REPORT TO THE HOUSE COMMITTEE ON WAYS AND MEANS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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Performance Of The Social Security Administration Compared With That Of Private Fiscal Intermediaries In Dealing With Institutional Providers Of Medicare Services

GAO compared performance and cost of the Division of Direct Reimbursement with that of four contract intermediaries. It found that the average cost of a bill processed by the Division in 1973 was greater than that of the four private insurance companies.

Higher salaries and lower productivity appear to be major reasons for higher costs of the Division, which, unlike the private intermediaries, had no production standards. Financial reports required of private intermediaries were not required of the Division.

GAO is recommending that HEW direct social security to (1) require that the Division develop cost data and (2) evaluate its performance.

SEPT. 30, 1975

MWD-76-7

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

The Honorable Al Ullman
Chairman, Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

As requested by the former Chairman in his letter dated November 1, 1973, we have reviewed the Government's performance in dealing with institutional providers of health care under Medicare, as compared with the performance of private contract intermediaries.

As agreed with the Committee staff, we are providing copies of this report to Congressman Barber B. Conable, Jr.

We want to invite your attention to the fact that this report contains recommendations to the Secretary, Department of Health, Education, and Welfare, which are set forth on pages 18 to 19. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for copies of this report to be sent to the Secretary and the four Committees to set in motion the requirements of section 236.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

BHI	Bureau of Health Insurance
DDR	Division of Direct Reimbursement
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

COMPTROLLER GENERAL'S
REPORT TO THE COMMITTEE
ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

PERFORMANCE OF THE SOCIAL SECURITY ADMINISTRATION COMPARED WITH THAT OF PRIVATE FISCAL INTERMEDIARIES IN DEALING WITH INSTITUTIONAL PROVIDERS OF MEDICARE SERVICES

D I G E S T

The Social Security Act authorizes HEW to contract with private organizations, generally health insurance companies, to act as fiscal intermediaries for institutional providers. Providers can also choose to deal directly with the Government rather than an intermediary. These providers are serviced by the Division of Direct Reimbursement of Social Security's Bureau of Health Insurance.

GAO compared the Division's performance and cost for 1973 with that of four contract intermediaries--Mutual of Omaha, Travelers, the Maryland Blue Cross Plan, and Hospital Service Corporation (the Chicago Blue Cross Plan).

GAO found that the average cost, excluding audit, of a bill processed by the Division, was $12.39 compared to $7.31 for Travelers, $7.28 for Mutual, $3.81 for Chicago, and $3.55 for Maryland.

The Division and intermediaries like Travelers and Mutual serve providers in a number of States, thus requiring field offices, and serve a higher percentage of skilled-nursing facilities, whose bills are considered more difficult to process than hospital bills. Such intermediaries can be expected to have higher costs than Blue Cross plans, which primarily serve hospitals in only one State or part of a State.

It appears that some of the higher costs of Travelers, Mutual, and the Division result from the wide geographic dispersion of their providers. There are many States where one of the above intermediaries serves only one or two providers.

GAO believes the committee should consider amending the Social Security Act, to allow HEW to redesignate an intermediary when because of geographic dispersion, the provider's selection appears to inhibit efficient administration. (See p. 19.)

The Division of Direct Reimbursement's costs substantially exceed the costs of Mutual and Travelers. Higher salaries and lower productivity appear to be major reasons for the higher costs of the Division, which, unlike the private intermediaries, had no production standards.

The Division's performance was not above average. It generally took longer than the private intermediaries to pay bills and make final settlements with providers. Its error rate was about average. (See pp. 12 to 14.)

The Social Security Administration did not compare the Division's costs with those of the private intermediaries. Financial reports required of private intermediaries were not required of the Division. GAO had to develop cost data for the Division to make its comparison.

GAO recommends that HEW instruct the Social Security Administration to:

--Require the Division to develop cost data similar to the private intermediaries.

--Evaluate the Division's performance as it evaluates the private intermediaries' performance. (See pp. 18 to 19.)

HEW did not agree with the methodology GAO used to compare the Division with private intermediaries. HEW provided data to show that the Division's cost per bill has dropped substantially since 1973. GAO has not verified this data. (See p. 22.)

CHAPTER 1

INTRODUCTION

In a November 1, 1973, letter, the Chairman, House Committee on Ways and Means, asked us to compare the performance of the Government (specifically, the Division of Direct Reimbursement (DDR), Bureau of Health Insurance (BHI), Social Security Administration (SSA)) with that of selected private contract intermediaries in dealing directly with institutional providers of Medicare health care. DDR functions as an intermediary for providers choosing to deal directly with the Government. (See app. I.)

We were asked to compare

--workloads,

--operational costs,

--quantitative performance data, such as error rates and bill processing time,

--bill processing systems,

--production standards,

--staffing and salary levels, and

--audit and cost report settlement activities.

THE STATUTORY AUTHORITY

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted July 30, 1965, established the Medicare program to help protect elderly persons from the high costs of health-care services.

The Medicare program, which became effective on July 1, 1966, is administered by SSA, Department of Health, Education, and Welfare (HEW), and provides two basic forms of protection for eligible persons, generally age 65 and over:

--Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain postrelease care in skilled-nursing facilities and patients' homes.

--Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums and Federal contributions, covering physician services and a number of other medical and health benefits.

Organizations called intermediaries handle part A benefits and organizations called carriers handle part B benefits. This report deals with intermediary organizations.

FUNCTIONS OF INTERMEDIARIES

Section 1816(a) of the Social Security Act authorizes HEW to contract with various private organizations nominated by providers to intermediate in administering Medicare benefits.

Intermediaries' responsibilities include

--paying providers at least monthly, on an estimated-cost basis, for covered services;

--consulting with providers to develop accounting procedures to insure that providers receive equitable payment under Medicare;

--serving as a communication conduit between HEW and providers;

--making necessary audits of providers' records to insure proper payment; and

--making final annual determinations of the amounts payable to or receivable from the providers.

Intermediaries are reimbursed for administrative costs incurred in performing these functions. In 1973, intermediaries' administrative costs to Medicare, including DDR, were about $134 million. During this period, intermediaries processed about 20.2 million bills and paid benefits totaling about $7.4 billion.

As of September 30, 1973, SSA had contracted with 10 organizations to act as intermediaries for 6,577 hospitals, 3,879 skilled-nursing facilities, and 1,880 home health agencies. One of these organizations, the Blue Cross Association, has subcontracted with 73 Blue Cross plans throughout the United States.

In addition, 184 hospitals, 83 skilled-nursing facilities, and 343 home health agencies had elected to deal directly with SSA. These organizations, located in 38 States, the District of Columbia, and Puerto Rico, are served by DDR.

The number of hospitals, skilled-nursing facilities, and home health agencies serviced by the various intermediaries is summarized in appendix II.

BASIS FOR SELECTING INTERMEDIARIES FOR REVIEW

In selecting intermediaries for our review, the Chairman asked us to consider (1) the type of providers serviced, (2) the geographic dispersion of those providers, and (3) the type of workload.

