United States General Accounting Office

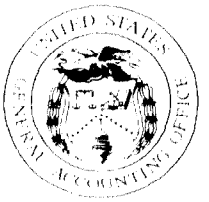
GAO

Report to Congressional Requesters

April 1991

MEDICARE CLAIMS PROCESSING

HCFA Can Reduce the Disruptions Caused by Replacing Contractors



GAO/HRD-91-44

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

Human Resources Division

B-243117

April 4, 1991

Congressional Requesters:[1]

In response to your request, this report addresses steps the Health Care Financing Administration should take to reduce the disruptions that often follow changes in its Medicare claims-processing contractors and to alleviate the impact of changes on beneficiaries and health care providers.

We are sending copies of this report to the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and other interested parties.

You may reach me on (202) 275-5451 if you or your staff have any questions. Major contributors to this report are listed in appendix III.

Janet L. Shikles
Director, Health Financing
and Policy Issues

[1]The requesters of this report are listed in appendix I.

Executive Summary

Purpose

Medicare beneficiaries and health care providers in Georgia and Florida faced serious payment delays and errors after December 1988—when the program changed its claims-processing contractor in Georgia and its data-processing subcontractor in Florida. The House Appropriations Committee and Members of Congress from Georgia and Florida requested that GAO review these changes. Specifically, GAO was to (1) determine the impact of these changes on beneficiaries and providers and (2) identify actions the Health Care Financing Administration (HCFA) should take to reduce the impact of any future changes.

Background

HCFA pays contractors, called carriers, to process claims for services—furnished by physicians, medical equipment suppliers, and clinical laboratories—and to make payments. Some carriers subcontract with outside firms to operate a data-processing system for processing claims. Changes in carriers and subcontractors occur periodically in the Medicare program. In earlier work, GAO found that contractor changes involve a significant risk of disruptions in claims processing.

Some carrier changes have resulted from carriers' decisions to withdraw from their Medicare contracts. Other carrier changes have resulted from HCFA's efforts to improve the quality and reduce the cost of claims processing by shifting carrier workloads—to increase efficiency—and ending contracts with inefficient carriers. Subcontractor changes have resulted from HCFA's efforts to promote competition between carriers.

Effective December 31, 1988, HCFA replaced the Prudential Insurance Company, which withdrew from its contract as the Georgia carrier, with the Aetna Life Insurance Company. Effective December 3, 1988, the carrier in Florida, Florida Blue Shield, changed its subcontractor from EDS-Federal Corp. to GTE Data Services, Inc.

Results in Brief

The changes in Georgia and Florida resulted in serious claims-processing disruptions. Processing slowed and backlogs grew; in Georgia, processing errors increased. Beneficiaries were confused by conflicting notices about their claims, and providers' finances were strained by payment interruptions.

Georgia and Florida contractors faced difficulties in addition to those that usually follow carrier and subcontractor changes. In Georgia, Aetna had a short time to get ready to process claims. In Florida, Florida Blue Shield had to accept its subcontractor's inefficient claims-processing

system because of weaknesses in the data-processing contract terms that HCFA had recommended.

In its guidance concerning carrier changes, HCFA does not identify the areas with the greatest potential for disruptions after these changes. Identifying these areas would be beneficial because the staff in HCFA's regional offices rarely manage changes; therefore, they lack the experience needed to identify potential disruptions. In addition, weaknesses in HCFA's instructions to carriers concerning terms for subcontracts need to be addressed.

Principal Findings

Changes Disrupted Claims Processing, Burdening Beneficiaries and Providers

After the carrier and subcontractor changes, the percentage of claims that required over 30 days to process rose from 4.6 to 25 percent in Georgia and from 3.9 to 28 percent in Florida. The interest that Aetna (in Georgia) and Florida Blue Shield paid on delayed claims increased from $375,000 in 1988 to $6.3 million in 1989. In Georgia, overpayment errors jumped from 0.65 percent of charges processed to 13 percent. These overpayment errors, GAO estimates, resulted in a $19.2 million increase in improper Medicare payments. (See pp. 13-18.)

Meanwhile, in Georgia, beneficiaries expressed frustration with telephone service, complaining of busy signals and long waits, and were confused by contradictory notices about claims. Payment delays, especially in Florida, interrupted providers' cash flow. At one point, Florida beneficiaries and providers were owed $76.9 million. The financial strain this interruption caused led some providers to seek loans or defer payments to employees and suppliers. (See pp. 20-21.)

Georgia and Florida Carriers Faced Added Difficulties

In Georgia, Aetna faced more difficulties in taking over claims processing than did new carriers in other states. First, it had no Medicare claims-processing office in the southeastern United States; it planned to establish a new office for Georgia. After equipping the new office, Aetna had just 3 months to hire and train its staff, and they were not adequately trained when they began processing claims. Second, 2 weeks before awarding a contract to Aetna, HCFA decided to initiate a pilot project; under this project, Aetna would subcontract for a review of claims to determine whether services were medically necessary. This

decision left the medical review subcontractor just 3 months to set up its operations and little chance to inform providers of the planned policy changes. (See pp. 22-25.)

The short time Aetna had to get ready to process claims added to the disruptions. The short time also prevented Aetna from comparing how its processing system handled a sample of claims with how the outgoing carrier's system had handled them—a test that would have helped identify needed adjustments in Aetna's system. (See pp. 25-26.)

In Florida, Florida Blue Shield faced disruptions when it brought in a new data-processing subcontractor. After awarding a subcontract to GTE Data Services, Inc., the carrier learned that GTE could not deliver on time a system that met specifications. At that point, the carrier had no time to obtain another subcontractor and had to accept a system that was less efficient than expected. (See pp. 26-27.)

Two areas magnified the disruptions resulting from the Georgia carrier change. First, Aetna did not spend enough time learning about the outgoing carrier's policies, procedures, and systems. As a result, when Aetna began processing claims, inadvertent changes it made in payment practices caused disruptions. Second, the outgoing carrier took several shortcuts in winding up its operations; these shortcuts increased Aetna's expected workload and contributed to claims-processing delays. (See pp. 33-36.)

HCFA Could Manage Changes Better

HCFA's guidance concerning carrier changes neither identifies potential disruptions nor discusses proven strategies to deal with them. HCFA's regional offices need detailed guidance because they lack practical experience in managing these changes. For example, before the Georgia carrier change, the Atlanta region had not managed a change since 1982. More specific guidance, the regional staff said, would be helpful. A HCFA study of three 1988 carrier changes should provide a sound basis for developing such guidance. (See pp. 31-32.)

Since the experience in Florida, HCFA staff advise carriers to include a new provision in subcontracts: an incumbent subcontractor must extend its agreement if a new subcontractor does not deliver a system as agreed. HCFA's written instructions concerning subcontracts do not mention such a provision, but simply provide for a carrier to assess penalties against a subcontractor that delivers an inadequate system. (See p. 28.)

Recommendations

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to

- require a new carrier to compare how its system handles a sample of claims with how the outgoing carrier's system handled them,
- review and revise HCFA's instructions to carriers concerning data-processing subcontract terms, and
- develop more practical, specific guidance on managing carrier changes. (See pp. 29 and 36.)

Agency Comments

HCFA agreed with GAO's recommendations. It has taken, as well as plans to take, a number of steps to (1) better identify policy and operational differences between old and new carriers' systems, (2) revise the terms included in carriers' data-processing subcontracts, and (3) develop additional guidance for its regional offices on managing carrier changes. (See pp. 29-30 and 36-37.)

Contents

Figures

Abbreviations

HCFA Health Care Financing Administration

Introduction

In 1988, new contractors took over Medicare claims-processing duties in Georgia and Florida, resulting in substantial disruptions in service for a time. Disruptions in payments to beneficiaries and providers—lateness and inaccuracy—often follow a change in a claims-processing contractor. This can greatly inconvenience beneficiaries and providers, who depend on reasonable payment times to avoid financial burden. The House Appropriations Committee and Members of Congress from Georgia and Florida requested that GAO review the contractor changes in these states in order to identify steps the Health Care Financing Administration (HCFA) could take to reduce claims-processing disruptions after contractor changes.[1]

Background

Medicare is a federal health insurance program authorized by title XVIII of the Social Security Act (42 U.S.C. 1395) that covers most Americans 65 years of age or older and certain Americans under 65 years of age including those who are disabled or have chronic kidney disease. HCFA, in the Department of Health and Human Services, administers Medicare, establishes program regulations and policies, and issues guidance to health care providers and others involved in the program.

Medicare part A (Hospital Insurance for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities; part B (Supplementary Medical Insurance for the Aged and Disabled) covers physician services and a range of other noninstitutional services, such as diagnostic laboratory tests and X-rays. In fiscal year 1989, Medicare paid $58.4 billion for services under part A and $37.5 billion under part B, insuring about 33 million Americans.

The law creating Medicare authorizes HCFA to contract with private insurers to process claims and to administer the program day to day. HCFA can award these insurers cost-reimbursement contracts and renew them annually without regard to laws that require competitive bidding. Under part A, HCFA refers to contractors as "intermediaries;" under part B, HCFA refers to contractors as "carriers." Currently, 34 carriers—Blue Cross and Blue Shield organizations and commercial insurance companies—process and pay part B claims. Our review focused on part B contractor changes; HCFA has experienced fewer problems with part A changes than with part B.

[1] Appendix I lists the requesters of this review.

With one exception, each carrier processes claims for services provided in a specific geographic area (generally, a state).[2] Claims may either be submitted by the medical service provider, whom the carrier then pays (called assigned claims) or by the beneficiary, whom the carrier pays directly (called unassigned claims). The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) required providers, beginning September 1, 1990, to complete and send to the carrier all Medicare claims for their patients, whether the claims are assigned or unassigned.

After a claim is submitted, the carrier reviews it to determine whether (1) the beneficiary is eligible for Medicare benefits and has met the Medicare deductible for the year and (2) the services are covered under Medicare and are medically necessary. The carrier then determines Medicare's approved amount for the services,[3] notifies the beneficiary of the decision it has made on the claim, and makes payment to either the beneficiary or provider.

In addition to processing claims, carriers have various other functions. When a beneficiary or provider disputes a carrier's decision on a claim, the carrier conducts a review of the case and may hear a formal appeal. Carriers also furnish beneficiaries and providers with information on the Medicare program; in addition, carriers notify providers of changes in Medicare coverage and reimbursement policies. Finally, carriers ask beneficiaries and others for information on insurance, besides Medicare, with primary liability for beneficiaries' claims.

