

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MONITORING MEDICARE CONTRACTOR
PERFORMANCE**

A NEW APPROACH



JUNE GIBBS BROWN
Inspector General

AUGUST 1995
OEL-01-93-00160

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EXECUTIVE SUMMARY

PURPOSE

To provide an early, preliminary assessment of the new approach that the Health Care Financing Administration used in 1994 to evaluate Medicare contractor performance in medical review and in fraud and abuse activities.

BACKGROUND

The Health Care Financing Administration (HCFA) contracts with 33 carriers to process Medicare claims for physicians and supplies, and with 46 fiscal intermediaries to process claims for institutional providers. The FY 1995 appropriation for these contractors is \$1.6 billion. In 1995, they are expected to process 785 million claims.

In 1994 HCFA instituted a new approach for reviewing contractor performance in two important areas of payment safeguards: fraud and abuse, and medical review. This approach had two basic features. First, the review used a qualitative assessment of contractor performance, rather than a standardized numerical scoring system. Second, HCFA used teams comprised of staff from different regional offices to conduct the reviews, rather than rely on a single staff member from the local regional office.

Our methodology relies on three data sources: a review of the narrative reports submitted to contractors following their review; interviews with HCFA staff from five regional offices and the central office; and interviews with staff from 15 contractors, including 10 contractors that were reviewed under the new approach and 5 that were not reviewed using this approach.

FINDINGS

EARLY EXPERIENCE INDICATES THAT THE NEW APPROACH HAS IMPROVED HCFA'S ABILITY TO ASSESS CONTRACTOR PERFORMANCE IN MEDICAL REVIEW AND IN FRAUD AND ABUSE.

The qualitative assessment used in the new approach gave HCFA a way of gathering useful information that it had not obtained before.

- The flexible protocol enabled the review team to target its inquiry on areas of each contractor's performance that the team identified as problematic.

Examples of problems identified:

- no system for prioritizing fraud cases
- inadequate data analysis system to identify aberrant billing patterns
- lack of system to evaluate success of provider corrective actions

- The new approach encouraged the review teams to identify strengths and weaknesses that cut across different operating units at individual contractors.

Examples of strengths identified:

- standardized format for referrals
- fraud unit staff conducts fraud detection training for *all* contractor staff

Examples of weaknesses identified:

- referral of non-fraud cases to fraud unit
- inadequate contractor wide training on fraud detection and prevention

Using teams from outside the local regional office to conduct the reviews enhanced the review for both HCFA and contractors.

- The external teams brought new information about contractor operations to both HCFA and the contractors.

Information brought to HCFA:

- impact of requirements on contractor operations
- central office involvement in contractor assessment

Information brought to contractors:

- improved understanding of HCFA policies and expectations
- improved ways of using data systems

- The use of external teams added an element of objectivity to the reviews.

Contractor perspectives on objectivity:

- "You are more challenged to really walk an outside team through your processes, to be sure you explain your operation to them."
- "If you deal with someone daily, they have more trouble finding fault. If they don't know us, they're not so concerned about future dealings with us."

OUR EARLY ASSESSMENT ALSO SUGGESTS THAT HCFA HAS NOT YET MADE FULL USE OF THE INFORMATION GATHERED IN THESE REVIEWS TO FURTHER CONTRACTORS' ABILITY TO SAFEGUARD MEDICARE PAYMENTS.

HCFA regional staff are using the written reports from these reviews in their ongoing assessment of contractor performance. However, regional staff may not be taking full advantage of these reports to provide more effective oversight of contractor activities.

The written reports varied widely in four significant ways:

Criteria for imposing corrective action plans;
Differing interpretations of similar facts;
No prioritization of recommendations; and
Different levels of detail reported.

In the course of the reviews, HCFA gathered national information on effective contractor practices, as well as practices to avoid. However, the agency has not yet conveyed this information to contractors as a way of strengthening overall operation of the Medicare program.

RECOMMENDATIONS

The real measure of the success of this new approach will be determining whether contractors in the years ahead are doing a better job of preventing inappropriate payments under the Medicare program. In order to build upon the process initiated this past year, we recommend that HCFA take the following steps:

THE HCFA CENTRAL OFFICE SHOULD BE SURE TO OBTAIN INFORMATION FROM THE REGIONAL OFFICES TO SEE HOW THEY ARE MONITORING CONTRACTOR IMPROVEMENT PLANS THAT AROSE FROM THESE REVIEWS OF FRAUD AND ABUSE ACTIVITIES AND MEDICAL REVIEW.