We selected Mutual of Omaha Insurance Company (Mutual), Travelers Insurance Company (Travelers), Maryland Blue Cross plan (Maryland), and Hospital Service Corporation--the Chicago Blue Cross plan (Chicago). Mutual served providers in 24 States and the District of Columbia, and Travelers served providers in 18 States. Providers served by Mutual and Travelers included many skilled-nursing facilities, whose bills are considered relatively difficult to process; DDR served a large number of home health agencies, whose bills are considered relatively difficult to process.

SSA and Mutual processed bills at a centralized office. Travelers processed bills at its eight field offices.

Maryland was located about 15 miles from DDR. Chicago was the largest of all intermediaries and, like DDR, was located in a medium to high wage area and served many municipal hospitals. Neither Blue Cross plan has field offices.

The 1973 administrative costs and number of bills processed for intermediaries we reviewed are shown below.

	DDR	Blue Cross plans Maryland	Chicago	Mutual	Travelers
Inpatient hospital	110,001	73,358	413,629	38,836	124,002
Inpatient skilled-nursing facility	15,061	2,161	5,368	88,164	113,818
Outpatient hospital and skilled-nursing facility	a/313,013	214,859	547,559	53,023	128,506
Home health agency	50,332	15,164	31,359	26,454	12,373
Other	10,253	2,548	-	11,418	512
Total	498,660	308,090	997,915	217,895	379,211
Administrative costs	$4,600,000	$1,500,000	$5,200,000	$2,300,000	$4,700,000

a/Includes 210,00 outpatient magnetic tape bills from New York City hospitals and 39,889 Community Health Center bills that are similar to outpatient bills. See page 7 for a discussion of outpatient bills.

DEVELOPING COMPARATIVE COSTS

For our comparison, we classified intermediaries' administrative activities into the following four functions:

1. Bill processing includes

   --reviewing admission notices from hospitals and skilled-nursing facilities and start-of-care notices from home health agencies,

   --processing queries to SSA's central records to ascertain the patient's eligibility and benefit status and transmitting SSA's responses to providers,

   --reviewing bills from providers,

   --batching and transmitting paid bills to SSA for recording on the patient's master beneficiary record, and

   --providing liaison with provider utilization review committees and handling routine inquiries from beneficiaries or providers.

2. Provider assistance includes

   --holding workshops and meetings with providers and physicians,

DDR performed certain functions not performed by contract intermediaries, such as processing provider-based physician claims and servicing direct-dealing Group Practice Prepayment plans. We eliminated costs of these functions from DDR's administrative costs. DDR personnel also were involved in special projects, and where identified, these costs were eliminated.

DDR used services of other organizations, such as SSA's Bureau of Data Processing, HEW regional offices, and, for disbursements, the U.S. Treasury. To be comparable with contract intermediaries, costs of such services were added to DDR costs. An analysis of how we developed DDR's total administrative costs appears in appendix III.

For contract intermediaries, we verified the accuracy and consistency of administrative costs reported to SSA.

CHAPTER 2

INTERMEDIARY COSTS

SSA has used the cost per bill processed to show performance in its intermediary administrative costs reports. Although provider audit cost has not been measured in relation to bills processed because this cost is incurred long after the related bills have been paid, we have included such costs to provide an overall picture. The intermediaries' cost per bill processed in 1973 is shown below. (See app. IX for SSA comments regarding fiscal year 1975 costs.)

Function	DDR (note a)	Blue Cross plans		Mutual	Travelers
		Maryland	Chicago		
Bill processing	$4.24	$1.98	$2.11	$ 3.37	$ 4.56
Provider assistance	1.27	.09	.51	2.17	.62
General/administrative	1.73	1.17	.88	1.74	2.13
Blue Cross Association costs (note b)	-	.31	.31	-	-
Total excluding audit	7.24	3.55	3.81	7.28	7.31
Audit	1.99	1.39	1.32	3.16	5.02
Total, including audit	$9.23	$4.94	$5.13	$10.44	$12.33

a/Includes New York City municipal hospitals' outpatient bills, which are not processed by DDR. (See discussion below.)

b/The Blue Cross Association is reimbursed by the Government for the administrative costs of supervising its subcontractor plans and for certain operational costs connected with Medicare. These administrative costs, which amounted to $.31 per bill in 1973, have been added to the plans' costs for purpose of comparison.

In comparing costs, it should be noted that SSA has arranged with the New York City municipal hospitals, serviced by DDR, to submit their outpatient bills on magnetic tape directly to SSA's Bureau of Data Processing. DDR does not process these outpatient bills. Eliminating these bills (about 210,000 in 1973--or about 42 percent of DDR's claimed workload) and related costs of about $32,000 incurred by SSA for processing such bills and by SSA's New York regional office for following up on exceptions, would substantially change DDR's cost per bill processed. The following table shows the 1973 cost per bill processed with SSA's magnetic tape bills excluded, and is a more valid comparison.

Function	DDR	Blue Cross plans Maryland	Chicago	Mutual	Travelers
Bill processing	$ 7.21	$1.98	$2.11	$ 3.37	$ 4.56
Provider assistance	2.20	.09	.51	2.17	.62
General/administrative	2.98	1.17	.88	1.74	2.13
Blue Cross Association costs	-	.31	.31	-	-
Total, excluding audit	12.39	3.55	3.81	7.28	7.31
Audit	3.44	1.39	1.32	3.16	5.02
Total, including audit	$15.83	$4.94	$5.13	$10.44	$12.33

The national average cost, excluding audit, per bill processed for private intermediaries was $6.45.

Intermediary officials and SSA generally agreed that certain types of bills are more difficult to process than others. SSA says it has attempted for several years to develop weighting factors to use in comparing and evaluating intermediary performance but has not done so primarily because of insufficient staff.

Both Mutual and Travelers had developed weighting factors by bill-type and Travelers was using its factors for measuring and comparing the productivity and performance of its eight field offices. Travelers weights ranged from 1.00 for an outpatient bill to 3.35 for an inpatient, skilled-nursing-facility bill.

The adjusted unit cost--excluding provider audit costs--giving recognition to Traveler's weighting factors, was $5.07 for DDR; $2.67 for Maryland; $2.55 for Chicago; $3.18 for Mutual; and $3.50 for Travelers. By eliminating SSA's magnetic tape bills and related costs, however, DDR's adjusted unit cost would be $7.13.

We do not know if Traveler's weighting factors accurately reflect the relative difficulty of processing different types of bills. However, they do represent a formal recognition of these differences.

To further analyze differences between intermediary costs, we examined personnel compensation and bills-processed per man-year in detail.

PERSONNEL COMPENSATION

Personnel costs account for about 65 percent of an intermediary's expenses. Our comparison of average annual salaries for personnel performing similar jobs as of December 31, 1973,

showed that DDR personnel were consistently higher paid than personnel in comparable jobs with the four private intermediaries. A comparison of personnel that charge most or all of their time to the intermediary function is included in appendix IV.

Comparisons of annual compensation for three jobs representing large portions of total personnel costs--registered nurses, claims examiners, and accountants and auditors--are shown in the following table. Annual compensation includes the value of fringe benefits such as health insurance, retirement, and life insurance. We have also included comparability adjustments for DDR's higher vacation and sick leave benefits which, except for Mutual, are generally offset by the private intermediaries' shorter workweek.

