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STATEMENT OF
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HUMAN RESOURCES DIVISION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON
THE USE OF COMPETITIVE
FIXED-PRICE CONTRACTING IN MEDICARE

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Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our review of the three experiments with competitive fixed-price contracting under part B of Medicare. Our review of the experiments in Maine, upstate New York, and Illinois was requested in January 1980 by the Chairman, Subcommittee on Health, House Committee on Ways and Means. The Chairman asked us to review the three experiments as a followup to our June 1979 report 1/ to the Congress on Medicare claims processing.

In that report we expressed some concerns about the potential impact of competitive fixed-price contracting on the Medicare program. We recommended that the experimental fixed-price contracts be thoroughly evaluated by the Department of Health and Human Services (HHS) before any broad legislative changes are made in Medicare's contracting provisions.

As requested by the Chairman, the objectives in our recently completed review were to (1) follow up on the recommendations made in our June 1979 report, (2) evaluate the performance of the three experimental fixed-price contractors and (3) relate the results of the experiments to the legislative issue of competitive fixed-price contracting in Medicare. As requested,

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1/"More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing," HRD-79-76, June 29, 1979.

our major emphasis was on the performance of the experimental contractor for Illinois because of reports of beneficiary and provider dissatisfaction with the claims processing and related services provided by the new contractor.

Our report entitled "Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare" (HRD-82-17) addressed to the Chairmen, Subcommittees on Health and Oversight, House Committee on Ways and Means, will be released in the next few days.

In summary, the results of Medicare's three fixed-price experiments have varied. Contractor performance has ranged from satisfactory in the Maine experiment to unsatisfactory in the Illinois experiment. Performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance.

There were different circumstances associated with each experiment that weighed heavily on the results. Although much can be learned from these experiments, we believe they are inconclusive as to whether the broad application of competitive fixed-price contracting in Medicare can produce administrative cost savings without unacceptable negative effects on program payments and services.

To authorize HHS to use competitive fixed-price contracting in the Medicare program, except in experiments, the Congress would have to enact legislation. We believe such

legislation would be premature at this time. We do not have a closed mind on this issue, however. If and when a competitive fixed-price procurement approach can be designed and implemented to assure consistently acceptable or improved levels of performance in terms of beneficiary and provider services and accuracy of program payments, we would be willing to reexamine the issue.

BACKGROUND

Medicare contracts with carriers which process claims for physician and other practitioner services (part B) and intermediaries which process claims for institutional services (part A). As required by Title XVIII of the Social Security Act, these contracts have traditionally been on a cost reimbursement basis.

In addition to the three part B competitive fixed-price experiments, there is only one experiment with competitive fixed-price contracting in part A. This experiment places all part A services in Missouri under one contractor. Previously, there were five intermediaries servicing institutional providers in Missouri. The contractor became fully operational on July 1, 1981.

HCFA has two experiments underway with incentive contracting. One experiment is in New York, where the workloads of seven Blue Cross plans have been consolidated, and only one plan now has a subcontract 1/ with Medicare. This part A contract is a negotiated

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1/The prime contractor remains the Blue Cross Association.

fixed-price experimental contract containing provisions for both liquidated damages for substandard performance and incentive payments if performance standards are exceeded. The part B experiment in Maine was recently recompeted and the contract modified to include certain incentive provisions.

Section 12 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977, directed us to study the claims processing system under Medicare to determine what modifications should be made to achieve more efficient claims administration.

In our June 29, 1979, report, we cited many opportunities for HHS to improve its administration of Medicare and recommended a number of actions for the Congress and HHS. We stated that, while competitive fixed-price contracting may well be the ultimate and most desirable goal for modifying Medicare's administrative structure, we believed there was insufficient information to make such a legislative change at that time.

We suggested that a more logical and prudent approach would involve a tripartite strategy featuring

--a careful and objective evaluation of the ongoing experiments in competitive fixed-price contracts to assess their effect on benefit payments and services to providers and beneficiaries,

--further experiments aimed at evaluating (1) whether it was feasible to merge parts A and B under a single contractor and (2) whether incentive contracts will work successfully in the Medicare program, and

--immediate action to reduce the number of contractors in the program by eliminating the less efficient performers.

Our recently completed review of the three part B experiments involved analyzing various performance data compiled by the Health Care Financing Administration (HCFA) for all three contractors and reviewing the steps taken by HCFA and the contractors during the transition phase of the contracts--the period when the new contractors were transferring records and files from the incumbents and preparing their processing systems to begin operations. Where major processing problems--such as claims and correspondence backlogs--arose after the implementation began, we reviewed the actions taken by HCFA and the contractors to resolve them.