Obtaining this information is important for three reasons:

HCFA needs to assess the results of this new approach over time;
HCFA should have a mechanism for determining how the regional offices are accepting findings of reviews conducted by outside teams; and
HCFA should have a central source for assessing the practical usefulness of the reports.

THE HCFA SHOULD DEVELOP A GENERAL FORMAT FOR KEY INFORMATION TO BE CONTAINED IN THE WRITTEN REPORTS.

At a minimum, we believe that this information should include:

the basis for imposing corrective action plans;
the supporting data needed to portray accurately the results of the reviews; and
prioritization of recommendations for improvement.

THE HCFA SHOULD TAKE IMMEDIATE STEPS TO PREPARE AN ANALYSIS OF EFFECTIVE PRACTICES, AND PRACTICES TO AVOID, BASED ON FINDINGS FROM THE 1994 REVIEW PROCESS. THE HCFA SHOULD SHARE THESE ANALYSES WITH ALL FISCAL INTERMEDIARIES AND CARRIERS.

The HCFA should evaluate the success of this effort, perhaps through conducting user feedback surveys. If the approach is meaningful for the contractors, we would urge HCFA to continue to conduct and share similar analyses in the future.

COMMENTS ON THE DRAFT REPORT

We sought comments on the draft report from HCFA and from the Assistant Secretary for Planning and Evaluation (ASPE). The HCFA concurred with our

recommendations and summarized steps that the agency is taking to implement those recommendations. The ASPE also concurred with our recommendations, but offered no additional comments. We include HCFA's full comments as Appendix A.

In response to our first recommendation, HCFA indicates that regional offices are submitting copies of Contractor Performance Improvement Plans to the central office. Central office and the regions are working to develop a mechanism for continuous monitoring of these Performance Improvement Plans.

In response to our second recommendation, HCFA notes that it is providing general guidelines for review teams concerning key information to be communicated in written reports. The actual report format will be determined by the review teams, as is currently being done for the national review in the Medicare Secondary Payer area.

In response to our third recommendation, HCFA states that it already has disseminated best practices to carriers and intermediaries.

We appreciate HCFA's positive response. We would be pleased to work with the agency in the future to evaluate the effectiveness of its actions in these areas.

INTRODUCTION

PURPOSE

To provide an early, preliminary assessment of the new approach that the Health Care Financing Administration used in 1994 to evaluate Medicare contractor performance in medical review and in fraud and abuse activities.

BACKGROUND

The Health Care Financing Administration (HCFA) contracts with 46 fiscal intermediaries to process claims for institutional providers, and with 33 carriers to process claims for physicians and supplies. The FY 1995 appropriation for Medicare contractors is \$1.6 billion. In 1995, these contractors are expected to process nearly 785 million Medicare claims.¹

Contractor Performance Evaluation Prior to 1994

Historically, HCFA used the Contractor Performance Evaluation Program (CPEP) to monitor contractor performance. The CPEP used a tightly defined numerical scoring system on a wide range of performance criteria.² Beginning in FY 1993, HCFA began to incorporate some major changes in CPEP. These changes were driven in part by budgetary considerations. More significant, however, was dissatisfaction with the effectiveness of the annual CPEP review process. These dissatisfactions included:

- 1) Concerns were raised that CPEP was not measuring the most important aspects of contractor performance. The General Accounting Office criticized CPEP because "it has focused more on process rather than outcome. Therefore, CPEP does not sufficiently emphasize efforts to save program benefit payments, particularly through its measurement of the effect of payment safeguards."³ For example, CPEP assessed the timeliness of contractor responses to complaints, or the ability of the contractor to process claims within mandated time frames.
- 2) Because contractors knew exactly what they were being measured on, and had even helped to develop the evaluation protocol, they managed their contracts in a way that would maximize their score. The CPEP did not assess other areas of contractor performance.
- 3) The potential also existed for regional office staff involved in the CPEP reviews to become too close to contractors, threatening their objectivity. For example, because the regional office staff member knew the contractor staff, he or she might not be unbiased when it came to reviewing the organization. Or, the regional office staff member might not subject the contractor to rigorous scrutiny because of an assumption that the contractor would continue to perform adequately, as it had done in the past.

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HCFA's New Approach to Contractor Performance Review

In 1994 HCFA instituted a significantly revised approach for reviewing contractor performance in the areas of fraud and abuse and medical review. The 1994 CPEP was designed "to determine the degree to which contractors are ensuring effective management of these program areas and whether the trust funds are being protected."⁴

This new approach had two fundamental features:

- *Qualitative Assessment of Contractor Performance*

The new approach turned from a numeric scoring system to a qualitative assessment of contractors' strengths and weaknesses. The review considered the consequences of any weaknesses and provided recommendations for improvement. Rather than provide a single numeric score for the contractor, the new review process produced a written narrative. These reviews addressed two areas related to safeguarding the Medicare Trust Fund: Contractors' detection of fraud and abuse and their medical review practices.

