118487

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

HUMAN RESOURCES DIVISION

RESTRICTED — [illegible] General Accounting [illegible] approval by the [illegible]

B-207365

MAY 19, 1982

RELEASED

The Honorable Bill Archer
House of Representatives

Dear Mr. Archer:

Subject: Delays in Processing Medicare Beneficiary Claims in Texas (GAO/HRD-82-74)

On October 6, 1981, you requested that we make an indepth review of the processing of Medicare claims in Texas. You expressed concern about unusual and serious delays experienced by Medicare beneficiaries and their physicians in getting Medicare claims processed and paid in an accurate and timely manner.

Our review confirmed your concerns. These delays resulted from a substantial backlog of unprocessed claims which developed in mid-1981, when Texas Blue Cross and Blue Shield, the Medicare intermediary and carrier in Texas, converted to a new computer system for processing Medicare claims.

There seems to be no question that these delays resulted in financial hardships to beneficiaries and providers; the extent of these hardships would vary on a case-by-case basis. Our followup on individual cases was limited to the 17 provider and beneficiary complaints we received from your Houston office. Two of these complaints did not include sufficient information for Texas Blue Cross and Blue Shield officials to identify the claims in question.

The claims identified in the other 15 complaints had been paid or otherwise disposed of by the end of December 1981, as shown by the information provided to your office under separate cover. However, the processing times ranged from about 1 to 10 months, with the typical processing time being about 6 months. 1/ For all but one of these claims, Blue Cross and Blue Shield officials attributed the processing delays to the problems experienced in converting to the new computer system. One complaint involved delays resulting from lost checks.

1/As a basis for comparison, under Medicare's performance standards over 90 percent of the claims should be processed within 1 month.

(106218)

522097

Our review was made at Texas Blue Cross and Blue Shield and the Health Care Financing Administration (HCFA) Regional Office in Dallas, Texas. We discussed the system implementation problems with officials of these organizations, reviewed and analyzed workload and quality control reports, examined the contract for the new system and the related bid evaluation, and reviewed progress reports during the period that the new system was being installed. Our review was made in accordance with the Comptroller General's current standards for audits of governmental organizations, programs, activities, and functions.

The following sections of this report contain additional information on (1) the role of Texas Blue Cross and Blue Shield in the administration of Medicare, (2) its procurement of a new claims processing system, (3) the implementation of the new system and related claims processing problems, (4) the adverse impact on the quality of claims payments, and (5) the current status of the new system.

ADMINISTRATION OF MEDICARE

Medicare, which became effective on July 1, 1966, is a Government program which helps pay the health care costs of eligible persons 65 years old or older and certain disabled persons. The program is administered by HCFA, within the Department of Health and Human Services (HHS).

Medicare consists of two parts. Part A--Hospital Insurance for the Aged and Disabled--covers inpatient hospital care, home health care, and, after a hospital stay, inpatient care in a skilled nursing facility. HCFA administers the Part A benefits furnished by institutional providers--such as hospitals--through contracts with public or private agencies called intermediaries. The principal Medicare intermediary is the Blue Cross and Blue Shield Associations in Chicago, Illinois, which in turn subcontracts with local Blue Cross plans, such as Texas Blue Cross and Blue Shield, to pay claims submitted by the institutional providers on the basis of their reasonable costs. Payments directly to beneficiaries are usually not made by the intermediaries under Part A. During fiscal year 1980, Texas Blue Cross and Blue Shield paid about $1.1 billion in benefits to institutional providers.

Part B--Supplementary Medical Insurance for the Aged and Disabled--covers (1) physician services, (2) outpatient hospital care, (3) home health care, and (4) other medical and health services.

HCFA administers the Part B benefits furnished by noninstitutional providers--such as doctors, laboratories, and suppliers--with the assistance of 40 carriers under contracts with the Government. Carriers pay claims on the basis of reasonable charges, and payments can be made directly to the provider when he or she accepts assignment 1/ or to the beneficiaries when the provider does not accept assignment. In the latter case, the settlement of the provider's bill is a matter between the provider and the beneficiary. Texas Blue Cross and Blue Shield is the Medicare carrier in Texas; in fiscal year 1980, it paid about $760 million in Part B benefits to beneficiaries and noninstitutional providers.