Contractor Changes Have Been Infrequent, but Will Recur

Although changes in Medicare contractors do not take place frequently, HCFA's management of its contractor network results in occasional changes. In Georgia and Florida, two very different kinds of contractor changes took place.

Carrier Changes

One of HCFA's principal objectives in managing its network of carriers is to obtain quality claims-processing services at reasonable cost. Over the

[2]Travellers Insurance Co. processes claims for all Railroad Retirement Board beneficiaries, regardless of where the services are provided.

[3]The approved amount is generally the lowest of (1) the actual charge (the billed amount), (2) the provider's customary charge (the median charge by the provider for the service over the previous 12 months), or (3) the prevailing charge (sufficient to cover the customary charge for three out of four bills for all providers in the geographic area). Since the mid-1970s, increases in prevailing charges have been linked to an index that reflects changes in general wages and physicians' practice costs.

past decade, HCFA's efforts to improve the quality and reduce the cost of claims processing for part B have led to occasional carrier changes. HCFA has awarded some competitive fixed-price contracts to determine whether such contracts would encourage carriers to be more cost-conscious; at other times, HCFA has consolidated carrier territories to make operations more economical. In some cases, HCFA has replaced carriers it identified as chronically poor performers. Finally, HCFA has had to replace some carriers who decided to withdraw from the Medicare program.

In one voluntary withdrawal, effective December 31, 1988, the Prudential Insurance Co. decided to withdraw from its contract as part B carrier for Georgia; HCFA selected the Aetna Life Insurance Co. to replace it. At the same time, Prudential also withdrew from New Jersey and North Carolina as part B carrier and from three part A contracts.

Data-Processing Subcontractor Changes

Of 34 carriers, 10 currently subcontract with another firm to operate the data-processing systems that support the carriers' claims processing. HCFA requires its carriers to competitively award data-processing subcontracts, generally for a term of 5 years. HCFA retains authority to review the requests for proposals that carriers issue for data-processing services, carrier plans for evaluating proposals, and carrier selections of subcontractors.

Since 1986, HCFA's carriers have held eight competitions for data-processing system subcontracts. In five of these competitions, the incumbents won and no change took place; in three others, a new subcontractor was selected. In Florida, effective December 3, 1988, Florida Blue Shield selected GTE Data Services, Inc. to replace EDS-Federal Corp. as its subcontractor.

Past Contractor Changes Have Been Troublesome

Our earlier work shows that contractor changes involve a significant risk of disruption in claims processing.[4] Between 1980 and 1985, Members of Congress requested that we review a number of individual contractor changes in various states, citing numerous complaints from beneficiaries and providers, as well as serious delays. We reviewed the

[4]Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare (HRD-82-17, Dec. 1, 1981); Medicare: Performance of Blue Shield of Massachusetts Under the Tri-State Contract (GAO/HRD-88-81BR, Mar. 31, 1988); Administration of Selected Medicare Activities in Ohio (GAO/HRD-86-28FS, Oct. 18, 1985); and Delays in Processing Medicare Beneficiary Claims in Texas (GAO/HRD-82-74,May 19, 1982).

award of experimental fixed-price carrier contracts in Illinois, Maine, New York, and the Maine-New Hampshire-Vermont (referred to as the Tri-state) region. We also reviewed subcontract awards in Ohio and Texas.

We found that immediately after these changes, carrier performance was substandard in several areas. First, claims processing slowed and claim backlogs (the carriers' inventories of unprocessed claims) grew. For example, in Illinois and New York, 3 months after the carrier changes, the backlog of unprocessed claims was four and three times (respectively) as large as 1 year before; 6 months after the Illinois change, the backlog had doubled in size. In Ohio and Texas, after subcontract changes were made, backlogs increased to levels about three times as high as before the changes.

Second, claims-processing errors increased, resulting in more erroneous payments. In the quarter after the Illinois carrier change, for example, about 35 percent of the claims processed had an error of some kind, with payment errors amounting to about 8 percent of charges processed. The new carrier's error rates were between two and three times those of the two carriers it replaced. For the year after the Tri-state carrier change, payment errors amounted to almost 5 percent of charges. In Texas, the quarter after the subcontractor change, payment errors amounted to 6.4 percent of charges—two times the rate before the change.

The disruption in timeliness and accuracy generally was corrected after some months. About 4 months after the Maine carrier change, for example, the new carrier met HCFA standards for most performance measures; timeliness had improved substantially about 6 months after the Ohio change. In Illinois, in contrast, the new carrier's performance was still considered unacceptable 2 years after the change. Claim backlogs had been reduced to normal levels about 6 months after the Texas subcontractor change.

Objectives, Scope, and Methodology

As agreed with the requesters, our objectives were to review the Medicare carrier change in Georgia and the data-processing subcontractor change in Florida to (1) determine how the changes affected beneficiaries and providers and (2) identify actions HCFA should take to reduce the disruptions resulting from changes.

We did our work at HCFA's headquarters in Baltimore and its regional office in Atlanta; we also did work at the Aetna Life Insurance Co., the Prudential Insurance Co., and HealthCare COMPARE, Corp.—the firms that were involved in the Georgia carrier change. We visited Florida Blue Shield and EDS Corp.—which were involved in the Florida data-processing subcontractor change.[5] In both Georgia and Florida, we also consulted representatives of beneficiaries and health care providers concerning these changes. Finally, we consulted HCFA and carrier officials in other states that have experienced carrier changes since 1986—Connecticut, Nebraska, New Jersey, New Mexico, North Carolina, and Wyoming—and in other states that have experienced subcontractor changes since 1986—Colorado and Illinois.

We interviewed HCFA officials and representatives of the firms involved in the contractor changes; we analyzed HCFA statistical data to determine changes in the timeliness and accuracy of claims processing resulting from contractor changes; and we discussed contractor changes with beneficiary and provider representatives to obtain information on how these groups had been affected by the changes. We also reviewed HCFA documents concerning review and approval of contract awards, monitoring of contractors' preparations for new workloads, and actions to address problems arising after contractors began work. Finally, we reviewed the results of a HCFA survey of the carriers that replaced Prudential in Georgia, New Jersey, and North Carolina.

We did our work from December 1989 through August 1990 in accordance with generally accepted government auditing standards.

[5]We consulted GTE Data Services, Inc., the new data-processing subcontractor in Florida, which gave us written comments on certain issues, but declined to meet with us.

Medicare Contractor Changes Burden Beneficiaries and Providers and Cost the Program Millions

Historically, changes in Medicare's contractors have caused disruptions in payments to Medicare beneficiaries and providers. A serious disruption in claims processing followed the recent contractor changes in Georgia and Florida. Claims processing slowed while backlogs of unpaid claims grew; in Georgia, claims payment errors also escalated dramatically, resulting in an estimated $19.2 million increase in improper payments over normal payment error amounts. The Georgia and Florida carriers focused their efforts on addressing the growing backlogs, leading to deteriorating performance in other important areas.

Claims-processing errors and unexpected payment changes caused confusion among beneficiaries and frustration for providers. Delays in payments affected providers' cash flow, which led some to seek loans or defer payrolls. At one point, excessive claims backlogs amounted to $6.4 million owed to Georgia beneficiaries and providers and $76.9 million to Florida beneficiaries and providers.

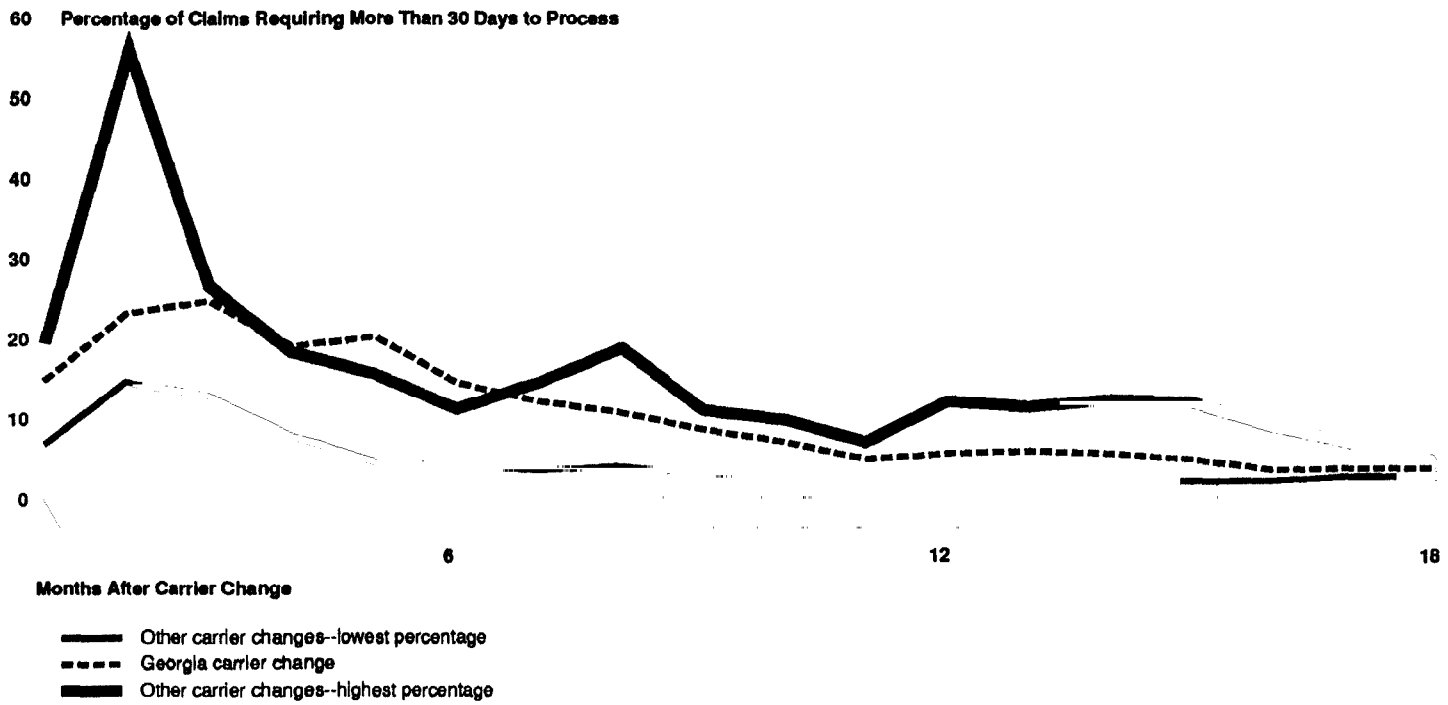
Claims Processing Deteriorated After Contractor Changes—A Familiar Pattern

In Georgia and Florida, claims-processing disruptions followed a familiar pattern. Claims processing slowed down, backlogs grew, and, in Georgia, payment accuracy deteriorated. These disruptions increased costs to the Medicare program because carriers paid more interest on delayed claims and made more payments in error.

