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Report to Congressional Requesters

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MEDICARE

New Claims Processing System Benefits and Acquisition Risks

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Health, Education, and
Human Services Division

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January 25, 1994

The Honorable John D. Rockefeller IV
Chairman, Subcommittee on Medicare and Long-Term Care
Committee on Finance
United States Senate

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Each time Medicare introduces or revises a payment or coverage policy—of which there are many in response to legislative or administrative initiatives—the changes have to be independently incorporated into as many as 14 different automated systems. This process is costly and inefficient. It has also resulted in national program mandates and policies being applied inconsistently and at different times by Medicare contractors. In addition, as we recently reported and testified, there are problems associated with the Medicare program's management and safeguard efforts (see app. I). These problems have exposed the program to considerable fraud, waste, and abuse.

As part of an overall strategy to improve the efficiency and effectiveness of Medicare operations, the Health Care Financing Administration (HCFA)—the agency within the Department of Health and Human Services (HHS) that administers Medicare—is acquiring a new automated system for processing claims called the Medicare Transaction System (MTS). MTS is intended to replace the claims processing functions currently performed by the multiple automated systems with a single automated system that has improved capabilities. HCFA also believes the new system will achieve other significant advancements in Medicare's management and operations.

At your request, we reviewed the process Medicare is using to procure MTS, including (1) what benefits HCFA expects to obtain from MTS, (2) whether sufficient safeguards have been built into the procurement process to assure that an adequate system is developed, and (3) how MTS might fit under a reformed health system.

Background

Medicare operates through a complicated administrative structure. The program's authorizing legislation—title 18 of the Social Security Act of

1965—required the program to contract with the private sector for claims processing and payment functions. This requirement has led to a large contractor network, comprised of insurance companies that are responsible for processing Medicare claims in a given state or states. The network consists of (1) 47 fiscal intermediaries that process claims for hospital services and care provided by skilled nursing facilities, hospices, and home health agencies (part A of the Medicare program) and (2) 32 carriers that process claims for physician care and other covered expenses, such as laboratory services (part B of the program).

In addition, nine contractors operate the common working file (CWF) system, which merges information from the part A and part B systems for an entire region into a central database. CWF provides contractors with access to eligibility and entitlement data. It also is intended to help contractors avoid improper payments and facilitate research and policy development regarding Medicare payments.

In the early 1970s, HCFA developed a model computer system for part B and the Blue Cross/Blue Shield Association developed one for part A. These model systems standardized many claims processing activities and at the same time accommodated individual contractor's different payment policies and procedures. But not all contractors used the model systems and many retained or developed their own. In 1979, HCFA abandoned its model systems strategy, forcing those contractors that had been using a model system to begin maintaining these systems or to acquire others.

By January 1989, 87 contractors were using 58 different systems to process Medicare claims. Asserting that the diversity of claims processing systems contributed to excessive administrative costs and in an attempt to promote uniformity, HCFA implemented an initiative in 1989 that encouraged contractors to share systems. At the time, HCFA believed that alternative operating systems were preferable to a single standard system because they encouraged system innovation. Contractors used 1 of 14 different automated systems (6 for part A and 8 for part B) to process and pay about 700 million claims in 1993. These systems are operated by the contractors and HCFA has limited control over their operation.

HCFA's current claims processing plan envisions MTS as a single, government-owned system, operated by fewer contractors and capable of processing part A and part B claims and performing all CWF functions. It also anticipates that MTS will provide new capabilities that will support HCFA's long-term plans to improve Medicare operations.

On September 17, 1992, HCFA issued a Request for Proposals (RFP) to analyze the existing claims processing and CWF systems, define system requirements, and design and develop the new system. This RFP also included maintaining the system for the contractors that would eventually use the system to process claims. HCFA expects to award the contract in January 1994 and have the system completely developed and tested by October 1996. A separate RFP and contract award is planned to provide assistance to HCFA in monitoring the performance of the MTS contractor[1] and for actual operation of MTS. HCFA expects contractors will begin processing claims using MTS in late 1996 and will implement MTS at all Medicare contractor locations by December 1998.