- *External Team Reviews*

Rather than rely on review by a single staff member from the local regional office, HCFA used review teams made up of staff from different regions to conduct the 1994 reviews. Each review team comprised at least two of these external staff. For some reviews, a third individual from the HCFA central office joined the team. The review team communicated its findings in a report directly to the contractor, rather than through the local regional office.

The HCFA used one set of six teams to examine fraud and abuse detection for both intermediaries and carriers. Another set of four teams examined medical review for intermediaries, and a different set of four teams examined medical review for carriers. The HCFA teams reviewed 34 contractors for fraud and abuse detection (16 Part A, 18 Part B), 20 for Part A medical review, and 19 for Part B medical review.⁵

METHODOLOGY

Our methodology relied on three data sources:

First, we reviewed each of HCFA's narrative reports submitted to contractors following their review.

Second, we used a semi-structured guide to interview HCFA staff from the central office and from the following five regional offices: Region 1 (Boston), Region 3 (Philadelphia), Region 4 (Atlanta), Region 5 (Chicago), and Region 6 (Dallas). We selected these regions after reviewing the narrative reports, to provide a distribution

among the regions in terms of their participation in the review process and the findings with respect to different contractors.

Third, we used a semi-structured guide to interview staff from the following 15 contractors. We selected three contractors from each region, two that had been reviewed under the new approach and one that had not. We chose these contractors based on our review of the narrative reports and discussions with the HCFA regional office staff:

Region 1: Blue Cross and Blue Shield of Massachusetts; Blue Cross of Maine; MetraHealth, Connecticut.

Region 3: Xact Medicare Services, Pennsylvania; Blue Cross of Virginia; Blue Cross of Maryland.

Region 4: Blue Cross of North Carolina; Blue Shield of Florida; Blue Cross of Georgia.

Region 5: AdminaStar Federal, Indiana; MetraHealth, Minnesota; Wisconsin Physician Services.

Region 6: Blue Cross and Blue Shield of Texas; New Mexico Blue Cross; Aetna Life Insurance, Oklahoma.

All told, the ten contractors that had been reviewed under the new approach comprise six Part A and seven Part B contractors (three hold both A & B contracts). They received reviews as follows: five Part A medical review; six Part B medical review; four Part A fraud and abuse; and six Part B fraud and abuse. The five contractors that did not participate in the 1994 reviews hold three Part A contracts and two Part B contracts.

We conducted this study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

EARLY EXPERIENCE INDICATES THAT THE NEW APPROACH HAS IMPROVED HCFA'S ABILITY TO ASSESS CONTRACTOR PERFORMANCE IN MEDICAL REVIEW AND IN FRAUD AND ABUSE.

The qualitative assessment used in the new approach gave HCFA a way of gathering useful information that it had not obtained before.

We compared the narrative reports submitted by the review teams for the 1994 review with the 1993 Reports of Contractor Performance provided by HCFA for these same 52 contractors. The outcomes of the reports--the strengths, weaknesses, and recommendations for improvement identified in 1994 versus the numerical scores issued in 1993--provide clear evidence that the new approach gave a greater level of information about contractor performance in fraud and abuse and medical review.

In 1994, the review teams found weaknesses and areas for improvement in every contractor reviewed. The most serious problems, requiring contractors to submit formal corrective action plans (CAPs) to their regional office, were found at contractors in 22 out of 73 reviews conducted (30 percent). These 22 contractors included 14 that had received perfect scores in the prior year.

In 1993, in comparison, 28 of the 52 contractors (54 percent) reviewed in 1994 had perfect scores of 100; 46 (88 percent) contractors received a total score of 95 or higher, and only one contractor scored below 90. We recognize that the actual criteria on which they were judged varied between the two years. However, the weaknesses found in the 1994 review provide solid evidence that contractors, which had been judged to be performing at a high level in 1993, were weak in some areas in 1994. The clear implication is that the 1994 protocol was more sensitive to contractor operations in fraud and abuse and/or medical review than the 1993 version.