Annual Compensation for Selected Positions

Intermediary	Accountants and auditors	Claims examiners	Registered nurses
DDR	$21,600	$11,600	$13,600
Maryland	17,300	7,700	12,900
Chicago	18,600	9,800	12,600
Mutual	13,700	7,200	10,000
Travelers	13,800	7,000	11,400
Average (unweighted) of the four private intermediaries	$15,900	$ 7,900	$11,700

DDR's annual compensation exceeded the average annual compensation of the four private intermediaries by 36 percent for accountants and auditors, 47 percent for claims examiners, and 16 percent for registered nurses.

DDR's annual compensation exceeded Maryland's annual compensation by 25 percent for accountants and auditors, 51 percent for claims examiners, and 5 percent for registered nurses, although DDR and Maryland are about 15 miles apart and compete in the same job market.

BILLS-PROCESSED PER MAN-YEAR

The most meaningful measure of employee productivity in processing bills is the number of bills processed per productive man-year. SSA has developed a standard formula for use by its contract intermediaries in computing the number of available productive man-years--excluding provider audit functions.

The following table shows number of bills processed per productive man-year by intermediary.

Intermediary	Number of bills processed
DDR (note a)	1,456
Travelers	1,762
Mutual	1,944
Maryland	4,197
Chicago	4,204

a/Does not include magnetic tape bills discussed on page 7.

As mentioned before, there are differences in the relative difficulty of types of bills-processed. Also, because of differences in amounts of annual and sick leave, break time, and hours worked per week, the number of productive hours in a man-year varies among intermediaries.

After making adjustments for Travelers' weighting factors and providing comparability in the number of productive hours in a year, we computed the adjusted bills-processed per man-year as shown below.

Intermediary	Number of bills processed
DDR	2,500
Travelers	3,900
Mutual	4,200
Maryland	5,700
Chicago	6,600

Although adjustments result in differences in number of bills processed per man-year, they do not change the intermediaries' rankings.

Each private intermediary has some types of production standards or goals to measure employee performance. DDR had no such standards.

OTHER FACTORS AFFECTING COST

In addition to salaries, productivity, and differences in the relative difficulty of types of bills, an intermediary's costs are affected by its type of organization, the number of bills per provider, and the location of its providers. For example, in its 1972 performance evaluation of Mutual, the Bureau of Health Insurance noted that Mutual must maintain field offices to service its providers across the

country, whereas most intermediaries operate from a central location in only one State or part of a State. These field offices would result in higher costs for such items as travel and communication.

CHAPTER 3

INTERMEDIARY PERFORMANCE

Intermediaries deal with providers in three areas--bill processing, provider assistance, and provider auditing and settlement. These areas encompass three of the four intermediary activities. The fourth activity, general administration and support, involves the overall management necessary to carry out the other three functions.

This chapter discusses the activities and compares the performance of intermediaries in the three areas mentioned above. While many objective standards are used to evaluate bill processing, there are no established standards for evaluating provider assistance or audits and settlements.

BILL PROCESSING

The intermediaries' bill processing systems consist of (1) determining eligibility for Medicare benefits and (2) processing for payment bills submitted by providers for services rendered to eligible beneficiaries.

Chicago processed home health agency and skilled-nursing facility bills manually, but had a partially automated system for hospital bills. The other four intermediaries processed all bills manually, except for Maryland which automated its outpatient and inpatient bill processing systems beginning March and July 1973, respectively. All five used automated systems to compile data and transmit and receive information from SSA on beneficiary eligibility.

Except at DDR, claims examiners did not process bills through the system; they specialized by function (such as updating the report of eligibility or verifying charges) or by type of bill. For example, registered nurses reviewed bills from home health agencies and skilled-nursing facilities. DDR's examiners were responsible for the bill from time of receipt until approval for payment.

PERFORMANCE INDICATORS

Various statistical measurements, such as weeks of work on hand and number of errors in bills, are used to evaluate intermediary performance. Performance measures are affected by type of providers served, number of bills received, and processing procedures used by the intermediary.

Intermediaries report their production to SSA in a monthly workload report. Many statistics are based on inventories of bills at the end of each month, and supporting documentation is generally maintained for less than 6 months. Therefore, to verify some figures, we reviewed only 1 to 3 months' documentation for 1973 or 1974.

We found minor discrepancies due to errors in inventory procedures. However, the discrepancies did not have a significant effect on our comparisons.

Weeks of work on hand

The national average for all intermediaries for 1973 was 1.4 weeks of work on hand. The weeks of work on hand for intermediaries reviewed at the end of 4 selected months in 1973 is shown below.

Intermediary	March	June	September	December
DDR	3.4	3.2	3.4	5.0
Maryland	.8	.8	1.2	1.3
Chicago	.8	1.0	1.5	2.4
Mutual	.7	.6	1.0	1.6
Travelers	.8	.7	.6	.7

Bills pending over 30 days

At the end of four selected months in 1973, intermediaries had the following percent of bills pending over 30 days.

Intermediary	March	June	September	December
DDR	12.1	12.1	18.1	26.8
Maryland	19.1	32.4	13.0	32.3
Chicago	14.9	20.3	19.5	18.9
Mutual	16.4	13.8	12.6	11.7
Travelers	11.0	19.1	18.8	12.2

Bill processing time

Bill processing time is measured from receipt of the bill until the check is written. Because some types of bills are more difficult or involve different processing steps, processing time varies.

Intermediaries generally process four types of bills--inpatient hospital, inpatient skilled-nursing facility, outpatient hospital and skilled-nursing facility, and home health agency.

We computed the percentages of bill types paid within certain time periods, based on a random sample of bills paid during 1973. This information is shown below.

Type of bill	Percentage of bills paid				
	DDR	Maryland	Chicago	Mutual	Travelers
Inpatient hospital paid within:					
15 days	46	79	89	86	86
30 days	85	93	96	94	94
45 days	94	98	97	99	97
60 days	96	99	98	100	99
Inpatient skilled-nursing facility paid within:					
15 days	7	28	29	77	83
30 days	50	69	57	92	96
45 days	73	81	75	94	99
60 days	83	87	83	99	99
Home health agency paid within:					
15 days	28	34	3	92	67
30 days	66	73	23	99	93
45 days	78	84	48	99	98
60 days	84	91	75	99	100
Outpatient hospital and skilled-nursing facility paid within:					
15 days	47	67	61	66	57
30 days	77	97	88	96	87
45 days	90	98	94	98	94
60 days	97	99	96	100	98

DDR said that the New York City and State and Puerto Rican Government hospital bills were extremely difficult to process. Therefore, we eliminated these bills to see how their absence affected bill processing time. Without them the percentage of bills paid increased from 46 to 54 within the 15-day range.

Errors in health insurance bills

SSA reviews bills from intermediaries twice to determine if information on the bill (1) is consistent and (2) agrees with eligibility and utilization data in the health insurance master beneficiary record at SSA headquarters.

SSA sends quarterly reports to intermediaries showing the number of erroneous bills.

For 1973, the percentage of bills returned for errors was 3.1 for DDR, 1.3 and 2.2 for Maryland and Chicago respectively, 3.3 for Mutual, and 3.9 for Travelers.