PROCUREMENT OF NEW MEDICARE CLAIMS PROCESSING SYSTEM

Before May 1981, Texas Blue Cross and Blue Shield processed Medicare claims with its own staff and facilities using two separate computer-based systems--one for institutional providers under Part A and another for noninstitutional providers and beneficiaries under Part B. An increased workload and the desire to improve claims processing productivity and quality led Texas Blue Cross and Blue Shield to conclude it needed to procure a new computer processing system. In January 1980, Texas Blue Cross and Blue Shield issued a Request for Proposal (RFP) for a contract for a combined or integrated Part A and Part B computer processing system. This request was the first attempt in the Nation to install and implement an integrated Medicare Part A and Part B processing system. Such an integrated system was perceived as more efficient and less costly than the two separate systems for processing Medicare claims. Among the perceived advantages of an integrated system include more effective utilization review of concurrent institutional and noninstitutional provider services, more complete beneficiary history, and lower data processing administrative costs.

Three companies submitted proposals in response to the RFP, but one withdrew its proposal before it was evaluated. The evaluation resulted in Electronic Data Systems Federal Corporation (EDSF) of Dallas, Texas, being selected to install and implement a new integrated Medicare Part A and Part B automated claims processing system The estimated value of this award was about $21 million over 3 years. A letter of agreement dated October 29, 1980, which incorporated the RFP and EDSF's proposal, provided for the installation of the new system to begin September 17, 1980,

---

1/When the provider accepts assignment, he or she agrees to accept Medicare's reasonable charge as the full charge and to bill the beneficiary for the Part B 20-percent coinsurance amounts based on Medicare's reasonable charge.

and required the proposed processing system to be implemented during a period not to exceed 226 days from the September 1980 award date or no later than on or about May 1, 1981. It specified a minimum of 30 days for system testing before the operational date and a minimum of seven claims processing cycles during the system testing period.

The agreement also required that, before the new system's operational date, the contractor must have demonstrated the ability to process both Part A and Part B Medicare claims through all required subsystems and that all required system features 1/ must have been satisfactorily implemented. If the system was not fully operational at the time specified, the contract provided for a $15,000-per-day penalty (reduction in payment) against EDSF until the system was fully operational, as determined by acceptance tests performed by Texas Blue Cross and Blue Shield. The agreement provided for processing claims for 2 years with an option to renew for a third year. As provided for under its contractual arrangement with Texas Blue Cross and Blue Shield, HCFA approved the selection of EDSF on September 16, 1980, but has not approved the final contract between Texas Blue Cross and Blue Shield and EDSF which was executed in February 1981.

PROCESSING SYSTEM IMPLEMENTATION AND OPERATION

The new integrated claims processing system was implemented by EDSF on May 4, 1981. Texas Blue Cross and Blue Shield officials told us they were aware of problems with the system immediately before implementation, but that they had no choice but to put the system into operation. The only alternative at that point would have been to stop processing Medicare claims, because in March 1981 Blue Cross and Blue Shield had decided to proceed with implementing the new integrated system and phasing out the two old systems. Later, management considered delaying implementation of the integrated system because of the recognized problems, but the phaseout of the old systems had progressed to the point that reactivation would have required 60 to 80 days. Blue Cross and Blue Shield officials believed they would be well on their way to resolving problems with the new system within the time required to reactivate the old systems, which had ceased to process claims on April 24, 1981.

After going operational on May 4, 1981, the new system was immediately beset by problems which adversely affected the timeliness of Medicare claims processing. These problems included errors in the program (software) for determining reasonable or

---

1/This refers to functions that the system must do, such as ensuring that all claims data are received and processed to completion.

allowable charges for services provided by physicians and suppliers which resulted in the first series of checks produced under the new system being canceled. As a result of the conversion and its accompanying problems, no Part B claims were paid by the new integrated system until May 19, 1981, about 1 month after the old systems had been phased out. During this period Blue Cross and Blue Shield received about 713,000 Part B claims; consequently, the backlog of pending claims increased to a level substantially higher than normal.

From January through March 1981, the final 3 full months of processing under the old systems, the average month-ending pending claims backlog consisted of about 32,000 Part A and 396,000 Part B claims. During June 1981, the pending backlog had reached a peak of 174,670 Part A claims and 1,366,366 Part B claims. This backlog of pending claims occurred because the new computer processing system was implemented before known problems were resolved and before the system's operational capability was demonstrated as provided for under the agreement with EDSF.