One important accomplishment of the 1994 reviews was to provide information for HCFA on how far contractors had come, and how much further they need to go, to meet HCFA's expectations for performance in fraud and abuse and in medical review. A regional HCFA official summarized this issue when he said that, "The old CPEP was a scorecard, and as long as you did what the protocol dictated, you'd get an "A". With this new approach, we were looking at no matter what you were doing, how could you do it better." These expectations, and the focus of the 1994 reviews, addressed issues such as contractors' capacity to:

- develop a strategy for prioritizing high cost, high incidence, high dollar claims.
- conduct large scale data analysis and statistical work to identify significant local aberrancies;

- establish methods to evaluate contractors' success in correcting inappropriate provider billing; and
- proactively deter fraud.
- *The flexible protocol enabled the review team to target its inquiry on areas of each contractor's performance that the team identified as problematic.*

Our interviews with HCFA and contractor staff confirmed that the 1994 protocols provided HCFA with information that was more useful for contractor evaluation. The new evaluation protocols did not use a scoring system, but focused on identifying strengths and weaknesses, with recommendations for improvement. A key feature of the protocols was the intention to let the review team delve into areas that the team identified as important while they were on site at the contractor. The highlighted examples, typical of those we heard from several participants, show that these protocols seem to have accomplished those goals.

"At one contractor, we spent a lot of time on their data analysis system. We never got into individual case reviews, because the data system is where the problems were. We were able to tailor the protocol to what we actually found on site."

HCFA review team member

"At one contractor, 14 of 20 cases we reviewed had significant delays in processing--an average delay of a year. This served as a springboard, and we found out that the contractor had no system in place for prioritizing cases and no methods for analyzing cases--and some involved very significant dollar amounts."

HCFA review team member

Contractors we interviewed, both those who had been reviewed and those who had not been reviewed, saw this new approach as a positive step. Several contractors used the term "trivia" to describe the measures in the prior review. One contractor staff member summarized the positive benefit of the changes as follows: "We are no longer worrying about timelines--arguing over whether a letter was answered in 30 days or 31 days--but on whether we are doing what we should, like referring good cases to OIG."

- *The new approach encouraged the review teams to identify strengths and weaknesses that cut across different operating units at individual contractors.*

The new approach focused on the processes that contractors use to carry out their work. Areas of inquiry included the way that different operating units interact with each other, the flow of information across units, and the entire organization's commitment to payment safeguards. To obtain this information, review teams assessed how other operating units of the contractor interacted with the one under review.

One review team member capsulized how this process worked. "We had a lot more leeway in conducting reviews. Rather than just talk to the manager or the fraud staff, we interviewed everyone in the fraud unit, plus people in other units--medical review, claims processing, even the receptionists. In the past we'd found a lack of communication between fraud and abuse and other units; now we could factor that in to the report."

Through these interviews, the teams were able to identify issues of concern that went beyond the specific area at hand. Examples from four reviews illustrate these points.

Weakness:

"There was not an active and regular exchange of data with the fraud and abuse, claims processing, and audit units for conducting focused medical review other than on an informal and as needed basis."

from a Part A Medical Review narrative report

Strength:

"A medical review action team made up of fraud and abuse, medical review, carrier medical director and provider relations meets every week."

from a Part B Medical Review narrative report

Weakness:

"The majority of complaints referred to the fraud unit are non-fraud issues. Research and disposal of these types of complaints by the fraud unit is taking away resources that could be used to develop the high priority fraud caseload in the unit."

from a Part B Fraud and Abuse narrative report

Strength:

"Complaints are screened in the mailroom to assure that only true allegations of potential fraud are routed to the fraud unit and that complaints that can more properly be handled by other contractor components are routed to those components."

from a Part A Fraud & Abuse narrative report

Using teams from outside the local regional office to conduct the reviews enhanced the review for both HCFA and contractors.

- *The external teams brought new information about contractor operations to both HCFA and the contractors.*

Information brought to HCFA

The HCFA received new information from these reviews in three principal ways. First, HCFA central office staff participated on the review teams. In 32 of the 73 reviews (44 percent), central office staff were members of the review teams. For the regional office staff, the benefit of this participation was best characterized by the staff member who said that, "It would have been beneficial if we had fully experienced people from central on every review--not so much for conducting the review, but for

training them so that central office understands that there are multiple ways to do something." A central office staff person verified this when she said that "Instructions for performance originate in Baltimore, and it was good for us to see how things work out there where they really hit the road."

Second, office staff from other regional offices learned how their counterparts elsewhere operated and the impact of their policies. The benefit of this cross-fertilization was best characterized by the contractor who told us, "Sharing best practices from the other regions prompted our local regional office to look at things differently as well. I'm sure that regional offices exchange information at some level, but the team review gave them a very specific framework to do this."

Third, HCFA staff received input from the contractors regarding problems that they faced with HCFA and suggestions for improvement. This input was most formal in the reviews conducted for Part B medical review, where the narrative reports included the carriers' recommendations for HCFA. Every carrier reviewed in this area had some recommendations for HCFA. This section was not included in the reports for Part A medical review, nor for the fraud and abuse reviews.