PROVIDER ASSISTANCE

DDR uses its headquarters' staff and direct-dealing specialists from each of SSA's 10 regional offices for provider assistance. Chicago and Maryland serve relatively small geographic areas and have no field offices. Mutual has a field operations section which includes staff at five field locations to handle provider assistance. Travelers furnishes provider assistance from eight field offices.

Intermediaries have different criteria for provider visits. Maryland, Chicago, and DDR said that they visit providers as needed.

Mutual has an annual goal for visits to each type of health provider. For a skilled-nursing facility, Mutual's goal is a yearly review by a field representative and a nurse; for a hospital, its goal is four reviews a year by a field representative; and for a home health agency, its goal is three or four visits a year, generally by a nurse.

Travelers' personnel are required to visit providers at least once a year to perform a utilization review and a Medicare audit and to attend a utilization review committee meeting. Hospitals are visited at least three times each year. Skilled-nursing facility visits are based on the number of approved admissions.

In 1973, private intermediaries visited providers as follows: Maryland--234, Chicago--3,645, Mutual--2,500, and Travelers--2,026.

DDR did not record the total number of visits to providers. DDR said that SSA's regional offices did not have a significant role in provider relations. This matter is discussed below.

Assistance to direct-dealing providers by SSA regional personnel

In computing DDR's costs, we included about $438,000, BHI's estimate of the regional office costs associated with direct-dealing activities.

By an August 1, 1974, letter, the director of DDR, said that he took exception to our inclusion of certain regional office salaries and benefits as part of DDR's administrative costs because we did not allocate similar regional office costs to the private intermediaries. The director's main point was that most provider assistance activities for direct-dealing providers were handled by DDR personnel at SSA headquarters.

We did not include similar costs for other intermediaries because regional offices do not provide them with a similar service. BHI instructions state that each regional office is the primary resource and contact point for direct-dealing providers and, therefore, should have at least one person designated to handle direct-dealing activities.

We reviewed operations of the New York and Chicago regional offices relating to direct-dealing activities. The New York office had a reimbursement branch which handled direct-dealing activities. In 1973, the New York office made 291 visits to direct-dealing providers, State agencies, the New York City Health and Hospitals Corporation, and other organizations involved with Medicare. The Chicago office made 124 visits to 82 providers.

We used BHI's 1973 budget estimate of 20 man-years for direct-dealing activities for its 10 regional offices to compute DDR's costs. The New York and Chicago offices were allocated 5.3 and 2.7 man-years, respectively; they incurred 8.9 and 3.2 man-years, respectively, in 1973 in implementing their direct-dealing responsibilities. Since actual man-years for the two regional offices were about 50 percent more than budgeted man-years, we believe we are being reasonable in attributing SSA regional office costs of about $438,000 to DDR's activities.

COST REPORT AUDIT AND SETTLEMENT ACTIVITY

Providers are paid during the year at interim rates. At the end of its fiscal year, each provider submits a cost report and settlement is made based on its costs.

SSA instructions require that cost reports be submitted to intermediaries within 90 days after the end of the provider's accounting period. Before final settlement, a desk review, including a cost analysis and a review of the intermediary's past experience with the provider, is made of the cost reports. Final settlement may be made after the desk review. When the provider is scheduled for field audit, intermediaries make a tentative settlement based on the desk review. The results of the desk review determine when a field audit is to be made.

After deciding to perform a field audit, the intermediary determines whether it should be of full or partial scope. Intermediaries generally require a full-scope audit for a first-year cost report or when there has been a change of ownership. However, most audits are partial, designed to investigate areas of concern identified during the comprehensive desk audit.

The percent of cost reports for the 2-year period ending June 30, 1973, settled without audit as of December 31, 1973, was 11 for Maryland, 17 for Chicago, 30 for DDR, 59 for Mutual, and 62 for Travelers.

There were lengthy delays in the various steps of the settlement process during the program's first several years. Later audits and settlement activity partially involved reducing backlogs of earlier years' unaudited and unsettled reports.

In 1973, cost reports settled by the five intermediaries exceeded cost reports due by 13 to 38 percent, indicating progress in reducing the backlog.

The percent of cost reports received and settled as of December 31, 1973, is shown below.

	Cost reports due from program inception through 6-30-71		Cost reports due from 6-30-71 through 6-30-73	
Intermediary	Percent received	Percent received reports settled	Percent received	Percent received reports settled
DDR	94	67	88	44
Maryland	92	87	82	69
Chicago	99	97	97	92
Mutual	99	93	99	84
Travelers	99	96	98	90

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND MATTER FOR CONSIDERATION BY THE COMMITTEE

CONCLUSIONS

DDR's costs for 1973 were substantially higher than those of the private intermediaries we reviewed. The average cost, excluding audit, per bill processed by DDR was $12.39, compared with $7.31 for Travelers, $7.28 for Mutual, $3.81 for Chicago, and $3.55 for Maryland.

Intermediaries similar to DDR, serving (1) providers in a number of States and thus requiring field offices, and (2) a higher percentage of skilled-nursing facilities, have higher costs than Blue Cross plans, which generally serve providers (mostly hospitals) in only one State or part of a State. However, DDR's costs substantially exceed Mutual's and Travelers', whose operations are more similar to DDR's.

The higher salaries and lower productivity of DDR employees appear to be major reasons for DDR's higher costs. DDR was the only intermediary reviewed that did not have employee production standards.

Despite DDR's higher costs, it generally took longer than other intermediaries to pay bills and settle with providers. Its error rate was average.

SSA did not compare DDR's costs with the costs of private intermediaries. Financial reports required of private intermediaries were not required of DDR. We had to develop cost data for DDR's intermediary functions.

RECOMMENDATIONS

We recommend that the Secretary, HEW, instruct SSA to:

--Require DDR to develop and report all relevant costs, including regional office costs, for performing intermediary functions, so that SSA can evaluate DDR's cost effectiveness.

--Continuously evaluate DDR's performance as it does private contract intermediaries.

--Develop weighting factors which recognize the relative difficulty in processing different types of bills, to permit better evaluation of intermediary performance.

MATTER FOR CONSIDERATION BY THE COMMITTEE

Section 1816 of the Social Security Act permits providers to select their intermediaries. As a result, no intermediary has an exclusive territory, as do the carriers who handle part B Medicare benefits. It is rare for one intermediary to handle all part A providers in a State.

Some of the higher costs of Travelers, Mutual, and DDR apparently result from the wide geographic dispersion of providers, resulting in the need for field offices and distant travel. There are many States where one of the above intermediaries serves only one or two providers.

The Committee should consider amending the Social Security Act to authorize the Secretary, HEW, to redesignate an intermediary when the provider's selection impedes efficient administration because of the small number of providers in the provider's geographical area that are served by the selected intermediary.

AGENCY AND INTERMEDIARY COMMENTS

HEW did not agree with the methodology we used to compare DDR with the private intermediaries.

It noted that in determining DDR's unit cost, we excluded magnetic tape bills on the grounds they are not processed by DDR, even though (1) the costs analyzed include claims examination, cost auditing, and professional relations and (2) automated bills processed by intermediaries are included in determining their unit costs.