Claims Processing Slowed

Claims processing slowed substantially after carrier changes. During the first 6 months of 1988, when Prudential was still the Georgia carrier, the percentage of claims requiring more than 30 days to process averaged 4.6 percent. After the change, this percentage peaked at about 25 percent. Claims-processing timeliness, after the Georgia carrier change and after other carrier changes that have taken place since 1986—in Connecticut, Nebraska, New Jersey, New Mexico, and North Carolina, is shown in figure 2.1. (Because the Wyoming carrier change took place in April 1990 and limited data on changes in timeliness and accuracy were available at the time of our review, we did not include the Wyoming carrier change in this and succeeding figures.)

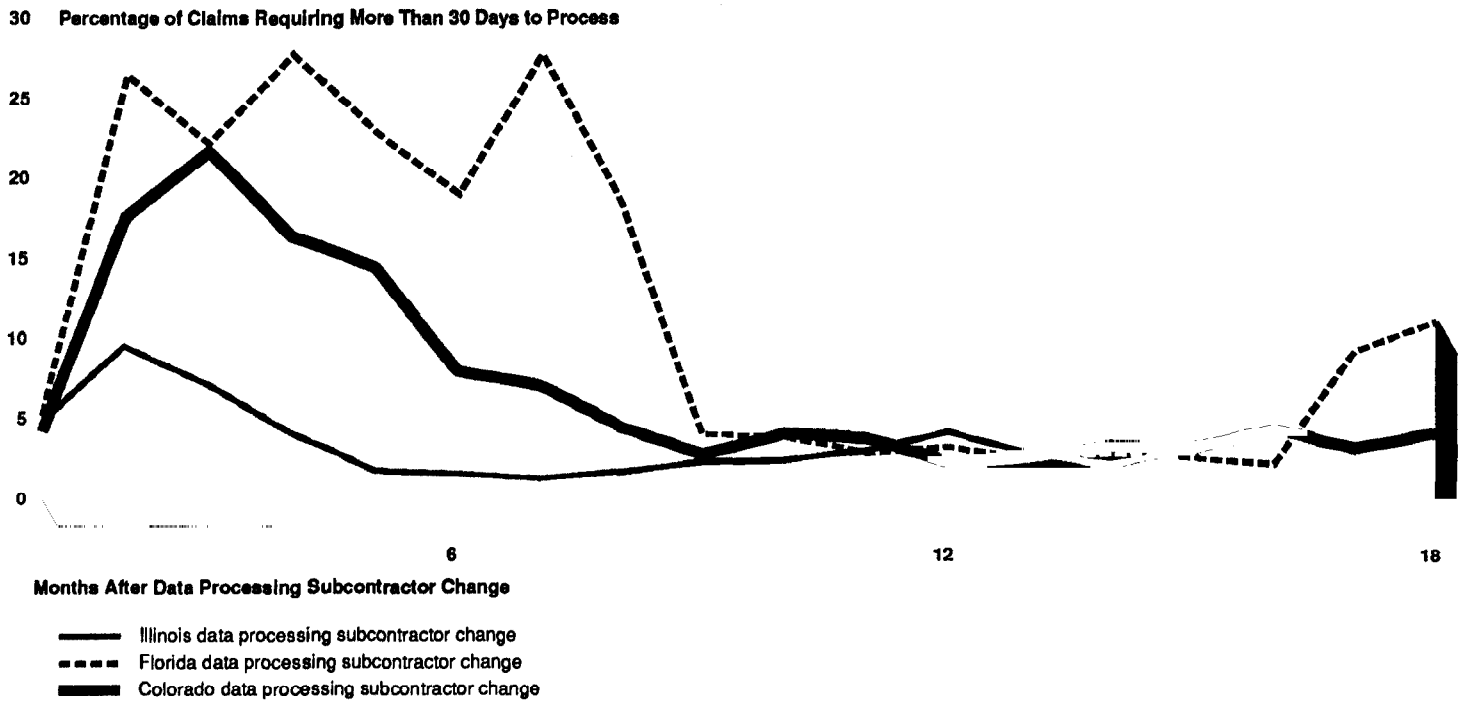
Figure 2.1: Claims-Processing Timeliness After Carrier Changes



Note: "Lowest percentage" and "highest percentage" refer to the lowest and highest monthly percentages of claims requiring more than 30 days to process.

Data-processing subcontractor changes also affected the timeliness of claims processing. During the first 6 months of 1988, before the Florida subcontractor change, about 3.9 percent of claims took more than 30 days to process in Florida. After the change, this percentage peaked at about 28 percent. Claims-processing timeliness after the Florida change and the changes in Colorado and Illinois are shown in figure 2.2.

Figure 2.2: Claims-Processing Timeliness After Data-Processing Subcontractor Changes



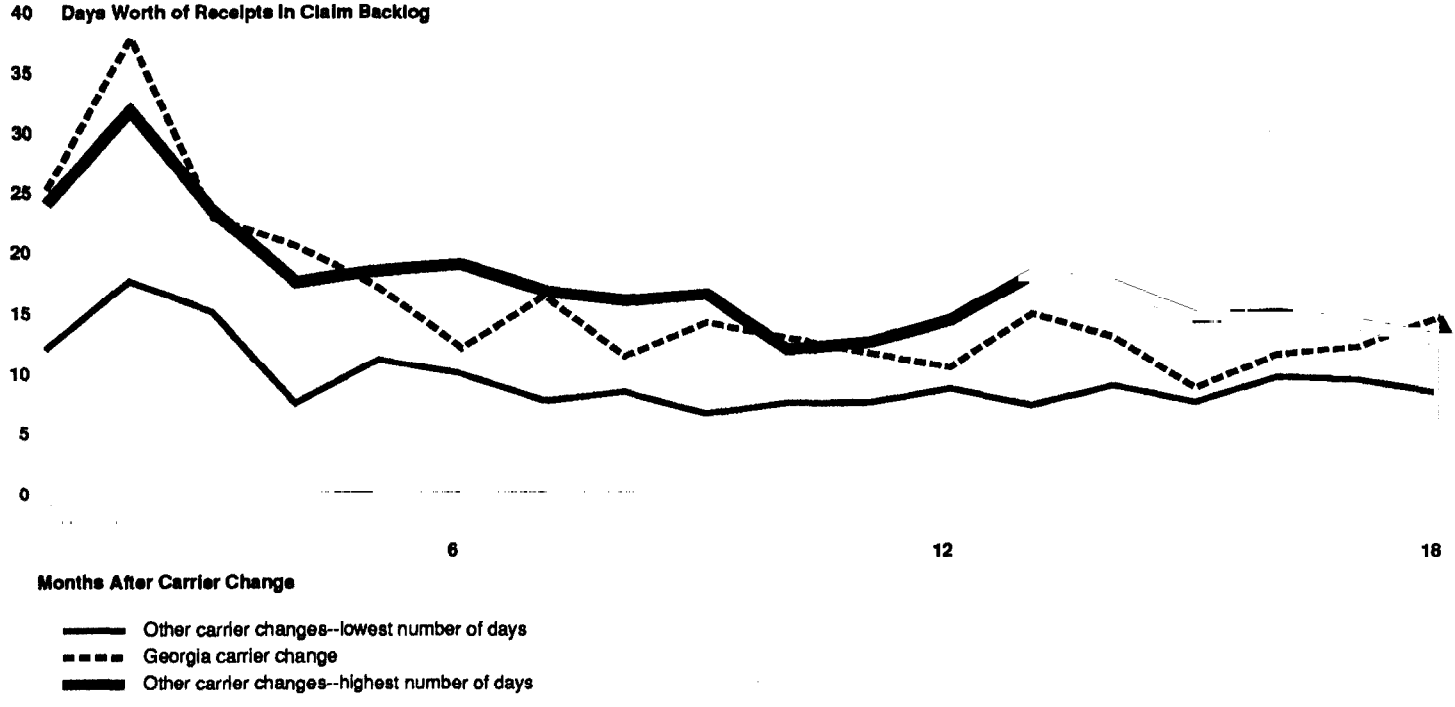
The slowdown in claims processing at Aetna (in Georgia) was generally comparable with that which followed other carrier changes; the slowdown at Florida Blue Shield was greater and lasted longer than that which followed other subcontractor changes. The two carriers' timeliness improved substantially through the summer of 1989 and, later, matched that of carriers not involved in a contractor change in January 1990 (12 months after the Georgia change) and August 1989 (8 months after the Florida change).

Because the Medicare law requires that interest be paid on claims that carriers do not pay within established times, slower claims processing increases Medicare costs. During 1988, interest payments on claims in Georgia and Florida combined totalled about $375,000. In 1989, interest payments totalled about $700,000 in Georgia and about $5.6 million in Florida, representing about 60 percent of the interest carriers paid nationally.

Claim Backlogs Grew

Claim backlogs (inventories of unprocessed claims) also increased significantly. For the first 6 months of 1988, when Prudential was still the Georgia carrier, backlogs averaged 15 days of receipts. After Aetna took over, backlogs peaked at about 37 days (773,000 claims). (See fig. 2.3.) Many claims underwent extended processing delays; up to 15 percent of the backlog in Georgia consisted of claims that had been on hand for more than 60 days.