Examples of Carrier Recommendations to HCFA in Focused Medical Review:

"HCFA needs to communicate its expectations more effectively. Changes in emphasis from educational contacts to overpayment recoupment were not conveyed in writing or consistently conveyed to all contractors on a timely basis."

"The carrier would like HCFA to provide national data so that the most current data is available in September. Otherwise, the carrier must start focused medical review with old data."

A typical contractor comment about this opportunity was, "The open discussion helped us. We were able to bring issues to light to them to communicate with central office. Our manual has changed so much over the last three years that this was a good discussion."

Information brought to contractors

Contractors received new information through two primary mechanisms. First, the process brought contractors a better understanding of HCFA policies and expectations. These policies had been conveyed in contractor manuals, but the reviews reinforced HCFA's emphasis on specific items, such as fraud prevention and detection. The importance of the external review teams in conveying this message was best characterized by the regional official who told us that, "The review team and this approach really were instrumental in giving a wake up alarm that these problems were not just local regional office concerns, but HCFA speaking from a national perspective."

"The reviews complemented and reinforced HCFA's new contractor manual instructions and methods of evaluation. Now HCFA is pushing prioritization of claims--highest dollar, highest profile cases--using data analysis and trend analysis to detect fraud and abuse up front, and deter it, rather than playing "pay and chase".

Regional office staff

"HCFA told us we weren't taking enough risk in fraud prevention, but we thought we were doing what they wanted. Now we see that HCFA wants a different approach, and we know what their future expectations are. The dialogue clarified that HCFA wanted us to be more aggressive in fraud detection and in suspending payments, so we have strengthened those areas."

Contractor

Second, contractors found it particularly beneficial to learn more about how others dealt with similar problems. Several people we interviewed considered this to be the strongest benefit of using the external teams.

"One fiscal intermediary in our region was hit very hard in medical review. The review team members were very familiar with the shared data analysis system that the contractor used, and they made some very good and specific suggestions on how to improve its use here, based on their experience elsewhere. The FI had never had an opportunity to see these things, and has been very responsive in adopting them.

Regional office staff member

- *The use of external teams added an element of objectivity to the reviews.*

In our interviews, contractors and HCFA staff identified three ways in which the use of external teams added objectivity to the review process. First, all agreed that the external teams placed some new demands on the contractors. One HCFA staff member explained this as, "They didn't know us and we didn't know them. So they had to show us something new, not the same old thing that they would dust off for the regional office reviewers." One aspect of this fresh look was that in most cases the review teams went to the contractors with no advance contact with the local HCFA regional office. Although this lack of contact may have meant that the team was not fully informed on local issues, those we spoke with thought that this "lack of contact didn't really matter. If there was a problem we found it in our review, and didn't need someone to point it out ahead of time."

Second, contractors felt the need to justify and explain their operations to the new team--and to themselves--as part of this process. One contractor explained this as follows: "If you deal with someone on a daily basis, they may have trouble coming in and finding fault. If they don't know us, they can be more objective, not as concerned about our feelings or their future dealings with us." Another contractor told us that "The regional office is good, because you know them; but with an outside team, you are more challenged to really walk them through your processes, to be sure you explain them."

Finally, the use of teams themselves appears to have brought a sense of balance to the review. One contractor characterized this as, "Each regional office has its strengths and weaknesses; each team brings different perspective." Another noted that, "You can run into problems in the individual philosophies of different reviewers that may disagree with us. Teams tend to overcome that perspective, because the group tends to moderate the extremes."

The potential exists that external reviewers might not be knowledgeable about unique local situations affecting contractors. However, our interviews with contractors suggested that this was not the case. One contractor explained that "The team did not have all of our history, but that wasn't a problem. You'd probably have to walk the local regional office team through the process also to bring them up to speed." Another told us, "We had an initial concern about the external teams. But they were up to speed. This was clear once we found that they wanted to talk rather than just lock themselves in a room with documents! They talked, listened, were very open. If there was a question, we could explain it to them."

OUR EARLY ASSESSMENT ALSO SUGGESTS THAT HCFA HAS NOT YET MADE FULL USE OF THE INFORMATION GATHERED IN THESE REVIEWS TO FURTHER CONTRACTORS' ABILITY TO SAFEGUARD MEDICARE PAYMENTS.

HCFA regional staff are using the written reports from these reviews in their ongoing assessment of contractor performance. However, regional staff may not be taking full advantage of these reports to provide more effective oversight of contractor activities.

