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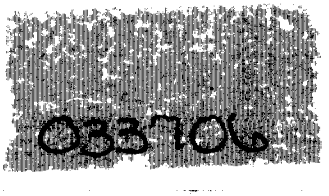
BY THE U.S. GENERAL ACCOUNTING OFFICE

Fact Sheet For The Honorable Howard M. Metzenbaum United States Senate

Administration Of Selected Medicare Activities In Ohio



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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

October 18, 1985

B-220833

The Honorable Howard M. Metzenbaum
United States Senate

Dear Senator Metzenbaum:

In response to your February 14, 1985, letter and later discussions with your office, we reviewed selected issues related to (1) the administration of the Medicare part B program in Ohio and (2) time frames for paying beneficiaries whose Social Security Disability Insurance claims were approved by either administrative law judges or federal courts.

After briefing your office on August 21 and September 24, 1985, on our review results, we agreed to prepare separate fact sheets on the above subjects. This document discusses the performance of the Medicare part B claims processing contractor in Ohio and the reinstatement of Medicare eligibility to individuals whose deaths had been erroneously reported to the Social Security Administration (SSA). Next month, we will give you a fact sheet on (1) disability payment issues and (2) the status of SSA's plans for staffing its field offices.

In doing our work, we relied primarily on statistical information obtained from the Health Care Financing Administration (HCFA) and the Nationwide Mutual Insurance Company, which processes and pays part B claims in Ohio. We also interviewed HCFA, Nationwide, and SSA officials. In examining reinstatements after erroneous death reports, we reviewed cases obtained from SSA's District Office in Columbus, Ohio.

According to Nationwide officials, the following factors have, in the short term, adversely affected Nationwide's ability to process claims: (1) its conversion to a new computer system on May 1, 1984; (2) its conversion to a new medical procedure coding system on January 1, 1985; and (3) its increased claims volume in fiscal year 1985.

We found that for the cases we reviewed, SSA took an average of 5 weeks to restore to its Master Beneficiary Record (MBR) an individual erroneously presumed to be dead. While SSA can use special procedures to resume paying benefits to these individuals before restoring them to the MBR, their Medicare eligibility cannot be reinstated until the MBR is updated.

Because of your request to expedite issuance, we did not obtain written comments on this document, nor did we discuss a draft of it with agency officials.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this fact sheet until 30 days from its issue date. At that time we will send copies to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties and make copies available to others on request.

Should you need additional information on the contents of this document, please call me on 275-5451.

Sincerely yours,

Franklin A. Curtis

Franklin A. Curtis
Associate Director

Contents

ABBREVIATIONS

EDSF	E.D.S. Federal Corporation
HCFA	Health Care Financing Administration
IMPACC	Immediate Payment Critical Case
MBR	Master Beneficiary Record
SSA	Social Security Administration

ADMINISTRATION OF SELECTED MEDICARE ACTIVITIES IN OHIO

INTRODUCTION

The Medicare program, authorized by title XVIII of the Social Security Act, pays health care costs for eligible persons age 65 or older and certain disabled persons. Medicare consists of two parts--part A (hospital insurance) and part B (supplementary medical insurance). Part B covers physician services and a variety of services and supplies, including X-rays, laboratory tests, physical therapy, and durable medical equipment.

The Department of Health and Human Services' Health Care Financing Administration (HCFA) administers the Medicare program. HCFA, in turn, contracts with organizations (called carriers) to review and process Medicare claims submitted by physicians and suppliers (which we will refer to as providers) or eligible individuals. HCFA evaluates carrier performance, maintains an automated system containing information on eligible Medicare beneficiaries, and issues rules and procedural instructions to carriers on such matters as covered services and allowable charges.

Providers of part B services may submit claims directly to Medicare carriers on behalf of beneficiaries and receive payments directly. For these "assigned claims," providers agree to accept Medicare's determination of the reasonable charge for the service rendered. Generally, Medicare pays 80 percent of the reasonable charges for covered services and supplies and the beneficiary pays the other 20 percent. If a provider does not serve a Medicare beneficiary on an assignment basis, the beneficiary pays the provider and then submits a claim to the Medicare carrier (unassigned claim) for reimbursement of 80 percent of the reasonable charge.

Nationwide Mutual Insurance Company is the carrier that processes part B claims in Ohio and West Virginia. In fiscal year 1984, Nationwide, under contract with HCFA, processed about 10.6 million part B claims and paid out over $678 million in Medicare benefits. HCFA also paid Nationwide about $24.9 million, of which about $20.4 million was for claims processing costs.