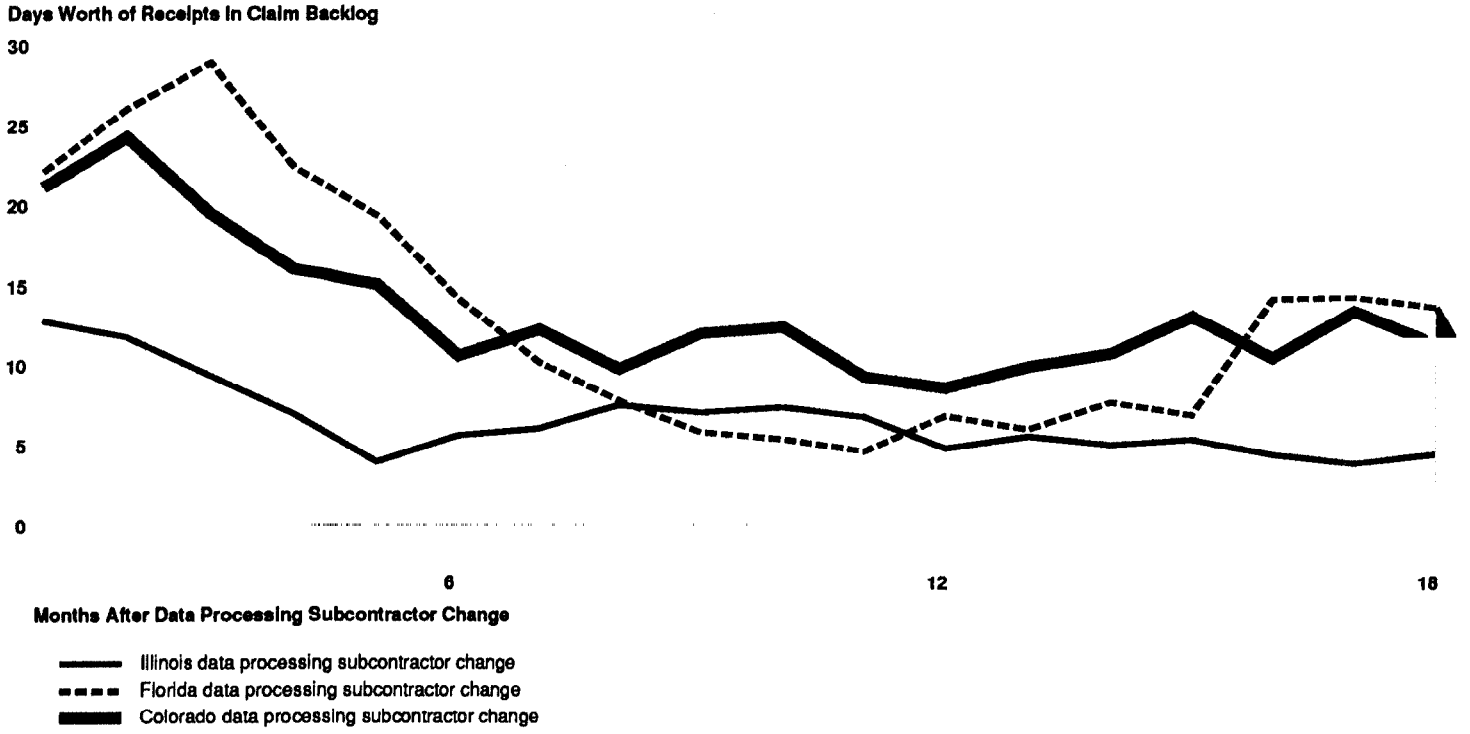
Figure 2.3: Claim Backlogs After Carrier Changes



Note: "Lowest number of days" and "highest number of days" refer to the lowest and highest monthly number of days worth of receipts in the claim backlog.

Backlogs also increased after subcontractor changes. During the first 6 months of 1988, before Florida Blue Shield's subcontractor change, backlogs averaged about 6 days' receipts in Florida, but peaked at about 26 days (2.7 million claims) after the change. At one point, about 37 percent of Blue Shield's backlog consisted of claims that had been on hand over 60 days. Data on claim backlogs after the Florida subcontractor change, as well as the Colorado and Illinois changes, are shown in figure 2.4.

Figure 2.4: Claim Backlogs After Data-Processing Subcontractor Changes



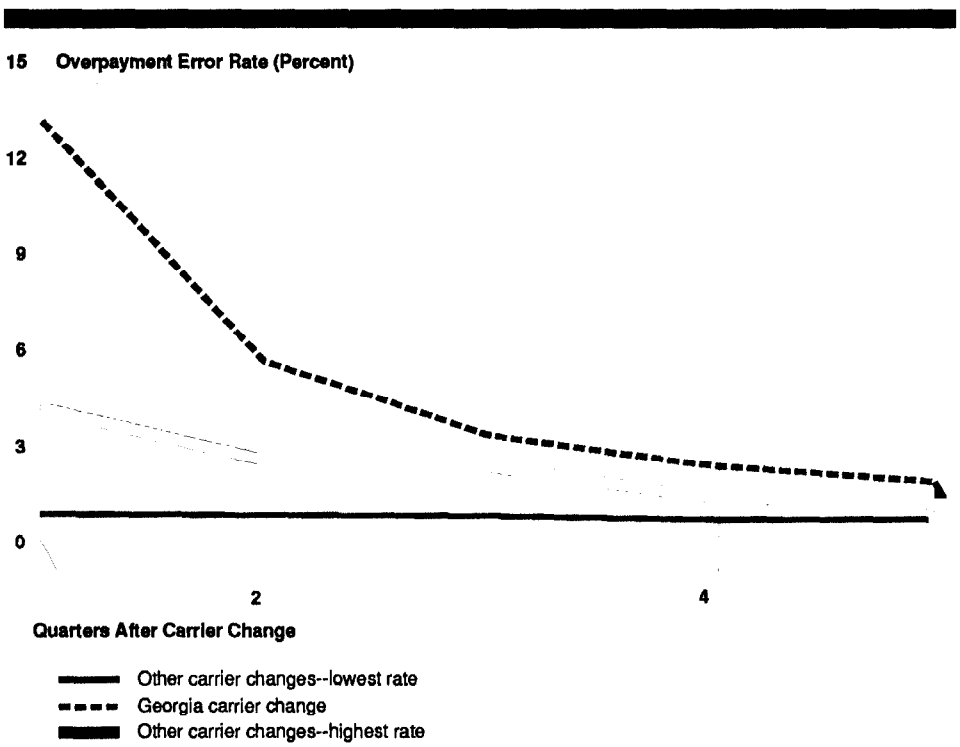
For the first 3 months after the Georgia carrier change, Aetna's backlogs were proportionately larger than backlogs after the other carrier changes we examined, but were generally comparable thereafter. For the first 7 months after the subcontractor change in Florida, Florida Blue Shield's backlogs were proportionately larger than backlogs after the other subcontractor changes. Within 12 months after the Georgia carrier change and 8 months after the Florida subcontractor change, backlogs reached levels comparable with those at carriers not involved in a contractor change.

Payment Errors Increased

HCFA data indicate that as was the case in Florida, subcontractor changes normally do not affect payment error rates. As in other carrier changes, however, payment accuracy suffered after the carrier change in Georgia. For the first 6 months of 1988, when Prudential was still in place, overpayments amounted to 0.65 percent of the charges processed in Georgia. In the first quarter after the change, overpayments averaged

13 percent of charges processed. Data on overpayment errors after the Georgia carrier change, as well as after other carrier changes, are shown in figure 2.5.

Figure 2.5: Claims-Processing Accuracy After Carrier Changes



Note: "Lowest rate" and "highest rate" refer to the lowest and highest monthly overpayment error rate.

The increase in Aetna's error rates in Georgia was substantially greater than that which followed other carrier changes. By the third quarter after the carrier change (July-Sept. 1989), Aetna had improved claims-processing accuracy, though its overpayment rate was still the highest of any carrier. This rate was still more than 1 percent higher than the national average, as of the first quarter of 1990 (the latest quarter for which data were available.) Between January 1989 and March 1990, in Georgia, we estimate that the increase in improper payments because of higher error rates amounted to $19.2 million.

Claims-Processing Disruptions Led to Poorer Performance in Other Areas as Well

Because the Georgia and Florida carriers needed to focus resources on their claim backlogs, performance deteriorated in other areas. During the months after the Georgia and Florida contractor changes, processing the growing claim backlogs became a first priority for both carriers; Aetna also devoted much effort to identifying and correcting the underlying causes of increasing claims-processing errors. To address these issues, Aetna, especially, diverted staff from other areas of its Medicare operations to assist with claims processing. Consequently, other carrier activities were carried out less effectively.

Processing of claims reviews for those cases in which a beneficiary or provider disputed the carrier's decision was delayed substantially. During the first 6 months after the Georgia carrier change, Aetna processed an average of 3,372 reviews per month, a 25-percent decline from the average of 4,509 reviews processed before the change. In February 1989, the percentage of reviews exceeding HCFA's goal of 45 days reached 89 percent; the percentage did not drop below 50 percent until September 1989. At Florida Blue Shield, review processing declined by 90 percent during the 6 months after the change, from 45,323 a month to 4,488. The percentage of reviews requiring more than 45 days to process reached 79 percent in January 1989 and 95 percent in September.

The carriers also reported less success in identifying other insurance with primary liability for claims. For the first 3 months after the Georgia carrier change, savings from identifying such insurance amounted to about $2 million, a 44 percent decline from the $3.6 million saved during the comparable time a year earlier. In Florida, savings declined from $6.8 million to $2.9 million, or about 57 percent. For the year following the contractor changes, savings declined from the previous year by 19 percent in Georgia and 11 percent in Florida.

Although savings declined from 1988 to 1989, the value of claims processed increased by about 20 percent in Georgia and about 37 percent in Florida. In view of such increases, we would expect the carriers to have identified higher savings from insurance with primary liability for claims.

Claims-Processing Disruption Was a Burden to Beneficiaries and Providers

The deterioration in claims processing after the Georgia and Florida contractor changes burdened beneficiaries and providers. In Georgia, beneficiaries were (1) frustrated by difficulties in obtaining accurate information about their claims and (2)confused by contradictory information on benefit notices and unexplained changes in payments. Providers experienced similar frustration. In Florida, especially, providers experienced an interruption in Medicare payments that affected their finances.

Errors Caused Confusion and Frustration

In Georgia, beneficiaries were frustrated by the carrier's inability to provide prompt and accurate responses to their questions. When calling Aetna, before speaking to a representative, beneficiaries often experienced busy signals and long waits. The answers Aetna gave were sometimes incorrect. For example, one Georgia beneficiary called Aetna for information about a notice concerning the payment it made after processing her claim; the Aetna representative inaccurately told her that the claim had never been processed.

Contradictory notices about claims and changes in payments also confused Georgia beneficiaries. Aetna sent one beneficiary a notice that read: "We are paying a total of?????????on the enclosed check." (A check for $88.17 was enclosed, the beneficiary said.) Aetna initially sent another beneficiary a notice saying it would not pay for the services because it needed more information to determine its payment; about a month later it sent her a notice erroneously stating that her physician had agreed to bill Medicare directly for the services. Aetna also paid a beneficiary $25.68 for cortisone injections for which, the beneficiary said, Prudential had regularly paid $51.20. The carrier later acknowledged that this payment had been reduced erroneously.