After issuing its written report, the review team's role in contractor monitoring ended. When it had recommended a corrective action plan (CAP), review team members received a copy of the contractor's response. But approval of the CAP and oversight of its implementation are the responsibility of the contractor's local regional office. In reviews in which the team *did not* impose a CAP, even if other weaknesses were identified, no specific action is required of the regional office.

The written reports contain a substantial amount of information that would be useful to a regional office in its ongoing monitoring of contractor performance--whether or not a formal corrective action plan was required. Our interviews with HCFA staff indicated that the way in which the reports are actually used to monitor contractors is up to the individual regional offices. The HCFA central office has apparently adopted a hands-off approach. As individuals there told us, "We don't know how the follow-up worked. It's up to the home region to do and we haven't done any real follow-up with them. Contractor evaluation is really their job."

"We view the recommendations as a baseline. In our ongoing monitoring we expect contractors to work toward improving on that baseline."

HCFA regional office staff

"You need more than a narrative report; you need to go on site yourself. It is very difficult to compress hard data and suspicions of things that are going on into a short report that is a comprehensive narrative."

Another HCFA regional office staff

The contractors we interviewed shared different experiences with follow-up.

"Our regional office got a copy of the report, but we're not sure what happened with it there."

Medicare Fiscal Intermediary

"At the time we wrote the CAP, our regional office raised the review. But, since then we've had no real discussions on the process, other than a few conversations on specific claims issues."

Medicare Carrier and Fiscal Intermediary

"The regional office has been out twice. We will use the report as a baseline; if another team comes in, they could look at where our weaknesses had been and how we are addressing these."

Medicare Carrier and Fiscal Intermediary

One apparent reason for this inconsistency is that the primary audience for these reports is not clear. According to those we interviewed, at HCFA and the contractors, the primary audience for the report was *not* the regional office. During the course of our interviews, we asked individuals from the regional offices, central office, and contractors who they thought was the focus of the written reports. Four responded that the primary audience was the HCFA central office, while nine said that the audience was the contractor. None indicated that the primary audience was the regional office. We recognize that this is not a statistically valid sample, but believe that it does provide a strong indication that those involved did not really view these reports as a way of enhancing contractor monitoring by the local regional office.

The written reports varied widely in four significant ways.

- *Criteria for imposing corrective action plans*

The criteria for imposing a formal corrective action plan were not clear. A review team could require a CAP if it determined that the contractor did not comply with the requirements of the Medicare manual. In some reports, the findings were tied directly to individual sections of the manual; in other reports, the findings were more broadly constructed, along with details about how the team thought the contractor should come into compliance with the manual. At still other contractors, it was not even clear from reading the report whether a formal CAP was required, or whether the

team was merely identifying weaknesses and making recommendations for improvement.

It is also worth noting that the teams reviewing focused medical review at fiscal intermediaries were much more likely to impose CAPs, doing so on at least 15 of the 20 intermediaries reviewed. In contrast, the review teams required a CAP for only 4 of 19 carriers in medical review, and 2 of 16 intermediaries and 1 of 18 carriers in fraud and abuse.

- *Differing interpretations of similar facts*

We found instances in which differing interpretations were attached to similar situations, impacting on recommendations, strengths and weaknesses. The following boxes provide examples of two such apparent conflicts.

<p>A strength: <i>"The carrier is interviewing applicants to fill two positions which will enhance their FMR/data analysis activities: an additional registered nurse and a statistician.</i> from a Part B Medical Review Narrative report</p> <p>A weakness: <i>"At the time of the site visit, the carrier had not yet filled 2 of its 3 Medical Review Analyst positions."</i> from a Part B Medical Review Narrative report</p>

<p>A strength: <i>"The carrier recognizes the need for more automation and is currently in the process of enhancing data needs."</i> from a Part B Medical Review narrative report</p> <p>A weakness: <i>"The carrier intends to provide SAS training for the medical review staff."</i> from a Part B Medical Review narrative report</p>

- *No prioritization of recommendations*

The reports did not indicate which recommendations offered to contractors were the most important. The reports listed recommendations for improvement or corrective actions in the sequence in which they had appeared in the written report. In fact, it appears that some weaknesses are more consequential than others and probably should be corrected first, whereas others appear to be less significant.

- *Different levels of detail reported*

The reports varied among teams in the detail that was provided. For example, when describing a contractor's data analysis capabilities, some reports described only the software that the contractor used in a brief paragraph. Other teams provided

extensive information on the type of hardware, software, reports issued, and how the data were analyzed. We raise this as a concern because it reflects on the audience for these reports. The contractor will already know this information; the level of detail may be more than HCFA central office needs (unless some type of standardization is being considered); and the regional office is likely to already be familiar with the contractor.