Scope and Methodology

We reviewed MTS documents and met with HCFA officials at headquarters. We also met with officials from Bendix Field Engineering Corporation, a HCFA support contractor for MTS, to review HCFA's analysis of MTS' costs and benefits. We obtained the views of General Services Administration, HHS Office of Inspector General, and Office of Management and Budget officials on HCFA's acquisition strategy. Finally, we met with Blue Cross/Blue Shield Association officials to obtain their views on the MTS initiative. Our work was performed from September 1992 through November 1993, in accordance with generally accepted government auditing standards.

Results in Brief

HCFA considers MTS to be a critical step in its long-term strategy to improve the management of Medicare. Replacing Medicare's multiple, contractor-operated claims processing systems with a single system with improved capabilities could help HCFA obtain significant benefits. Some of these benefits are described below.

- Administrative efficiency. Using one automated system operated by fewer contractors would save administrative dollars and simplify certain administrative tasks. Under a single system, incorporating major payment and policy changes and procedural updates would require modifying only one system rather than several.
- Better management of contractors. A single system would format claims data uniformly and would enhance HCFA's ability to compare data on contractors' workloads, savings resulting from payment controls, and

[1]An RFP was issued on November 5, 1992, calling for an independent contractor to assist HCFA in evaluating and validating the MTS contractor's approach, plans, analyses, methods, and processes for designing, developing, and deploying MTS. This independent contractor is also expected to help evaluate the adequacy of all work products prepared by the MTS contractor.

other performance indicators. Such uniformity of information could improve the reliability of HCFA's assessments of contractor performance and ultimately its decisions regarding funding and contract renewal.

- Greater emphasis on safeguarding program dollars and improving beneficiary and provider service. A single system could provide improved capability to identify inappropriate patterns of payments made to providers. It would also permit the application of other, more sophisticated analysis techniques.

While some of the benefits HCFA anticipates could be achieved by other program or system changes, a well-designed and implemented MTS should make it easier to attain these benefits.

HCFA's initial approach to acquire MTS involved considerable risks that the system would take longer, cost more than expected, and when deployed, would not achieve intended benefits. In particular, HCFA's cost-benefit analysis had numerous limitations. Also, HCFA did not fully define system capabilities, including the need to enable MTS to work effectively with Medicare's other automated systems to accomplish program objectives. Moreover, HCFA allowed considerable overlap among contract phases and did not prepare adequate contingency plans to protect against the potential failure of the MTS design contractor to meet expectations. Finally, HCFA did not build in sufficient management reviews of contractor progress at key points in the contract. In response to these concerns, HCFA officials agreed and have begun to implement several planning and acquisition strategy changes to reduce these risks. Inherent risks remain due to the size, complexity, and importance of MTS to the Medicare program. As a result, continued top management and congressional support and oversight will be important to the system's success.

MTS Expected to Make Medicare More Efficient and Serve Providers and Beneficiaries Better

MTS is an important part of HCFA's plans to restructure Medicare to improve operations. Specifically, HCFA officials expect MTS to help them increase Medicare's claims processing and system maintenance efficiency; better oversee program activities; reduce program losses due to waste, fraud, and abuse; and improve services to beneficiaries, physicians, hospitals, and other providers.

Greater Administrative Efficiency

HCFA believes that moving to one automated system offers significant potential to reduce administrative costs. From its experience with prior system consolidations, HCFA estimates that this move will produce

multimillion dollar savings annually during MTS' initial years of operation (1997 to 2002). HCFA asserts that additional savings would accrue from optimizing the number of claims processing sites.[2]

Specifically, HCFA expects MTS to reduce the differences in data, procedures, and processes among the existing claims processing contractors. MTS is expected to have the capacity to process over 2 billion claims per year—about three times the current volume of claims processed by the contractors' individual systems. This capacity will allow HCFA to consolidate claims processing functions at a much smaller number of contractors (claims submitted to Medicare's 79 contractors are currently processed at 62 different locations). HCFA believes that the current contracting environment does not lend itself to the scale of consolidation and standardization obtainable under the MTS conceptual model. HCFA also believes that piecemeal consolidation is inherently less efficient, more difficult to manage, and requires compromises in operating efficiencies that could be obtainable under a comprehensive approach.