Physicians also often had difficulty reaching Aetna by phone and, once they reached Aetna, received inaccurate responses to their inquiries. Because of processing errors, Aetna often sent payments to the wrong addresses and confusing notices about claims. To cite one example, Aetna notified a provider that Medicare owed $0.03 on a claim plus $0.03 in interest, but showed the total payment made as $0.00.

Disruption in Cash Flow Affected Provider Finances

Delays in provider payments interrupted provider cash flow, especially in Florida. To estimate the magnitude of this disruption, we determined the extent, in Georgia and Florida, to which backlogs exceeded normal levels after the contractor changes. Using the average amount the carriers approved for claims, we calculated that the excess claim backlog reached $76.9 million in Florida and $6.4 million in Georgia.

Some providers experienced sharp declines in Medicare payments after the contractor changes, even though the amounts they billed to Medicare remained stable. Payments for a Florida medical equipment supplier averaged about $14,900 a month before the change; in December 1988, it received $104.32. In January 1988, a Georgia clinic received about $173,000; in January 1989, $60,000. Until December 1988, a Florida clinic received an average of $575,000 a month; in December 1988, it received $46,000.

Payments eventually returned to normal levels, providers said, but this cash flow disruption caused financial difficulties for some providers. After the change in Florida, according to a vice president of the Florida medical association, many bankers called the association seeking confirmation that payment delays, which physicians seeking loans had described to them, were short-term in nature. To survive the cash flow disruption, provider representatives said, providers deferred payroll payments or payments to suppliers. One small clinic in Georgia said that it borrowed $70,000 to meet its payroll. To address the financial problems that providers reported, HCFA's Atlanta Regional Office authorized the Georgia and Florida carriers to make advance payments to providers.

Agency Comments and Our Evaluation

HCFA noted that our review focused primarily on the contractor changes in Georgia and Florida, and expressed concern that readers will conclude that the difficulties experienced in the two states are typical of all contractor changes. The data presented in this chapter indicate that the contractor changes in Georgia and Florida were among the most troublesome HCFA has experienced since 1986. By using these two states to illustrate the problems that can occur during contractor changes, we hope to help HCFA better address problems during future changes. In addition, the Members of Congress requesting this study asked us to review the Georgia and Florida changes.

Replacing Contractors Poses Program Risks

The potential for a disruption in claims processing is always present when (1) HCFA selects a new carrier and (2) its carriers select a new data-processing subcontractor. Under standard carrier contracts, HCFA must move quickly to select a new carrier and the new carrier has a relatively brief time to prepare to take over operations. In Georgia, Aetna faced more difficulty in preparing for operations than some other carriers have; short preparation time compounded these problems. When carriers contract with firms to operate data-processing systems, the contract provisions recommended in HCFA instructions do not provide carriers workable alternatives if a new subcontractor's system does not meet the carrier's requirements. In Florida, Florida Blue Shield had few options left to it when its new subcontractor's system did not perform as promised.

Aetna Faced Greater Difficulty Than Some Carriers

Short time frames compounded the difficulty Aetna faced when it took over claims processing in Georgia, although HCFA had acted quickly in selecting Aetna to replace Prudential. Two factors made Aetna's preparations to process Georgia claims more difficult than those carriers in other states have faced. First, Aetna planned to establish a new claims-processing office, but was unable to provide its new clerks enough training to process claims effectively. Second, HCFA made a last-minute decision to subcontract the medical review function in Georgia, instead of relying on Aetna staff for this. Aetna's subcontractor had little time to set up its operation, determine how its review policies would affect providers, and inform providers of the changes they should expect.

Selection Time Frames Short

On April 20, 1988, Prudential notified HCFA it planned to withdraw from its Georgia contract, effective December 31, 1988. Standard HCFA carrier contracts require, before a contract expires, that a carrier give HCFA at least 3 months' notice that it does not wish to renew the contract; a carrier must also allow HCFA to extend the contract 3 months; thus, carrier contracts assure HCFA 6 months to replace a new carrier. This 6-month period, HCFA and carrier officials acknowledged, provides a new carrier scant time to prepare to process claims. Prudential's notification allowed HCFA just over 8 months to replace the Georgia carrier.

In order to allow the new carrier as much time as possible to prepare to process claims, HCFA expedited the process of contractor selection. HCFA's procurement plan provided 23 days to evaluate proposals, negotiate cost and implementation details, and select a carrier. During this period,

workload pressures on HCFA staff were intense: they were also evaluating proposals from insurers interested in Prudential's New Jersey and North Carolina contracts and Prudential's three part A contracts.

Although providing more time to replace a carrier may appear to be an attractive option, several factors impede HCFA's doing so. Since carrier contracts have a 1-year term, the advance notice HCFA can require is, realistically, limited. When a carrier's contract is not renewed, an official of the Blue Cross and Blue Shield Association explained, the carrier's performance is likely to deteriorate. First, the carrier's staff often begin to seek and accept other jobs, knowing that their employment with Medicare will end soon. Second, carrier management has less incentive to maintain high-quality performance, knowing that their involvement with Medicare will also end. Thus, if HCFA provided more time to replace a carrier, it might also have to tolerate substandard performance by the outgoing carrier for a longer period.

Carrier Staff Received Inadequate Claims-Processing Training

In taking over claims processing in Georgia, Aetna's approach differed from that used by carriers in other states. Aetna had no Medicare claims-processing office in the southeastern United States; it planned to establish a new office instead of expanding an existing one. Before staff hiring and training could begin, Aetna had to refurbish the new office and install furniture and equipment in it. Aetna's plan, therefore, allowed 3 months to hire and train staff. In two other states (New Jersey and North Carolina), the new carriers HCFA selected expanded an existing office. The deterioration in claims processing after the carrier changes in these two states was less serious than in Georgia. At their old facilities, these carriers began to hire and train staff 6 months before they were scheduled to begin processing claims. The longer training period, officials of these carriers explained, would allow the new staff to gain additional experience with Medicare policies, increasing their productivity rates for claims processing.

Poorly trained staff were a key cause of problems in Georgia. After Aetna began processing claims, HCFA staff, during a March 1989 review, identified numerous processing errors. Erroneous billed amounts for services and incomplete information on services were entered into the carrier's computer system. In addition, some carrier staff incorrectly indicated that Medicare did not cover such services as physician office visits and diagnostic X-rays. HCFA staff concluded that additional training and experience were needed; in May 1989, an Aetna review

team recommended more staff training in how to use internal policy and procedure manuals to resolve questions.

Medical Review Experiment Created Unexpected Confusion

Two weeks before awarding a contract, as it was evaluating bidders' plans to take over claims processing in Georgia, HCFA decided to initiate a pilot project. The project was meant to test new approaches for determining whether the services on claims were medically necessary. HCFA directed the bidders on the Georgia contract to plan to subcontract for these medical reviews.[1] Originally, carrier staff were to do these reviews. The relatively brief period Aetna's subcontractor had to set up its operations caused disruption in the claims process and a vehement reaction from Georgia providers.

Aetna selected HealthCare COMPARE, a Chicago-based medical review firm, as its subcontractor before receiving the Georgia contract. For this subcontract, COMPARE planned to establish its first field office outside the Chicago area, scheduled to begin operations January 1, 1989. COMPARE deferred hiring staff, officials explained, pending negotiation of a subcontract and operating budget, which were completed on September 22, 1988. After negotiations, COMPARE had about 3 months to hire and train its staff, develop its medical review policies and procedures, determine how these differed from Prudential's, and inform providers of the changes in medical review policies and procedures they should anticipate.

COMPARE had difficulty obtaining the information it needed to develop medical policies, and did not reach a final decision on the policies it would implement in Georgia until the middle of December 1988. Accordingly, COMPARE did not furnish providers detailed information on medical review policies until April 1989, about 3 months after it began operations. These policies resulted in substantially more claims denials than Prudential's. During the last quarter of 1988, Prudential denied or reduced payments, totalling $1.1 million, as a result of medical review; during the first quarter of 1989, denied and reduced payments amounted to $5.3 million.

Georgia physicians point to the changes in medical review policy that COMPARE implemented as physicians' principal source of concern about

[1]This project involved comparing the results of subcontracted medical reviews in Georgia with (1) the experience of two carriers that were provided increased funding for medical reviews and flexibility to change their review process and (2) the experience of two other carriers that made no changes to their review process.

Aetna's operations. The inspector general of the Department of Health and Human Services reviewed COMPARE's policies and found them consistent with HCFA guidance and with the policies of other carriers. The Medical Association of Georgia, however, characterized COMPARE's medical review policies as arbitrary and unreasonable. Officials expressed concern that COMPARE did not notify them of the policy changes it would be making and questioned the accuracy of COMPARE's medical review decisions. Following these policy changes, inquiries and requests for reviews increased; Aetna received about 8,600 review requests a month in the months after the carrier change, an 82 percent increase.

Additional Testing Would Have Highlighted Potential Processing Problems

HCFA did not direct the new Georgia carrier to conduct a comparative test of its claims-processing system before taking over the state's operations. Aetna's testing verified that computer systems and data-file conversion programs were functioning correctly, but several unanticipated processing problems occurred when Aetna took over in Georgia. A test using actual claims and data files from the outgoing carrier, which compared how Aetna's system and the outgoing carrier's system handled the claims, should have detected these problems. Our discussions with other carriers indicated that such tests would be beneficial.

Aetna did test its computer system. As described in the testing plan that HCFA approved, Aetna tested (1) the programs developed to convert Prudential data files to Aetna formats, (2) the claims-processing software and hardware that would be used in Georgia, and (3) the telecommunications network. HCFA's instructions for transitions, however, describe a test in which a new carrier would (1) obtain copies of a day's worth of claims from the old carrier (over 28,000 claims in Georgia) and (2) have its staff key these claims into the system, process the claims, and generate all routine system outputs. Aetna processed over 5,000 Prudential claims through its system, but did not compare how the system handled these claims with how Prudential's system had handled them. The short time available for testing, an official said, did not permit Aetna to do so.

Other carriers indicated that such a test would be beneficial. Health Care Service Corporation, the Illinois carrier, processed 5,000 claims through both its old system and the new claims-processing system it planned to install. By comparing how the two systems handled these claims, carrier officials identified several system errors, they said, and corrected them before the new system was activated. By determining how many claims would require manual review under the new system,

company officials were able to adjust staffing in order to handle the workload most efficiently. Officials of other carriers encountered processing problems after changes, they said, that comparative tests of their system, using actual claims and data files, would have detected.