In the course of the reviews, HCFA gathered national information on effective contractor practices, as well as practices to avoid. However, the agency has not yet conveyed this information to contractors as a way of strengthening overall operation of the Medicare program.

Nine of the fifteen contractors we interviewed told us that they wanted information on effective practices of other contractors that HCFA learned from the reviews. These contractors told us this in unsolicited discussion, *i.e.*, not in response to a particular question we asked.

The interest in this information was particularly noticeable among the contractors we interviewed that had not been reviewed under the new approach. All five of those we spoke with requested this information. But four of the ten contractors that were reviewed also wanted to receive such information.

Four of these contractors told us that they had received from HCFA a general listing of strengths and weaknesses in fraud and abuse at a December 1994 meeting of contractors. Even those contractors who did obtain that summary told us that they wanted a more formalized analysis of what the 1994 reviews showed to be effective practices and practices to avoid. They indicated that they would use the material to examine ways of improving their own operations.

RECOMMENDATIONS

We recognize that this approach marked a new direction for HCFA. This new approach clearly involved a learning curve--for the reviewers, for the contractors, and for HCFA administrators. We also recognize that the subjective nature of the reviews leaves substantial discretion to the individual review teams. By its nature as an evolving process, the HCFA staff learned lessons as they pursued the reviews, including development of additional questions to guide the review and their subsequent reflection in the report.

The real measure of the success of this new approach will be determining whether contractors in the years ahead are doing a better job of preventing inappropriate payments under the Medicare program.

In order to build upon the process initiated in 1994, we believe that HCFA could strengthen that process and its intended outcomes through the following steps:

THE HCFA CENTRAL OFFICE SHOULD BE SURE TO OBTAIN INFORMATION FROM THE REGIONAL OFFICES TO SEE HOW THEY ARE MONITORING CONTRACTOR IMPROVEMENT PLANS THAT AROSE FROM THESE REVIEWS OF FRAUD AND ABUSE ACTIVITIES AND MEDICAL REVIEW.

We recognize that contractor evaluation and monitoring remain the primary purview of the regional offices. At the same time, we believe that it behooves the agency to continue to have central knowledge about contractors' progress in implementing corrective actions and recommendations made by the review teams. We believe that obtaining this information is important for three reasons.

First, because this was a dramatically new approach to contractor evaluation, HCFA needs to assess its impact over time. Because this evaluative approach was designed to change contractor behavior and improve their performance, HCFA needs to know how and to what extent the new approach has been successful in achieving these goals.

Second, the regional offices were not involved in reviewing contractors within their own region. To the extent that the regional office staff may feel somewhat disenfranchised or left out of these reviews, it is important that HCFA have some mechanism to determine whether the regional offices have accepted the findings of the reviews, particularly when the reviews were done by teams from outside of the region.

Third, as we note in our findings, there appear to be different ways of approaching and using the reports among the regions. To be sure that the goals of this review are realized, HCFA needs to have some central source for assessing the practical usefulness of the reports.

THE HCFA SHOULD PROVIDE GUIDANCE FOR REVIEW TEAMS REGARDING KEY INFORMATION TO BE CONTAINED IN THE WRITTEN REPORTS.

In our findings, we note that there are discrepancies in the format and supporting data contained in the written reports. At a minimum, we believe that this information should include:

- the basis for imposing corrective action plans;
- the supporting data needed to portray accurately the results of the reviews; and
- prioritization of recommendations for improvement.

We believe that HCFA should ensure that the reports contain this minimum information for two important reasons.

First, having this information will let the agency compare and understand performance from a broad national perspective. Even though HCFA is no longer ranking contractors, the agency still needs to have information that lets it assess performance across the different organizations with which it contracts.

Second, having a solid base of information would be particularly important in the event that the agency must take adverse action against a contractor. The HCFA needs to be sure that the evaluation of that contractor will stand up under scrutiny.

In developing a format for this information, we urge HCFA to be cautious not to lose the vibrancy and creativity contained in the team reviews. The ability of the teams to identify important issues at each contractor, and to examine different levels and depths of information is one of the significant benefits of the new approach.

THE HCFA SHOULD TAKE IMMEDIATE STEPS TO PREPARE AN ANALYSIS OF EFFECTIVE PRACTICES, AND PRACTICES TO AVOID, BASED ON FINDINGS FROM THE 1994 REVIEW PROCESS. THE HCFA SHOULD SHARE THESE ANALYSES WITH ALL FISCAL INTERMEDIARIES AND CARRIERS.

In the spirit of continuous quality improvement, HCFA could help all contractors meet its expectations for performance in fraud and abuse and in medical review. We found a strong demand for this type of information among contractors, to help strengthen their practices and to help them avoid "reinventing the wheel." By providing information on practices that are successful in achieving these outcomes, HCFA would benefit the contractors, while also helping to safeguard the Medicare trust funds.