WHAT FACTORS HAVE AFFECTED NATIONWIDE'S ABILITY TO PROCESS MEDICARE CLAIMS?

According to Nationwide officials, between May 1984 and July 1985, the following factors have, in the short term, adversely affected Nationwide's ability to process claims:

--Its conversion to a new computer system on May 1, 1984.

--Its conversion to a new medical procedure coding system on January 1, 1985.

--Its increased claims volume in fiscal year 1985.

Conversion to a new computer system

In 1982, Nationwide solicited proposals for a new automated data processing service contract. Nationwide's contractor at the time, E.D.S. Federal Corporation (EDSF) submitted two proposals: the first, to upgrade Nationwide's existing claims processing system; the second, to replace it with a more advanced system. EDSF projected productivity gains and personnel savings over a 5-year period if Nationwide chose the new system. In 1983, Nationwide, with HCFA's approval, contracted with EDSF for the new system because it had more features and promised productivity improvements.

The new system was adapted from systems being used by other EDSF clients and consisted of new hardware and software. According to a Nationwide official, the company delayed converting to the new system for 1 month when problems were encountered in processing claims during its testing period. When the system was activated on May 1, 1984, claims backed up as additional system problems surfaced. According to this official, a major problem with the new system was its inability to process a claim after initially rejecting it.

As shown in figure 1, the number of claims waiting to be processed increased from about 270,000 at the end of April 1984 to over 700,000 three months later.

Figure 1: Medicare Claims Inventory for Nationwide Mutual Insurance Company (End of Month January 1984-July 1985)

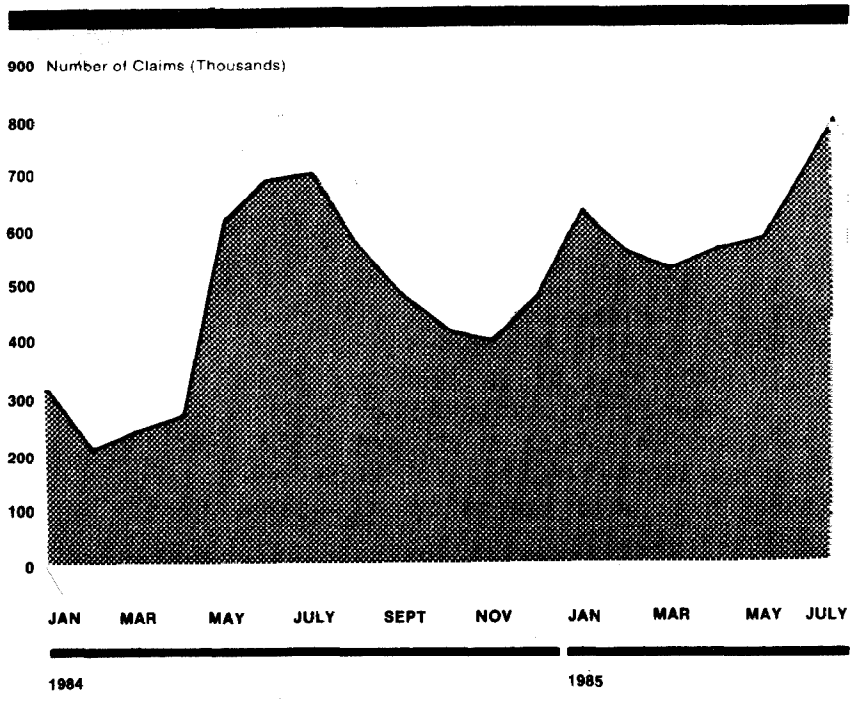
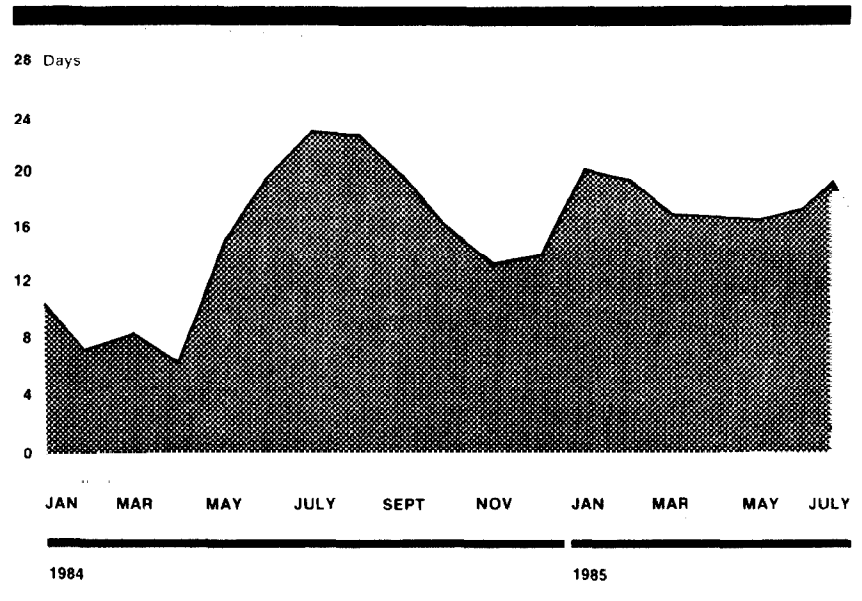