Much of our work had already been done for the Maine contract. In our 1979 report, we reported on the transition phase and the early months following implementation. The remaining work involved analyzing the more recent performance data supplied by the contractor and HCFA.

In New York we concentrated primarily on reviewing the steps HCFA took to determine that the new contractor had accurately transferred records and files from the previous contractors and that it had properly set up and tested its new data processing system. Most of our work involved reviewing the records and files of these activities at HCFA's offices in New York City and interviewing the HCFA staff who worked with the contractor.

We also discussed these transitional efforts with the managers at the contractor's Medicare offices in Binghamton, New York.

Our work in Illinois was on a much broader scale. Although we began with the same objective as in New York, several circumstances required us to modify our approach. During our review, most of which was performed at the contractor's offices in Des Plaines, Illinois, we received numerous complaints and allegations about the contractor's performance. Because of the seriousness of these problems, the requestor asked us to shift the focus of our review to address these allegations. Additionally, we could not follow the approach we took in New York of reviewing the step-by-step transitional tasks because of the lack of documentation at HCFA and the contractor in Illinois.

Formal monitoring of the three contractors' performance is based on two sets of standards--System One and System Two. System One has five workload-related standards and is measured on the basis of reports submitted by the contractors, which include quality assurance analyzes. There are seven System Two standards which are based on the contractors' compliance with all pertinent operational instructions in seven functional areas. The three experimental contracts also included provisions for monetary penalties for substandard performance. The penalties are assessed for any standards failed in a 3-month period. The penalties range from $10,570 per standard in Maine to $52,250 per standard in Illinois.

Two of the five workload standards pertain to claims processing quality. Two error rates are considered--the occurrence error rate 1/ and the payment/deductible error rate. 2/ The payment/deductible error rate is very important because it reflects the accuracy of the contractor's benefit payments.

THE MAINE EXPERIMENT

Blue Shield of Massachusetts (BSM) completed the final year of its fixed-price contract to process Medicare part B claims in Maine on September 30, 1981. HCFA estimated that it saved $341,400 by awarding this contract on a competitive basis. BSM's performance has been satisfactory and better than its performance under a traditional cost-reimbursable contract to process similar claims in Massachusetts. The performance penalties associated with the fixed-price contract acted as a major incentive for effective performance. The better performance under the fixed-price contract may also be partly attributable to the performance standards developed for the experiments.

1/The estimated number of errors made in the processing of claims for every 100 claim line items in the universe of claims processed in the reporting period.

2/The estimated amount of payment/deductible dollar errors for every $100 of submitted charges in the universe of claims processed. Payment/deductible dollar errors include actual dollar amounts paid in error, actual dollar amounts not paid which should have been paid, and dollar amounts misapplied (either over or under) to the deductible.

BSM began claims processing in Maine on December 1, 1977. HCFA's monitoring of performance began on April 1, 1978. For the 13 evaluation periods (quarters) ended June 30, 1981, BSM, on a cumulative basis, has passed 147 of the aggregate 156 contract standards. The nine failed standards all relate to claims processing errors detected through HCFA's quality assurance program.

Although the transition of carrier responsibilities in Maine went well, this may be largely because BSM kept many of the claims processing features of the previous carrier, which maintained consistency in payments to providers and eliminated potential problems arising from an entirely new processing system. Because of this approach, however, BSM had to maintain a basically separate staff and was not able to benefit from potential economies of scale from having the same system for both Maine and Massachusetts. BSM's financial reports indicate that the company incurred a loss on the contract.

THE NEW YORK EXPERIMENT

Blue Shield of Western New York (Buffalo Blue Shield) is in the third year of its experimental fixed-price contract to process part B claims for upstate New York. The experiment saved an estimated $10.8 million in administrative costs, and is progressing smoothly after overcoming some initial performance problems.

Buffalo Blue Shield encountered difficulties when it began processing claims, however, resulting in large backlogs of claims and correspondence and high clerical error rates. It was able

to straighten these initial problems out after about six months, and HCFA now considers the carrier an above-average performer. Buffalo Blue Shield's initial difficulties were caused largely by problems that could be experienced by any Medicare carrier in taking over a new service area. They included a new and inexperienced staff, medical policy differences between Buffalo Blue Shield and the prior carriers, and the difficulty of converting files from the prior carriers.

Contract standards were not applicable during Buffalo Blue Shield's first 7 months of operations. For the six evaluation periods (quarters) beginning January 1980, and ending June 30, 1981, Buffalo has passed 69 of the 72 aggregate contract standards.

