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## Testimony

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Ways and Means, House of Representatives

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# MEDICARE

## Improvements Needed in Provider Communications and Contracting Procedures

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Madam Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss modifications to the Medicare program proposed in the Medicare Regulatory and Contracting Reform Act (MRCRA) of 2001.<sup>1</sup> Providers have raised concerns that while the Medicare program has become increasingly complex, the education and outreach services needed to comply with Medicare coverage and billing policies are inadequate. Others have raised questions about whether the program could benefit from changes to the way Medicare's claims processing contractors are selected and paid for the functions they perform.<sup>2</sup> To address some of these issues, Members of this Subcommittee and others in the Congress have introduced legislation, and the Administration has proposed several new initiatives.

We are currently conducting, or have recently completed, work on several operational and structural elements of the Medicare program that frustrate providers and hamper effective management. Specifically, we are reviewing how the Centers for Medicare and Medicaid Services (CMS) works with its contractors to facilitate communications with Medicare providers.<sup>3</sup> We have also evaluated ways in which CMS contracting for claims payment and provider and beneficiary service activities could be modified to promote better performance. Accordingly, you asked us to focus our remarks today on our findings related to (1) Medicare provider education and communications, and (2) Medicare contracting for claims administration services. Several of the reforms outlined in the MRCRA proposal address aspects of both issues.

In summary, our ongoing work for the Subcommittee shows that physicians often do not receive complete, accurate, clear, and timely guidance on Medicare billing and payment policies. We found shortcomings in print, electronic, and telephone communications that Medicare contractors use to provide information to physicians and

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<sup>1</sup>H. R. 2768, sponsored by Reps. Nancy Johnson, Pete Stark, and others, was introduced on August 2, 2001.

<sup>2</sup>Medicare claims are processed by private organizations that contract to serve as the fiscal agent between providers and the federal government.

<sup>3</sup>In June of this year, the Secretary of Health and Human Services (HHS) announced that the agency's name would be changed from the Health Care Financing Administration (HCFA) to CMS. Our statement will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

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respond to their questions. To substantially improve Medicare contractors' provider communications, we believe that CMS needs to develop a more centralized and coordinated approach. This is consistent with several provisions in MRCRA, which require CMS to centrally coordinate contractors' provider education activities, establish communications performance standards, appoint a Medicare Provider Ombudsman, and create a demonstration program to offer technical assistance to small providers. MRCRA would also require contractors to monitor the accuracy, consistency, and timeliness of the information they provide.

Further, our analysis of Medicare contracting reform issues has found that the rules governing CMS contracts with its claims processors lack incentives for efficient operations. Medicare contractors are chosen without full and open competition from among health insurance companies, rather than from a broad universe of potentially qualified entities. In addition, CMS almost always uses cost-only contracts, which pay contractors for costs incurred but generally do not offer any type of performance incentives. MRCRA would broaden CMS authority so that entities of various types would be able to compete for claims administration contracts and their payment would reflect the quality of the services they provide.

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## Background

The operation of the Medicare program is extremely complex and requires close coordination between CMS and its contractors. CMS is an agency within HHS but has responsibilities for expenditures that are larger than those of most other federal departments.<sup>4</sup> Under Medicare's fee-for-service system—which accounts for over 80 percent of program beneficiaries—physicians, hospitals, and other providers submit claims to receive reimbursement for services they provide to Medicare beneficiaries. In fiscal year 2000, fee-for-service Medicare made payments of \$176 billion to hundreds of thousands of providers who delivered services to over 32 million beneficiaries.

About 50 Medicare claims administration contractors carry out the day-to-day operations of the program and are responsible not only for paying claims but also for providing information and education to providers and beneficiaries that participate in Medicare. Contractors that process and

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<sup>4</sup>Medicare ranks second only to Social Security in federal expenditures for a single program.

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pay part A claims (i.e., for inpatient hospital, skilled nursing facility, hospice care, and certain home health services) are known as fiscal intermediaries and those that administer part B claims (i.e., for physician, outpatient hospital services, laboratory, and other services) are known as carriers.

Contractors periodically issue bulletins that outline changes in national and local Medicare policy, inform providers of billing system changes, and address frequently asked questions. To enhance communications with providers, the agency recently required contractors to maintain toll-free telephone lines to respond to provider inquiries. It also directed them to develop Internet sites to provide another reference source. While providers look to CMS' contractors for help in interpreting Medicare rules, they remain responsible for properly billing the program.