Aetna's Testing Did Not Surface All Problems

Several relatively simple problems contributed to the disruption that followed Aetna's takeover of claims processing in Georgia; a test comparing how Aetna's and Prudential's systems had handled actual claims would have surfaced these. To cite one example, physicians may not bill Medicare for clinical lab services that are purchased from outside labs unless the physicians also give the name of the lab performing the test and the amount of the lab's fee. Aetna trained its clerks to look for a code that physicians would add to the procedure code for a lab service; this code would indicate that the service had been performed in the physician's office and not purchased. Prudential allowed physicians to write "No purchased services" on claims, instead of using the code. Physicians often omitted this statement, Aetna maintains, because Prudential sometimes paid claims without it. Since Aetna's clerks did not find the codes they had been trained to look for on claims, they denied some lab claims incorrectly.

Florida Carrier Had to Accept a Substandard Data-Processing System

The contract provisions discussed in HCFA instructions to carriers do not adequately address situations where a new subcontractor's system does not meet expectations. In its bid, GTE Data Services proposed to upgrade several segments of its system to meet Blue Shield's requirements. After awarding a subcontract, Blue Shield found that GTE would have difficulty completing these upgrades on time; Blue Shield asked the incumbent subcontractor to continue operations until the GTE system was ready. The incumbent declined because the subcontract did not require continued operations. At this point, locating another supplier was not feasible for Blue Shield so it had to accept GTE's system. This system lacked many of the features GTE promised in its proposal, and was less efficient than anticipated. We sought GTE's comments on its system's ability to meet Blue Shield's specifications; GTE officials declined to meet with us.

GTE Had Problems Meeting System Specifications

The claims-processing system GTE proposed to operate for Florida Blue Shield appeared superior to the other proposals. Three firms submitted proposals for Blue Shield's data-processing subcontract. Blue Shield organized teams of technical experts to evaluate these proposals, and

GTE's proposal received the highest scores. GTE's proposal, however, indicated that (1) its claims-processing system would need to be modified to meet Blue Shield's specifications and (2) if awarded the subcontract, it would develop additional software to carry out 79 functions as described in Blue Shield's specifications.

Soon after awarding a subcontract to GTE, Blue Shield concluded that GTE would have difficulty delivering the proposed system. Award of the subcontract had been delayed by about 1 month, to May 9, 1988, giving GTE less time than planned to complete modifications before activating its system on December 3, 1988. To allow GTE more time to complete work on the system, Blue Shield asked the incumbent subcontractor to extend its agreement for 3 months, to February 28, 1989. The incumbent's subcontract did not provide for such an extension, and the incumbent declined to do so.

When Blue Shield staff examined the GTE system in detail, they concluded that software modifications were needed to enable the system to carry out about 300 functions as described in the specifications. When GTE activated its system in December 1988, Blue Shield officials said, the system still did not perform 235 functions as described in the specifications. GTE has been required to make additional modifications to accommodate Medicare policy and payment procedure changes announced after the proposal was prepared; this has made addressing the limitations on the 235 functions more difficult. Modifications to carry out 163 of these 235 functions, Blue Shield officials said, had yet to be completed as of July 1990.

GTE System Less Efficient Than Anticipated

During the fall of 1988, while Blue Shield was training its employees to use the new system, GTE was continuing to modify its system. Training staff to operate an evolving system was difficult, according to Blue Shield officials. They estimated that their staff would achieve no more than 50 percent productivity during December 1988. Blue Shield processed about 1.4 million claims during December, 43 percent less than the 2.4 million monthly claims average for the previous year. When Blue Shield recognized that GTE was having difficulty completing system modifications, Blue Shield directed GTE to focus its work on functions that prevented improper payments and to defer work on functions that automated clerical processes. Since the GTE system was less automated than Blue Shield had planned, Blue Shield was employing 1,303 staff in its claims-processing operation by June 1989, 23 percent more than the 1,062 estimated when GTE was awarded the subcontract.

Several Approaches Could Address Substandard System Performance

Delays in developing claims-processing software, with resulting operational disruptions, are not new to the Medicare program. Since developing and installing a Medicare claims-processing system is a complex task, a carrier cannot readily replace its subcontractor when the subcontractor encounters such delays. HCFA's guidance concerning data-processing subcontracts directs carriers to include in their subcontracts certain provisions that assess penalties when subcontractors fail to deliver required systems features. Such penalties, we believe, are of little benefit to Medicare beneficiaries and providers who feel the effects of substandard system performance. HCFA does not recommend that carriers require firms to conduct demonstrations—showing that their systems meet all specifications—before receiving subcontracts. Requiring such a demonstration would avert the problems a substandard system causes, but limit competition because few data-processing firms, without a contract commitment from a carrier, would be willing to modify their systems to meet the carrier's unique requirements.

The HCFA staff who review data-processing subcontracts that carriers propose to award have adopted one approach to addressing a subcontractor's failure to complete systems development. Since the experience in Florida, these staff advise carriers to include a provision in subcontracts allowing the carrier to extend an incumbent subcontractor's agreement for up to 6 months. This allows additional time to complete system modifications that prove to be more complex than anticipated.

During our work, another approach to revising data-processing subcontract provisions was suggested to us. We believe this approach would be useful for addressing a subcontractor's failure to complete systems development. HCFA could direct carriers to conduct a test about 2 months before the scheduled activation of the system, to demonstrate that the system meets all specifications. If a subcontractor's system failed this test, its contract would be cancelled. To provide continuity of operations, HCFA could direct that incumbents' subcontracts would require them to remain in operation for up to 2 years in the event a new subcontractor's contract had to be cancelled. During this 2-year period, a new procurement would be conducted. This would allow the carrier to retain a proven system should a new subcontractor prove unable to deliver the system promised.

Conclusions

Because HCFA contracts with private firms to process Medicare claims, there is some risk of disruption in claims processing when HCFA must

replace a contractor. Although HCFA moved quickly to select a new carrier for Georgia, several decisions complicated the new carrier's task. First, Aetna decided to establish a new (rather than expanding an existing) processing office; second, HCFA directed Aetna to subcontract its medical review function to an outside firm. Given the relatively brief period Aetna had to prepare for operations, these decisions compounded Aetna's problems. Moreover, Aetna did not conduct a comparative test of its claims-processing system; this would have detected some of the problems encountered once Aetna began to process claims.

Few suppliers of data-processing services would be willing to modify their systems to meet a carrier's unique requirements if they had no contract with the carrier. Therefore, carriers, after awarding a subcontract, must depend on their data-processing subcontractor to complete any required system modifications. Although HCFA staff currently advise carriers that they should require subcontractors to agree to extend their contracts for up to 6 months, HCFA's instructions to carriers only direct them to assess penalties on subcontractors that do not deliver a system that meets specifications. We believe HCFA should revise its instructions to carriers to assure they have a better alternative than acceptance of a substandard processing system.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to require that a new carrier (1) process a sample of the outgoing carrier's claims through the new carrier's system and (2) compare how its system handles the claims with how the outgoing carrier's system handled them, so that processing differences between the two systems can be identified and addressed before the new carrier begins operation. We also recommend that the Secretary direct the Administrator to determine what subcontract provisions would best enable carriers to address situations where a data-processing subcontractor's system does not function as agreed. After having done so, HCFA should revise its carrier instructions concerning data-processing subcontracts to require them to include such provisions.

Agency Comments and Our Evaluation

HCFA stated that our analysis should consider (1) beneficiaries' and providers' resistance to change, (2) the complexity and rapid evolution of the Medicare program, and (3) HCFA's limited resources—factors that affect all carrier changes. HCFA, however, reaches conclusions similar to ours—that inexperienced staff, as well as unanticipated policy and operating

differences between the old and new carriers' systems, can complicate a carrier change.

HCFA concurred with our recommendation that a new carrier be required to process a sample of the outgoing carrier's claims through the new carrier's system in order to identify processing differences between the two systems. HCFA is analyzing how best to implement this recommendation and is taking other initiatives to better identify and address policy and operating differences between old and new carriers.

HCFA states that it now requires carriers to include in data-processing subcontracts a provision that allows the carrier to extend the subcontract for up to 6 months. We believe HCFA should revise its written instructions to carriers to reflect this requirement.

HCFA Can Better Address the Problems That Develop During Transitions

Making a transition from one carrier to another presents unavoidable risks of claims-processing disruptions, but we believe HCFA can improve its capability to manage these risks. HCFA has not summarized the lessons it has learned from past transitions into guidance that identifies areas that pose the greatest risk of creating disruption. During our work, we identified two areas that magnified the disruption that followed the Georgia carrier change. First, the incoming carrier did not develop a full understanding of the outgoing carrier's systems, procedures, and policies. Second, the outgoing carrier took several shortcuts in the last months of operations that made the incoming carrier's task more difficult.

HCFA Guidance on Managing Transitions Does Not Identify High-Risk Areas

Currently, HCFA's guidance for transitions does not identify areas that warrant special attention from transition managers. The number of transitions varies greatly from year to year, and HCFA relies on its regional offices to supervise transitions from day to day. Since regional offices manage transitions only infrequently, regional office staff lack the practical experience that would allow them to focus their efforts most effectively. HCFA recently conducted an exhaustive survey of the carriers that replaced Prudential as Medicare carriers; this survey should be of considerable value in developing guidance for regional offices.

HCFA has provided its regional offices guidance on managing the transition from one carrier to another, but this guidance provides limited insight into the activities the regions should accord highest priority. Since 1983, HCFA has periodically invited its regional offices to volunteer transition lessons that HCFA compiled into memorandums distributed to all regional offices. In 1986, HCFA also issued the Transition Handbook to assist regional staff in managing transitions. This handbook lists areas that regional office staff should monitor, but does not identify which areas have caused significant problems in past transitions. Neither does this handbook discuss strategies that have proven effective in addressing problems in past transitions.

The workload of transition management is unpredictable. Seven carrier changes have been made since 1986—two in 1986, four in 1988, and one in 1990. HCFA relies on its regional offices to take the lead in the day-to-day management of transitions. Headquarters staff serve as advisers to the regions and attend selected transition meetings. The transitions that took place during 1988 were a strain on the resources of HCFA headquarters.