THE ILLINOIS EXPERIMENT

Electronic Data Systems Federal Corporation (EDSF) is in the third year of its experimental fixed-price contract to process part B claims in Illinois. The experiment saved an estimated $20.6 million in administrative costs, but during the first year of the contract, EDSF experienced numerous performance problems resulting in disruptions of services to beneficiaries and providers, a relatively high degree of inaccuracy in processing and paying claims and a lack of responsiveness to beneficary and provider inquiries. While EDSF has made improvements, performance problems continue to exist, particularly in beneficiary services and the administration of program payments. EDSF's payment errors from April 1, 1979 to June 30, 1981, have exceeded $67.6 million. This is about $34 million more than would

have been made by EDSF if it had met the contract standard for error rates each quarter. While overpayments and underpayments have been almost equal, adjustments favorable to claimants have far exceeded overpayment adjustments, and an estimated $27.7 million in overpayments remains unrecovered. The problematic nature of the contract has required HCFA to use far more resources for monitoring than originally planned, including a special unit established to monitor EDSF exclusively. The $20.6 million estimated savings in administrative costs from the award process and the contract penalties HCFA has collected have been significantly eroded by the Government's additional monitoring costs and the excessive overpayment errors.

Since the contract standards went into effect with the quarter ended December 31, 1979, EDSF has failed 55 of the aggregate 84 standards for the seven quarters evaluated 1/ Most of these failures are in the workload-related standards which EDSF has met only 5 times out of 45, including the first 6 months of the contract when financial penalties (liquidated damages) were not applicable.

Of the 12 contract standards, EDSF has consistently failed 6 to 9 of them each quarter. Six of the standards have never been passed. There has been a gradual improvement,

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1/Five of the failures are considered tentative as EDSF has the opportunity to correct the deficiences found and reverse HCFA's decision.

however, in its performance against some of the standards, as shown by the table in appendix I.

For each performance standard failed, EDSF's contract payments are to be reduced by $52,250 starting with the quarter ended December 31,1979. EDSF is subject to $2.9 million in liquidated damages for failing to meet the contract standards through the quarter ended June 30,1981--$1.6 million for failing System One standards and $1.3 million for failing System Two standards. 1/

In appendix I we show the prior carriers' (Chicago Blue Shield and Continental) average occurrence and payment/deductible error rates for calendar year 1978. Also, to the extent they could be reconstructed from readily available data, we added other comparable statistics for the prior carriers related to the EDSF contract standards for claims processing in 15 days or less and for claims pending over 30 days. These data show that EDSF did not begin to compare favorably with the previous carriers for the timeliness standard until the quarter ended September 30, 1980, and for the claims pending and payment/deductible standards until the quarter ended December 31, 1980. For the fourth indicator (occurrence error rate), EDSF has never compared favorably with the prior carriers.

1/As of October 21, 1981, HCFA has officially assessed EDSF a total of $1.8 million.

A CHANGE TO COMPETITIVE FIXED-PRICE CONTRACTING WOULD BE PREMATURE AT THIS TIME

We have historically supported the use of competitive fixed-price procurement by the Government, where conditions are appropriate. Generally, this type of procurement results in a fair and reasonable price for the Government, and places the greatest risk of performance on the contractor. Because the contractor assumes full responsibility for all costs over the fixed price, there is incentive for effective cost control.

A change to fixed-price contracting in Medicare would require a change in legislation. Current law provides that HHS enter into cost reimbursement contracts with carriers and intermediaries which result in neither a profit nor a loss from carrying out Medicare activities. As we stated in our June 1979 report on Medicare contracting, a change in the legislative contracting authority may well be the ultimate and most desirable goal for modifying the administrative structure of Medicare. However, we believe such a broad legislative change would be premature at this time because the circumstances and the results of Medicare's three fixed-price experiments in part B have varied, and the experiments are inconclusive as to whether competitive fixed-price contracting can be carried out successfully in Medicare. In addition, the following factors further support our position that such a broad change would be premature.

1. A thorough evaluation of the experiments by HCFA has not been completed and the results analyzed. HCFA awarded a $500,000 contract in September 1981 for an independent evaluation of the experimental contracts. The scope of work covers all phases of the contract procurements, beginning with the preparation of the RFP through the transition, implementation, and operational phases. The scope is much broader and more complex than the scope of our review of the experiments. Also, HCFA has underway several other contracting initiatives, including experiments involving different types of contractual arrangements and different modes of contractor selection and reimbursement. Little is known about the results of these initiatives.

