveillance  
Plan Performance**

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<sup>6</sup>Financial Management measures a MAC's efforts to maintain and report its financial records to CMS to ensure effective and efficient use of Medicare trust fund dollars.

<sup>4</sup>Medicare Secondary Payer measures a MAC's performance in managing and providing customer service on claims and inquiries for which Medicare is not the primary payer.

<sup>7</sup>Provider Customer Service—Provider Contact Center measures a MAC's ability to maintain its provider contact center activities at satisfactory performance levels, as measured by CMS, in regard to call center satisfaction.

<sup>1</sup>Provider Outreach and Education involves educating and training providers about the Medicare program and billing issues. Under this functional area, the MAC is required to conduct new provider training, education on preventive benefits, and education about local coverage determinations, among other things.

<sup>8</sup>Customer Service—Provider Satisfaction Survey measures providers' overall satisfaction with their Medicare contractors by using the Medicare Contractor Provider Satisfaction Survey.

<sup>10</sup>Medical Review involves a MAC's development of a structured approach to reduce the claims payment error rate by evaluating information such as medical records, to determine the medical necessity of Medicare claims. For this functional area, a MAC shall develop a medical review strategy that defines what risks to the Medicare trust funds its medical review program will address and the interventions that will be used during the fiscal year.

<sup>1</sup>Audit and Reimbursement refers to a requirement that MACs conduct Medicare cost report audits of providers using Medicare audit programs and follow Medicare reimbursement principles. For example, for this functional area CMS can assess whether a MAC accurately settled a cost report, a report that outlines cost data by cost account, that did not require an audit.

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# Appendix VIII: Three Medicare Administrative Contractors' Award Fees Earned

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The Centers for Medicare & Medicaid Services's (CMS) Award Fee Plan reviews for three Medicare Administrative Contractors (MAC) showed that they had improved their performance from the first review period to the most recent review period we reviewed, but because the MACs did not meet all incentive metrics, they did not receive full award fees. Figure 10 of this appendix includes information about the award fee earned by each MAC and the incentive metrics the MACs were assessed against from 2006 through 2008.

**Appendix VIII: Three Medicare Administrative Contractors' Award Fees Earned**

**Figure 10: Three MACs' Award Fee Earned for Each Incentive Metric CMS Assessed from 2006 through 2008**

	MAC I			MAC II		MAC III		
	Review periods			Review periods		Review periods		
	09/2006 to 07/2007	07/2007 to 01/2008	01/2008 to 07/2008	06/2007 to 11/2007	12/2007 to 11/2008	07/2006 to 12/2006	12/2006 to 06/2007	07/2007 to 12/2007
<b>Total percentage of award fee earned</b>	41	54	75	36	56	47	60	86
<b>Incentive metrics</b>	<b>Incentive metric not met/partially met/met</b>							
Contract Administration <sup>a</sup>	●	●	●	●	●	●	●	●
Provider Relations—Accuracy <sup>b</sup>	○	○	●	○	○	○	○	○
Provider Relations—Listserv <sup>b</sup>	●	N/R						
Provider Relations—Web site <sup>b</sup>	N/R	○	○	N/R	●	N/R	N/R	●
Claims Processing Timeliness <sup>c</sup>	○	N/R	N/R	○	●	○	●	●
Appeals <sup>d</sup>	●	N/R	N/R	○	○	○	○	●
Qualified Independent Contractor Support <sup>e</sup>	○	●	●	○	●	○	●	●
Medicare Redetermination Notices <sup>f</sup>	N/R	○	○	N/R	N/R	N/R	N/R	N/R
Beneficiary Inquiries <sup>g</sup>	○	○	●	○	○	○	○	●
Program Safeguard Contractor Support <sup>h</sup>	○	●	●	○	N/R	●	●	●
Program Integrity Support—Overpayments <sup>i</sup>	N/R	N/R	N/R	N/R	○	N/R	N/R	N/R
Program Integrity Support—Law Enforcement <sup>i</sup>	N/R	N/R	N/R	N/R	○	N/R	N/R	N/R
Systems Security <sup>j</sup>	N/R	○	●	N/R	○	N/R	N/R	N/R
Medicare Contractor Provider Satisfaction Survey <sup>k</sup>	N/R	N/R	N/R	N/R	○	N/R	N/R	N/R
Enterprise Data Center (EDC) Collaboration <sup>l</sup>	N/R	N/R	N/R	N/R	●	N/R	N/R	N/R
Comprehensive Error Rate Testing <sup>m</sup> (CERT)	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
<b>Metrics met/total assessed, per review period</b>	<b>3/8 (38%)</b>	<b>3/8 (38%)</b>	<b>6/8 (75%)</b>	<b>1/7 (14%)</b>	<b>5/12 (42%)</b>	<b>2/7 (29%)</b>	<b>4/7 (57%)</b>	<b>7/8 (88%)</b>
<b>Metrics met/total assessed per MAC, for all review periods</b>	<b>12/24 (50%)</b>			<b>6/19 (32%)</b>		<b>13/22 (59%)</b>		