In addition, HCFA believes that MTS could adopt money-saving technologies that would be expensive to introduce across the program's existing systems. For example, programming MTS for the use of electronic cards that provide on-line information on a beneficiary's eligibility and medical history could help simplify Medicare's billing procedures. Also under MTS, many tasks now done manually by contractors could be automated. For example, Medicare's process for reconsidering claims payment decisions could be made essentially paperless by making most of the information available on-line. Constraints with existing systems, including the lack of uniformly formatted data, currently limit the feasibility of applying this technology.

HCFA's cost-benefit analysis does not attempt to quantify all the benefits cited above. Although HCFA believes that the implementation of MTS could result in significant program dollar and administrative savings, the agency's cost-benefit analysis did not assess program savings[3] and included only some administrative savings (such as savings on system maintenance). It did not include administrative savings expected from

[2]Currently, under section 1816 of the Social Security Act (42 U.S.C. 1395h), HCFA has authority, for part A Medicare services, to contract only with entities that are nominated by providers. Thus, to have part A and B claims processed by the same contractor, HCFA officials believe that a legislative change to its contracting authority is desirable. Clarifying legislation would facilitate HCFA's efforts to fully consolidate part A and B claims processing.

[3]Program savings are difficult to determine but could result from improved oversight and controls to detect fraud, waste, and abuse.

optimizing the number of claims processing sites. In its analysis, HCFA initially concluded that MTS would save about $100 million annually during the first 6 years of operation. We believe this figure may be inaccurate because the savings assumptions were determined from the data of certain Medicare contractors that were not typical of all Medicare contractors. In addition, HCFA's cost estimate is uncertain because HCFA has not yet fully defined MTS capabilities. (See app. II for further details.) HCFA is continuing to update its savings estimates using current data.

Better Program Oversight

While HCFA stresses increased efficiency as the single system's major contribution to program savings, we believe that better management of the Medicare dollar through improved HCFA oversight of its contractors also would be a significant potential benefit from MTS. HCFA has difficulty aggregating information on key contractor activities because claims data are not always comparable among its many claims processing contractors. The ways contractors report workload and other management data are not now always comparable. HCFA has difficulty assessing, for example, the effectiveness of contractors' methods used to flag questionable claims. HCFA also has difficulty obtaining current information on contractors' workloads that could signal the development of backlogs or the abandonment of the use of certain payment controls.

By storing consistent data in one system, MTS could help satisfy HCFA's need to aggregate uniform and accurate management information promptly. Through MTS, HCFA expects to obtain data that will facilitate comparisons of

- payments for procedures per Medicare enrollee. This information can help analysts identify excessive spending and the need for payment controls.
- contractor effectiveness in identifying and correcting payment problems. This information can help HCFA assess contractor performance.

The ability to make such comparisons, although essential for making reliable assessments of contractor performance, has been lacking under HCFA's current management information systems. Improved data also offers opportunities to develop better methods of measuring contractor performance. We believe such improvements in contractor evaluations should enhance HCFA's ability to allocate contractor budgets, terminate or not renew contracts, or take other actions against poor-performing contractors.

HCFA also expects that better management information, combined with moving the claims processing function to fewer contractors, would help refocus and improve its oversight of the other operations that contractors perform in administering Medicare. These other operations include service to providers and beneficiaries, the analysis of spending patterns and trends, activities to recover overpayments, and the prevention of future losses. In the past, HCFA oversight and contractors' performance over these operations has been deficient. For example, since 1991 we have reported on contractors' neglect of activities to adequately investigate complaints of fraud and abuse telephoned in by Medicare beneficiaries,[4] reclaim over $250 million in overpayments owed by hospitals,[5] and recover over $1 billion in claims mistakenly paid by Medicare that may have been the responsibility of other health insurers.[6]