Two intermediaries included in our comparisons used automated bill processing to some extent. However, both received bills on standard billing forms and converted the data into a format compatible with their automated processes. DDR's magnetic tape bills were prepared by the provider and received and processed by SSA's Bureau of Data Processing. DDR does not consider such bills as workload in determining its bill-processing staff requirements. DDR estimated that it spent about one-fourth of a man-year on work directly related to processing these 210,000 bills. Our computation of unit cost which excludes magnetic tape bills also excludes the processing costs related to these bills.

As noted on page 16, the actual time spent by the New York region on direct-dealing activities was substantially more than was included in our cost estimates. We believe the understatement of such costs more than offsets any cost that could be attributed to professional relations regarding the magnetic tape bills.

Our determination of audit cost was not adjusted to eliminate the costs attributable to magnetic tape outpatient bills because audits involve providers' total activity. The providers submitting magnetic tape outpatient bills are also inpatient hospitals, and in some instances, skilled-nursing facilities. It would not be possible to determine the audit cost related solely to magnetic tape bills.

Our report shows DDR's costs per bill both with and without the magnetic tape bills, and audit costs are shown separately. We found that higher salaries and lower productivity were major reasons for DDR's higher costs. The salary data is based on salaries paid for comparable positions and is irrelevant to the volume of bills processed. Productivity data does not include the audit function. Therefore, any time spent on provider audit related to magnetic tape outpatient bills would not affect those figures.

HEW objected to our use of the Travelers' weighting factor. While our report shows the cost per bill and productivity per man-year using Travelers' weighting formula, we state that we do not know if it accurately reflects the relative difficulty of processing different types of bills. Our report recommends that SSA develop weighting factors to permit a better evaluation of intermediary performance. HEW noted that efforts to develop a methodology capable of weighting bill mix and the many other factors that complicate comparative evaluation will be continued.

According to HEW, we included costs incurred by the regional offices in assisting DDR but did not include these costs associated with the intermediaries. The SSA regional office costs we attributed to DDR are for provider-relations activities of regional office personnel. The private intermediaries do not use SSA regional office personnel for provider relations.

HEW stated that we did not go beyond budget estimates in determining the cost of DDR's nonintermediary functions and in allocating the costs of other Government components to DDR. Our estimates of such costs were obtained from SSA officials including those of BHI and DDR. These were based on estimated time spent and actual time charges and services

used. To our knowledge, these estimates represent the best data available, and HEW has neither challenged the cost figures nor suggested a better methodology.

HEW said we failed to address the qualitative factors in intermediary operations; we addressed only the mechanical handling of bills and no aspect of quality in claims processing or other intermediary or DDR operations. The Blue Cross Association (see app. V) also noted that our report concentrated on quantitative aspects of operations.

While our report only addresses quality in terms of errors in bills, BHI addresses other quality factors in its evaluations of private contract intermediaries. As of August 1975, annual contractor evaluation reports had been issued for Travelers, covering 1973, and for Chicago, covering the first 9 months of 1973. The most current reports for Maryland and Mutual covered 1972.

The reports for 1972 did not use uniform rating terminology and in some instances did not rate specific performance areas. These reports did give overall ratings, and both Mutual and Maryland received overall ratings of satisfactory.

The reports for 1973 did not provide overall performance ratings. Instead, ratings were provided for each of eight operating areas: bill processing, provider reimbursement, provider cost-report settlement process, provider appeals procedures, utilization review, beneficiary activities, administrative management, and fiscal management. Each area was supposed to be rated as satisfactory, adequate but needs improvement, or unsatisfactory.

Chicago was rated "satisfactory" in all areas except beneficiary activities, which was rated as "adequate but needs improvement." Travelers was rated "satisfactory" in all areas except utilization review, which was rated as "adequate but needs improvement," and administrative management, which was rated as "adequate, requiring substantial improvement."

Thus, it appears that the private contract intermediaries discussed in this report are generally fulfilling their Medicare responsibilities satisfactorily. While HEW stated that we did not address quality, it did not provide any information on the quality of DDR's performance.

On September 16, 1975, SSA provided fiscal year 1975 cost data for DDR and the private intermediaries. (See app. IX.) We have not verified this data.

According to SSA, DDR processed 1,097,362 intermediary bills in fiscal year 1975, including 443,286 magnetic tape bills. DDR's total costs for the intermediary function were $6,242,472, including $1,737,425 for audit. DDR's cost per bill for fiscal year 1975 was $5.69 including audit and $4.11 excluding audit, compared with calendar year 1973 costs of $9.23 and $7.24, respectively. Excluding the magnetic tape bills, DDR's cost per bill for fiscal year 1975 was about $9.40 including audit and about $6.80 excluding audit, compared with $15.83 and $12.39, respectively, for calendar year 1973.

According to SSA, the intermediaries' fiscal year 1975 costs, including audit, were: Travelers--$9.41; Mutual--$7.80; Chicago--$4.62; and Maryland--$4.57 per bill. Without audit, the per bill costs were $6.98 for Travelers, $5.87 for Mutual, $3.72 for Chicago, and $3.76 for Maryland.

DDR's bills processed, excluding magnetic tape bills, increased from 288,660 in calendar year 1973 to 654,076 in fiscal year 1975--an increase of 365,416. About 64 percent of this increase is due to Community Health Center bills, which increased from 39,889 in calendar year 1973 to 275,053 in fiscal year 1975. SSA records show that these bills require less processing time than other types of bills.

Also, because of problems in automating its bill processing in fiscal year 1974, DDR's fiscal year 1975 workload included an unusually high number of the preceding year's bills. DDR processed about 45,000 more bills than it received in fiscal year 1975.

According to the Blue Cross Association, the Secretary of HEW already has the power to redesignate an intermediary when efficient administration is impeded because the intermediary selected serves few providers in the geographical area. We do not agree with this position. If the Secretary determines that it is inconsistent with efficient administration of the program for intermediaries to serve small numbers of providers within a given geographical area, he will have substantial difficulty proving, in the hearing required by section 1816(e) of the Social Security Act, that the arrangement is disadvantageous so that the relationship can be terminated.

Moreover, even assuming the Secretary has this authority, he cannot designate a substitute intermediary. Rather, he must service the providers directly until a group or association of providers nominate, and he approves, an acceptable substitute intermediary. He has no authority at the present time to require providers to deal with any particular organization.

Travelers (see app. VI) concurred with our report as far as it concerned that company.

Mutual (see app. VII) said that its fiscal year 1975 cost per bill was $8.24--a decrease from its cost per bill of $10.44 for 1973. Mutual attributed this cost reduction in large part to an increase in the number of hospitals serviced whose bills are considered easier to process than skilled-nursing facility or home health agency bills.

APPENDIX I

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

November 1, 1973

B-164031(4)

The Honorable Elmer B. Staats
Comptroller General of
the United States
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Staats:

Among the information which will be helpful in considering the various national health insurance plans, as well as evaluation of medicare operations as such, the Committee on Ways and Means is interested in obtaining data about the performance of the Federal Government in dealing directly with institutional providers of health care compared with the performance of fiscal intermediaries.