Regional office staff normally have limited experience with transitions. HCFA's Atlanta Regional Office is the only office that has managed more than one transition since 1986. Before 1988, this office was last involved in transitions in 1982; at that time, Florida Blue Shield absorbed several southern Florida counties into its territory and a new firm took over management of the processing office and staff of the Kentucky carrier. The associate regional administrator for the Atlanta office and the transition coordinators for Georgia and North Carolina were responsible for the 1988 transition; only the associate regional administrator had any previous experience with carrier changes. The written guidelines were helpful, as was the Transition Handbook prepared by headquarters staff, the transition coordinators said; one added that the guidelines and handbook would be more helpful if they included more specific and practical advice on the order and timing of tasks. Officials in other regions echoed this comment.

During the last half of 1988, the Atlanta region was managing transitions involving the Georgia and North Carolina carriers and the Florida data-processing subcontractor. Regional staff were unable to attend some meetings they considered important—new carrier presentations to providers and meetings between the data-processing staffs of the new and old carriers. While carrier officials we spoke to generally complimented the efforts of regional staff, staff inexperience appears, occasionally, to have led them to misdirect their activities. One new carrier, for example, found burdensome the regional office's insistence on frequent reports on their processing workload.

Recently, HCFA conducted an exhaustive survey of the new carriers in Georgia, New Jersey, and North Carolina. The survey covered a wide range of topics, including productivity levels and accuracy rates of new claims-processing staff, data systems and file conversion issues, coverage and reimbursement policy issues, approaches to provider relations, and issues related to the outgoing carrier's performance. Carrier responses to the survey indicate problems in these areas similar to those we learned of during our work. As of November 1990, HCFA had not completed its analysis of these responses. One objective of this analysis was to identify strategies for making transitions less disruptive. Information on effective strategies for addressing problems that develop during transitions should be valuable to HCFA's regional offices.

New Georgia Carrier Did Not Fully Understand the Old Carrier's Policies and Systems

In order to avoid unnecessary disruptions to beneficiaries and providers, incoming carriers must fully understand the old carrier's systems and procedures before implementing new ones. The Atlanta Regional Office relied on Aetna to report any problems in obtaining such information, the region's transition coordinator said, rather than assessing how complete Aetna's understanding was. Inadvertent changes in two areas (medical review and specialty coding) magnified the disruption of the carrier change in Georgia.

New Subcontractor for Medical Review Did Not Understand Previous Carrier's Policies

Aetna's medical review subcontractor, HealthCare COMPARE, instituted major changes in Georgia's medical review policies without intending to do so, COMPARE officials told us. COMPARE officials met for 2 days with Prudential's medical review staff to discuss their policies, and requested copies of their policies and procedures. But, COMPARE officials said, Prudential's policies and procedures were not clearly documented or logically organized. Consequently, COMPARE decided to (1) review only those categories of claims that HCFA requires all carriers to review and (2) apply what COMPARE believed were common-sense criteria for review. COMPARE's medical review policies and procedures, however, produced substantially more claims denials than Prudential's and provoked an angry reaction from providers.

Spending more time researching the outgoing carrier's policies and procedures can help reduce disruption. The new carrier in North Carolina, for example, decided to retain Prudential's medical review policies. Officials of this carrier experienced the same difficulties in obtaining information about Prudential's medical policies that COMPARE did, but made a concerted effort to fully understand the policies. To review available procedure manuals and policy memorandums, the carrier sent a team to Prudential's claims-processing office. The team spent time observing medical review operations to determine what policies were being applied in practice because the manuals and memorandums appeared incomplete. After the carrier change was completed, HCFA received relatively few complaints from providers about the new carrier's operations.

Aetna Misunderstood How Prudential Recorded Physician Specialty Data

Aetna's computer system uses a different method from Prudential's for recording information on the specialty a physician practices. Prudential's data files contained two items of information relating to physician specialty: "pricing specialty" and "actual specialty." This is because HCFA allows carriers to establish different payment limits for physicians in different specialties. Prudential used pricing specialty to

set payment limits, and grouped all internal medicine physicians into one category. For internal medicine practitioners, actual specialty indicates the physician's subspecialty—for example, cardiology, nephrology, or urology. In Aetna's system, the data files contain only one item of information about a physician's specialty.

Aetna's study of Prudential's data system did not take into consideration the importance of the two classifications of physician specialty information. Data-processing staff assumed that Prudential's system recorded specialty data in the same way Aetna's did. When Aetna converted Prudential's data files, it did not convert the actual specialty data.

HCFA requires that all carriers review claims to identify cases where two physicians are treating a patient at the same time, called concurrent care, since a second physician's services may not be necessary. When the two physicians practice different specialties and are treating different conditions, concurrent care may be appropriate. Unable to recognize subspecialties, Aetna's computer system reported any case where two internal medicine specialists were treating a patient as possibly unnecessary concurrent care. In addition, COMPARE's medical review staff were unable to determine the subspecialties of physicians to assess the need for a second physician's services. Consequently, in early 1989, many of Aetna's concurrent care denials were incorrect.

Correcting this problem also caused payment changes that concerned physicians. When physicians brought the problem to Aetna's attention, Aetna corrected its data files. Since Aetna's system establishes physicians' payment limits based on specialties, however, corrections sometimes resulted in changes in Aetna's payment for services.

Outgoing Carrier's Actions Can Complicate a Transition

Last-minute shortcuts departing carriers take in winding up their operations may make the incoming carrier's task more difficult. Prudential turned over more unprocessed claims to Aetna than Aetna expected, including some marked "processed" and some that were more difficult to process than expected. The Atlanta Regional Office monitored Prudential's claims backlog as Prudential was winding up operations, but did not detect these problems. Similar problems were described by other incoming carriers we spoke to.

Prudential Records Mislabelled and Disorganized

Aetna inherited a larger claims backlog than planned. It anticipated starting processing with a backlog of about 400,000 claims. HCFA estimates that it started with a backlog of 590,000 claims, including unopened mail containing about 140,000 claims. Moreover, Aetna received about 876,000 claims during January 1989, 41 percent more than Prudential normally received. Thus, Aetna's staff were faced with a larger workload than planned for.

Further, Prudential claims records were not well organized. Boxes containing pending claims were not clearly labeled, and boxes of unopened claims were labelled "completed." These claims contributed to the exceptional increase in claims receipts Aetna reported during January 1989. Furthermore, microfilm records of pending claims were not arranged in sequential order; therefore, when Aetna staff found it necessary to obtain from these microfilm records copies of documents submitted with claims, the staff had difficulty doing so. Aetna paid some questionable claims, Aetna officials said, because of these difficulties.

Former Carriers Lax in Last Months Before Leaving

Georgia claims also proved to be more complicated to process than Aetna anticipated. First, Georgia providers omitted information from claims more often than anticipated because, Aetna maintains, Prudential was lax in enforcing HCFA claims information requirements. Second, more claims than expected required action to obtain additional information or resolve inconsistent information. This was because Prudential brought in a less-skilled night shift to assist in claims processing, and these staff made more errors than Prudential's regular processing staff. For the first 3 months of 1988, Prudential reported that about 6.4 percent of the claims it processed lacked complete information; for the first 3 months of 1989, Aetna reported that 13.5 percent of the claims it processed lacked complete information. The time and effort required to obtain this missing information slowed processing.

Other new carriers experienced similar problems. In four of the six other states for which we reviewed carrier changes, excessive claim backlogs, officials said, initially overloaded the operation the new carrier set up to process the state's claims. The new carrier in North Carolina also received poorly organized and, in some cases, incorrectly labelled records from the outgoing carrier. In particular, carrier officials said, boxes of unopened claims were incorrectly labelled and consequently not discovered until after operations started. Some of these carriers also reported that claims left as part of the claims backlog were more difficult than would be normally expected. Many of the claims in the New

Jersey backlog had 9 or 10 pages of attachments—far more than a routine claim—an official of that state's carrier said. In North Carolina, the new carrier's officials said, for many claims, the outgoing carrier had entered only a control number and beneficiary identification number into its system. In order to process these claims, the new carrier had to locate documentation concerning the claims and enter data on services provided and charges, which added substantially to the claims-processing effort.

Conclusions

Staff in HCFA's regional offices who manage the transition from one carrier to another would benefit from improved guidance that (1) identifies areas of highest potential for disruption after a transition and (2) provides practical strategies for minimizing such disruptions. The results of HCFA's study of recent transitions should prove valuable for developing this guidance.

Two factors magnified the disruption that followed the Georgia carrier change. First, because the new carrier did not fully understand the outgoing carrier's systems, policies, and procedures, the new carrier inadvertently made substantial changes to the payment procedures that beneficiaries and providers had grown accustomed to. Second, the outgoing carrier took several shortcuts in winding up its operations; this left the new carrier with an initial workload that was larger and more difficult to process than it had anticipated.

Recommendations to the Secretary of Health and Human Services

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to develop guidance concerning carrier transitions that (1) identifies areas that warrant special attention because they pose a high risk of causing disruption and (2) describes strategies that are effective in addressing problems in these areas. Further, the Administrator should periodically update this guidance to incorporate the experience gained from future transitions.

Agency Comments and Our Evaluation

HCFA agreed with our recommendation and said that it is developing additional guidance for its regional offices. In particular, HCFA reports that it is taking several initiatives to improve its monitoring of an outgoing carrier's performance. HCFA noted that it has devoted considerable time and effort to informing its regional offices of lessons learned in past transitions. We believe HCFA should update its guidance periodically

to incorporate the experience gained from future transitions; HCFA has agreed to do so.

List of Congressional Requesters

Members of Congress From Florida

U. S. House of Representatives	Charles E. Bennett Michael Bilirakis Sam Gibbons Porter J. Goss Earl Hutto Andy Ireland Craig T. James Tom Lewis Ileana Ros-Lehtinen E. Clay Shaw Lawrence J. Smith Cliff Stearns C. W. (Bill) Young

Members of Congress From Georgia

United States Senate	Wyche Fowler, Jr. Sam Nunn
U. S. House of Representatives	Doug Barnard, Jr. George (Buddy) Darden Newt Gingrich Charles Hatcher Ed Jenkins Ben Jones John Lewis Richard Ray J. Roy Rowland Robert Lindsay Thomas

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 19 1991

Ms. Janet L. Shikles
Director for Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused By Replacing Contractors." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors"

Overview

GAO largely confines its review to the transition experiences of Medicare contractors in Georgia and Florida. While much can be learned from these two cases, lessons that might be learned from other transitions are not considered. Also the reader is given the impression that the Georgia and Florida transitions were representative of the Health Care Financing Administration's (HCFA's) experience in other transitions which they were not. Therefore the findings and recommendations presented, while useful, must be considered within the narrow scope of GAO's study.