Improved Controls to Detect Fraud, Waste, and Abuse

HCFA believes that MTS has the potential to help its contractors improve their methods of identifying and investigating spending on unnecessary or inappropriate services. Currently, historical information on a beneficiary's use of physician, hospital, and home health services is kept in separate computers, some of which are not accessible during claims processing. However, the medical necessity of individual services or medical items is not always understood in isolation from other services or items provided to the beneficiary. Because complete information on a Medicare beneficiary's care is not available simultaneously with the processing of the claims, contractors' claims processing staff can lack the information they need to correctly determine medical necessity.

To identify providers submitting questionable claims, contractor staff currently receive data from HCFA's national database and download data from their own claims processing systems. Using their own software packages, contractors manipulate and array the data, within the capabilities of a particular system, to analyze the patterns of payments made to providers. According to HCFA, MTS could provide the capability to access and examine all Medicare payments made on behalf of a

[4]Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991) and (GAO/T-HRD-92-2, Oct. 2, 1991).

[5]Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991) and Medicare: Funding and Management Problems Result in Unnecessary Expenditures (GAO/T-HRD-93-4, Feb. 17, 1993).

[6]Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

beneficiary. HCFA officials believe that this would be more efficient and would permit the application of more sophisticated analysis techniques.

MTS could also enhance HCFA's ability to establish better controls over provider billing procedures. Within Medicare's current contractor network there are numerous provider number identification systems. As we recently reported, providers can conceal patterns of excessive billing by routing claims through multiple Medicare billing numbers.[7] Under MTS, providers would be given only one identification number under the single system for processing claims. In addition, as reported in an HHS Inspector General study, HCFA overpaid physicians millions of dollars when a Medicare contractor's computer system did not detect certain abusive billing practices.[8] MTS could improve the capability to detect these practices.

Improved Service to Beneficiaries and Providers

HCFA believes that the capacity of MTS to make a beneficiary's claims history available at a single location would enhance Medicare's ability to respond to beneficiary and provider inquiries. Under Medicare's current structure, inquiries regarding a beneficiary who was hospitalized and received subsequent home care could involve several contractors to get a complete accounting of Medicare's payments for this episode of care. For example, questions about hospital care require contacting the hospital's intermediary; home health, the designated home health regional intermediary; physician care, the physician's designated carrier; and medical equipment, the designated regional carrier.[9]

Under MTS, claims histories and the status of pending claims for hospital and related services (now stored in part A systems) and claims for physician and related services (now stored in part B systems) would be in one location. Therefore, contractors responding to inquiries could provide "one-stop shopping" by obtaining information consolidated on a single automated system.

HCFA also expects that MTS will enable Medicare contractors to offer providers and beneficiaries better coordination of benefits with other insurers, including state Medicaid agencies and those who sell policies

[7]Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

[8]Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursements, (HHS Inspector General, A-03-91-00019, Aug. 30, 1991).

[9]HCFA has recently begun using regional carriers to process medical equipment claims.

that supplement Medicare. MTS could also help contractors provide physicians with better information comparing their treatment patterns with those of other physicians.

MTS Initial Planning and Acquisition Strategy Involved Considerable Risks

Although MTS is a critical step in HCFA's plans to improve Medicare program management and operations, the process for implementing this new system involves considerable risk. We found that HCFA's initial planning process and strategy to acquire MTS increased the risks inherent in any large computer system procurement—cost overruns, schedule delays, and the system's failure to perform as expected. HCFA officials have begun implementing corrective actions to reduce these risks. In addition, HCFA did not specify a formal process for ensuring congressional oversight and continued top-level HHS and HCFA management direction and support.

Planning Deficiencies

Until recently, HCFA did not follow sound information resources management planning practices to define MTS capabilities. HCFA was, therefore, not in a position to ensure that MTS would provide the capabilities needed to support the agency's broader plans to improve the Medicare program.