As you know, the major program which the Federal Government is involved in dealing directly with health care institutions, such as hospitals and skilled nursing homes, is under the medicare program. The Division of Direct Reimbursement of the Social Security Administration serves as the fiscal intermediary for about 650 institutions, or about 3 percent of the institutions providing health services under the medicare program. The remaining institutions deal with other organizations acting in the capacity of intermediaries, such as Blue Cross and commercial insurance companies. These organizations are under contract with the Social Security Administration to function as fiscal intermediaries under the medicare program.

Therefore, I am asking the Government Accounting Office to make a comparative analysis of the performance of the Division of Direct Reimbursement in the Social Security Administration and selected contract intermediaries including, but not necessarily limited to, the following elements:

Compare the workload and operational cost of the

Division of Direct Reimbursement against selected contract intermediaries. In selecting these intermediaries, consider (1) the type of providers services, (2) geographic dispersion of those providers, and (3) the type of workload.

Analyze a sample of quantitative data that indicates performance characteristics such as: (1) error rates in bills, (2) bill processing time and workload inventories, (3) rate of denial and reversals upon reconsideration, (4) workload data, including production per man-year, (b) bill processing costs including ratio of administrative expense to benefit payments and unit cost per bill, and (6) staffing levels, including salary data.

In addition, analyze the cost report activity to determine the number of cost reports (1) due but not received, (2) received, (3) audited and not audited, (4) that have been settled, and (5) that have not been settled. Finally, for each intermediary included in the review, as well as the Division of Direct Reimbursement, a description of its bill processing system, including production standards, and other pertinent data.

In conducting this study, we would like your office to follow your usual practices of securing advance comments from the organizations involved in the study.

Your cooperation in this matter would be greatly appreciated. Please keep me advised of developments as the study progresses.

Sincerely yours,

Wilbur D. Mills
Chairman

WDM/ft

APPENDIX II

HOSPITALS, SKILLED-NURSING FACILITIES, AND HOME HEALTH AGENCIES SERVICED BY ALL INTERMEDIARIES AS OF SEPTEMBER 30, 1973

Intermediary	Hospitals	Skilled-nursing facilities	Home health agencies	Total
Total Blue Cross Assoc.	6129	2118	1733	9980
Blue Cross plan, Chicago, Ill. (note a)	(280)	(29)	(80)	(389)
Blue Cross plan, Towson, Md. (note a)	(56)	(18)	(20)	(94)
Mutual of Omaha Insurance Company	27	661	31	719
The Travelers Insurance Company	109	559	21	689
Aetna Life and Casualty	154	360	21	535
The Prudential Insurance Company of America	35	80	29	144
National Mutual Insurance Company	8	70	27	105
Inter-County Hospitalization Plan, Inc.	51	13	7	71
Hawaii Medical Service	26	14	6	46
Kaiser Foundation Health Plan, Inc.	23	3	3	29
Cooperative de Seguros de Vida de Puerto Rico	15	1	2	18
Private intermediary total	6577	3879	1880	12,336
DDR	184	83	b/343	b/610
Total	6761	3962	2223	12,946

a/Numbers in parentheses are included in Blue Cross Association totals.

b/About 300 home health agencies in 4 States go through State offices and file consolidated cost reports. Therefore, DDR's total workload for the provider audit and settlement function is about 320 providers.

APPENDIX III

DDR'S ADMINISTRATIVE COSTS AS A DIRECT-DEALING INTERMEDIARY DURING 1973 (EXCLUDING NONINTERMEDIARY FUNCTIONS)

Administrative costs:			
Total DDR salaries and benefits			$3,319,300
Add:			
SSA central office and Treasury support costs	$649,300		
Regional office costs (intermediary function only)	438,000		
Contracts with public accounting firms	358,400		
Computer costs (intermediary function only) (Bureau of Data Processing)	300,700		
Travel	59,000		
Physician consultant fees	39,300		
Non-DDR costs relating to comprehensive health centers	38,800	$1,883,500	
Less:			
Estimated DDR cost for processing hospital-based physician bills and for other nonintermediary functions	447,700		
Estimated space and central office support costs for nonintermediary functions	79,000		
Estimated costs for servicing direct-dealing group practice prepayment plans	53,500		
Estimated contracts with public accounting firms for auditing group practice prepayment plans	20,700	600,900	1,282,600
			4,601,900
Audit costs:			
Salaries and benefits for DDR's accounting and negotiations branch	812,600		
Contracting with public accounting firms (net of contracts for auditing group practice prepayment plans)	337,700		
Costs for comprehensive health centers	77,600		
Travel	26,600		
Postage	6,100	1,260,600	
Less:			
Estimated costs for nonintermediary functions		141,100	
Estimated costs for provider relations functions		128,000	991,500
Total administrative cost excluding audit			$3,610,400

STAFFING AND SALARY DATA FOR COMPARABLE POSITIONS BY INTERMEDIARY AS OF DECEMBER 31, 1973

Job Title	DDR		Blue Cross plans: Maryland		Blue Cross plans: Chicago		Mutual		Travelers	
	No. of persons	Salary	No. of persons	Salary	No. of persons	Salary	No. of persons	Salary	No. of persons	Salary
Fringe benefits	-	8.7%	-	20.4%	-	23.1%	-	19.5%	-	10.7%
Administration:										
Medicare director	1	$32,000	1	$19,500	1	$26,400	1	$24,900	1	$17,000
Deputy Medicare director	1	30,100	-	-	-	-	-	-	-	-
Supervisory medical officer	1	35,800	1	35,500	-	-	1	28,000	-	-
Administrative assistant	1	11,000	1	13,200	1	10,100	-	-	-	-
Bill processing:										
Claims manager	1	24,200	1	13,300	1	22,800	1	16,300	-	-
Field office manager	-	-	-	-	-	-	-	-	8	16,200
Deputy claims manager	1	22,100	1	11,200	1	15,600	1	14,100	-	-
Section supervisor	2	15,000	-	-	6	11,400	-	-	a/8	13,900
Unit supervisor	8	11,500	2	7,400	6	9,100	-	-	-	-
Registered nurse	13	12,500	5	10,600	b/22	9,800	7	8,800	20	9,800
Edit clerk	10	7,500	-	-	40	6,300	-	-	-	-
General clerk	61	7,300	5	6,500	47	4,800	28	4,700	-	-
Keypunch operator	6	5,700	1	6,500	-	-	4	5,200	-	-
Claims examiner	79	10,700	13	6,300	2	7,600	18	6,400	83	6,000
Reconsideration examiner	5	14,200	1	9,900	6	10,200	-	-	(a)	-
Provider relations:										
Field representative	8	21,800	1	7,800	6	14,300	8	9,800	7	9,600
Registered nurse	-	-	-	-	-	-	6	10,200	3	9,800
Audit, settlement, and reimbursement:										
Accountant/auditor	34	19,900	13	14,200	84	14,500	24	12,100	36	11,900
Clerk	5	7,700	3	6,600	2	5,400	-	-	-	-

a/Section supervisors also act as reconsideration examiners.

b/Registered nurses also process bills.

APPENDIX IV

APPENDIX V

Bernard R. Tresnowski
Senior Vice President
Federal Programs
and Health Care Services

840 North Lake Shore Drive
Chicago, Illinois 60611
(312) 440-6029

July 25, 1975

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to review and comment on the draft report, "The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries." The Maryland and Chicago Blue Cross Plans, which were a part of the study, were provided with copies of the draft report and have presented their comments to us for incorporation into this letter.