In congressional hearings held earlier this year, representatives of physician groups testified that they felt overwhelmed by the volume of instructional materials sent to them by CMS and its contractors. Following up on these remarks, we contacted 7 group practices served by 3 carriers in different parts of the country to determine the volume of Medicare-related documents they receive from the CMS central office, carriers, other HHS agencies, and private organizations. Together, these physician practices reported that, during a 3-month period, they received about 950 documents concerned with health care regulations and billing procedures. However, a relatively small amount—about 10 percent—was sent by CMS or its contractors. The majority of the mail reportedly received by these physician practices was obtained from sources such as consulting firms and medical specialty or professional societies.

Congress has also held hearings on management challenges facing the Medicare program. We recently testified that HHS contracts for claims administration services in ways that differ from procedures for most federal contracts.<sup>5</sup> Specifically:

- there is no full and open competition for these contracts,
- contracts generally must cover the full range of claims processing and related activities,

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<sup>5</sup>*Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services*, (June 28, 2001, [GAO-01-918T](#)).

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- contracts are generally limited to reimbursement of costs without consideration of performance, and
  - CMS has limited ability to terminate these contracts.

Since 1993, HCFA has repeatedly proposed legislation that would increase competition for these contracts and provide more flexibility in how they are structured. In June 2001, the Secretary of HHS again submitted a legislative proposal that would modify Medicare's claims administration contracting authority.

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## Substantial Improvement Needed in Medicare Provider Communications

CMS relies on its 20 carriers to convey accurate and timely information about Medicare rules and program changes to providers who bill the program. However, our ongoing review of the quality of CMS' communications with physicians participating in the Medicare program shows that the information given to providers is often incomplete, confusing, out of date, or even incorrect.<sup>6</sup> MRCRA provisions establish new requirements and funding for CMS and its contractors that could enhance the quality of provider communication.

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## CMS Information Was Confusing and Often Inaccurate

We found that carriers' bulletins and Web sites did not contain clear or timely enough information to solely rely on those sources. Further, the responses to phone inquiries by carrier customer service representatives were often inaccurate, inconsistent with other information they received, or not sufficiently instructive to properly bill the program.

Our review of the quarterly bulletins recently issued by 10 carriers found that they were often unclear and difficult to use. Bulletins over 50 pages in length were the norm, and some were 80 or more pages long. They often contained long articles, written in dense language and printed in small type. Many of the bulletins were also poorly organized, making it difficult for a physician to identify relevant or new information. For example, they did not always present information delineated by specialty or clearly

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<sup>6</sup>In our study, we reviewed selected contractors' bulletins and Web sites and evaluated them for consistency, timeliness, clarity, and completeness. In addition, we visited three contractors to observe their call center operations and examined their approaches to monitoring the performance of customer service representatives. To test the quality of contractors' responses to physicians' phone inquiries, we posed "frequently asked questions" that appeared on contractor Web sites to customer service representatives and assessed the accuracy and completeness of the responses.

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identify the states where the policies applied. Moreover, information in these bulletins about program changes was not always communicated in a timely fashion, so that physicians sometimes had little or no advance notice prior to a program change taking effect. In a few instances, notice of the program change had not yet appeared in the carriers' bulletin by its effective date.

To provide another avenue for communication, carriers are required to develop Internet Web sites. However, our review of 10 carrier Web sites found that only 2 complied with all 11 content requirements that CMS has established. Also, most did not contain features that would allow physicians and others to readily obtain the information they need. For example, we found that the carrier Web sites often lacked logical organization, navigation tools (such as search functions), and timely information—all of which increase a site's usability and value. Five of the nine sites that had the required schedule of upcoming workshops or seminars were out of date.

Call centers supplement the information provided by bulletins and Web sites by responding to the specific questions posed by individual physicians. To assess the accuracy of information provided, we placed approximately 60 calls to the provider inquiry lines of 5 carriers' call centers. The three test questions, all selected from the "frequently asked questions" on the carriers' Web sites, concerned the appropriate way to bill Medicare under different circumstances. The results of our test, which were verified by a CMS coding expert, showed that only 15 percent of the answers were complete and accurate, while 53 percent were incomplete and 32 percent were entirely incorrect.

