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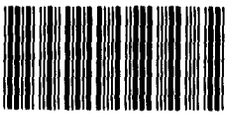

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MEDICARE

Shared Systems Policy Inadequately Planned and Implemented

Statement of Frank Reilly
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Mr. Chairman and Members of the Subcommittee:

I am pleased to participate in the Subcommittee's hearings on the Health Care Finance Administration's (HCFA) Medicare program. As you know, HCFA contractors processed over half a billion transactions representing $108 billion in Medicare claims in fiscal year 1991. Because of the complexity and magnitude of the Medicare program, these contractors rely extensively on automated data processing (ADP) systems to review medical services and determine if claim payments are justified. I will be talking today about HCFA's approach in implementing a major initiative that encouraged contractors to share ADP systems with other contractors.

HCFA implemented this initiative--the shared systems policy--in January 1989 to reduce the administrative costs of maintaining multiple systems and to promote uniformity.[1] However, although HCFA estimates that its shared systems policy will save about $16 million through fiscal year 1992, these savings may be offset by millions of Medicare program dollars lost during conversion. The issues I am discussing are described in greater detail in our report Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, March 18, 1992), which is being issued today.

Both we and the Department of Health and Human Services' Inspector General have identified Medicare payment problems that have resulted in millions of dollars in overpayments. Our review of HCFA's shared systems policy raises concerns about how effectively HCFA manages and monitors contractors' systems that make these payments. HCFA implemented this policy without adequate planning and provided little or no oversight during policy implementation. For example, HCFA did not establish minimum automation requirements to ensure that claims would be processed efficiently and accurately. Without such requirements, HCFA had no criteria by which to evaluate individual contractor systems. Such an evaluation is essential to identify and select the best systems for sharing with other contractors. Further, in developing its policy HCFA focused primarily on administrative savings, ignoring the effect that ADP systems have on Medicare claims-processing effectiveness. Finally, HCFA encouraged contractors nationwide to comply with its policy without first defining a long-term automation strategy.

SYSTEMS REQUIREMENTS NOT DEFINED AND EVALUATION OF CONTRACTOR SYSTEMS INADEQUATE

One of the first steps in initiating a major system change should

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[1]HCFA believes that by reducing the number of ADP systems and having multiple contractors share one system, processing operations will be easier to standardize and maintain.

be to identify and document minimum automation or functional requirements to support mission needs. In the case of HCFA, these requirements would provide contractors with specific claims functions and program controls that should be performed by shared systems. For example, the requirements would establish data standards to ensure that claims are processed in a consistent manner. The requirements would also describe the minimum number and types of computer screens and edits needed to review Medicare claims.[2]

Despite the essential need for early planning, HCFA did not develop a list of minimum automation requirements for Medicare part A until January 1991, almost 2 years after instituting the shared systems policy. Only recently, in January 1992, did HCFA develop requirements for Medicare part B.[3] By the time these requirements had been defined, the majority of contractors had already converted to shared maintenance or processing systems arrangements.

HCFA also did not perform system evaluations before implementing its shared systems policy. Such evaluations are needed in order to assist contractors in identifying the most appropriate systems for sharing. In 1991 HCFA performed a post-conversion evaluation of the six systems that shared ADP arrangements for Medicare part A. We analyzed these evaluations and found that none of the six systems fully met HCFA's minimum automation requirements. For example, five of the systems did not have adequate computer screens with which to review for duplicate claims.

In the absence of system evaluations, contractors were generally left on their own to decide which other contractors' systems to share. Failure to select the right system resulted in costly claims-processing problems. For example, we estimated that Blue Shield of California overpaid nearly $33 million in Medicare part B payments during the 6 months following its conversion to a shared system.[4] Specifically, before the contractor entered into a shared systems arrangement, its system had about 200 computer screens to review Medicare claims. These screens review

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[2]Contractors use screens and edits to review claims for coverage, unnecessary procedures, and other factors that may make payment unwarranted.

[3]HCFA currently has requirements for 10 major categories, including data collection and validation, reporting, file maintenance, correspondence, and claims adjudication.

[4]We compared Medicare payments denied per claim processed for seasonally comparable periods before and after conversion and projected the overpayment by multiplying the difference per claim by the number of claims processed in the post-conversion period.

claims to detect unnecessary and uncovered procedures and erroneous and duplicate payments. After switching to another contractor's system, the company lost 75 of these computer screens. We also estimate that Nationwide Mutual Insurance Company, another HCFA contractor, may have made about $7.2 million in Medicare overpayments during its conversion period. Nationwide's vice president said the new system initially failed to identify all duplicate billings and that certain edit screens were shut off to reduce processing backlogs, resulting in more overpayments.

In addition, many contractors experienced claims-processing disruptions and reduced productivity during conversion to shared systems. Of the 34 contractors who converted to shared ADP systems in fiscal years 1989 and 1990 (40 percent of all contractors), all had problems in at least one of the following three areas: decreased program safeguards, increased interest payments, and increased payment errors. For example, Blue Cross of South Carolina and Blue Shield of Michigan both lost an automated feature that helped them identify when a Medicare patient had other insurance coverage. We estimate that the loss of this feature may have resulted in overpayments of $951,000 for Blue Cross of South Carolina and $1.1 million for Blue Shield of Michigan during the 6 months following conversion.

HCFA did not consider the impact that system conversions would have on Medicare payment activity. Instead, the agency performed a limited analysis, comparing the systems' conversion costs to estimated administrative savings. HCFA's shortsighted focus on administrative savings, while ignoring systems impact on the Medicare program, has jeopardized the ADP systems' effectiveness in safeguarding the hundred-billion-dollar Medicare program.

HCFA HAS NOT DOCUMENTED OR COMMUNICATED ITS LONG-TERM SYSTEMS PLAN

Although HCFA will have spent $39.6 million through fiscal year 1992 in implementing the shared systems initiative, it has done so without a long-term systems plan or vision for the future. In effect, HCFA has not formally examined how best to process Medicare claims given current technology, but rather decided merely to reduce the number of ADP systems used. A long-term plan would identify the types of systems HCFA eventually hopes to have in place to best process claims given the state of ADP technology. This plan would also provide contractors with a better understanding of how HCFA envisions its future contractor ADP operations. The lack of such a plan has left contractors to speculate on how HCFA's ADP operations will evolve.

Moreover, HCFA has been considering further changes in its shared systems policy. In a December 1991 memorandum to all contractors, HCFA made it clear that shared processing, rather

than shared maintenance, is the preferred systems arrangement. HCFA stated that it would provide additional funding for claims-processing improvements only to contractors in shared processing arrangements. HCFA has specified that its goal is to determine the optimal number of shared systems arrangements that would provide the lowest possible administrative costs to maintain. This may require further conversions. HCFA has not yet established, however, that additional conversions would be cost-beneficial.

We support the concept of shared systems that are properly planned and implemented. However, we are concerned that if HCFA does not improve its implementation of this policy by better evaluating its needs, identifying options, and developing a strategy and plan to improve claims-processing efficiency and effectiveness, then millions of additional Medicare dollars may be wasted.

We are recommending that HCFA suspend further implementation of its shared systems policy until the deficiencies we have identified are addressed.

Mr. Chairman, this concludes my statement. I will be glad to answer any questions you or other Members of the Subcommittee may have.

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