For example on April 7, 1981, HCFA attempted to apply its Carrier Systems Testing Project (CSTP) to the new integrated system. CSTP consists of about 150 test claims designed to evaluate various phases of Part B claims processing from the initial edit screens to the payment of the claim. The new system was incorrectly querying HCFA headquarters in Baltimore, Maryland, on the status of the beneficiaries' annual $60 deductible 1/ for all claims even when the deductible had been met. Because of this and other problems, CSTP could not be completed before the May 4, 1981, operational date.

Texas Blue Cross and Blue Shield and EDSF, by working overtime, hiring additional claims processing personnel, and turning off certain computer system edits and audits designed to identify potential duplicate claims or claims for medically unnecessary services, reduced the large backlog of pending claims substantially between July and December 1981.

1/Before January 1, 1982, a Medicare beneficiary was responsible for the first $60 in allowed charges for covered Part B services for any calendar year. The status of each beneficiary's deductible is maintained by HCFA in its master beneficiary records in Woodlawn, Maryland. Before paying a claim, a carrier is supposed to check with HCFA on the beneficiary's deductible status; but once the deductible for the year is met, the carriers are supposed to stop querying the HCFA master records. Effective January 1, 1982, the annual deductible was increased to $75 by section 2134 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) approved August 13, 1981.

The impact of the conversion problems on the timeliness of claims processing is illustrated in the following table, which shows the number of processed and unprocessed claims for the months immediately before and after converting to the new claims processing system.

	Claims processed during month		Claims pending at end of month	
	Part A	Part B	Part A	Part B
Feb. 1981	126,530	727,888	35,893	416,140
Mar. 1981	131,677	810,678	32,413	387,384
Apr. 1981	94,095	577,845	65,492	136,859
May 1981 (note a)	5,679	90,354	140,115	1,148,239
June 1981	105,460	621,033	131,536	1,331,853
July 1981	152,565	1,177,720	83,421	883,916
Aug. 1981	107,951	1,110,778	96,947	569,089
Sept. 1981	138,139	865,781	85,918	474,997
Oct. 1981	134,350	958,963	66,947	319,621
Nov. 1981	128,052	788,525	48,127	325,085
Dec. 1981	135,033	837,734	40,979	273,843

a/System conversion on May 4, 1981.

The delays in claims processing and payment probably caused more of an adverse financial impact on Part B providers and beneficiaries than on Part A institutional providers. To assure that the usual level of Medicare payments to Part A providers was not adversely affected, a special method of reimbursement, called the Temporary Interim Payment System, was developed by Texas Blue Cross and Blue Shield. This payment system provided advance biweekly payments based on past actual claims paid to those Part A providers that were not already being reimbursed under the usual interim payment program, called the Periodic Interim Payment program. The advance payments under these programs were expected to mitigate any cash flow problems resulting from delays in claims processing and payments during conversion to the new processing system. These interim payment programs could not apply to the majority of the noninstitutional providers or to any beneficiaries because their claims activity could not be anticipated or projected based on previous payments; however, some physicians and suppliers were provided interim payments to ease their cash flow problems.

Blue Cross and Blue Shield officials could not provide us documentation to show that EDSF had demonstrated the ability to successfully process Medicare claims through all required phases, or that all required system features were satisfactorily implemented as specified by the contract. Texas Blue Cross and Blue Shield officials could not provide a system acceptance checklist

and declined to specify the date that the new processing system was accepted as fully operational. In fact, as of February 1982 they would not say whether it has ever been accepted as fully operational. However, in a May 28, 1981, letter, Blue Cross and Blue Shield placed EDSF on notice that the claims processing system had not been fully operational since implementation, and that all required system features had not been satisfactorily implemented. In this letter, EDSF was given notice that the reduction-in-payment provisions were being imposed.

In responding to a HCFA inquiry regarding the status of penalty imposition, Texas Blue Cross and Blue Shield replied in a December 1, 1981, letter that it had not monitored all the EDSF contract requirements during June through August 1981 because of efforts to reduce the claims backlog. Blue Cross and Blue Shield advised HCFA that it was completing an evaluation of compliance with contract requirements and would recommend appropriate penalties. HCFA officials stated that, although they have repeatedly requested Blue Cross and Blue Shield to report on the status of its plans to apply the reduction in payment, as of February 5, 1982, detailed status information had not been provided and that penalties had not been imposed. On February 8, 1982, Blue Cross and Blue Shield officials advised us that the application of any reduction in payment under the EDSF contract is a legal issue being negotiated with the EDSF legal staff.