We found that CMS has established few standards to guide the contractors' communication activities. While CMS requires contractors to issue bulletins at least quarterly, they require little else in terms of content or readability. Similarly, CMS requirements for web-based communication do little to promote the clarity or timeliness of information. Instead, they generally focus on legal issues—such as measures to protect copyrighted material—that do nothing to enhance providers' understanding of, or ability to correctly implement, Medicare policy. In regard to telecommunications, contractor call centers are instructed to monitor up to 10 calls per quarter for each of their customer service representatives, but CMS' definition of what constitutes accuracy and completeness in call center responses is neither clear nor specific. Moreover, the assessment of accuracy and completeness counts for only 35 percent of the total

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assessment score, with the representative's attitude and helpfulness accounting for the rest.

CMS conducts much of its oversight of contractor performance through Contractor Performance Evaluations (CPEs). These reviews focus on contractors that have been determined to be "at risk" in certain program areas. To date, CMS has not conducted CPE reviews focusing on the quality or usefulness of contractors' bulletins or Web sites, but has begun to focus on call center service to providers. Again, the CPE reviews of call centers focus mainly on process—such as phone etiquette—rather than on an assessment of response accuracy.

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## CMS is Making Efforts to Improve Provider Communications

CMS officials, in acknowledging that provider communications have received less support and oversight than other contractor operations, noted the lack of resources for monitoring carrier activity in this area and providing them with technical assistance. Under its tight administrative budget, the agency spends less than 2 percent of Medicare benefit payments for administrative expenses. Provider communication and education activities currently have to compete with most other contractor functions in the allocation of these scarce Medicare administrative dollars. CMS data show that there are less than 26 full-time equivalent CMS staff assigned to oversee all carrier provider relations efforts nationwide, representing a just over 1 full-time equivalent staff for each Medicare carrier. This low level of support for provider communications leads to poorly informed providers who are therefore less likely to correctly bill the Medicare program for the services they provide.

Despite the scarcity of resources, CMS has begun work to expand and consolidate some provider education efforts, develop venues to obtain provider feedback, and improve the way some information is delivered. These initiatives—many in the early stages of planning or implementation—are largely national in scope, and are not strategically integrated with similar activities by contractors. Nevertheless, we believe that these outreach and education activities will enhance some physicians' ability to obtain timely and important information, and improve their relationships with CMS.

For example, CMS is working to expand and consolidate training for providers and contractor customer service representatives. Its Medlearn Web site offers providers computer-based training, manual, and reference materials, and a schedule of upcoming CMS meetings and training opportunities. CMS has produced curriculum packets and conducted in-

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person instruction to the contractor provider education staff to ensure contractors present more consistent training to providers. CMS has also arranged several satellite broadcasts on Medicare topics every year to hospitals and educational institutions. In addition, CMS established the Physicians' Regulatory Issues Team to work with the physician community to address its most pressing problems with Medicare. Contractors are also required to form Provider Education and Training Advisory groups to obtain feedback on their education and communication activities.

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## MRCRA Provides Needed Statutory and Financial Support

We believe that the provisions in Section 5 of MRCRA can help develop a system of information dissemination and technical assistance. MRCRA's emphasis on contractor performance measures and the identification of best practices squarely places responsibility on CMS to upgrade its provider communications activities. For example, it calls on CMS to centrally coordinate the educational activities provided through Medicare contractors, to appoint a Medicare Provider Ombudsman, and to offer technical assistance to small providers through a demonstration program. We believe it would be prudent for CMS to implement these and related MRCRA provisions by assigning responsibility for them to a single entity within the agency dedicated to issues of provider communication.

Further, MRCRA would channel additional financial resources to Medicare provider communications activities. It authorizes additional expenditures for provider education and training by Medicare contractors (\$20 million over fiscal years 2003 and 2004), the small provider technical assistance demonstration program (\$7 million over fiscal years 2003 and 2004), and the Medicare Provider Ombudsman (\$25 million over fiscal years 2003 and 2004). This would expand specific functions within CMS' central office, which would help to address the lack of administrative infrastructure and resources targeted to provider communications at the national level. Although we have not determined the specific amount of additional funding needed for these purposes, our work has shown that the current level of funding is insufficient to effectively inform providers about Medicare payment rules and program changes.

MRCRA also establishes contractor responsibility criteria to enhance the quality of their responses to provider inquiries. Specifically, contractors must maintain a toll-free telephone number and put a system in place to identify who on their staff provides the information. They must also monitor the accuracy, consistency, and timeliness of the information provided.