We will observe the limitations on use of the draft report, as stated on the report cover. Both involved Blue Cross Plans are also aware of and will observe the limitations.

There are several comments on the draft report which we feel may be useful in preparing the final report. First, near the bottom of page 9, reference is made to a surcharge by the Blue Cross Association to each Plan, through which the Association recovers its administrative costs. The reference is not correct in that the Association's administrative costs are not reimbursed through a surcharge on the Plans. Blue Cross Association is the Intermediary contracting with the Secretary of HEW. The Association's administrative costs, which are incurred in carrying out its performance supervision of the subcontracting Plans as well as certain operational functions including telecommunications, maintenance of an EDP system for processing Medicare claims, provider audit, financial management, etc., are reimbursed through its own budget which

is directly funded by the government. However the basic point intended to be made in the draft report is correct. The Association's administrative costs are sometimes converted to a per-claim amount when comparisons are made with other Intermediaries, on a Plan by Plan basis. In such instances, the per-claim cost of the Association is added to the individual Plan's per-claim cost for purposes of the comparison. A minor language change in the draft report would serve to correct the information as to how the Association is funded.

Second, on page 11 reference is made to weighting factors used by Travelers to equate the relative difficulties in processing the several types of Medicare claims. For your information, we support the need to apply appropriate weighting factors to statistical and operational measurements of components of the Intermediary functions where such factors can be identified and applied with reasonable confidence. The Association has identified and weighted for a number of economic and operational noncontrollable variables. These weights are used in the Plan performance analyses done by the Association in its performance improvement activities with Plans. For example, regression analysis of our statistical base supports the Travelers' ranking of outpatient claims and we have incorporated a weighting factor for it in our comparative performance indicators for the Plans. We were not able to discover and adopt a factor for the other claims. In the case of the inpatient skilled nursing facility bills, current indications are that the percentage of these bills in each subcontracting Plan, of the total of the total of all bills processed, is too low to produce a significant and therefore a usable weighting factor.

Third, the essential nature of the report is that of a comparative statistical analysis of the operations reviewed. As such, the report appears not to have and may in fact not have taken into account the effect on such a statistical analysis, of variations of a significant nature in the quality of the operations reviewed. For example, the workload (claims) statistics shown on pages 17 and 18 may be, to a significant degree, affected by variations in the commitment to careful attention and follow-up on questions of medical necessity of services provided and appropriateness of the level of care provided to the type of institution in which it was provided. To state it another way, should the care have been

APPENDIX V

provided in a hospital, or in a skilled nursing facility? An unreasonably low commitment to such quality aspects will result in very low pending workload statistics. Conversely, an unreasonably high commitment will generally evidence itself by very high pending workload statistics. Another facet of the same quality-impact question can be found in an organization that staffs for very high-quality operations so that the impact is not found in the pending workload statistics, but rather in a noticeably high per-claim administrative cost as well as a lower productivity per unit of net productive hours. Similar effects of variations in quality of operations are also found in other aspects of an Intermediary operation, such as auditing of providers where professional judgments are vital to determinations of the scope of such audits as well as determination of complex provider cost questions. Our experience in analyzing potential performance problems, identified by statistical comparisons, has in some instances revealed variations of quality as being significant in contributing to the statistical variation. The need is, of course, to assure there is neither an inadequate nor an excessive commitment of resources to the quality aspects of the Intermediary functions. Program guidelines are helpful in making these determinations, as well as the experience and judgments of all Intermediaries where Program guidelines are not definitive.

Finally, on page 28 of the draft report, there is a recommendation that the Committee consider amending the Act to permit redesignation of an Intermediary when the provider's selection does not appear to be consistent with efficient administration because of the small number of providers served by the selected Intermediary. As we read Sections 1816(b) and (e) of the Act, the Secretary already has the necessary authority to take actions as suggested in the draft report when questions of efficient administration are raised due to small numbers of providers being served by one Intermediary, in specific areas of the country or generally.

If you or any members of your staff want to discuss any of these comments, please let me know.

Very truly yours,

Bernard R. Tresnowski

BRT:sh

GAO note: Page numbers cited may not agree with the actual loation of the material.

APPENDIX VI

MEDICARE

July 23, 1975

Mr. Gregory J. Ahart
Director
United States General Accounting Office
441 "G" Street, N.W. - Room 6850
Washington, D.C. 25048

Dear Mr. Ahart:

The Performance of the Social Security Administration In Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries

We are pleased that the captioned Draft Report recognizes that there are significant differences in the cost for administering the Program for various types of providers (Hospitals, Skilled Nursing Facilities, and Home Health Agencies). For example, in handling a comparable number of claims, The Travelers must administer the program for 689 providers as compared to 94 for Maryland Blue Cross.

We find that the facts as they pertain to The Travelers are essentially correct for the period reviewed.

We sincerely appreciate the opportunity to review and comment on this report.

Very truly yours

L. E. Carter
Second Vice President
Medicare Administration

LEC:0

APPENDIX VII

Mutual of Omaha Insurance Company ■ Home Office: Dodge at 33rd Street, Omaha, Nebraska 68131 ■ V. J. Skutt, Chairman of the Board ■ J. D. Minton, Presi

Contractor for
MEDICARE

Address reply to
MUTUAL OF OMAHA
Medicare Department
Box 456, Downtown Station
Omaha, Nebraska 68101
Telephone Area 402 348-9170

July 28, 1975

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Manpower and Welfare Division
Washington, D.C. 20548

Re: The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries

Dear Mr. Ahart:

We appreciate the opportunity to review the draft of this report.

A factor of major significance in Part A performance comparisons is the relative difficulty of claim processing when the preponderance of claims are from skilled nursing facilities and home health agencies as opposed to hospitals. We are pleased to note the question was conclusively researched in this study.

This position is further supported by our fiscal 1975 unit cost of $8.24, reduced from the $10.44 reported in this draft. The increase from 27 to 73 in the number of hospitals Mutual serves contributed largely to this reduction.

Sincerely,

B. H. Patterson
Vice President
Medicare Administration

BHP:mw

APPENDIX VIII

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

AUG 22 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Charles Fuller

~~John D. Young~~
Assistant Secretary, Comptroller

Enclosure

APPENDIX VIII

COMMENTS ON GAO DRAFT REPORT ENTITLED "THE PERFORMANCE OF THE SOCIAL SECURITY ADMINISTRATION IN DEALING DIRECTLY WITH INSTITUTIONAL PROVIDERS OF MEDICARE SERVICES COMPARED WITH THE PERFORMANCE OF PRIVATE FISCAL INTERMEDIARIES"

Overview

The data in the draft report--on which GAO's analyses as well as conclusions are based--is nearly two years old. It reflects neither the improvements that have been made in our direct reimbursement operations, nor the very substantial changes in workload that have occurred since 1973. In this connection, the number of paper bills handled by the Division of Direct Reimbursement (DDR) has risen from 288,000--as shown in GAO's report for calendar year 1973--to 354,000 in fiscal year 1974 and to 654,000 in fiscal year 1975. And actuarial predictions are that the increase will continue for 1976 and 1977. At the same time, there has been only a moderate increase in DDR staff, so that we anticipate a dramatic reduction in DDR unit costs.