2. The results of the part B experiments have revealed several weaknesses in the contracting procedures followed by HCFA in these experiments. The contractor selection process and contract design used by HCFA in the experiments were insufficient to assure a smooth transfer of responsibilities between contractors or to safeguard the Government's and the beneficiaries' interests in the Medicare program. Performance and beneficiary services deteriorated to varying degrees during and after contractor changeover, and program payments were not adequately controlled. HCFA has stated that what it learned from these experiments will enable it to more effectively manage future contract initiatives.

3. More improvements can be made under existing contracting authority to achieve some of the advantages sought by competitive fixed-price contracting--chiefly, administrative cost savings and fewer contractors--through consolidation of workloads and and the elimination of high cost contractors.

4. Long-term expectations of cost savings from competitive fixed-price contracting should be viewed with caution. Only the administrative costs (accounting for about 3 percent of program costs) are being competed. Also, where administrative cost savings are realizable, we believe these savings are generally only realizable from the initial contract change, and that recompeting the contracts might not produce additional savings beyond those already realized. The re-competition of the Maine contract seems to support this hypotheses 1/.

ANALYSIS OF DUPLICATE PAYMENTS MADE BY EDSF

In our recent report we recommended that the Secretary of HHS direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois--now estimated to be about $27.7 million. We believe that HCFA should analyze the overpayment situations detected through the quality assurance program to determine

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1/BSM was the low bidder on the new 36-month contract and won with a price of $9,866,706, including implementation costs. This price is considerably higher than the contract price of $5,285,000 for the previous 39-month contract although such a comparision is made difficult by several factors, such as inflation, increases in claim volume, certain changes in the contractor's work requirement, and financial incentive provisions added to the new contract.

if some of the incorrect payments can be identified and recovered. HHS has agreed with this recommendation.

Our analysis of some of these situations showed certain commonalities to these overpayments that suggest that further analysis to identify patterns to these errors may identify specific cases. For example, many cases of duplicate payments were made as a result of multiple account numbers for physicians. There have also been many instances of wrong procedure codes being used by data entry personnel that have resulted in duplicate, as well as other incorrect payments. Further HCFA analysis of the quality assurance results could lead to identification and recovery of incorrect payments.

Because all carriers make overpayments to varying degrees, and the quality assurance programs only specifically identify a small percentage of such cases, we developed a computer model to demonstrate the feasibility of going back through paid claims history to identify specific overpayment cases for potential recoveries. We focused our efforts on duplicate payments in Illinois not only because of the relatively large amount of estimated overpayments, but because we believed the conditions during EDSF's first year of operations were conducive to an abnormally high number of duplicate claims being paid. These conditions were principally (1) claims processing delays which generally lead to repeated claims submissions from beneficiaries and providers, and (2) a high clerical error rate

which can lead to identical claims being processed differently, and possibly not being detected as duplicative.

Our primary objective was not to estimate how many overpayments or duplicate payments the contractor may have made, but rather to identify specific cases of overpayments and to facilitate the recovery of these monies. We obtained claims history records from EDSF involving 1 million beneficiaries and claims payments made by EDSF from April 1, 1979, through July 30, 1980. We randomly selected for detailed analysis the histories for 10 percent of the beneficiaries.

Medicare claims can involve one service or a number of services rendered over a period of days, weeks, or months. Information describing each service is coded by carrier personnel and entered into the carrier's computer system as an individual claim line item. For the 98,755 beneficiaries we randomly selected, EDSF's records showed about 2.2 million claim line items with allowed amounts of $62.6 million. 1/

Our computer model included several definitions for potential duplicates and analyzed EDSF's claims history for payments that matched the characteristics of our definitions. We used several variations of key claims data to define a potential duplicate.

1/There were 191 beneficiaries whose individual histories were so large that we had to process them separately. The results for these beneficiaries are not included in our findings.

Our objective was to continually refine our model until the proportion we analyzed manually had a significantly high percentage of actual duplicates (generally, greater than 70 percent). If this could be accomplished, we believed a similar analysis by HCFA or EDSF of the remaining 90 percent of the beneficiaries' records should be productive.