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## Contracting Reform Could Improve Program Management

Current law and long-standing practice in Medicare contracting limit CMS' options for selecting claims administration contractors and frustrate efforts to manage Medicare more effectively. We have previously identified several approaches to contracting reform that would give the program additional flexibility necessary to promote better performance and accountability among claims administration contractors.

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## Current Contracting Law and Practice Limit CMS' Management Options

CMS faces multiple constraints in its options for selecting claims administration contractors. Under these constraints, the agency may not be able to select the best performers to carry out Medicare's claims administration and customer service functions. Because the Medicare statute exempts CMS from competitive contracting requirements, the agency does not use full and open competition for awarding fiscal intermediary and carrier contracts. Rather, participation has been limited to entities with experience processing these types of claims, which have generally been health insurance companies. Provider associations, such as the American Hospital Association, select fiscal intermediaries in a process called "nomination" and the Secretary of HHS chooses carriers from a pool of qualified health insurers.

CMS program management options are also limited by the agency's reliance on cost-based reimbursement contracts.<sup>7</sup> This type of contract reimburses contractors for necessary and proper costs of carrying out Medicare activities, but does not specifically provide for contractor profit or other incentives. As a result, CMS generally has not offered contractors the fee incentives for performance that are used in other federal contract arrangements.

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## Medicare Could Benefit From Open Competition and Increased Flexibility

Medicare could benefit from various contracting reforms. Perhaps most importantly, directing the program to select contractors on a competitive basis from a broader array of entities would allow Medicare to benefit from efficiency and performance improvements related to competition. A full and open contracting process will hopefully result in the selection of stronger contractors at better value. Broadening the pool of entities allowed to hold Medicare contracts beyond health insurance companies

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<sup>7</sup>According to CMS, requirements of the Social Security Act that call for the use of cost-based reimbursement contracts preclude the program from offering financial incentives to contractors for high-quality performance.

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will give CMS more contracting options. Also, authorizing Medicare to pay contractors based on how well they perform rather than simply reimbursing them for their costs could result in better contractor performance.

We also believe that the program could benefit from efficiencies by having contractors perform specific functions, called functional contracting. The traditional practice of expecting a single Medicare contractor in each region to perform all claims administration functions has effectively ruled out the establishment of specialized contracts with multiple entities that have substantial expertise in certain areas.<sup>8</sup> Moving to specialized contracts for the different elements of claims administration processing would allow the agency to more efficiently use its limited resources by taking advantage of the economies of scale that are inherent in some tasks. An additional benefit of centralizing carrier functioning in each area is the opportunity for CMS to more effectively oversee carrier operations. Functional contracting would also result in more consistency for Medicare-participating providers.

Several key provisions of MRCRA would address these elements of contracting reform. MRCRA would establish a full and open procurement process that would provide CMS with express authority to contract with any qualified entity for claims administration, including entities that are not health insurers. MRCRA would also encourage CMS to use incentive payments to encourage quality service and efficiency. For example, a cost-plus-incentive-fee contract adjusts the level of payment based on the contractor's performance. Finally, MRCRA would modify long-standing practice by specifically allowing for contracts limited to one component of the claims administration process, such as processing and paying claims, or conducting provider education and technical assistance activities.

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## Concluding Observations

The scope and complexity of the Medicare program make complete, accurate, and timely communication of program information necessary to help providers comply with Medicare requirements and appropriately bill for their services. The backers of MRCRA recognize the need for more resources devoted to provider communications and outreach activities,

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<sup>8</sup>This has recently started to change in response to new contracting authorities granted by the Health Insurance Portability and Accountability Act of 1996, which resulted in the selection of 12 Program Safeguard Contractors that perform specific payment safeguard activities.

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and we believe the funding provisions in the bill will help assure that more attention is paid to these areas. MRCRA also contains provisions that would provide a statutory framework for Medicare contracting reform. We believe that CMS can benefit from this increased flexibility, and that many of these reform provisions will assist the agency in providing for more effective program management.

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Madam Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or other Subcommittee Members may have.

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## **GAO Contact and Staff Acknowledgments**

For further information regarding this testimony, please contact me at (312) 220-7767. Jenny Grover, Rosamond Katz, and Eric Peterson also made key contributions to this statement.

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# Related GAO Products

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*Medicare Management: CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs* ([GAO-01-1014T](#), July 26, 2001).

*Medicare: Successful Reform Requires Meeting Key Management Challenges* ([GAO-01-1006T](#), July 25, 2001).

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

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

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

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

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

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

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

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