- N/R Incentive metric not reviewed during this review period
- Incentive metric not met, or 0 percent of award fee earned for the metric
- Incentive metric partially met based on GAO's determination, or 1 to 99 percent of award fee earned for the metric
- Incentive metric met, or 100 percent of award fee earned for the metric

Source: GAO analysis of CMS data.

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**Appendix VIII: Three Medicare  
Administrative Contractors' Award Fees  
Earned**

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Notes: The Award Fee Plan review includes selecting incentive metrics for each MAC and conducting assessments of each metric to determine what share of an award fee each MAC will earn in each review period. The Award Fee Plan reviews for the three MACs in our study were conducted during different time frames based on when the contract was awarded.

Unlike subjective metrics, MACs generally can either meet or not meet objective metrics—a quantitative metric based on defined parameters for measuring performance—earning either the entire portion of the award fee for which they were eligible for that specific metric or none of it, respectively. Under extenuating circumstances as determined by CMS, the agency may offer a portion of the award fee for an objective metric. For example, while MAC III did not meet the Qualified Independent Contractor Support metric overall, CMS awarded a portion of the award fee for the metric to acknowledge the contractor's improved performance in the area during the second review period.

<sup>a</sup>Contract Administration assesses how well the contract is managed and administered and how well the MAC provides service to CMS.

<sup>b</sup>Provider Relations—Accuracy measures how accurately the MAC responds to Medicare policy questions. Provider Relations—Listserv measures the number of providers out of the total providers for the entire jurisdiction that are on its electronic provider Listserv. Provider Relations—Web site measures providers' satisfaction with the MAC provider Web site.

<sup>c</sup>Claims Processing Timeliness measures whether a specific percentage of claims are processed within specified time frames.

<sup>d</sup>Appeals measures whether the MAC processes and mails notices of appeals within a specified time frame.

<sup>e</sup>Qualified Independent Contractor Support measures whether the MAC forwards a percentage of requests to the Qualified Independent Contractor for case files within a specified time frame.

<sup>f</sup>Medicare Redetermination Notices measures whether a percentage of the Medicare redetermination notices contain clear and understandable support for the MAC's redetermination decision.

<sup>g</sup>Beneficiary Inquiries measures whether the MAC responds to telephone and written inquiries from beneficiaries within a specified time frame.

<sup>h</sup>Program Safeguard Contractor Support measures whether the MAC provides claims-related data to the Program Safeguard Contractor by a specified date.

<sup>i</sup>Program Integrity Support—Overpayments measures the timeliness for submitting overpayment information to the Program Safeguard Contractors. Program Integrity Support—Law Enforcement measures the MAC's responsiveness to requests for information by the Program Safeguard Contractor.

<sup>j</sup>System Security measures the MAC's compliance with CMS's system security standards.

<sup>k</sup>Medicare Contractor Provider Satisfaction Survey measures the MAC's overall provider satisfaction, as assessed by the Medicare Contractor Provider Satisfaction Survey.

<sup>l</sup>Enterprise Data Center (EDC) Collaboration measures the MAC's performance in collaborating with the EDC without affecting the EDC's shared system production environment.