As part of a strategic planning process, agencies are required to identify the system capabilities needed and specify how existing and new information systems will work together to accomplish program objectives.[10] This process calls for system capabilities to be defined using a structured approach that analyzes the agency's business functions, planned program improvements, and potential system improvements. The process also calls for agencies to analyze financial, technical, and schedule risks associated with acquiring a new system. Agencies need to consider not only all these elements during the initial planning phase but also the use of a staged implementation strategy, if appropriate, to reduce financial, schedule, and technical risks.

Initially, however, HCFA did not fully consider the improvements needed for MTS and other systems to support its program objectives. Instead, HCFA's planning focused on replacing Medicare's multiple claims processing systems with a single system with similar capabilities. Although HCFA recognized the need to develop improved capabilities to support planned program improvements, these capabilities would not have been defined until after MTS was designed. For example, HCFA planned to

[10]See 41 C.F.R., chapter 201.

incorporate five highly automated Medicare claims processing functions into MTS. At a later time, HCFA planned to analyze the feasibility of adding two labor-intensive functions—data entry and medical review. However, incorporating these functions later—without having adequately considered them in the initial planning process—would increase risks because the system might not have sufficient flexibility to accommodate the needed changes.

These planning deficiencies occurred, in part, because HCFA did not adequately take advantage of the agency's information resources management expertise. Although HCFA's information resource management group uses a structured planning process to connect information system capabilities with agency program objectives, the MTS project staff did not use this structured planning process in the original MTS planning effort.

HCFA officials agreed that the MTS project staff would use the structured planning process of the agency's information resources management group to better integrate MTS with the agency's long-term mission objectives. To assist in this effort, HCFA has hired a contractor with strategic information planning experience. In addition, HCFA is reorganizing the staff assigned to the MTS project and increasing the information resources management group's involvement to ensure that planning activities are fully addressed. Finally, HCFA officials have directed the MTS project staff to develop and deploy MTS capabilities using a staged implementation strategy, if appropriate. These actions should better ensure that MTS capabilities support HCFA's overall plans to improve Medicare operations.

System Acquisition Risks

HCFA's initial acquisition strategy did not adequately address problems involved with schedule concurrency and development of contingency plans. These inadequacies added undue risk to the MTS procurement.

To avoid technical problems, federal system acquisition guidance calls for agencies to minimize overlap, or concurrency, of tasks among different contract phases—analysis of system capabilities, system design, software development, testing, and system deployment. HCFA's scheduling of the MTS procurement, however, called for significant overlap, or concurrency, of contract phases. For example, at one point in 1995, requirements analysis, design, and development are scheduled to proceed at the same time. If a contractor advances too far into a succeeding phase before sufficient progress has been made in previous phases, the risk that technical

problems will occur is significantly increased. HCFA also did not develop adequate contingency plans, which are important in the event of technical obstacles.

HCFA agreed that changes should be made to the acquisition strategy. HCFA plans to review the MTS schedule to identify and eliminate any unnecessary concurrency. In addition, HCFA agreed to develop additional contingency plans. If properly implemented, these corrective measures would help ensure that (1) the contractor does not advance too far into the next phase before completing necessary tasks in the prior phase and (2) HCFA has alternatives to overcome problems should they occur.

Top Management Leadership and Oversight Needed

A 1990 GAO report[11] pointed out that clear direction and support from top management is essential to successfully implement major automation initiatives. The report also noted that establishing partnerships at all levels of the organization helps ensure that the best available knowledge is provided and that concerns, ideas, and solutions are aired and addressed. Providing the Congress with information about the system's status was cited as a way to help the Congress make informed oversight decisions.

With respect to top management involvement, HCFA's acquisition strategy did not schedule reviews of the MTS contractor's progress at key procurement points, such as at the completion of the requirements analysis, design, and development phases. HCFA agreed to improve its evaluation of the MTS contractor's progress by instituting top management reviews and approvals at several key points in the contract. A formal process involving HCFA's top management will help ensure adequate direction and support throughout the entire project.