QUALITY OF CLAIMS PROCESSING

In order to make a timely response to your request, we did not independently test the quality or accuracy of the claims processed since the system conversion. However, according to the Part B quality assurance report, the quality of claims processing has deteriorated. Quality assurance reports prepared by Blue Cross and Blue Shield show that the Part B claims payment/deductible error rate doubled after the conversion to the new system. 1/ For the quarter ended March 31, 1981, immediately preceding conversion, the payment/deductible error rate was 3.06 percent; for the quarter ended June 30, 1981, immediately following conversion, the rate increased to 6.39 percent; and for the quarter ended September 30, 1981, it was 6.52 percent. These error rates are excessive when compared to the national average Part B payment/deductible error rate of only 1.9 percent for the quarters ended June and September 1981.

1/The payment/deductible error rate is expressed as a percentage of submitted charges and represents the dollar value of payment errors identified by the quality assurance program.

The payment/deductible error rate includes (1) overpayments, (2) underpayments, or (3) over- or under-application of claims to deductibles, as identified in statistical samples of claims reviewed by Blue Cross and Blue Shield and by HCFA. Considering that claims with submitted charges totaling about $411 million were processed during the quarter ended September 30, 1981, an error rate of more than 6 percent of submitted charges represents erroneous payments of about $26 million.

CURRENT STATUS OF CLAIMS PROCESSING SYSTEM

Substantial progress has been made in reducing the backlog of unprocessed claims, and new claims are now being processed more rapidly. For example, the average processing time for Medicare Part B claims in December 1981 was 10.7 days compared to an average of 21.5 days for July 1981. However, at the end of December 1981, there were still over 40,000 unprocessed Part B claims more than 60 days old, 28,000 of which were more than 90 days old. Blue Cross and Blue Shield officials stated that this backlog of aged claims resulted from early system problems and that these claims must be processed manually.

According to HCFA personnel, as of February 1982, the new integrated Medicare claims processing system was continuing to experience problems. In November 1981, HCFA regional office staff completed a comprehensive review of the processing system's 637 contractually required functional elements to measure the system's actual performance.

Examples of the required functional elements are that the system must:

--Provide an audit trail ensuring that all input is received and processed to completion with safeguards against "loss of data."

--Provide for the proper handling of returned checks and other returned mail.

--Provide for automatic (and followup) billings for amounts due to the Medicare program.

--Maintain for each beneficiary a record of every transaction received throughout each processing cycle. This record must be available daily to intermediary/carrier staff in a readily understood format.

The results of this review indicate that 303 (48 percent) of these elements had been working, but that 334 (52 percent) had not been working. According to the HCFA report submitted to us on April 20, 1982, among the key elements that were not working as of November 1981 were those relating to pre- and post-payment utilization review, the ability of the system to input claims data received from institutional providers on magnetic tape, controls over potential duplicate payments, and the timely generation of workload reports.

Also, the new integrated system failed the CSTP, which was finally completed by HCFA in October 1981. A passing score under CSTP is 90, and the new EDSF system scored 87.1. Of the 150 test claims, there were processing problems with 49 out of 127; the other 23 claims could not be located. 1/ The CSTP was the only formal operations test accomplished by HCFA at the time our fieldwork was completed in February 1982.

Although the backlogs of pending Medicare claims had been brought down to levels comparable to those experienced before the implementation of the new EDSF system, in our view, there were two significant issues that were unresolved at the completion of our fieldwork. The first unresolved issue involves the imposition of the $15,000-per-day penalty on EDSF to the extent that the system was not fully operational on the date specified by the contract. Because Texas Blue Cross and Blue Shield is reimbursed by HCFA on a cost basis, the penalty payment should be collected and passed on to the Government as a reduction in reimbursable costs. The second unresolved issue involves the quality of the claims processing under Part B. A 6-percent payment/deductible error rate for Part B claims is unsatisfactory under HCFA's Medicare Part B performance standards, which approximate the national average of about 2 percent, and should be brought down to that level.

- - - -

We did not take the time to obtain formal comments from officials at HCFA or Texas Blue Cross and Blue Shield; however, we did discuss the contents of the report with them. We plan no further

---

1/Texas Blue Cross and Blue Shield and EDSF dispute these findings.

distribution of this report until 10 days from its issue date, unless you publicly announce its contents earlier. At that time, we will send copies to HCFA, Texas Blue Cross and Blue Shield, and other interested parties and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director