Figure 2 shows that over the same period, the average time to process a claim rose from 8 to 23 days.

Figure 2: Mean Processing Time for Claims by Nationwide Mutual Insurance Company (January 1984-July 1985)



From August through November 1984, in an effort to reduce the claims backlog, Nationwide increased its use of overtime and temporary employees. The company also hired additional full-time claims examiners in July and September 1984. By the end of November 1984, Nationwide had reduced its inventory to about 400,000 claims and its average processing time to 14 days. A Nationwide official believed that the claims processing problems had become "manageable" by that time.

In discussing the conversion to the new computer system, Nationwide officials told us that they would have preferred to work with their systems contractor on an ongoing basis to achieve system enhancements. On the other hand, HCFA had advised Nationwide in January 1982 that if bids were not solicited for a new data processing services contract, this would "discourage the limited competition now available in the Medicare systems marketplace and thus adversely affect the potential long range cost and operational benefits to be realized through competition."

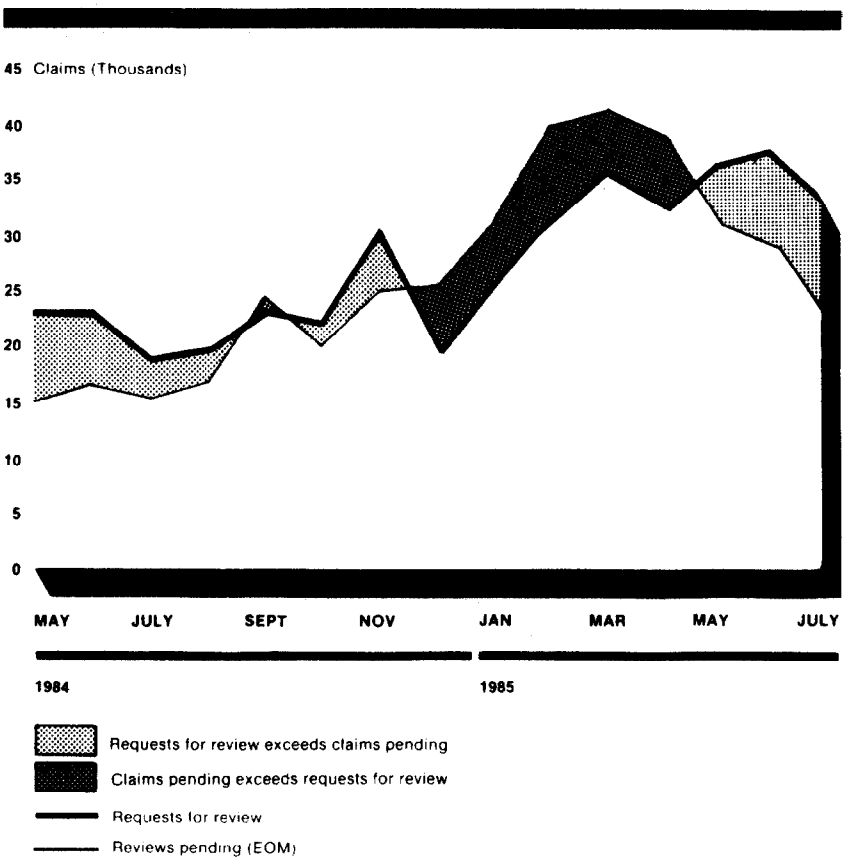
Conversion to a new medical procedure coding system

Nationwide's difficulties in processing claims in a timely manner did not end with the implementation of the new computer system. Pending workloads and average processing times rose again in December 1984 and January 1985. (See figures 1 and 2.) According to Nationwide officials, these increases resulted from HCFA's decision to convert to the Common Procedure Coding System for medical services.