Moreover, HCFA did not make optimal use of information management resources available within HHS. HHS information management officials told us that they have had a limited role in providing assistance to the MTS project staff. In addition, past work at other HHS components showed that some components, such as the Social Security Administration (SSA), have extensive experience in acquiring major information systems. In fact, SSA staff were initially consulted when HCFA officials were developing the MTS RFP. These departmental components offer a resource that could continue to be called on to provide additional knowledge and experience to HCFA staff.

[11]Meeting the Government's Technology Challenge: Results of a GAO Symposium (GAO/IMTEC-90-23, Feb. 20, 1990).

The importance of MTS to the Medicare program warrants keeping congressional appropriations and oversight committees informed of the status of system acquisition efforts. Such information could be provided through periodic status reports describing progress and problems in designing, developing, and deploying MTS.

MTS Compatibility With Health Care Reform

The Congress, the administration, and many states are considering significant changes to the way health care is financed and delivered. How the health care debate will play out—for example, the extent to which health maintenance organizations and preferred provider plans will be used—is uncertain. HCFA officials believe, nevertheless, that the approach to acquiring and developing MTS provides the flexibility to accommodate most changes. HCFA officials believe that MTS is being designed to accommodate both encounter data transactions now used in certain managed care settings as well as the traditional fee-for-service transactions that constitute Medicare's current reimbursement system. On the other hand, in the event that health reform mandates a capitated reimbursement system—based on lump-sum rather than per-service payments—modification to MTS would be necessary.

Conclusions

A new system for processing Medicare claims offers considerable opportunities to improve Medicare operations and safeguard program dollars. As such, MTS could enhance HCFA's ability to manage contractor performance. Some of these benefits could be obtained with multiple claims processing systems, but with greater effort and, probably, additional cost. Our examination of HCFA's cost-savings estimate indicates that although the new system should generate some administrative cost savings, the exact amount of these is uncertain.

Risks are associated with HCFA's planning and acquisition strategy for MTS that could result in the new system not achieving intended benefits and in cost increases and schedule delays. HCFA is initiating several planning and acquisition strategy changes that address these concerns and that we believe should be implemented. These include better integrating the MTS initiative with the agency's long-term program objectives, reducing contract schedule concurrency, and incorporating key decision points and reviews in the contract schedule. However, because of the size, complexity, and importance of the system to the Medicare program, oversight by top management and the Congress is essential.

Recommendations

We recommend that the Secretary of HHS assure that the agency's intended actions to address the planning and acquisition issues identified in this report are implemented immediately. Among other things, the Secretary should ensure that

- HCFA top management is continuously involved in the MTS project,
- HHS information resources management officials participate in the MTS project and that experts from other department components are available to assist HCFA, and
- HCFA provide progress updates each January to congressional appropriations and oversight committees describing the status of MTS, including progress, problems, milestones, and costs in designing, developing, and deploying the system.

Agency Comments and Our Evaluation

HHS provided comments on a draft of this report, which we have incorporated as appropriate (see app. III). HHS generally agreed with our findings and recommendations and provided a progress report addressing most of our recommendations. We also incorporated technical comments provided by HHS, but have not included them in the appendix.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send 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. Copies also will be made available to others upon request. This report was prepared under the direction of Sarah A. Jaggar, Director, Health Financing and Policy Issues and Frank W. Reilly, Director, Information Resource Management-Human Resources Division. If you have any questions regarding it, they can be reached at (202) 512-7119 or (202) 512-6408, respectively. Other major contributors are listed in appendix IV.

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Contents

Abbreviations

CWF	common working file
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
SSA	Social Security Administration
MTS	Medicare Transaction System
RFP	Request for Proposals

GAO Reports and Testimonies on HCFA Management and Payment Safeguards (1991-93)

Medicare Secondary Payer Program: Identifying Beneficiaries With Other Insurance Coverage Is Difficult (GAO/T-HRD-93-13, Apr. 2, 1993).

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (GAO/T-HRD-93-4, Feb. 17, 1993).

Medicare: HCFA Monitoring of the Quality of Part B Claims Processing (GAO/T-PEMD-92-14, Sept. 23, 1992).