<sup>m</sup>Comprehensive Error Rate Testing (CERT) involves CMS's assessment of a MAC's CERT error rate, which is the proportion of claims a MAC has improperly paid. At the time of this review, CMS had not made any award fee determinations for this metric. The metric will be evaluated when the November 2008 CERT error rate report is released.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

**MAR 1 2010**

Kathleen M. King  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street N.W.  
Washington, DC 20548

Dear Ms. King:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICARE CONTRACTING REFORM: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards" (GAO-10-71).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea Palm", written over a horizontal line.

Andrea Palm  
Acting Assistant Secretary for Legislation

Enclosure

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE CONTRACTING REFORM: AGENCY HAS MADE PROGRESS WITH IMPLEMENTATION, BUT CONTRACTORS HAVE NOT MET ALL PERFORMANCE STANDARDS" (GAO-10-71)**

The Department appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report entitled, "MEDICARE CONTRACTING REFORM: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards." We appreciate the GAO's recognition of the progress made by the Centers for Medicare & Medicaid Services (CMS) in implementing Medicare fee-for-service (FFS) contracting reform through the establishment of the Medicare Administrative Contractors (MACs).

We agree with GAO's finding that CMS took many effective steps to implement contracting reform, one of the most complex operational initiatives ever undertaken by the Agency. For example, the GAO recognizes that CMS established a multi-component team to facilitate the coordination and integration of a number of major Agency initiatives affecting Medicare FFS operations, and GAO notes the real achievement of the integrated implementation schedule that CMS developed.

The GAO found that in the implementations they reviewed, CMS and the new MACs encountered more pending workload of certain types from outgoing legacy fiscal intermediaries and carriers than CMS had estimated in its contract solicitations. As a result, some MACs initially received more pending appeals cases from the outgoing legacy contractors and/or received more provider telephone calls than they had planned and these workload issues resulted in service issues noted by GAO. We note that there are many variables to consider in estimating Medicare claims contractor workloads, and these uncertainties are particularly difficult to gauge for contract implementation scenarios. We have made adjustments in our later MAC procurements based on our experience in the early ones, including adjusting certain operational workload estimates during the immediate post-implementation period to minimize the impact on service of future MAC implementations.

The GAO performed an in-depth review of CMS's performance assessments concerning a limited number of MACs (GAO studied 3 out of the 13 MACs now operational), and found that these MACs were not meeting all their standards and metrics. We note that CMS conducts rigorous oversight of MACs to ensure that when metrics and standards are not met, MACs make appropriate adjustments in operational performance. We are pleased that GAO acknowledges that CMS includes "stretch" performance metrics in the MAC award fee plans that exceed base contract requirements.

Finally, GAO finds that the costs and savings associated with Medicare contracting reform are uncertain. CMS appreciates that GAO agrees that we provided a full accounting of the funds appropriated by Congress to support Medicare contracting reform-related costs borne by contractors. GAO correctly notes that CMS does not capture data on a project-by-project basis for its internal salary-related expenses. We do note that CMS has implemented Medicare contracting reform within its existing staffing base, and so the significant majority of all reform-related expenditures are quantified. We agree with GAO that the full savings associated with

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE CONTRACTING REFORM: AGENCY HAS MADE PROGRESS WITH IMPLEMENTATION, BUT CONTRACTORS HAVE NOT MET ALL PERFORMANCE STANDARDS" (GAO-10-71)**

Medicare contracting reform is very difficult to quantify, particularly the question of Medicare trust fund expenditures. However, CMS did provide GAO with information supporting CMS's observations concerning a post-2005 reduction in Medicare FFS operating costs, and some of this data does not appear in the draft report.

The Department appreciates the significant effort invested by GAO in this review.

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# Appendix X: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathleen M. King, (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Sheila K. Avruch, Assistant Director; Jennie F. Apter; La Sherri Bush; Jill Center; Helen Desaulniers; Sarah-Lynn McGrath; Roseanne Price; Kristal Vardaman; Ruth S. Walk; Jennifer Whitworth; and William T. Woods made key contributions to this report.

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