Nationwide officials believe that in the future the new system will improve processing efficiency because it is largely based on an American Medical Association coding system with which physicians should be familiar. However, conversion to the new codes on January 1, 1985, required the retraining of claims examiners, resulting in lowered productivity while examiners familiarized themselves with the new codes. Also, conversion to the new codes initially caused confusion in the provider community and generated many inquiries and requests for review of previously adjudicated claims.

For the period May 1984 to July 1985, figure 3 shows (1) a general increase in the number of provider and beneficiary requests for review of claims previously adjudicated by Nationwide and (2) the number of these requests that were pending at the end of each month.

Figure 3: Nationwide's Adjudicated Medicare Claims
Requests for Reviews vs. Reviews Pending (May 1984-July 1985)



Increase in claims volume

In July 1985, Nationwide had an end-of-month inventory of over 803,000 unprocessed claims (see figure 1). According to Nationwide officials, the number of unprocessed claims had increased because (1) from January to June 1985, Nationwide received over 16 percent more claims than it had received in the same period in 1984 (nearly 920,000 more claims), (2) HCFA had not approved most of Nationwide's fiscal year 1985 requests for supplemental funds to process the increased claims volume, (3) Nationwide, to respond to increases in the number of beneficiary and provider requests for reviews of previously adjudicated claims, had to shift 24 examiners from work on new claims to work on these requests, and (4) Nationwide, to keep within the contract amount, reduced (in May 1985) and then eliminated (in June 1985) the use of overtime by its examiners who processed claims.

HOW DOES NATIONWIDE COMPARE TO OTHER PART B CARRIERS?

Under HCFA's Contractor Performance Evaluation Program, HCFA ranked Nationwide 4th among the 47 part B carriers evaluated in fiscal year 1984. Because several portions of the evaluation were completed before Nationwide's computer system problems began in May 1984, HCFA's evaluation only partially reflected the problems encountered by Nationwide in the summer of 1984. HCFA's statistical reports on timeliness, cost, and accuracy of claims processing that contain information comparing Nationwide's performance to that of other part B carriers are discussed in the following sections.

Timeliness

One set of HCFA's standards relating to the timely processing of claims is based on the percentage of claims processed within 30 days of receipt--94.5 percent for assigned claims and 93 percent for unassigned claims. As shown in table 1, Nationwide did not meet these standards in several quarters after implementing its new computer system in May 1984.

Table 1

Percent of Medicare Claims Processed Within 30 Days

	Assigned claims		Unassigned claims	
	Percent	Rank[a]	Percent	Rank[a]
October-December 1983	96.6	25	95.5	28
January-March 1984	96.5	15	95.1	19
April-June 1984	94.6	35	93.5	34
July-September 1984	85.2	48	79.0	49
October-December 1984	93.2	29	88.3	39
January-March 1985	92.4	27	88.0	35
April-June 1985	93.0	32	93.5	25

[a]HCFA ranked 51 carriers.

Processing costs

In recent years, Nationwide's processing costs per claim have decreased. In fiscal year 1984, the most recent year for which data were available, HCFA paid Nationwide about $20.4 million to process about 10.6 million claims. Table 2 shows, for fiscal years 1982 to 1984, Nationwide's costs to process a claim and Nationwide's ranking among carriers.

Table 2

Nationwide's Processing Cost Per Claim

	Fiscal years		
	1982	1983	1984
Nationwide's cost per claim	$2.24	$2.18	$1.93
Nationwide's ranking/carriers ranked	13/50	25/48	11/48

Accuracy of claims processing

According to HCFA quality control reports, Nationwide's error rates (dollars overpaid and underpaid as a percentage of total charges submitted on claims) have been consistently better than the national average for all carriers. Nationwide's 0.8-percent error rate in the first quarter of fiscal year 1985 represents $2.6 million in overpaid and underpaid claims out of $327 million in claims submitted.

Table 3

Nationwide's Error Rate

Total error rate	Fiscal years			
	1982	1983	1984	1985[a]
Nationwide's average (percent)	1.3	0.7	1.2	0.8
Nationwide's ranking	14	3	11	3
Number of carriers ranked	50	44	49	44

[a]October to December.

WHAT HAS NATIONWIDE DONE TO IMPROVE ACCESSIBILITY TO ITS TOLL-FREE TELEPHONE SERVICE?