Health Insurance: Medicare and Private Payers Are Vulnerable to Fraud and Abuse (GAO/T-HRD-92-56, Sept. 10, 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy (GAO/PEMD-92-28, July 17, 1992).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992 and GAO/T-HRD-92-29, May 7, 1992).

Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, Mar. 18, 1992 and GAO/T-IMTEC-92-11, Mar. 18, 1992).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991 and GAO/T-HRD-92-2, Oct. 2, 1991).

Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO/HRD-91-44, Apr. 4, 1991).

MTS Cost-Benefit Analysis and Savings

In acquiring automated information systems, federal regulations and guidance require that the cost and benefits be analyzed to provide adequate information with which to analyze and evaluate alternative approaches.[1] The starting point for the MTS cost-benefit analysis was HCFA's policy decision that a primary objective was a single system combining parts A and B and the common working file. HCFA's analysis compared the administrative costs and financial benefits of current claims processing systems with (1) designing and developing a new system and (2) 12 combinations of integrating existing systems.

The analysis concluded that a new system should be built, incorporating five of seven activities studied.[2] It also suggested that considerable financial benefits were possible by consolidating the other two activities—considered labor-intensive—into MTS and recommended a study of this option's feasibility.[3] Agency officials explained that, because they wanted to break the task of restructuring Medicare into workable parts, they deferred this study.

HCFA's primary justification for MTS was its estimate that the new system would produce administrative savings of about $200 million a year during the first 6 years of operation (1997 to 2002). We question some of the assumptions and data used in arriving at this estimate.

HCFA's $200 million estimate is expressed in future-value dollars. Its internal cost-benefit analysis also indicated that, in present-value terms, MTS could be expected to save $100 million annually. Although the standard criterion for deciding whether a government program can be justified on economic grounds is net present value, HCFA used the higher future-value figure in justifying the MTS initiative. In addition, these estimates were determined using HCFA's assumption that savings for MTS could be expected from the results of some contractors' conversion to a shared system. However, these data involved low-volume, high-cost contractors who converted to a shared system in the initial stages of the program—not typical of the majority of current contractors. Further, HCFA projected that MTS' savings rate would continue at the same level for several years beyond implementation, assuming that a contractor's unit costs for processing a claim would continue to decrease after MTS

[1]Federal Information Resources Management Regulation, 41 C.F.R., subpart 201-20.2 (1993).

[2]The five activities or functions that the analysis concluded should be incorporated into MTS are provider file maintenance, automated claim edits, claims pricing and payment calculations, claims payment and related notices and statements, and administrative and fiscal management reports.

[3]The two labor-intensive functions are (1) claims receipt, entry, and control and (2) medical review.

implementation. We believe that a more reasonable assumption is that unit costs will stabilize and that, as this happens, MTS savings will progressively decrease. HCFA is revising its cost-benefit analysis to incorporate more current data and assumptions. Tentative results indicate that savings will result from MTS but that these will be less than initially projected.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

DEC 6 1993

Ms. Sarah F. Jaggar
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Enclosed are the Department's comments on your draft report, "Medicare: New Claims Processing System Benefits and Acquisition Risks." 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,

June Gibbs Brown
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office (GAO) Final Report, Medicare: New Claims Processing System Benefits and Acquisition Risks

We have reviewed the GAO report on the Health Care Financing Administration's (HCFA's) Medicare Transaction System (MTS) and are pleased that it highlights some of the significant ways in which the MTS initiative could improve our service to the program's customers. We also agree with GAO that the MTS project has the potential to significantly improve the efficiency of Medicare operations, the oversight of Medicare intermediaries and carriers, and the effectiveness of program safeguards against waste, fraud and abuse.

GAO is aware that HCFA has spent the past few years strategically evaluating the current program environment and the challenges that the future will bring. The MTS is a critical component of our plan to meet these challenges. This report indicates that GAO also fully recognizes the importance of the MTS project.

We appreciate the significant resources and effort that GAO has devoted to its review of the MTS project. GAO has been very willing to meet and discuss its experience and insights with us regarding success factors for major information systems projects, and we believe that the project will benefit from GAO's recommendation.