Although our review of duplicate payments is continuing, the analysis completed to date has identified many instances of duplicate payments. For example, we identified 3 types of potential duplicate situations, which our analysis of sample claims showed would have a high percentage of actual duplicates. In these 3 situations, we identified 2,725 potential duplicate payments--each involving allowed amounts of $25.00 or more, and totalling about $240,000. Based on our review of a sample of 137 of these situations, we estimate that about 90 percent of the payments were duplicative. 1/

Although we are unable to reliably project the total dollars involved in our 3 categories because of the small size of our samples and the variability of actual payments, we believe it is reasonable to assume that if our model, or a similar model, was used to analyze the full beneficiary

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1/To determine if these and other identified duplicate payments were later refunded, or otherwise voided, we requested canceled checks in several cases of allowed amounts over $100.00. We have received complete information on 20 cases involving the 3 categories discussed here, and checks were issued and cashed in all but 2 cases. On 2 cases, checks were voided after July 30, 1980, therefore the voided transactions were not identified in the history records we used.

history through July 30,1980, the same relative proportion of actual duplicate payments could be found. We plan to discuss our results with HCFA and EDSF in the near future with the view of determining the feasibility of recovering these amounts.

CONCLUSIONS

To use competitive fixed-price contracting in the Medicare program, other than through experiments, the Congress would have to provide HHS with authorizing legislation. The results to date from the Medicare part B experiments indicate that administrative costs savings will result initially, but too many problems are associated with other aspects of contractor performance to assure the success of such contracting on a broader scale. The only experiment in part A is just underway.

Because it is not possible to predict what the circumstances would be in a broader application of this contracting strategy in parts A or B, but recognizing what the risks are in terms of program payments and services to beneficiaries and providers, we believe a change in legislative contracting authority would be premature at this time. However, as indicated earlier in my statement, we continue to have an open mind on this issue, if and when such risks can be adequately controlled.

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Mr. Chairman, this concludes our statement. We will be pleased to respond to any questions you or other members of the Subommittee may have.

System Two standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. Claims process	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
2. Coverage and utilization safeguards	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
3. Program reimbursement	-	-	passed	passed	passed	passed	passed	passed	passed
4. Electronic data processing operations	-	-	passed	passed	passed	passed	passed	passed	passed
5. Beneficiary services and professional relations	-	-	failed	failed	failed	failed	failed	failed	e/failed
6. Program integrity	-	-	passed	failed	failed	failed	failed	passed	passed
7. Quality assurance	-	-	passed	passed	passed	passed	passed	passed	passed
Number of standards passed	-	-	4	3	3	4	5	6	4
Number of standards failed	-	-	8	9	9	8	7	e/6	e/8
Cumulative liquidated damages (millions)	-	-	$.2	$.9	$1.4	$1.8	$2.1	$2.5	$2.9

a/Standards were not applicable for assessment of liquidated damages until quarter ended December 31, 1979. Also, EDSF's performance relative to the System Two standards was not evaluated until the same quarter.

b/Standard is 70 percent for quarters ended March 31.

c/Prior carriers' (Chicago Blue Shield and Continental, respectively) performance statistics for calender year 1978; N/A is not available.

d/Although EDSF's performance was below the standard, HCFA has deemed this standard passed because of problems with the Social Security Administration's computer system that adversely affected EDSF's processing timeliness.

e/Tentative results for System Two standards. EDSF has an opportunity to correct deficiencies.

ELECTRONIC DATA SYSTEMS FEDERAL CORPORATION QUARTERLY PERFORMANCE RESULTS

IN ILLINOIS FROM APRIL 1, 1979, TO JUNE 30, 1981

System One standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. 75 percent of claims must be processed in 15 days or less (percent) (note b) [76.2, 77.9] (note c)	44.5	39.1	37.6	46.6	67.0	81.6	84.5	d/68.1	73.0
2. No more than 12 percent of claims pending at end of month can be over 30 days old (percent) [7.8, 9.2] (note c)	31.1	27.6	50.0	23.2	25.6	20.7	10.4	10.3	13.7
3. Occurrence error rate must be less than the median of all other carriers Median [13.3, 11.0] (note c)	34.7 (8.5)	32.5 (8.0)	25.6 (9.3)	27.0 (8.6)	23.1 (8.7)	19.3 (9.9)	20.3 (7.9)	18.8 (8.0)	16.6 (7.0)
4. Payment/deductible error rate must be less than the median of all other carriers Median [2.4, 2.8] (note c)	8.1 (2.0)	6.6 (2.2)	5.8 (2.5)	5.3 (2.3)	4.2 (2.0)	3.6 (2.5)	2.7 (1.8)	2.9 (1.9)	2.8 (1.7)
5. Average processing time for informal reviews must be 25 days or less (days) [N/A] (note c)	28.2	21.5	63.2	82.5	50.4	47.1	52.4	68.6	35.0