As a result of a HCFA study of Nationwide's toll-free telephone service, Nationwide installed new telephone equipment and increased staffing of its telephone service in December 1984. In August 1985, after our review and a review by the telephone company showed that many callers would get busy signals, Nationwide added four more lines to its Ohio toll-free service.

HCFA's study of Nationwide's toll-free telephone service in fiscal year 1984 indicated that accessibility to the service did not meet the agency's standard that a carrier should answer at

least 80 percent of the calls (no more than 20 percent busy signals). Nationwide officials attributed this problem largely to the high volume of calls generated by the claims processing backlog and by physicians who called for explanations of changes to the Medicare program made by the Deficit Reduction Act of 1984 (Public Law 98-369).

Nationwide installed new telephone equipment and added staff in December 1984 as shown in table 4.

Table 4

Changes in Nationwide's Toll-Free Telephone Service
December 1984

Number of incoming lines	Old system	New system
Ohio	11	14
Local (Columbus, Ohio, area)	6	7
West Virginia	4	5
Total	21	26
Staffing		
Supervisor	1	2
Lead representative	2	4
Telephone representative	24	33
Total	27	39

After the new system was installed, the average number of calls handled per month by Nationwide increased from 32,661 from July through December 1984 to 44,525 from January through June 1985.

We tested accessibility to Nationwide's toll-free Ohio lines by placing 100 calls during the week of June 10 to 14, 1985. For these 100 random calls, Nationwide representatives answered the phone 56 times, we received a busy signal 41 times, we were placed on hold 2 times, and 1 call was answered with a recording that said to call back later.

In another June 1985 test of phone-line accessibility, Nationwide contracted with the telephone company for a 2-week study of its Ohio and West Virginia toll-free lines. This study identified a busy signal rate of 55 percent on Nationwide's Ohio lines and 13 percent on its West Virginia lines. The study also

showed that when callers were placed on hold, they waited only a short time. Nationwide interpreted the study to mean that its incoming Ohio lines were busy and callers could not be placed on hold, a condition similar to the one we noted. Based on these studies, Nationwide in August 1985 added four Ohio toll-free lines to its telephone system without increasing the number of telephone representatives. Nationwide expects this action to reduce the rate of busy signals and to increase the number of callers put on hold. The company considers this the most cost-effective way to improve accessibility for Ohio callers.

DO CLAIMS GET LOST IN PROCESSING?

HCFA and Nationwide have both tested the company's control over claims. These tests appear to show that Nationwide is not losing claims. However, according to a Nationwide official, problems with backlogged claims could give the impression that the company has lost some claims.

Twice a year, HCFA representatives take a random sample of claims from incoming mail and record identifying information from them. After 15 working days, Nationwide is asked to produce either the original claim or a copy, showing the date received. We examined the results of the two tests conducted by HCFA at Nationwide in fiscal year 1984 and the first test conducted in 1985. In these tests, Nationwide was able to account for all 157 claims sampled by HCFA. Most sampled claims have either been paid or are well along in the processing cycle when Nationwide is asked to produce evidence of the sampled claim. These test results appear to indicate that Nationwide is not losing claims.

Nationwide also conducts its own tests and samples 15 claims each month following procedures similar to HCFA's. According to Nationwide officials, for September 1984 through May 1985, Nationwide has accounted for all claims sampled.

A Nationwide official told us that claims might appear to be lost for several reasons. First, Nationwide only processes claims for services actually performed in Ohio or West Virginia. Claims from providers or beneficiaries residing in those states for services performed elsewhere are transferred to other carriers for payment. Second, claims sometimes are backlogged awaiting initial examination. In each of these cases, evidence of the claim would not appear in Nationwide's system, and the company's telephone representatives would not be able to answer inquiries about them. This could give claimants the impression that Nationwide has lost their claims. This official told us that these representatives often tell callers to allow 4 to 6 weeks for processing and to resubmit their claim if they do not hear anything in that time.

DOES NATIONWIDE MAKE ADVANCE PAYMENTS TO PART B PROVIDERS WHO EXPERIENCE CASH-FLOW PROBLEMS BECAUSE OF A CLAIMS BACKLOG?

HCFA does not have procedures for routinely advancing funds to part B providers. In addition, Nationwide has no regular procedures for identifying part B providers with potential cash-flow problems and for making advance payments to them. If a provider requests relief and can document cash-flow problems caused by delayed claims processing, the HCFA regional office may approve an advance payment that Nationwide would make. As Nationwide processes claims against the provider, the advance payment would be offset.