Because of our concern that readers of the GAO report would draw opinions and conclusions based on out-dated information, we asked GAO in July for additional time to respond to the report to enable us to include in the response cost data applicable to fiscal year 1975, which will be available by the end of August.

[See GAO notes 1 and 2, p. 36.]

We might add that some time ago DDR attempted to develop unit costs for purposes of comparison with the other intermediaries, and these attempts proved unsuccessful, partly for reasons of methodology.

Methodology

The GAO study results are more dependent on methodology than on the actual operations of DDR. For example, bills handled by a tape-to-tape operation established by DDR are excluded from the number divided into DDR costs in determining unit cost on the grounds the bills "are not processed by DDR," even though the costs analyzed include costs such as claims examination, cost auditing, and professional relations with respect to the services represented by these bills. At the same time, automated bills processed by intermediaries are included in developing intermediary unit costs for comparative purposes.

Also, while the report recognizes that billing mix (i.e., occurrence of bills of differing degrees of processing difficulty) is a critical factor in comparing DDR efficiency to that of intermediaries, no effort is made to properly weight billing mix. Rather, the weighting formula developed for internal purposes by an intermediary quite unlike DDR in billing mix and operation is accepted and used in the analysis, even though it is not known whether the weighting factors accurately reflect the relative difficulty of processing different types of bills.

There are other matters that range from major problems, such as charging costs incurred by SSA regional offices in assisting DDR without developing and charging costs incurred by these offices in assisting the intermediaries, to inconsistencies of relatively minor impact on the findings. Of particular note is failure to go beyond budget estimates in allocating costs between the direct dealing provider operations of DDR and the many other functions it performs for the Bureau. A similar approach is taken with respect to costs of activities of other components of Government allocated to DDR operations by GAO.

Perhaps the most serious problem is failure to address in a meaningful way the qualitative factors in intermediary operation. In considering the professional relations aspect of intermediary operation, for example, the report relies on number of reported visits as a measure of performance without any reference to visit content or results. In considering audit effort, the report relies on the number of "audits"--a term that embraces activities that range from limited audits of single aspects of provider operations to full-field audits of the total operations of providers and related organizations--and does not assess the quality of cost settlements based on these audits. The study addresses only the mechanical handling of bills and no aspect of quality in claims processing or any other aspect of the intermediary or DDR operation. The result does not, in our opinion, constitute a valid review of performance.

We are in process of developing updated cost data for submission to the Committee. In this connection, though, we must reiterate that we do not believe that such data can be meaningfully compared with data on intermediary costs on the basis advanced by GAO. [See GAO note 1.]

We will continue our efforts to develop a methodology capable of weighting bill mix and the many other factors that complicate comparative evaluation of intermediary performance.

GAO notes:

1. The data referred to above has been provided to GAO and is included as appendix IX. Therefore, HEW no longer plans to submit it to the committee.

2. The deleted portion is no longer applicable.

APPENDIX IX

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:

SEP 16 1976

IAD-32

Mr. Gregory J. Ahart, Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

In regard to your draft report on the intermediary function carried out by the Social Security Administration, we are enclosing material reflecting fiscal year 1975 costs and workload of the Division of Direct Reimbursement, Bureau of Health Insurance, together with a cost comparison of the Division with the private intermediaries discussed in the report.

We appreciate your consideration of this material in finalizing the report and regret any inconvenience we may have caused you and your staff.

Sincerely yours,

E. R Lawson

F. D. DeGeorge for
Associate Commissioner
for Management and Administration

Enclosure

APPENDIX IX

Supplemental Comments on Findings and Recommendations Included in the GAO Draft Report Titled "The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries"

Attached is the computation of DDR's "intermediary" operating costs for the fiscal year ending June 30, 1975. These costs were delineated and compiled using the same basic approach employed by GAO during their audit of DDR's calendar year 1973 costs.

As you will note from the spread sheet, we processed a total of 1,097,362 "intermediary" bills during FY 1975. This bill count total includes 443,286 magnetic tape bills.

We have segmented the aggregate and unit bill costs as follows:

1. Total intermediary costs attributed to DDR's operation (claims processing, audit, and regional office costs)

   $6,242,472 ÷ 1,097,362 = $5.69 cost per claim

2. Total intermediary costs shown in item 1 less all costs attributed to provider reimbursement and audit ($1,737,425).

   $6,242,472 - $1,737,425 = $4,505,047

   $4,505,047 ÷ 1,097,362 = $4.11 per claim

APPENDIX IX

CALCULATION OF DDR'S INTERMEDIARY ADMINISTRATIVE COSTS

FY 6/30/75[1]

Total DDR salaries, benefits, and other costs		$4,855,000
Add:		
Printing (BHI)	$ 76,000	
Division of Management (BHI)	186,000	
Staff Development Associate	25,000	287,000
Sub-Total		$5,142,000
SSA Overhead (15%)	771,300	
Bureau of Data Processing	481,300	
Postal	56,600	
Treasury Department	3,575	
Audit Contracts	462,000	
CPPP Costs of Administering Community Health Centers	118,000	
Regional Office Salaries, Benefits, and Other	710,367	2,603,142
Total		$7,745,142
Less:		
Carrier Operation (Including RO $20,893)	$763,936	
Renal Branch	452,597	
Non-intermediary costs	286,137	(1,502,670)
Grand Total		$6,242,472

Claims Processing Costs Including Provider Audit and Provider Reimbursement

$6,242,472 ÷ 1,097,362 claims = Cost Per Claim $5.69

Claims Processing Costs Including Provider Audit and Provider Reimbursement	$6,242,472
Less: Provider Audit and Provider Reimbursement	(1,737,425)
Total Administrative Costs Excluding Provider Audit and Provider Reimbursement	$4,505,047

$4,505,047 ÷ 1,097,362 claims = Cost Per Claim $4.11

Claims Processing Costs (Per Above)	$4,505,047
Less: Remaining Regional Costs Included in Above	(548,445)
Total Administrative Costs Excluding Audit and Regional Offices	$3,956,602

$3,956,602 ÷ 1,097,362 claims = Cost Per Claim $3.61

[1]Above calculations include 443,286 tape-to-tape billings.

APPENDIX IX

ADMINISTRATIVE COSTS - JULY-JUNE, FY 1975

Intermediary	Bills Processed	Unit Cost Per Bill (Excl. Audit)	Unit Cost Per Bill (Incl. Audit)
DDR	1,097,362**	4.11**	5.69**
Travelers	490,063	6.98	9.41
Mutual	390,406	5.87	7.80
*Chicago BC	1,217,441	3.72	4.62
*Maryland BC	386,061	3.76	4.57
*Total BC Plans	23,156,663	4.64	5.76
Total Commercials	2,566,691	5.46	7.17
Total BC Plans and Commercials	25,723,354	4.72	5.90

*Includes BCA costs of $.29 for Model System users, and $.23 for non-model system users. (Maryland BC uses Model System; Chicago does not.)

**Includes tape billings.