GAO recommends that, before we award the design contract for the MTS system, we first implement a number of actions to address certain planning and acquisition issues identified by GAO. We agree with GAO's recommendation, and offer the following report on our progress in addressing the issues identified:

- HCFA needs to better integrate the MTS initiative with the agency's information systems planning process.

  We have made significant progress in this area. As noted by GAO, we have hired a consultant with strategic information planning experience to assist us in documenting the business functions required in Medicare claims administration. The resulting business function model will assist our efforts to apply the MTS project to our program objectives. We will also use the model as a tool in carrying out our oversight of the MTS design contractor.

The consultant is now working intensively with a core group of HCFA staff, in addition to the entire MTS project team. We expect to complete work on the business model well in advance of the award of the MTS design contract.

We have also taken action to increase the involvement of HCFA's Information Resource Management (IRM) planning body in the MTS project on a day-to-day basis. We have included more staff in our MTS workgroups, have consulted with IRM staff about our information management training needs, and intend to involve them in the review of numerous MTS design contractor deliverables. We will be including senior IRM management in the Executive Steering Committee for the MTS project. Finally, we have designated staff to work on integrating systems initiatives relating to Medicare operations into the agency's overall IRM planning process. We believe that all of these actions, taken together, more than address GAO's concerns.

- o HCFA needs to schedule review of the MTS design contractor's progress at key points in the project.

We have clarified to the offerors that the design contractor will be expected to meet with senior HCFA staff during the analysis phase of the contract. This will ensure that all needed capabilities are built into the new system. Further, we are building decision points into the project schedule in several places. Senior-level official approval will be required at these points. These decision points focus on key contract deliverables at the conclusion of the analysis, design, and development phases. We will reflect these decision points in our contract management plan prior to the award of the design contract.

- o HCFA needs to reduce schedule overlap.

We reviewed the project schedule and significantly revised it to reduce the amount of overlap. These changes were communicated to offerors in an amendment to the Request for Proposals (RFP) earlier this past summer.

- HCFA needs to develop contingency plans in the event of technical obstacles.

  As we pointed out in earlier correspondence to GAO, the RFP itself requires the MTS design contractor to provide certain plans to address contingencies such as a compressed project schedule. We have also designed a structured process for our MTS workgroups to use in identifying issues relating to MTS implementation and in forwarding their analyses and recommendations to senior HCFA management.

  The MTS project team will itself develop plans to address other types of contingencies. These plans will be reflected in the contract management plan and other documents as appropriate prior to award of the contract.

We disagree, however, with GAO's statement on page 19 that "if health reform mandates a fully capitated financing approach for Medicare, significant adjustments to the MTS may become necessary."

Certainly there would be more changes required if a fully capitated financing approach was mandated, but one of the many reasons HCFA chose to go forward with the MTS was because the current fragmented approach to Medicare claims processing does not lend itself well to the expanding managed care environment. Currently, our systems only accommodate claims paid on a fee-for-service basis, and to change incrementally (one system at a time) would be cost-prohibitive. We believe the future indeed will include a diversity of options available to our beneficiaries. Therefore, we planned from the beginning to build into the MTS the ability to handle managed care options and to allow for the possibility that in the future, Medicare beneficiaries may be enrolled in a variety of managed care plans; each providing coverage for different services and/or different levels of services.

We also believe that MTS will work well in any transaction environment, whether claims driven or encounter data driven, or a combination of both. The MTS will be able to process different deductibles, coinsurance and payments from any proposed point-of-service networks and allow for management and quality oversight of capitated plans. We believe that regardless of whether managed care or fee-for-service, HCFA will be responsible for ensuring our beneficiaries and providers receive a greater level of service. The MTS is essential to providing this assurance.

Finally, under the President's proposed Health Plan, should there be a need for the Federal government to process claims; e.g., if a State plan were to fail, we believe the MTS would have the capability to ensure the beneficiaries would have their medical claims processed.

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