To be effective and useful, this product must be more than just a listing of what individual teams found on site. The analysis needs to be a short term, but thorough, appraisal of what actions and approaches work, their potential to achieve program goals, ways of measuring success, and other pertinent information. This review would

result in HCFA's constructive assessment of what contractors should be doing to safeguard Medicare payments.

We urge that HCFA evaluate the success of this effort, perhaps through conducting surveys to gain feedback from the contractors who receive this information. If the approach is successful and meaningful for the contractors, we would urge HCFA to continue to conduct and share similar analyses in the future.

AGENCY COMMENTS

We sought comments on the draft report from HCFA and from the Assistant Secretary for Planning and Evaluation (ASPE). The HCFA concurred with our recommendations and summarized steps that the agency is taking to implement those recommendations. The ASPE also concurred with our recommendations, but offered no additional comments. We include HCFA's full comments as Appendix A.

In response to our first recommendation, HCFA indicates that regional offices are submitting copies of Contractor Performance Improvement Plans to the central office. Central office and the regions are working to develop a mechanism for continuous monitoring of these Performance Improvement Plans.

In response to our second recommendation, HCFA notes that it is providing general guidelines for review teams concerning key information to be communicated in written reports. The actual report format will be determined by the review teams, as is currently being done for the national review in the Medicare Secondary Payer area.

In response to our third recommendation, HCFA states that it already has disseminated best practices to carriers and intermediaries.


We appreciate HCFA's positive response. We would be pleased to work with the agency in the future to evaluate the effectiveness of its actions in these areas.

APPENDIX A

HCFA COMMENTS ON DRAFT REPORT



The Administrator
Washington, D.C. 20201

DATE JUL 29 1995
FROM Bruce Vladeck 
Administrator
SUBJECT Office of Inspector General Draft Report "Monitoring Medicare
Contractor Performance: A New Approach," (OEI-01-93-00160)
TO June Gibbs Brown
Inspector General

This draft report institutes a new approach for reviewing contractor performance in two areas of payment safeguards: medical review and fraud and abuse activities.

We concur with the report recommendations. Our specific comments are attached. Thank you for the opportunity to review and comment on this report.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General Draft Report: "Monitoring Medicare
Contractor Performance:
A New Approach," (OEI-01-93-00160)

Recommendation 1

HCFA Central Office (CO) should be sure to obtain information from the regional offices (RO) to see how they are monitoring contractor improvement plans that arose from these reviews of fraud and abuse activities and medical review.

HCFA Response

We concur. Currently, ROs are submitting copies of their Contractor Performance Improvement Plans and CO will be working with the regions to develop a mechanism for continuous monitoring of the Performance Improvement Plans.

OIG Recommendation 2

HCFA should provide guidance for review teams regarding key information to be contained in the written reports.

HCFA Response

We concur. HCFA will provide general guidelines for review teams concerning key information to be communicated in written reports. However, the review teams will determine their own formats for the reports. This is currently being done for the national review of the Medicare Secondary Payer area.

OIG Recommendation 3

HCFA should take immediate steps to prepare an analysis of effective practices and practices to avoid based on findings from the 1994 review process. HCFA should share these analyses with all fiscal intermediaries and carriers.

HCFA Response

We concur. HCFA has already disseminated "best practices" to all carriers and intermediaries. The fraud and abuse "best practices" were shared during the 1994 national meeting. In February 1995, the medical review "best practices" was distributed to all Medicare contractors. We have not gathered information on practices to avoid.

APPENDIX B

ENDNOTES

1. Conference Report 103-73, to accompany H.R. 4606; Public Law 103-333.
2. The standards and criteria on which contractors are evaluated are published annually in the *Federal Register*.
3. U.S. General Accounting Office, *Medicare: HCFA's Contacting Authority for Processing Medicare Claims*, GAO/HEHS-94-171, 2 August, 1994, p. 7.
4. Letter to All Medicare Contractors, from Carol J. Walton, Director, HCFA Bureau of Program Operations, May 20, 1994.
5. Of the 79 Medicare contractors, 52 were actually reviewed using the new approach. These comprised 28 intermediaries and 24 carriers. Eight intermediaries and carriers were units of single overall organization, eg, a Blue Cross-Blue Shield plan that held a contract for both Parts A and B.

The HCFA teams conducted a total of 73 reviews. The teams reviewed 20 intermediaries in only 1 area, and 8 in both areas. The teams reviewed 11 carriers in only 1 area, and 13 in both areas.