As the report notes, HCFA managed numerous contractor changes over the past 5 years as well as the implementation of numerous changes in claims processing systems. In 1988 alone, in addition to those transitions reviewed by GAO, HCFA managed the transfer of Prudential's intermediary workload to three intermediaries, the transfer of Prudential's carrier workload in New Jersey and North Carolina to new carriers, the transfer of provider-based home health agencies to regional bill processors, and the transfer of the Nebraska Part B workload to another carrier.

We note that more problems arose in the Georgia and Florida transitions than had been the case in any other workload or claims system transition during the past 5 years. It should also be noted that 1988 entailed an unprecedented level of transition activity for HCFA. Most of these transitions were accomplished with substantially less disruption to providers and beneficiaries.

GAO acknowledges that Aetna faced special challenges in Georgia arising from the medical review subcontract and its decision to open a new claims processing office. GAO also mentions that the Georgia transition was accomplished within a short period of time. GAO further mentions that tight timeframes will continue to present a major challenge in future transitions due to the 1-year term for Medicare contracts, as is currently required in the contracts.

GAO's analysis of the carrier change in Georgia should also consider the following factors applicable to any transition:

Page 2

- Beneficiary and provider resistance to change: Providers and beneficiaries become accustomed to a carrier's own business style and methods of administering the Medicare program. Prudential had served the Georgia Medicare community for approximately 20 years. Therefore, it was anticipated that Aetna might require some time to establish a good working relationship with its new customers, even in the absence of the problems mentioned in the report.

- Complexity of the Medicare Part B program: This factor not only raised the frustration level of beneficiaries and providers over the past few years, but has greatly increased the number and complexity of the tasks necessary to accomplish transitions.

- The high rate of change in the Medicare program: The Medicare program is constantly changing, largely due to new legislative requirements. Consequently, the "target" towards which HCFA and Prudential's replacements were directing their energies was itself constantly changing. Resources that might have been directed towards effectuating a successful transition were expended in the effort to absorb and operationalize the changes. In addition, Medicare beneficiaries and health care providers often believed the source of unpopular changes to be the incoming carrier rather than changes required by law.

- Limited HCFA resources: To the extent that transitions result from a contractor's decision to withdraw from the program, the location and timing of transitions cannot be predicted. Consequently, personnel ceilings require that the unpredictable work be absorbed within current resources. In addition, the current budgetary environment limits funding available for conducting site reviews and other oversight activities. These problems particularly impacted HCFA's Atlanta regional office (RO) during the Georgia and Florida transitions, since these occurred simultaneously. The resource limitations in that RO were compounded by the fact that it also had to oversee the North Carolina transition at the same time.

Page 3

Now on p. 32.

GAO notes in several places (for example, see page 40) that HCFA conducted its own survey of the new carriers in Georgia, North Carolina and New Jersey. An analysis of this survey has been completed and a set of final recommendations is undergoing review.

HCFA experience and the above referenced survey underscores the critical nature of the following three issues:

- Productivity of incoming carriers staff needs to be maximized: GAO properly points out that many of Aetna's problems in Georgia resulted from its inexperienced staff. This is a condition faced by many new carriers and can be combatted in two ways: the incoming carrier may apply experienced staff from a pre-existing operation to the new operation; or, it can implement a strong training program. Our survey results have provided us with substantial insight into the strengths and weaknesses of these strategies. The knowledge will be used to strengthen HCFA's procurement strategies documents, and protocols.

- Incoming and outgoing carrier operations need to be addressed carefully: We agree with GAO's conclusion that it is critical that policy and operating differences be identified during a transition. In addition to comparing test results between systems, we also intend to pursue other activities in this area. HCFA now requires carriers to maintain written medical policies, and the standard systems initiative should reduce the documentation problem in future transitions. HCFA will also provide more "up-front" guidance to carriers in regard to policy and operating differences in future transitions. Finally, HCFA will give more attention to implementing demonstration projects, or significant policy changes, where future transition activity is anticipated.

- Outgoing carriers need to be tightly managed: While GAO recognizes problems that can be caused by an outgoing contractor's performance, it does not offer any solutions to this problem. HCFA has already implemented tighter reporting and monitoring controls on outgoing

Page 4

contractors. Further activities in this area are contemplated, including the development of increased financial controls to be applied to outgoing contractors. In addition, the Common Working File system may eventually enable both incoming and outgoing contractors to process claims simultaneously; this would eliminate the problem caused by larger-than-expected carryover workloads.

GAO Recommendation

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to require a new carrier to process a sample of the outgoing carrier's claims through its system and compare how its system handles the claims to how the outgoing carrier's system handled them, so that processing differences between the two systems can be identified and addressed before the new carrier begins operation.

Department Comment

We concur. A similar recommendation was developed internally as a result of the Prudential experience; it is under consideration by HCFA. Our review of the Prudential carrier transitions highlighted the importance of identifying key differences in operations and policy between the incoming and outgoing carriers before contract cutover, so that appropriate strategies can be developed and pursued.

Careful analysis will be required to develop operating procedures for implementing the recommendation, given the time and resource constraints which are inherent in transitions.

GAO Recommendation

We also recommend that the Secretary direct the Administrator to determine what subcontract provisions would best enable carriers to address situations where a data processing subcontractor's system does not function as agreed. After having done so, the Administrator should require carriers to include such provisions in their data processing subcontracts.

Page 5

Department Comment

We agree with this recommendation, and specifically believe that HCFA should require carriers to include a provision in subcontracts allowing the carrier to extend an incumbent subcontractor's agreement on a month-to-month basis for up to 6 months. This recommendation has already been implemented. HCFA has required carriers to include such a provision in every systems and facilities management subcontract since the Florida transition.

GAO Recommendation

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to develop guidance concerning carrier transitions that (1) identifies areas that warrant special attention because they pose a high risk of causing disruption, and (2) describes strategies that are effective in addressing problems in these areas. Further, the Administrator should periodically update this guidance to incorporate the experience gained from future transitions.

Department Comment

We agree with this recommendation, and are in the process of implementing it using lessons learned from our review of the Prudential carrier transitions. The questionnaires used in our study were largely devoted to soliciting information from Aetna, Equicor and Pennsylvania Blue Shield about those transition areas posing the most "trouble potential", and in developing solutions to these problems. Our findings are being incorporated into a revised version of the Transition Handbook. We will, of course, continue to disseminate lessons learned from future transitions to all ROs.

HCFA continues to provide guidance to its ROs. The 1986 edition of the Transition Handbook reflects an appropriate focus on establishing a strong transition management structure within the RO early in the transition. It also provides guidance to RO staff in ensuring that the incoming and outgoing contractors afford ample resources and attention to the conversion of data files. The Handbook focusses on these areas because they were problems in transitions prior to 1986.

Page 6

HCFA has spent considerable time and effort in disseminating transition lessons to ROs through memoranda and workshops. Furthermore, staff from HCFA's central office consult with regional office staff prior and subsequent to the initial transition team meetings and assist in setting priorities.

Technical Comments

- Executive Summary, page 2, bottom: Reference here and in other places, GAO states that "HCFA changed the carrier in Georgia . . . ." This language implies that HCFA initiated the change in carriers, whereas the change resulted from Prudential's decision to withdraw from the Medicare program. Language in the report should be modified to reflect this.

Now on p. 3.

- Executive Summary, page 4, bottom: GAO states that HCFA decided to implement the medical review subcontract "at the last minute." HCFA notified Aetna and its competitors of this requirement approximately 1-month after Prudential notified HCFA of its withdrawal and more than 2 weeks prior to contract award. We request that reference to "at the last minute" be revised accordingly.

Now on p. 4.

- Executive Summary, page 6: As mentioned previously, HCFA now requires language in data processing subcontracts that provides for month-to-month extensions in the event that a new subcontractor does not deliver a new system as agreed.

Now on pp. 9-10.

- Page 12, top: The discussion regarding transitions only considers conditions regarding HCFA initiated contractor changes. Consequently, the discussion seems unbalanced, given that many changes resulted from a contractor's decision to withdraw from the program.

Now on p. 11.

- Page 13 and following: Reference to the term "backlog" is incorrect. All contractors are budgeted to maintain a volume of pending claims to ensure that contractor staff are constantly operating at a high level of efficiency.

Page 7

"Backlog" does not refer to the normal volume of pending claims, but to volumes significantly in excess of the normal volume. In many cases, the word "backlog" should be replaced with the word "pending".

Now on p. 12.

- Page 15: In the discussion of its methodology, GAO neglects to mention that HCFA provided it with copies of the Prudential replacement carrier survey questionnaires. As GAO staff indicated that these documents were helpful, the questionnaires should be mentioned.

See ch. 4, pp. 34-36.

- In Chapter 2, GAO does not discuss Prudential's performance over the final 6 months of its contracts in the discussion of claims processing timeliness and quality. This performance, and its effects on Aetna, should be discussed.

Now on p. 18.

- Page 21: Reference to Aetna's initial quality assurance results needs clarification. It is true that Aetna's overpayment error rates were far in excess of HCFA standards, but the statement that "overpayments averaged 13 percent of charges processed" is misleading.

  HCFA calculates error rates based on the review of a sample of claims. If the microfilm, or original copy, of a claim cannot be located by the carrier, then HCFA considers the entire payment made to be an overpayment for evaluation purposes. In the case of Aetna, the microfilm records could not be located for many claims that Prudential entered into the system and then transferred to Aetna, which eventually made payment. Many of these claims may, in fact, have been paid correctly.

  Nonetheless, because the sampled claims could not be located, HCFA charged Aetna a large penalty. If one considers only those claims on which actual overpayments were observed, then Aetna's error in the first quarter was approximately 2.5 percent. Given this, GAO's estimate that Aetna's actions resulted in overpayments of $69.8 million is probably overstated. The report should be modified to incorporate this important point.

Major Contributors to This Report

Human Resources Division

Mark V. Nadel, Associate Director, Public and National Health Issues, (202) 275-6195

Boston Regional Office

Nicholas White, Assistant Director
Robert Dee, Regional Assignment Manager
Monty Peters, Evaluator-in-Charge
Pamela L. Milligan, Evaluator
Lionel A. Ferguson III, Evaluator

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.

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

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100