Nationwide made advance payments in fiscal year 1984 to five part B providers. These payments totaled $229,239 and ranged from $567 to $123,250. In fiscal year 1985, HCFA had Nationwide and other carriers make advance payments that totaled over $2 million to a Pennsylvania supplier of durable medical equipment. Nationwide's share of the advance was about $737,000.

WHAT DISTRIBUTION HAS NATIONWIDE MADE OF PHYSICIAN DIRECTORIES?

Nationwide has distributed two directories (related to the extent to which physicians accept assignment) of part B providers as required by Public Law 98-369. Based on HCFA's instructions, Nationwide routinely distributes these directories to (1) Social Security offices, state and area agencies on aging, and state medical societies and organizations of health professionals and (2) beneficiary and consumer organizations that ask to be on a mailing list. Nationwide initially distributed these directories in November 1984 and has since provided copies on request.

One required directory is the Medicare Participating Physician/Supplier Directory. This directory lists part B providers who agreed to take all Medicare patients on an assignment basis. These initial directories, which were distributed in Ohio and West Virginia, were misleading because many hospitals and clinics listed staff physicians who in their private practices had not agreed to accept all cases on assignment. Consequently, Nationwide printed and distributed revised directories in January 1985.

Public Law 98-369 also required continued publication of the Physician/Supplier Assignment Rate Listing. This directory lists all providers with their medical specialties and the

percentage of Medicare claims taken on assignment during the preceding year.

WHY DOES IT TAKE LONGER TO REINSTATE MEDICARE ELIGIBILITY THAN TO RESUME SOCIAL SECURITY PAYMENTS AFTER AN ERRONEOUS DEATH TERMINATION?

According to a Social Security Administration (SSA) official in the office that has responsibility for SSA's program service centers, about 10,000 individuals who receive SSA benefits are erroneously removed from SSA's Master Beneficiary Record (MBR) and HCFA's master insurance record each year because they are presumed dead. SSA can reinstate these individuals to its rolls and make SSA payments to them sooner than HCFA can reinstate them to the Medicare rolls because (1) SSA can use special procedures to pay these individuals before the MBR is corrected and (2) Medicare rolls cannot be updated until after the MBR is corrected.

When an erroneous death termination occurs, the beneficiary usually calls an SSA district office to report nonreceipt of a check. Because SSA's MBR shows the person as deceased, district office personnel must conduct a face-to-face interview with the beneficiary and require positive identification before SSA can resume paying benefits. SSA's district offices use a special payment procedure called Immediate Payment for Critical Cases (IMPACC) to issue the missing check and issue later checks on schedule.

SSA's program service centers use the results of the district office investigation to correct the erroneous death report on the MBR. They also use the IMPACC records to update the payment history on the MBR. After the MBR is updated, regular data transfers are made to HCFA's Medicare master record to reestablish an individual's Medicare eligibility. Because HCFA does not update the Medicare record until after the MBR is updated, the beneficiary will likely begin receiving Social Security checks before the Medicare records are updated. Until this update occurs, carrier queries to the Medicare master record will indicate noneligibility.

For the 12 cases reviewed,[1] we determined how long it took to restore an individual to the MBR after SSA's district office initially input data on the IMPACC system. We found that the time it took ranged from 16 to 82 days and averaged 35 days.

By October 10, 1985, HCFA had given us information on 6 of these 12 cases. The time frames to restore these six individuals to HCFA's rolls after they had been restored to SSA's MBR were 1, 2, 3, 10, 14, and 127 days. For these six cases, the time frames from when data were initially entered on the IMPACC system until the individual was restored to HCFA's rolls ranged from 23 to 144 days.

According to an SSA official in the office that has responsibility for data processing systems requirements, SSA has no plans for its district offices to reinstate beneficiaries directly to the MBR. SSA believes that for internal control purposes, its program service centers rather than its district offices should continue to make these reinstatements. Since district office personnel know the personal circumstances of an SSA beneficiary, it is believed that they could more easily set up a fraudulent account than could an employee in a remote program service center.

SSA and HCFA have also considered and rejected a direct data exchange between the IMPACC and Medicare data bases that would expedite reinstatement to the Medicare file. They rejected this approach because the IMPACC data base does not contain all of the information needed to properly update the Medicare master record.

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[1]During this review, we examined all of the erroneous death cases handled by SSA's Columbus, Ohio, District Office from January 1984 to May 1985. Of the 15 cases identified, 12 involved reinstatement to the Medicare rolls and 3 were not eligible for Medicare benefits.

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